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JOHN W. RAWLINGS SCHOOL OF DIVINITY

A Framework for Utilizing Narrative Theory and Life Review in Healthcare Chaplaincy

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DOCTOR OF MINISTRY

by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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In healthcare chaplaincy, narrative theory can help the patient separate themselves from their grief or terminal illness. It has been said that chaplaincy is a "ministry of presence," however, just showing up is a low-level intervention. The purpose for this Doctor of Ministry thesis is to equip chaplains with a comprehensive framework for apply narrative theory and life review in the healthcare chaplaincy context. This thesis seeks to explore and define biblical models of storytelling and spiritual narratives. This thesis will encourage chaplains to have meaningful, engaging and longer visits in individual and group visits. If the spiritual care department at Queen City Hospice is fully educated about narrative theory and life review, then chaplains may be able to be better active listeners and incorporate appropriate interventions. The problem is that the spiritual care team at Queen City Hospice appears to not spend adequate time at the bedside and engaging patients and families given the time reports documented in the electronic medical record. To address the problem, a four-week training program was established to incorporate narrative theory and life review into the repertoire of chaplain interventions. The four-week program included a focus group of chaplains who volunteer to be in the study. A qualitative study utilized information gathered from surveys before and after the four-week program and includes interviews by chaplains within the focus group to gain a better perspective of how these clinical interventions can help them in their ministry. This thesis reveals that narratives can change the way in which patient's see themselves and the world.

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Abbreviations

APC	*Association of Professional Chaplains*
BCC	*Board Certified Chaplain*
CPE	*Clinical Pastoral Education*
DMIN	*Doctor of Ministry*
LUSOD	*Liberty University School of Divinity*
NIV	*New International Version*
QCH	*Queen City Hospice*
CCH	*Capital City Hospice*
DCH	*Day City Hospice*
MCH	*Miracle City Hospice*
POA	*Power of Attorney*
CMS	*Centers for Medicare & Medicaid Services*

CHAPTER 1: INTRODUCTION

Introduction

Everyone has a story, and everyone has a story to tell. The task of a hospice chaplain is to not only listen to the story, but for the story. Maya Angelou said, "There is no greater agony than bearing an untold story inside you."[1] Telling stories can change the way in which patient's see themselves and the world. In hospice chaplaincy, narrative theory can help the patient separate themselves from their grief or terminal illness by communicating and reflecting on stories. Healthcare chaplains can utilize narrative theory and life review to guide patients towards resiliency. It has been said that chaplaincy is a "ministry of presence," however, just showing up is a low-level intervention. Once the story is articulated and re-packaged, so to speak, healing may begin. The chaplain has the opportunity to connect the patient's story to the divine story.

Healthcare chaplains have the unique opportunity to hear stories and when it is appropriate, share stories as well. Chaplains have the task of storying the spiritual narratives with patients and families. The chaplain may create the opportunity to articulate the patient's experience, put words to meaning, and discover meaning at difficult times. Ultimately, words will fall short of articulation. This is limitation of spiritual care, the ability to express what cannot be conveyed with words. Romans 8:28 says, "The Spirit helps us in our weakness. We do not know what we ought to pray for, but the Spirit himself intercedes for us through wordless groans." When words fail us, the Holy Spirit intercedes on our behalf to God.

Stories create the opportunity for life review, or life histories. Understanding life stories and God's purpose of salvation is vital to every aspect of Christian theology and coping with

[1]Maya Angelou and Maya Angelou, *I Know Why the Caged Bird Sings* (New York, NY: Random House, 2018), 25.

terminal illness. Human death is the result of sin. Sin is and always has been the ruling principle behind every trouble that humanity has been experiencing since the beginning of time. Sin had its entrance with the fall of man, it affects all of humanity. Although the issue of death is effectively dealt with in Christ, the human condition is part of the ongoing struggle towards sanctification and immortality.

Human Documents and the Problem of Mortality

Psychological and sociological insights support pastoral care by merging both scientific and theological disciplines to create practical theories for patient care. Pastoral care quite often utilizes the social sciences to bridge the gap of understanding the patient in their context. Holistic care involves spiritual, psychological, and sociological concerns addressed by both individual approaches to care, and communal approaches to care.

Each patient is on their own spiritual journey. Holocaust survivor, Viktor Frankl, details his experience in the Nazi concentration camps. He explains the use and application of logotherapy and how it enabled him to survive his physical, emotional and spiritual journey during the some of the most difficult situations imaginable.

> These tasks, and therefore the meaning of life, differ from man to man, and from moment to moment. Thus, it is impossible to define the meaning of life in a general way. Questions about the meaning of life can never be answered by sweeping statements. 'Life' does not mean something vague, but something very real and concrete, just as life's tasks are also very real and concrete. They form man's destiny, which is different and unique for each individual. No man and no destiny can be compared with any other man or any other destiny. No situation repeats itself, and each situation calls for a different response. Sometimes the situation in which a man finds himself may require him to shape his own fate by action. At other times it is more advantageous for him to make use of an opportunity for contemplation and to realize assets in this way. Sometimes man may be required simply to accept fate, to bear his cross.[2]

[2] Viktor Emil. Frankl, *Man's Search for Meaning: An Introduction to Logotherapy* (New York, NY: Simon and Schuster, 1984) Page 49.

The primary function of a chaplain is to meet the person where they are, allow them to utilize their theology and spirituality to sustain them through their crisis. The chaplain must be aware of the many factors and limitations within each person's spiritual and emotional abilities. Chaplains may guide patients and families in making the appropriate healthcare decisions that are shaped both by scientific information, probable medical outcomes, religious norms, and values held by the patient and family as well.

The chaplain must recognize the opportunities to speak up and to be silent. Often, the chaplain can be a quiet companion for others to find active listening and reflection. The chaplain can utilize the space to work inside the theology of those they serve. However, there are occasions when the chaplain must recognize his/her position and assert their authority in a respectful manner. The chaplain can also serve as the patient's advocate around family members and medical staff.

A significant function of the chaplain is to be able to do great patient care by working from within, being able to connect with others by providing the basic human needs is essential. It is necessary for a chaplain to be connected but autonomous. This can become a difficult task at times because chaplains are always expending their efforts physically, emotionally, and spiritually. It is also necessary to practice self-awareness and understand when there are times that the chaplain is being stretched. Taking time between stressful visits can prove to be very beneficial, also, finding ways to regularly decompress can provide dividends for the chaplain. It can also be beneficial for the chaplain to have an outlet, such as a counselor (sometimes provided by the employee assistance program), to meet with on a regular basis. The chaplain can arrange to meet with other chaplains and clergy to process events and build relationships. The chaplain can enjoy outside hobbies such as exercise, writing, painting, music, poetry, etc. The chaplain

can also promote self-care within the organization and become a role-model for others to follow best practices.

The *modus operandi* for performing inclusive spiritual care is primarily rooted in the idea of Clenched-Fist, Open-Hand's theology. The Christian can pull from personal theology to sustain them to provide professional care to meet with patients, families, and staff, who may have different belief systems and a different worldview. The clenched fist means the chaplain will have a handful of absolute truths they do not deviate from; God as Creator, Jesus as Savior, the power of the Holy Spirit; and that the purpose of every existence is to love God and love people. This principle will continue for eternity. The idea of open hand theology is the chaplain may not have an absolute stand on certain theological topics. Some areas of theology need room to breathe and develop. The chaplain's personal theology must be inclusive enough to enable others to operate from their theology to assist them through their crisis and needs, and to meet them where they are.

Among the wide repertoire of clinical interventions healthcare chaplains use, the most common are active listening, sharing care and concern, providing a pastoral presence, honoring dignity and respect, collaborating with the care team and interdisciplinary team, generating rapport, connecting and providing emotional support. The consistent factor that ties through all these interventions is relationship.[3] Chaplains get to spend a great deal of their work building and fostering relationships. Chaplains journey alongside patients, families and medical workers and interweave life stories and experiences as a form of care and discipleship.

[3] Judith R. Ragsdale and Cate Michelle Desjardins, "Proposing Religiously Informed, Relationally Skillful Chaplaincy Theory," *Journal of Health Care Chaplaincy*, 2020, pp. 1-16, https://doi.org/10.1080/08854726.2020.1861533, 12.

Often, a chaplain is called to visit a patient at the end of life. Death is the outcome of sin. Death is not primarily physical but spiritual, relational, and in every aspect of life. The outcome of Adam's original sin is the living principle of sin in every man. The Bible calls this the "sin-nature," sometimes "flesh," or the "old man." This sin-principle in every man is something that Adam has passed on to the succeeding generations. There is an in-born predisposition within each living person to always go along the direction that is opposite to godly path. The Bible makes it clear the God hates sin, because sin is a violation of God's law, and His law is a description of his own perfect moral character, a mirror or transcript of divine holiness. Sin exists because there is a law, for something to be wrong we must first know what is good. The existence of law must come from an infinite source, the Creator God who establishes rule and authority over the subjective finite. Culture has lost its belief in sin when culture lost its belief in the sustainable infinite God. However, Paul reveals in Romans 1:18-32 that the knowledge of God's law is available to everyone through general revelation and men are "without excuse."

Ministry Context

Hospice chaplaincy is a pluralistic, multi-faith, multi-generational environment where patients chose to forgo curative treatment and therefor pursue palliative and comfort care. Typically, hospice chaplains are board certified, accredited through the Association of Professional Chaplains.[4] Chaplains are often confronted with cross-cultural challenges which must be met with patience, grace, wisdom and understanding. Chaplains routinely meet patients, co-workers, and friends who struggle with varying forms of grief. To be appropriate for hospice, the patient must have a six-month terminal diagnosis and desire to stop any form of curative

[4] Jennifer Kennedy and Carol Spense, "Standards of Practice for Hospice Programs" (National Hospice and Palliative Care Organization), accessed September 9, 2021, https://www.nhpco.org/wp-content/uploads/2019/04/Standards_Hospice_2018_EBR.pdf, 16.

treatment. Hospice is palliative in its nature; the goal is for the patient to have comfortable and peaceful death. They may elect to stay at home, at the hospice (general-in-patient), at a nursing center, in assisted living, or wherever they call home.

The mission of Queen City Hospice is to provide physical, emotional, and spiritual comfort to those experiencing a life-limiting illness, wherever they call home. Within the Medicare/Medicaid guidelines, chaplains are required to offer spiritual care support to each hospice patient.[5] Grief counseling is an essential function of the hospice chaplain. The nature of end-of-life care includes responses to physical, cognitive, emotional, and spiritual loss. Normally, grief is associated with the loss of a loved one, however, it can also be articulated as any life-altering loss: loss of a job, house, and divorce. Narrative theory assesses the story that is being told by the person experiencing grief, allows them to articulate their story, and find meaning and coping strategies through this brief therapy. This project will review the ethical theories that surround the chaplain field, with a specific attention to Christian ethics.

Queen City Hospice opened their doors for business roughly ten years ago. Since then, the census has experienced the normal ebbs and flows of patients. Queen City Hospice LLC is a regional hospice system in Ohio, with services in Cincinnati (Queen City Hospice), Dayton (Day City Hospice, Columbus (Capital City Hospice), and Cleveland (Miracle City Hospice). Prior to the acquisition in December 2020, Queen City Hospice was a portfolio company backed by private investors. Addus Homecare acquired the company and is incorporating the QCH model of care for their nationwide company. The fundamental ideology of the QCH standard of care is to have more staff, with lower profit margins, which allows the nurses, STNA's, social workers

[5] Jennifer Kennedy and Carol Spense, "Standards of Practice for Hospice Programs" (National Hospice and Palliative Care Organization), accessed September 9, 2021, https://www.nhpco.org/wp-content/uploads/2019/04/Standards_Hospice_2018_EBR.pdf, 17.

and chaplains to spend more time at the bedside. Communication between the disciplines has always been integral to the company's success; the management team, community education team and the field staff teams are all communicating together while following the same goal: being present at the end-of-life. The mission of Queen City Hospice is to provide the best hospice care.

> We are locally owned and operated and have a passion for helping members of this amazing area. We believe that quality care is determined by the wishes and needs of patients and their families. This care includes our commitment to keeping our patients wherever they call home through their journey with us. To achieve this, we work to support not only our patients but the expert team serving them. Our staff is given the time and resources necessary to provide the highest level of quality care. We are proud to employ staff members dedicated to quality hospice care, including physicians, nurses, home health aides, social workers, and chaplains. Our staff provides physical, emotional, and spiritual support through the different levels of hospice care to give our patients and their families the peace-of-mind they deserve. Each discipline is focused not only on maintaining comfort and dignity but on educating our patients and families on what to expect during end-of-life changes.[6]

In total, the spiritual care department provides care to nearly a thousand patients per day, all with challenging end-of-life issues that must be ethically and spiritually addressed by the chaplains. The chaplain department has a total of twenty chaplains and five bereavement coordinators. Each patient receives a care team, which includes a medical director, a nurse manager, a case manager (RN), an aide (STNA), a social worker, a chaplain, and a volunteer. Regulation 418.54(b) states the hospice interdisciplinary group, in consultation with the individual's attending physician, must complete the comprehensive assessment no later than five calendar days after the election of hospice care." [7]

[6] "Queen City Hospice," accessed February 25, 2021, https://www.queencityhospice.com/.

[7] "State Operations Manual: CMS Guidance to Surveyors for Long Term Care Facilities," accessed September 9, 2021, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf, 27.

The patient/Power of Attorney can choose to decline any of these disciplines, with the exception of the medical director/primary physician or case manager. When a patient is newly admitted to hospice, the assigned chaplain must complete the initial spiritual assessment, as required by the Medicare/Medicaid hospice benefit.[8] This assessment surveys the patient's faith affiliation and/or philosophical/existential beliefs, support systems, and anticipatory grief. The chaplain will then set the frequency for how often he/she will visit the patient. Lastly, spiritual care is available 24/7; there is an on-call rotation for chaplains to respond whenever there is a loss of life. §418.54(c) states the comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.[9] The Standards of Practice for Hospice Programs states that:

> Hospice spiritual care and services are based on an initial and ongoing documented assessment of the patient's and family/caregiver's spiritual needs by qualified members of the hospice interdisciplinary team (clergy, spiritual counselor, or someone with equivalent education, training, and experience) and provided according to the hospice interdisciplinary team's plan of care.
> Spiritual care and services include:
> 1. Assessing the spiritual status of the patient, family, and caregiver.
> 2. Documenting the spiritual assessment, goals for spiritual care, services provided, and the patient's and family/caregiver's response to spiritual care.
> 3. Acknowledging and respecting the patient's and family/caregiver's beliefs, culture(s), and values related to life's meaning, including suffering and loss, and desire for services/support.
> 4. Meditation, counseling, prayer, sacred rituals or practices, active listening, and supportive presence.
> 5. Assisting with funerals and memorial services as requested by the family/caregiver.

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[8] "Medicare Hospice Conditions of Participation Spiritual Caregiver" (The National Hospice and Palliative Care Organization), accessed August 3, 2021, https://hospiciokrystal.com/chaplain/Spiritual_tip_sheet.pdf, 1.

[9] "State Operations Manual: CMS Guidance to Surveyors for Long Term Care Facilities," accessed September 9, 2021, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf, 27.

6. Communicating with and supporting the involvement of local clergy and/or spiritual counselors as needed and as desired by the patient, family, and caregiver.
7. Consulting with and providing education to hospice interdisciplinary team members and patients and families/caregivers about spirituality and related care and services; and
8. Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures. [10]

A routine visit for a hospice patient varies with time, cognitive capabilities, trust, approachability, and a myriad of other factors. After each visit, the chaplain will follow-up with the care team and POA/family members. Due to the nature of hospice work, a typical day in hospice varies from routine visits, continuous care visits, when death is imminent, family meetings, groups, inter-disciplinary meetings, and staff meetings.

As a chaplain, it is imperative to utilize active listening skills while being a witness to suffering; then integrating and applying the diverse fields of ethical thought to bring about the common good. Chaplains give patients, families and loved ones the opportunity and outlet to share their stories. The chaplain's role is to connect the patient's story to the divine story. If the patient is not religious, narrative theory and life review can be a pivotal intervention to establish relationship and to provide support. During a conversation with a family of a newly admitted patient, the patient's daughter stated, "My mom just wants to tell her story." On a separate occasion, a World War II veteran and hospice patient would lay in his bed and listen to the chaplain read from his memoirs as he relived each moment and detail.

As patients and staff experience loss, the spiritual care team meets with them to provide spiritual care and emotional support. Due to the standards set by hospice, a chaplain may have little or no experience in ethical theories, grief counseling and purposeful tools such as narrative

[10] Jennifer Kennedy and Carol Spense, "Standards of Practice for Hospice Programs" (National Hospice and Palliative Care Organization), accessed September 9, 2021, https://www.nhpco.org/wp-content/uploads/2019/04/Standards_Hospice_2018_EBR.pdf, 100.

therapy. Narrative therapy is a developing theory within the chaplain profession which attempts to separate the person from their problem and restore autonomy, dignity, coping skills and resiliency through quest narrative.[11] Therefore, the events or diagnosis, which allows chaplains at Queen City Hospice to meet with patients and families, becomes an opportunity for them to share life experiences and personal stories which shape their identity, values, and relationships. The challenge is equipping our spiritual care team with the necessary resources to provide our patients and families with the best possible care, in often short amounts of time.

> Then, someone at my side says, "There, she is gone."
> Gone where?
> Gone from my sight. That is all. She is just as large in mast,
> hull and spar as she was when she left my side.
> And, she is just as able to bear her load of living freight to her destined port.
> Her diminished size is in me -- not in her.
> And, just at the moment when someone says, "There, she is gone,"
> there are other eyes watching her coming, and other voices
> ready to take up the glad shout, "Here she comes!"
> And that is dying. [12]

Chaplain visits are beneficial in numerous ways, including providing a remembrance that God cares for each individual person, prayer or scripture reading, making the hospitalization easier, giving hope, providing comfort, and helping to tap into inner strengths and resources.[13] Healthcare chaplains are tasked to find opportunities to give a new perspective to patients and families, and potentially "repackage" their stories and give them back in a new way. A common

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[11] Arthur W. Frank, The Wounded Storyteller: Body, Illness, and Ethics (Chicago: The University of Chicago Press, 2013), 159.

[12] Barbara Karnes, *Gone from My Sight: The Dying Experience* (Vancouver, WA: Barbara Karnes Books, 2018).

[13] Deborah B. Marin et al., "Relationship between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21, no. 1 (February 2015): pp. 14-24, https://doi.org/10.1080/08854726.2014.981417, 21.

resource booklet that hospice chaplains give to families shares this potential to articulate a new perspective.

Problem Presented

The problem is that the spiritual care team at Queen City Hospice appears to not spend adequate time at the bedside and engaging patients and families. The first obstacle to spending adequate time at the bedside and engaging families is assessing the current practices of end-of-life counseling theories and techniques at Queen City Hospice. Due to the busy schedules of our care team, it is imperative that time is made to review our practices and ensure that each chaplain is providing the best possible care, and to build upon the skills being utilized.

In early 2016, CMS approved a new code for Hospice Chaplain visits. The code: G9473 for services performed by a chaplain in the hospice setting, each 15 minutes. This is also a non-billable code.[14] Weekly reports from the electronic medical records reveal that most patient visits are between ten and fifteen minutes, which is not meeting compliance with the national standard. Queen City Hospice also has the expectation that chaplain visits are to be at least forty minutes to one hour, given that most chaplains have a caseload of fifty to sixty patients. Chaplain services are non-billable yet required for hospice providers. Short chaplain visits, limited interventions and lack of clinical chaplaincy education are all factors in patient care at Queen City Hospice which is evidenced in chapter four.

[14] Saul Ebema, "All You Need to Know about Hospice Chaplain Spiritual Care Code," Hospice Chaplaincy, July 13, 2021, https://hospicechaplaincy.com/2021/07/11/all-you-need-to-know-about-hospice-chaplain-spiritual-care-code/.

Often, the chaplain will spend a few minutes at the bedside, document the visit and go on to the next patient on their caseload. After prolonged periods of time, ineptitude and limited interventions can cause chaplains to feel inadequate and question their place in ministry. It has been shown that patients who report that their spiritual needs are supported by the healthcare team are more likely to have a higher quality of life, are less likely to have aggressive end of life care. Patient visits by chaplains during the course of the hospital stay leads to increased scores on patient satisfaction surveys. Historically, chaplaincy is not viewed as revenue generating. Studies suggest that meeting patients' spiritual needs increases patient satisfaction and may also have positive fiscal consequences.[15]

The second obstacle is establishing a fundamental understanding of ethics as appropriate to the healthcare context. Often, chaplains may need to request an ethics consult based on narrative that conflict with the appropriate standard of care. A basic understand of ethical theories is required by all board-certified chaplains. Therefore, this research will include a foundational study that will enhance the spiritual care department. It may empower chaplains to advocate for patients, families, and staff in ethical conflicts. Lastly, a formal study of ethics will serve as a guideline for establishing a framework for end-of-life care.

The third obstacle is the lack of understanding and implementing narrative theory and life review. This obstacle can be overcome by presenting information in the form of lectures, PowerPoint presentations, and sharing case studies utilizing narrative therapy at Queen City Hospice. This project will also educate the spiritual care department with resources, readings, homework, and handouts.

[15] Deborah B. Marin et al., "Relationship between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21, no. 1 (February 2015): pp. 14-24, https://doi.org/10.1080/08854726.2014.981417, 22.

The fourth obstacle is to establish a framework for narrative theory and life review that can be utilized in individual and group sessions. It is essential to adopt a model of pastoral counseling that can be utilized and exercised on a routine basis that will establish a consistent and effective practice.

Purpose Statement

The purpose for this Doctor of Ministry thesis is to equip chaplains with an emerging intervention in the field of chaplaincy of narrative theory and life review. With a comprehensive understanding of narrative theory and life review the spiritual care team will be adequately equipped with repertoire of interventions to be applied at in patient care. This thesis will also apply narrative theory to ethical problems and decision making at the end-of-life. The result is that chaplains will have a resource for journeying through grief and loss with patients, caregivers, and staff. Lastly, this thesis will provide a framework for narrative theory and life review in individual and group sessions.

Basic Assumptions

A major assumption is that the chaplains at Queen City Hospice do not currently utilize narrative theory and life review within their ministry context. The reason is grounded in the reality that these social interventions are not taught in seminary, however, they are beginning to find their way into the CPE curriculum. It may be difficult to add the toolbox of interventions if chaplains have a mindset of doing things a certain way. The assumption is that chaplains may not believe their visits are short and they already engage their patients and families with meaningful conversations. Within this framework for narrative theory and life review, it is assumed that the information and research that is shared is accurate and true. It is also assumed that the group of chaplains surveyed are willing to fully participate, respond and understand the material

presented. It is assumed that their responses will be truthful. It is assumed that the information provided by the spiritual care team will be objective and aid in furthering the research and application of the clinical interventions of narrative theory and life review. It is assumed that the surveyed sample will be representative of the whole hospice chaplaincy department. Lastly, it is assumed that this project will pursue truth and encourage fellow chaplains and researchers.

Definitions

The following definitions of key terms will be used in the ministry project:

Narrative: "Narrative is the thread or overriding story in the patient's story. Frank and Kleinnman defines three very different narratives that may weave through a patient's stories—the narratives of restitution, chaos and quest."[16]

Narrative Theory: Narrative theory was led by Arthur Frank and Arthur Kleinnman as they journeyed with the chronically ill. [17] Narrative theory provides a framework for why people need to tell stories and requires both a listener and a speaker. The process of storytelling allows the speaker to be heard, validated, and understood. They become separate from their grief, barriers, or terminal illness.

Bioethics: The discipline dealing with ethical questions that arise as a result of advances in medicine and biology and the "critical examination of the moral dimensions of decision-making in hearth-related contexts and in contexts involving the biological sciences." [18]

[16]James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 4.

[17]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 100.

[18]Thomas A. Shannon and Nicholas J. Kockler, *An Introduction to Bioethics* (New York: Paulist Press, 2009), 8.

Beneficence: "Is the positive dimension of non-maleficence. The Principle of Beneficence entails a duty to help others further their own interests when we can do this without risk to ourselves… Beneficence is a way of ensuring reciprocity in our relations and passing along to others the goods we have received in the past."[19]

Life Review: "A naturally occurring universal process, characterized by the progressive return to consciousness of past experiences and unresolved conflicts which are surveyed and reintegrated."[20]

Dignity therapy: "The goal of dignity therapy is to provide patients a generativity or legacy-making opportunity, in order to decrease the sense of suffering, while bolstering their sense of meaning, purpose, dignity and quality of life."[21]

Autonomy: "Is a form of personal liberty of action in which the individual determines his or her course of action in accordance with a plan of his or her own choosing."[22]

Non-Maleficence: "Is the technical way of stating that we have an obligation not to harm people – one of the most traditional ethical principles of medical ethics: 'First of all, do no harm.' This is the basic principle derived from the Hippocratic tradition. If we are unable to benefit someone, then at least we should do them no harm."[23]

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[19] Thomas A. Shannon and Nicholas J. Kockler, *An Introduction to Bioethics* (New York: Paulist Press, 2009), 46.

[20]Barbara K. Haight and Barrett S. Haight, *The Handbook of Structured Life Review* (Baltimore: Health profession Press, 2007), 12.

[21] McClement, Susan, Harvey Max Chochinov, Thomas Hack, Thomas Hassard, Linda Joan Kristjanson, and Mike Harlos. "Dignity Therapy: Family Member Perspectives." *Journal of Palliative Medicine* 10, no. 5 (2007): 1076–82. https://doi.org/10.1089/jpm.2007.0002.

[22]Thomas A. Shannon and Nicholas J. Kockler, *An Introduction to Bioethics* (New York: Paulist Press, 2009), 47.

[23] Ibid, 45.

Limitations

This project is limited in scope in applying narrative theory and life review to hospice chaplains providing end-of-life care. The interdisciplinary team, other healthcare professionals and chaplains serving in other capacities may benefit from this research, however, the primary audience is intended for hospice chaplains who minister to those with a terminal illness. Ideally, the research could be utilized to aid the chaplain in spending more time at the bedside and to apply the narrative theory and life review to encourage meaning-making opportunities in a pluralistic and multi-faith environment.

Although this project is intended for the hospice chaplain, other professions may benefit from applying the research and theories. The sample group is not random and will draw from the spiritual care teams at Queen City Hospice, Capital City Hospice, Day City Hospice and Miracle City Hospice. It is assumed that the chaplain team would share honest results during the survey, however, it is a limitation due to the potential for deceitful results.

Delimitations

The target population in this study will include chaplains and bereavement coordinators in the healthcare field, specifically in hospice. The four-week program included a focus group of ten chaplains, one bereavement coordinator and one social worker who volunteered to be in the study. A qualitative study was utilized to gather information from the focus group. The researcher will be under control of the focus group within the hospice agency. This thesis will address the issue of educating chaplains with the interventions in narrative theory and life review to create meaning-making opportunities which may also lead to longer visits. The project is bound by time and limited to the available resources on narrative theory and life review. This project is also limited to the inability to evaluate the long-term results and training of narrative

theory and life review. The results will be configured by a focus group within Queen City Hospice who approach their healthcare work with a range of experience, education and CPE. The sample size will be small and there is potential for participants dropping out. The project will be approached with humbleness and respect, with the ultimate goal of glorifying God.

Thesis Statement

The purpose of this thesis is to provide a comprehensive framework for applying narrative theory and life review. This thesis seeks to explore and define biblical models of storytelling and spiritual narratives. The thesis will apply narrative theory to ethical dilemmas and end-of-life issues relative to the hospice chaplaincy context. Chaplains will also have a unique application for ministering to those experiencing grief and loss. This thesis will encourage chaplains to have meaningful, engaging and longer visits in individual and group visits. If the spiritual care department at Queen City Hospice is fully educated about narrative theory and life review, then chaplains may be able to be better active listeners and incorporate appropriate interventions to overcome the aforementioned obstacles. Chaplains within the focus group may be able to apply the information and research to spend more time with patients.

CHAPTER 2: CONCEPTUAL FRAMEWORK

Literature Review

Narrative theory and life review are growing and emerging intervention within the field of chaplaincy. Narrative theory in medicine was coined by Dr. Rita Charon in 2001.[24] Rather than adapting a "ministry of presence," Chaplains must "shift the paradigm from chaplains as 'agenda-less' companions to clinicians with a repertoire of interventions which they should claim."[25] As chaplains' journey with patients throughout the end-of-life. The opportunities for the chaplain to lead the patient in spiritual growth are endless.[26] Ultimately, the chaplain is encouraging the patient to reclaim the story they are telling and allowing the opportunity to rewrite their narrative.[27] Since human consciousness is essentially temporal, patients can structure the human experience by telling stories to create meaning. The patient can compose from within, and through the life experience, the patient can construct a "storied self."[28] Narrative may find the opportunity to shift the conversation of what may be learned from the patient's illness experience and what they may be able to teach and share with others. The patient may also have a new awareness and identity of themselves. Frank states that learning these self-

[24] Rita Charon, "Narrative Medicine," JAMA 286, no. 15 (2001): p. 1897, https://doi.org/10.1001/jama.286.15.1897, 15.

[25]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 99.

[26]Richard F. Groves and Henriette Anne Klauser, *American Book of Living and Dying: Lessons in Healing Spiritual Pain* (Berkeley, CA: Celestial Arts, 2009), 252.

[27]David Denborough, *Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience* (New York: W.W. Norton & Company, 2014), 8.

[28] Bruce Allen Stevens, "The Dark Story: Does It Have a Place in a Life Review?" *Journal of Religion, Spirituality & Aging* 31, no. 4 (September 2019): pp. 369-376, https://doi.org/10.1080/15528030.2018.1534707, 369.

revelations should not become restitution narrative in form. He states that quest stories are about "finding a grateful life in conditions the healthy self would find intolerable"[29]

The use of narrative as a tool for inquiry beyond the limits of fiction and literature has gradually gained momentum over the twentieth, and now into the twenty-first, century. From the narrative form of the case study developed in medicine, psychology, and psychoanalysis, to a shift towards narrative in fields such as history, anthropology, law, biology, physics, education, philosophy, theology, gender studies, and political science.[30]

In the beginning of healthcare chaplaincy, Russell Dicks spoke at the annual meeting of the American Protestant Hospital Association in 1939 and described what chaplains do, seeing as work those things other healthcare professionals were unsure. He stated that chaplains are not "ministers conducting rituals at the bedside, but people interested in patients' physical recoveries and their spiritual growth."[31] Chaplaincy has continued to follow this framework of fostering spiritual growth. Healthcare chaplaincy involves "an active process of finding people who need spiritual care, identifying the nature of the need and responding to the need through theological reflection and the sharing of spiritual practices."[32]

From the early development of the hospice movement by Cicely Saunders in the UK in the 1950s there was a beginning of a move to separate medical care for the curable and for the

[29] Arthur W. Frank, The Wounded Storyteller: Body, Illness, and Ethics (Chicago: The University of Chicago Press, 2013), 205.

[30] Sue-Ann Harding, "'How Do I Apply Narrative Theory?'" *Target. International Journal of Translation Studies* 24, no. 2 (2012): pp. 286-309, https://doi.org/10.1075/target.24.2.04har, 287.

[31] Wendy Cadge, "Healthcare Chaplaincy as a COMPANION Profession: Historical Developments," Journal of Health Care Chaplaincy 25, no. 2 (2018): pp. 45-60, https://doi.org/10.1080/08854726.2018.1463617, 47.

[32] Harriet Mowat and John Swinton, What Do Chaplains Do?: The Role of the Chaplain in Meeting the Spiritual Needs of Patients (Aberdeen: Mowat Research Ltd., 2007), 8.

dying.[33] In 1967, Dame Cicely Saunders opened one of the United Kingdom's first hospice centers focused on treating the patient as a person rather than just treating disease (Baines, 2011). Dr. Saunders strongly believed that spirituality (defined as being concerned with the human spirit or soul as opposed to material or physical things) was just as important as medical management for these fragile patients living through their most difficult and precious days.[34] Recent estimates suggest that 40% of all people who die in the United States do so in hospice care.[35]

At the end of life, patients are largely preoccupied with the meaning of life, the questions of death, the need for forgiveness, the desire for hope and a longing for healthy relationships. It is reasonable to presume that most human beings strive for these things apart from the deathbed experience. However, when a patient knows they have an increasingly finite amount of time left, these questions have the ability to magnify and manifest in other emotional outlets. Also, it doesn't take a terminal illness to be presented with these questions and concepts. Leo Tolstoy struggled with these ideas during his life:

> My question, the one that brought me to the point of suicide when I was fifty years old, was a most simple one that lies in the soul of every person, from a silly child to a wise old man. It is the question without which life is impossible, as I had learnt from experience. It is this: what will come of what I do today or tomorrow? What will come of my entire life? Expressed another way the question can be put like this: why do I live? Why do I wish for anything, or do

[33] Elizabeth MacKinlay, "A Perspective on the Development of Knowledge of Spirituality and Aging in Nursing and Pastoral Care: An Australian Context," Journal of Religion, Spirituality & Aging 20, no. 1-2 (2008): pp. 135-152, https://doi.org/10.1080/15528030801922061, 142.

[34] Elizabeth Higgins et al., "The Cash Assessment Tool: A Window into Existential Suffering," Journal of Health Care Chaplaincy, 2021, pp. 1-15, https://doi.org/10.1080/08854726.2021.1922980, 2.

[35] Kristin Lindholm, "Handling Challenges Inherent in the Hospice Chaplain Role," Journal of Health Care Chaplaincy 24, no. 4 (2017): pp. 131-150, https://doi.org/10.1080/08854726.2017.1373055, 131.

> anything? Or expressed another way: is there any meaning in my life that will not be annihilated by the inevitability of death which awaits me?[36]

In the arena of healthcare chaplaincy, clinical interventions should be shaped by the ministry context. In hospice and palliative care, chaplains may have the benefit of multiple visits with the same patient. Asking the right questions may facilitate growth and learning for the patient to become the hero in their own story. Stories become the framework through which the storyteller is understood. The chaplain's duty, therefore, is to facilitate interpretation and meaning. Patients tell the stories they wish to tell in order to deal with their current situation. The storyteller takes the place of the protagonist as the disease, or death, takes the place of the antagonist.

Humans tell stories from their consciousness that attempt to articulate the universe around them and their place in it. Storied narratives weave in and out of philosophical ideas, religious interpretation, personal theology, inspirations. The prevailing stories that patients tell come from faith and family. The stories may often be hidden in reticence, guilt, shame or despondency. The storyteller may also find meaning in humor, lessons from the past or accomplishments in the face of defeat. Narratives create opportunities for chaplains to go beneath the surface and share in a gift of timeless mindfulness and meaning-making. Seeking these opportunities can allow the chaplain to "fill their cup" as they facilitate a gift of meaning for the patient, which can encourage the chaplain to be high-functioning and to take joy in their work.

Narratives, in its most basic understanding, are stories. Narratives are purposeful stories that retell historical events of the past to give meaning and perhaps direction for those in the

[36] Leo Tolstoy, *A Confession and Other Religious Writings* (New York, NY: Penguin Classics, 1987), 34-35.

present.[37] All narratives are composed of three basic parts: characters, plot and plot resolution.[38] There are three levels of narrative: the top level is the metanarrative, which is the universal plan that God is working out through creation. The middle level is the story of God redeeming his people. The bottom level are the endless individual narrative that fit into the other two levels.

Spiritual Care at the End of Life

In spiritual care, the phrase "care of souls" has its origin in the Latin *cura animarum.* While *cura* is most commonly translated, "care," it actually contains the idea of both care and cure. [39] The word, care, refers to measures taken to restore someone's well-being. From theological perspective, "spirit" refers to *ruach*, "the Spirit of God that hovered over the face of the waters" (Genesis 1:2); the breath of God that was breathed into Adam (Genesis 2:7); and, *pneuma*, the Holy Spirit.[40] A chaplain visit could be referred by a crisis, or problem, however, the goal of the visit is to achieve spiritual growth in relationship with the Divine. The problem, if the patient is experiencing one, is merely the point in which one can expect to meet God. The purpose of each pastoral visit is to connect their story to the Divine story of God's redemption of humanity. Spiritual care is with "persons experiencing all kinds of situations,

[37] Gordon D. Fee and Douglas K. Stuart, *How to Read the Bible for All Its Worth* (Grand Rapids, MI: Zondervan, 2014), 90.

[38] Ibid, 90.

[39]David G. Benner, *Strategic Pastoral Counseling: a Short-Term Structured Model* (Grand Rapids, MI: Baker Academic, 2004), 23.

[40] Stephen R. Harding et al., "Spiritual Care, Pastoral Care, and Chaplains: Trends in the Health Care Literature," *Journal of Health Care Chaplaincy* 14, no. 2 (November 2008): pp. 99-117, https://doi.org/10.1080/08854720802129067, 111.

events and feelings. It includes analysis (as in life review) and emotional experience (as in reminiscence), and it seeks healing and wholeness to the greatest degree possible."[41]

When a hospice patient is near the end-of-life, whether by gaining or illness, it is a time in which they will consider what will be carried on from their life. Naturally, human bodies are sure to die, however, spirits live on through memories and conversations.[42] The terminal illness raises two fundamental questions for both the patient and the caregivers: why me? (the question of bafflement), and What can be done? (the question of order and control).[43] Arthur Frank, an early pioneer of narrative theory, defines illness as how the sick person and the members of the family, live with, and respond to symptoms and disability. Illness can be a lived experience of checking bodily processes such as respiratory wheezes, cramps, sinuses, or painful joints.[44] Those experiencing a terminal, or experiencing grief and loss, must learn to think differently about themselves and their loved ones. This can be accomplished by an intentional, cognitive shift though storytelling, experiencing the reactions from the listener, and by hearing stories shared by others.[45]

[41]Stephen Roberts and Nancy Osborne, "Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook," in *Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook* (Woodstock, VT: SkyLight Paths Pub., 2014), pp. 149-161, 153.

[42]David Denborough, *Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience* (New York: W.W. Norton & Company, 2014), 245.

[43]Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 2013), 29.

[44] Ibid, 3.

[45]James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 82.

Often, the greatest fear about the death and dying process is losing control over the dying process and enduring pain and suffering.[46] There can be a sense of dignity in the final act of death, yet rarely in the process of dying. *Ars moriendi is ars Vivendi*: The art of dying is the art of living. Patients who live in dignity, die in dignity.[47] It is during the end-of-life that what we believe about both the reality and nature of the afterlife and hopes for a smooth transition, can deeply impact our personal experience when we think about the death and dying process.[48] Death is not a confrontation, rather, an event in the sequence of nature's ongoing rhythms. Death is the cessation that comes when the exhausting battle is over. Many of the sicknesses that permeate human beings are simply passages for the "inexorable journey by which each of us is returned to the same state of physical, and perhaps spiritual, nonexistence from which we emerged at conception. Every triumph over some major pathology, no matter how ringing the victory, is only a reprieve from the inevitable end."[49]

Healthcare chaplains can connect the patient with the Divine, which can be a way to escape time and space, allowing the patient to feel mindfulness and to center their thoughts. The timeless, eternal God is not bound by infinite time but through an absence of time.[50] When the patient connects with the Divine within themselves, they too transcend time as well as the other aspects of the natural world compelled by concepts such as time and space. "Eternity has no past.

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[46]Robert C. Atchley, *Spirituality and Aging* (Baltimore: Johns Hopkins University Press, 2009), 140.

[47] Sherwin B. Nuland and Paul Kalanithi, *How We Die: Reflections on Life's Final Chapter* (London: Vintage, 2019), f3.

[48]Robert C. Atchley, *Spirituality and Aging* (Baltimore: Johns Hopkins University Press, 2009), 133.

[49] Sherwin B. Nuland and Paul Kalanithi, How We Die: Reflections on Life's Final Chapter (London: Vintage, 2019), 10.

[50] Robert C. Atchley, *Spirituality and Aging* (Baltimore, MD: Johns Hopkins University Press, 2009), 127.

Eternity has no future. Eternity is a continuous now."[51] When chaplains enter into the sacred space of the divine and the patient, the opportunity exists to pause and reflect on God's goodness and glory. Humans possess an eternal dimension, there was a finite point beginning in time when the eternal god created human and gave them an eternal future.[52]

Storytelling creates the opportunity for reflection and mindfulness. Mindfulness and present-moment awareness can also be a form of timelessness, in the sense that the present moment is key, not the passing of time.[53] Mindfulness is the opposite of over-habituation. When patients are in a state of mindfulness, they may be intensely focused on the present moment and not preoccupied with time itself. Present-moment awareness is a form of timelessness, in the sense that the present moment, not the passage of time, is of the essence. God is not characterized by infinite time but by an absence of time. Thus, when patients connect with the experience of God within themselves, they transcend time as well as the other aspects of a phenomenal world bound by aspects such as time and space. Patients have the ability to rethink how they experience the passing of time as they connect with the eternal God, when they realize that time is in them, not that they are in time.[54]

Mindfulness through storytelling can also reveal underlying fear and anxiety. Within chronic illness, common spiritual issues are fear, self-blame, failure, guilt, and forgiveness.[55]

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[51] Joel S. Goldsmith and Lorraine Sinkler, A Parenthesis in Eternity (Pennsauken, NJ: BookBaby, 2013), 323.

[52] Millard J. Erickson, Christian Theology (Grand Rapids, MI: Baker Book House, 2007), 494.

[53] Sherwin B. Nuland and Paul Kalanithi, How We Die: Reflections on Life's Final Chapter (London: Vintage, 2019), 127.

[54] Robert C. Atchley, *Spirituality and Aging* (Baltimore, MD: Johns Hopkins University Press, 2009), 127.

[55]James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 82.

Focusing on story, allows the patient to understand their story of origin and to review the events of their lives to determine where they believe they will be heading.[56] Spiritual care is often about "standing in the chaos with another in faith that God's story has room and will work to redeem even this wreckage."[57]

Ethical Issues at the End of Life

Any framework centered on patient care should be grounded in ethics. Part of the work of a chaplain is to visit those are sick and in the hospital. Theology of chaplaincy is focused on the whole person, a human being as a psycho-somatic whole, an embodied soul made in the image and likeness of God.[58] The chaplain's most important role is to facilitate and foster this growing ministry of unchurched patients desiring to connect with the divine.

Ethics is the awareness and reflection of what is good and evil, right and wrong. Ethics is not limited to specific acts and moral codes, but encompasses the whole of moral ideals and behaviors, a person's philosophy of life. James Sire defines a worldview as

> Essentially this: A worldview is a commitment, a fundamental orientation of the heart, that can be expressed as a story or in a set of presuppositions (assumptions which may be true, partially true or entirely false) that we hold (consciously or subconsciously, consistently or inconsistently) about the basic constitution of reality, and that provides the foundation on which we live and move and have our being.[59]

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[56] James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 85.

[57]Stephen Roberts and Nancy Osborne, "Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook," in *Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook* (Woodstock, VT: SkyLight Paths Pub., 2014), pp. 149-161, 150.

[58] Millard J. Erickson, *Christian Theology* (Grand Rapids, MI: Baker Book House, 2007), 521.

[59] James W. Sire, *The Universe next Door* (England: Inter-Varsity Press, 2004), 17.

When making an ethical decision, "If we can isolate what makes something good or right, then this might help us to make the proper moral decision." [60] In ethical consultations, chaplains must be aware of ethical theories of decision making, worldviews and biblical theology. Chaplains may guide patients, families and staff through these competing worldviews. Ultimately, taking the time to hear and understand the patient's beliefs and values will tremendously impact their patient care.

Ethics is not limited to specific acts and moral codes, but encompasses the whole of moral ideals and behaviors, a person's philosophy of life. When making an ethical decision, chaplains can utilize the patient's stories and personal values to isolate what makes something good or right, then this might help us to make the proper moral decision. When making an ethical decision, the chaplain must be aware of the dominant worldviews in their ministry, understand the biblical foundations that shape their practice. Ethics involves making the right decision when challenged with a dilemma involving diverse beliefs and values. It invokes the questions of the ancient Greek philosophers -How ought we to live?

There are three main categories of ethical theories: virtue ethics, consequentialism ethics, and deontological ethics.[61] Each approach provides a different way to understanding ethics. In ethics, there is no single theory to answer all of the questions that a chaplain will encounter; instead, it is good practice to use a variety of theories to reach the best ethical decision.

As aforementioned, the three examples of ethics are tools for considering morality as a professional chaplain. Seldom do chaplains use one ethical approach exclusively and each has its limitations. Using values-based decision making; chaplains can effectively guide patients and

[60] K. D. Fedler, *Exploring Christian Ethics: Biblical Foundations for Morality*. (Louisville, Ky: Westminster John Knox Press, 2006), 15.

[61] Ibid, 5.

families in making the appropriate healthcare decisions that are shaped by scientific information and. likely medical outcomes. The chaplain must utilize active listening skills, gather the facts, explore the options, and incorporate theories, theologies and philosophies involved in the process while examining the alternatives. In spiritual care, the chaplain should strive to be the moral guide of the medical world. The chaplain must be aware of the ethical considerations involved in the healthcare field, particularly with patient care. If a difficult situation arises, the chaplain can request an ethical consult, or care conference. During this interdisciplinary meeting, the chaplain can collaboratively discuss a plan of care which will bring about the most good for the patient and to preserve the autonomy, dignity and values of the patient and their loved one. The purpose of Christ-centered chaplaincy is to enter the patient into a mutually loving relationship with God that brings glory to God and joy to human lives.

One definition of bioethics, a facet of applied ethics, is as follows, "The discipline dealing with ethical questions that arise as a result of advances in medicine and biology."[62] Another defining example is the "critical examination of the moral dimensions of decision-making in hearth-related contexts and in contexts involving the biological sciences."[63]

Often, advanced directives (living wills and durable power of attorney for health care decisions) allow patients with weakening medical conditions to continue to have a voice about the course of their treatment. Yet, many patients fail to have important discussions about their medical wishes with family members while they are still in relatively good health; chaplains can encourage patients to have such conversations to ease the burden for family members who may

[62]Thomas A. Shannon and Nicholas J. Kockler, *An Introduction to Bioethics* (New York: Paulist Press, 2009), 8.

[63] Ibid, 5.

face difficult decisions should the patient's condition deteriorate. When a patient has a terminal illness, the chaplain may be called in to help discern between pursing curative care, palliative care and hospice. Collaborative decision making must have the involvement of the patient or surrogate, the physician, chaplain, social worker, nurse, mental health worker, etc. The entire care team should exercise proper communication to ensure best care practices.

The chaplain can help family members understand how respect for sanctity of human life applies to each medical situation. It is the chaplain's responsibility to provide great physical, emotional, and spiritual care to every person they meet with. The chaplain will help others to sort through emotions, cultural norms, personal desires, and community preferences. The chaplain must also respect the fact that some may not be in the right frame of mind to process such events, or perhaps, they may be ready to engage in deep and meaningful conversations. The most important aspect of the chaplain's role is also the most privileged aspect, chaplains are witnesses and advocates of a person's life and values.

The phrase, "first do no harm", is vital to understanding the relationship between a patient and the interdisciplinary team. When a physician or medical professional is unable to cure a patient, the physician must be careful not to place unnecessary burdens on the patient that would result in more harm than benefit; such measures could be labeled as futile. Lastly, the chaplain must work with the care team to bring about the most good for the patient and help choose between bringing neither benefit nor harm to a patient and administering a benefit that contains a foreseen harm. Ultimate, the interdisciplinary team can utilize narratives to review the ethics consult with the patient/POA to guide them in the decision-making process. The chaplain can help family members understand how respect for sanctity of human life applies to each medical situation.

In hospice, the chaplain must be aware of the ethical issues present at the end-of-life. It is essential to be familiar with ethical theories. It is necessary to first determine exactly what an ethical dilemma may be and define it. Within healthcare and hospice ethics, there are four primary principles: beneficence, nonmaleficence, autonomy, and justice.[64] Hospice has evolved over the past hundred years and has only recently begun to be culturally accepted. The patient and the family must know all the facts and information regarding decisions and alternatives. Within healthcare, there is the principle of truth-telling, healthcare professionals must not knowingly lie to a patient. For patient consent to occur, the patient must be informed of diagnosis, prognosis, alternatives, and possible consequences. The hospice experience centers on fidelity. Hospice chaplains can provide a conduit between the problem and solution by story sharing. Human experience is structured by personal narratives and storytelling. Narrative proved structure and meaning to the temporal consciousness of the human experience, which is a significant element to spiritual growth.[65]

Narrative Theory

Outcome-oriented chaplaincy, established in the work of Lucas and colleagues, comprises a cyclical model based on assessing another's needs, hopes, and resources; determining appropriate interventions; and measuring outcomes. Chaplains also refer to this model as the diagnostic or medical model.[66] This model is often viewed as a framework finding a problem that needs to be fixed. Those experiencing pain and suffering needed a source of

[64]Kenneth J. Doka, Bruce Jennings, and Charles A. Corr, *Ethical Dilemmas at the End of Life* (Washington, D.C.: Hospice Foundation of America, 2005), 212

[65] Bruce Allen Stevens (2019) The dark story: Does it Have A Place in A Life Review? Journal of Religion, Spirituality & Aging, 31:4, 369-376, DOI: 10.1080/15528030.2018.1534707, 2.

[66] Annelieke Damen et al., "Can Outcome RESEARCH Respect the Integrity of Chaplaincy? A Review of Outcome Studies," *Journal of Health Care Chaplaincy* 26, no. 4 (2019): pp. 131-158, https://doi.org/10.1080/08854726.2019.1599258, 144.

healing, freedom from illness and meaning making through listening and sharing stories.[67] Consequences of the outcome-oriented model can be avoided by developing narrative assessments that provide space for unique individual context and a transcendental reality; such assessments can be carried out in dialog with the patient to better understand their wants and needs.[68] Narrative theory was led by Arthur Frank and Arthur Kleinnman as they journeyed with the chronically ill. They provided a framework for why people tell stories, and the value in facilitating the telling of those stories, is that stories are the narrative story-telling as a way for others to feel understood.[69]

The chaplain profession largely finds its place within the behavioral sciences to inform its practice within ministry in order to apply the appropriate responses and intervention.[70] Arthur Kleinman encouraged the collaborative relationship within the psychosocial discipline which creates meaning throughout the illness through "catharsis, persuasion, practical problem solving, and other of the mechanism of psychotherapeutic change. [71] The implications for utilizing a social theory for therapeutic arrives from the interpretive method of interpreting reality.[72]

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[67]Paul Giblin, "Building a New Life: A Pastoral Counselor's Response," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 112-119, 113.

[68] Annelieke Damen et al., "Can Outcome RESEARCH Respect the Integrity of Chaplaincy? A Review of Outcome Studies," *Journal of Health Care Chaplaincy* 26, no. 4 (2019): pp. 131-158, https://doi.org/10.1080/08854726.2019.1599258, 144.

[69]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 100.

[70]Ibid, 100.

[71]Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 2020), 246.

[72] Michael White and David Epston, Narrative Means to Therapeutic Ends (Royal New Zealand Foundation of the Blind, 2015), 3.

Patients have the opportunity to interpret life changes, life cycles, and their developmental processes, Life stories have the ability to be both linear in time and instantons.[73]

The storyteller is someone who shares the wisdom and understanding that they gain through their suffering and illness. This rejects the idea of victimization from the illness and instead empowers those to come to terms with the illness. The storytelling experience provides patients with continuity and meaning. All stories have a beginning – which embodies history, a middle – which represents the present, and an ending – which represents the future. Interpreting the current situation is as much "future-shaped as it is past-determined."[74] The narrative structure allows the storyteller to be selective in their experiences to mold into a dominant, overriding story.

Narrative theory is the thread or dominant story in the patient's life. Arthur Frank categorizes four types of bodies 'characters' that are present in the illness narratives: the disciplined body, mirroring body, dominating body, and the communicative body. The narrative depends on how the person experiencing the illness views the barriers of normal life, forcing them to reorient life goals and decisions. Frank describes three interweaving narratives throughout patient's stories; the narrative of restitution, chaos, and quest.[75] The restitution narrative is the one that culture maintains as the preferred path and one that most try to retell as their own. It recalls recovery as though nothing happened at all and minimizes the illness and

[73] Michael White and David Epston, Narrative Means to Therapeutic Ends (Royal New Zealand Foundation of the Blind, 2015), 11.

[74] Ibid, 10.

[75]James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 83.

separates the body from the self. Restitution narrative is the "old life," it is the unrealistic hope of a restitution of life as it was before the disease, therefore it can be a form of denial.

Restitution stories are the most commonly told narratives. The patient may articulate how they become ill, undergoes and suffers through treatment, and is returned to their health. These storylines are typically part of the chronic illness experiences. They may be easy to listen to and understand because they typically have a peaceful conclusion to the story, in which the patient is restored to health.[76]

Chaos stories are narratives in which the patient may focus the story on a disability or pain, Often, the nursing team and physicians are unable to correct the problem or understand the patient. These overriding narratives may lack any effective action.[77] The chaos narrative articulates the diminished self, and the unpleasant aspects of the illness. Chaos narrative is the absence of hope altogether.

The quest narrative is the narrative that has the opportunity to build meaning and purpose in the presence of the overwhelming effects of chronic illness. Quest narrative asks the questions, "What do you wish to become in this illness? What story do you wish to tell of yourself? How will you shape your illness, yourself in the stories you tell?"[78]

Lastly, the quest narrative understands the illness as a journey that the patient is on. The quest narrative is the self-story which transform the illness into metaphors. They appear in memories, manifestos, and stories of remembrance. White and Epston agree with Frank,[79] that

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[76] James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," Journal of Health Care Chaplaincy 19, no. 3 (2013): 81-98, 84.

[77] Ibid, 84.

[78] Arthur W. Frank, The Wounded Storyteller: Body, Illness, and Ethics (Chicago: The University of Chicago Press, 2013), 159.

[79] Ibid, 82.

the quest narrative allows the patient to gain personal agency in their lives and allows the patient to become the protagonist in their world; each retelling of a story is a new telling as they participate with others in the 're-authoring" of their life journey.

The communicative body shares truth and wisdom to others that may benefit from the lessons learned. These "listening devices," are not diagnostic but rather a resource for understanding the other person.[80] The chaplain can utilize the narrative framework to shift the paradigm from "unhealthy, problem-saturated stories to healthy, alternative narrative, counter stories."[81] The goal of this narrative approach is to empower the patient to achieve personal agency, responsibility, and to articulate what the patient can control in an uncontrollable situation. The goal is to enable a cognitive shift in identity by focusing on meaning making via the quest narrative. Stories allow the patient to redraw maps, have new destinations and restore what the illness has taken away from their humanity by rediscovering who they are and where they are going.[82] White and Epston compile a framework for therapy grounded in narrative thought:

1. Privileges the person's lived experience.
2. Encourages a perception of a changing world through the plotting or linking of lived experience through the temporal dimension.
3. Invokes the subjective mood in the triggering of presuppositions, the establishment of implicit meaning, and in the generation of multiple perspective.
4. Encourages the use of ordinary, poetic and picturesque language in the experience and in the endeavor to construct new stories.

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[80]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 102.

[81]Paul Giblin, "Building a New Life: A Pastoral Counselor's Response," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 112-119, 113.

[82]Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 2013), 25.

5. Invites a reflexive posture and an appreciation of one's participation in the interpretive acts.
6. Encourages a sense of authorship and re-authorship of one's life and relationships in the telling and retelling of one's story.
7. Acknowledges that stories are co-produced and endeavors to establish conditions under which the "subject" becomes the privileged author.
8. Consistently inserts the pronouns "I" and "you" in the description of events.[83]

Life Review

In the early 1963 psychiatrist Robert Butler developed the idea of life review. The idea has evolved over the years and has become a standard for caring for the aged. Robert Butler identified this as a normal part of aging and ultimately the death and dying process. Butler understood the opportunity for a life review to be "integrative and therapeutic."[84] He suggested that reminiscence was originally seen only relative to elderly patients and that it was essentially an aimless wandering of the mind. Butler discredited the idea of aimless wandering of the mind and understood that it was natural for elder patients to relive the past through stories. Therefore, reminiscence therapy and life review were formed from this recalling of the past. He defined a structured life review as "A naturally occurring universal process, characterized by the progressive return to consciousness of past experiences and unresolved conflicts which are surveyed and reintegrated."[85]

Life review utilizes questions to identify various plot points and highs and lows of life. It is a process where time comes together for the patient. The life reviewer can stand in the present time and looks forward to the realities of life and death while at the same time looking back on a

[83] Michael White and David Epston, Narrative Means to Therapeutic Ends (Royal New Zealand Foundation of the Blind, 2015), 83.

[84]Bruce Allen Stevens, "The Dark Story: Does It Have a Place in a Life Review?," *Journal of Religion, Spirituality & Aging* 31, no. 4 (September 2019): 369-376, 2.

[85]Barbara K. Haight and Barrett S. Haight, *The Handbook of Structured Life Review* (Baltimore: Health profession Press, 2007), 12.

"life full of joy and sorrows, successes and failures, well-integrated and unresolved events."[86] Life review examines the different stages of life, from childhood through adulthood. A short example of life review questions are:

> *Describe some of your family traditions.*
> *What kind of work did you do? Did you have any hobbies?*
> *What were the biggest challenges you faced?*
> *What were the best times you experienced?*
> *Where did you live?*
> *What, if anything, would you change about this time?*
> *Do you have any regrets?*
> *What are your biggest successes?*
> *Do you have a faith tradition?*
> *What words of wisdom or advice would you pass to your children or grandchildren?*
> *What do you think are the secrets of a meaningful and happy life?*
> *If you could relive any day in your life, what would it be?*
> *Do you have any last message you would like to leave for your loved ones?*

The time frame to utilizing life review is typically one visit per week in one-hour increments. This allows enough time for the reviewers to process their thoughts between each visit. The patient can often edit and evaluate their memories as well.[87] Life review exercises can be accomplished by asking courageous questions, the chaplain can examine the patient's personal priorities. The review can also involve examining consciousness – holding the good and bad parts of life together. Sealed order exercise, which is utilizing metaphor to see who we were created to be from birth. Life review can involve deathbed confession, which is a means of inviting the dying person to confess the sins of their past. There is a belief that clearing the slate is a way to give peace and freedom. Spiritual geography can also invite the patient to plot their life along a timeline, suggesting the three most challenging and life-giving moments. This

[86]Stephen Roberts and Nancy Osborne, "Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook," in *Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook* (Woodstock, VT: SkyLight Paths Pub., 2014), pp. 149-161, 150.

[87]Barbara K. Haight and Barrett S. Haight, *The Handbook of Structured Life Review* (Baltimore: Health profession Press, 2007), 22.

exercise allows the patient to notice a potential correlation between the ups and downs of life. The patient can reflect on their fears, regrets, seek forgiveness and review their life's work.[88]

Externalizing the Problem

One of the main benefits of narrative theory and life review is naming and externalizing the problem. When people are focused on a problem, ninety-five percent of the time they are thinking about themselves. Three-fourths of people are starving for sympathy.[89] The chaplain has the task of learning what dominant story the patient is telling, and whether it is healthy and encouraging to the patient. Externalizing a problem is a way to utilize psychotherapy to encourage the patient or caregiver to objectify and personality the oppressive problem they are experiencing.[90] After the counselee engages the therapeutic process, the goal is for them to understand the "person is not the problem; the problem is the problem."[91] There are many approaches to this exercise, the chaplain can utilize the visit to draw out the problem, direct the patient or caregiver to journal, or allow time between conversations for the recipient to reflect on the problem.

This process of externalizing the problem involves utilizing the ability to ask the patient appropriate questions. Asking guiding questions can allow the patient to explore multiple ideas and options. Chaplains should be aware that asking questions is a therapeutic intervention. The chaplain should also be comfortable within the silence that may come after the question is

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[88]Richard F. Groves and Henriette Anne Klauser, *American Book of Living and Dying: Lessons in Healing Spiritual Pain* (Berkeley, CA: Celestial Arts, 2009), 253.

[89] Dorothy Carnegie, *How to Win Friends and Influence People* (New York, NY: Simon & Schuster, 1981), 27.

[90]Michael White and David Epston, *Narrative Means to Therapeutic Ends* (Auckland, N.Z.: Royal New Zealand Foundation of the Blind, 2015), 38.

[91]David Denborough, *Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience* (New York: W.W. Norton & Company, 2014), 28.

presented – it is there that the possibility exists for patient to "find something divinely revealed."[92] By asking questions and externalizing the problem the patient is experiencing, it enables the recipient of care to detach themselves from the prevailing stories that have been shaping their lives and their relationships. The patient can examine any dominant stories they were unaware of and then become aware of the lived experiences they would rather pursue that was not shaped by former narratives."[93] When the patient externalizes and detaches themselves from the problem they may be facing, they can then center themselves on mindfulness.

Communication and Life Stories

When meeting with a patient who has a terminal diagnosis, communication becomes the conduit to personal dignity.[94] Proper verbal and nonverbal communication skills are necessary for chaplains to utilize in ministry. Patients can be softened and subdued in the presence of a patient and sympathetic listener.[95] Communication involves getting rid of your own agenda and trying to understand who the patient is and what they want.[96] It is imperative that the chaplain must be aware of how they are being perceived by the patient or recipient of care; "tone, inflection, timing, volume, pacing"—everything you do with your voice communicates something and has the potential to help you connect to or disconnect from others when you

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[92]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 100.

[93]David Denborough, *Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience* (New York: W.W. Norton & Company, 2014), 41.

[94] Ron Wolfson, *A Time to Mourn, a Time to Comfort: a Guide to Jewish Bereavement* (Jewish Lights Publishing, 2005), 12.

[95] Dale Carnegie, *How to Win Friends and Influence People* (New York, NY: Simon & Schuster, 1981), 83.

[96]John C. Maxwell and Wayne Shepherd, *Everyone Communicates, Few Connect: What the Most Effective People Do Differently* (United States: BookBaby, 2014), 44.

speak."[97] When a patient is communicating, the chaplain must take into context all aspects of the patient's story. What is their living situation like? What was their posture? Did they have eye contact? Where are they crying? What was their tone? These are often subtle clues for the chaplain to be aware of when listening for the patient's interweaving narratives. Listening to personal narratives and storylines is a means to examine the patient's ongoing struggle to find purpose and meaning. When the chaplain examines storylines in this manner, there is the opportunity to understand how the patient has responded to changing historical and cultural circumstances.[98] The chaplain can listen for themes of resiliency throughout diverse trials in the patient's lifetime and recall them in light of their current situation. Storytellers may be the most valuable workers of the twenty first century as the roots of storytelling come from scripture over thousands of years old. "Metaphor and storytelling were an integral part of the teaching tools of Christ and are generously woven through scriptures."[99]

Everyone enters a conversation with assumptions, it is imperative to be mindful of them. The following guidelines are suggested for encouraging conversation with someone who is experiencing a life-limiting illness: sit down and be eye level with the patient; make sure the patient wants to speak with you; be a sensitive listener without interruption, encourage the patient to talk with verbal prods such as "tell me more;" respect the silence; describe your feelings and let the patient know that you too may have difficulty speaking about the subject; do

[97]John C. Maxwell and Wayne Shepherd, *Everyone Communicates, Few Connect: What the Most Effective People Do Differently* (United States: BookBaby, 2014), 44.

[98]Ivor F. Goodson, *Developing Narrative Theory: Life Histories and Personal Representation* (Abingdon: Routledge, 2013), 20.

[99]Clinton, Dr. Timothy and Ohlschlager, Dr. George., *Competent Christian Counseling Foundations & Practice of Compassionate Soul Care* (Colorado Springs, CO: Waterbrook Press, 2002), 376.

not change the subject; be cautious about advice; reminisce life stories; utilize humor as appropriate.[100]

Chaplains enter conversations with their own opinions, feelings, theories, and experiences. This sequence of thoughts and feelings makes up our "personal pool of meaning." The pool of meaning informs our decision-making capabilities and decides the actions we take.[101] Through compassion and direction, the chaplain can journey through the patient's language, histories and utilize events, moments of resiliency and personal values. The chaplain looked for creative opportunities "that embodies the problem and/or reduces the person to a diagnostic label. He or she continuously remembers that the person is bigger than the problem."[102] Life stories focuses on personal stories; however, life histories attempt to understand stories within the context of their historical and cultural backgrounds. They are therapeutic tools which allows the chaplains to hear the individual and personalized story and locate the patient in historical time and space. [103] Lastly, the goal always remains to connect their story to the Divine story. Second Corinthians 10:5 (NIV) states that we are to "take captive every thought to make it obedient to Christ." Long-lasting change involves repenting of our mistakes, failures and shortcomings and allow God to become out truth and reality.[104]

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[100] Ron Wolfson, *A Time to Mourn, a Time to Comfort: a Guide to Jewish Bereavement* (Jewish Lights Publishing, 2005), 13.

[101]Kerry Patterson et al., Crucial Conversations: Tools for Talking When Stakes Are High (New York: McGraw-Hill, 2012), 25.

[102]Paul Giblin, "Building a New Life: A Pastoral Counselor's Response," Journal of Health Care Chaplaincy 19, no. 3 (2013): 112-119, 113.

[103]Ivor F. Goodson, Developing Narrative Theory: Life Histories and Personal Representation (Abingdon: Routledge, 2013), 6.

[104]Clinton, Dr. Timothy and Ohlschlager, Dr. George., Competent Christian Counseling Foundations & Practice of Compassionate Soul Care (Colorado Springs, CO: Waterbrook Press, 2002), 378.

Narratives in Grief Therapy

In grief counseling, narrative theory has the potential to serve as the foundation of theories that arise from telling and sharing stories. When the chaplain sits down, in person or by phone, the patient or loved one may begin to share stories of restitution, chaos and quest. These themes and storylines can be filtered through various models of grief counseling to establish appropriate and beneficial interventions for coping. Simply put, grief is the normal and natural reaction to loss.[105] A loss can include a death or nondeath related such as a loss of a relationship, divorce, separation, and job-loss. First and foremost, it must always be understood that there is no right way to grieve. The analogy of a fingerprint is utilized to make this point, everyone has a fingerprint and each person has a unique fingerprint unlike anyone else. The chaplain often serves in the role of bereavement coordinator and grief counselor to tend to the brokenhearted.

Grief counseling has its foundation in Elizabeth Kubler-Ross (1969) stages of grief. She proposed five stages that the bereaved find themselves in, denial, anger, bargaining, depression and acceptance. Death is "a universal fear even if we think we have mastered it on many levels. What has changed is our way of coping and dealing with death and dying and our dying patients.[106] There are four basic tasks of mourning, borrowed from developmental psychology, which include accepting the reality of the loss, processing the pain of grief, adjusting to a world without the deceased, and finding a way to remember the deceased while embarking on the rest of one's journey through life.[107]

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[105] Howard Robin Winokuer and Darcy Harris, *Principles and Practice of Grief Counseling* (New York, NY: Springer Publishing Company, 2016), 26.

[106] Elisabeth Kubler-Ross, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families* (New York, NY: Scribner, 2014), 19.

[107] J. William Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner* (New York, NY: Springer Publishing Company, LLC, 2018), 41.

It is significant for the chaplain to be aware of the theoretical foundations of grief therapy. Often, a chaplain may say to the bereaved family that the patient has "passed." However, it is important to note that the term "passing" may have theological roots that the bereaved family does not share. The term "passing" could make the assumption that the family believes the deceased patient has passed from this life to the next. Instead, many healthcare institutions will encourage staff to state directly that the patient has died. While most bereaved families will not split hairs linguistically, the chaplain's desire may simply be to take the edge off of painful realities and unknowingly point towards hope. It is always best practice to be aware of subconscious thoughts and transference. It is essential for the chaplain to separate and properly balance personal theology with inclusive, pluralistic chaplaincy.

C.S. Lewis wrote extensively about grief after the death of his wife.

> No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing. At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. it is so uninteresting.[108]

Psalm 147:3 says that "He heals the brokenhearted and binds up their wounds." Walter Brueggemann articulated the rhythms of life and uniquely characterized the Psalms into three themes: Psalms of orientation, our understanding of the world; Psalms of disorientation, the things that change how we see ourselves and the world; and Psalms of new orientation, in which God delivers us from our "pit" and we establish a new awareness about our lives and of God. [109] When patient's and loved ones fall into the "pit" their world has collapsed and their reality and worldviews are permanently altered. Chaplains may guide patients and loved ones towards a

[108] C. S. Lewis, *A Grief Observed* (London: Faber & Faber, 1973), 3.

[109] Walter Brueggemann, *Spirituality of the Psalms* (Minneapolis, MN: Fortress Press, 2002), 8.

"quest narrative" of new orientation where they learn from the illness or loss and develop a new awareness of self and the divine.

A common tool in grief groups includes following a weekly outline in the *Grief Recovery Handbook*, many grief support groups follow a similar pattern with this invaluable resource. It details how the bereaved may write a grief letter, to say goodbye to what is incomplete. The writer can say goodbye to pain, associated with the relationship, un-met hopes and dreams and unrealistic expectations.[110] The grief process involves immense emotions, and the chaplain should always validate the tears that come from any type of loss and heartbreak. It is also common for the chaplain to feel the need to "fix" the situation, this can manifest with providing theology or providing hope-filled ideas. This solution-focused intervention is not always appropriate for grief and loss, instead, the patient or the bereaved may simply need to have a feeling named and then someone to sit with them in the awareness of the pain that comes from that emotion. The narrative may then naturally shift towards hope and theology, however, the chaplain must be aware that the tears may continue to fall long after their visit. Often, theology may be completely lacking in a chaplain visit until the visit ends with prayer. Other times, the entire visit may be viewed as a prayer in and of itself.

There are no dominant theoretical models of grief counseling, however, there are four prominent paradigms of grief theory, attachment theory (Shaver & Tancredy, 2001; Stroebe, 2002), the dual process model (Parkes, 2002; Servaty-Seib, 2004; Stroebe & Schut, 1999),

[110] John W. James and Russell Friedman, *The Grief Recovery Handbook: 20th Anniversary Edition* (New York, NY: Harpercollins, 2009), 146.

constructivism (Averill & Nunley, 1993; Neimeyer, 2000; Neimeyer et al., 2002; Rosenblatt, 2001), and adaptive grieving styles (Doughty, 2009; Martin & Doka, 2000).[111]

Attachment theory was developed by the late British psychologist John Bowlby. Bowlby contributed a significant amount of study an understanding on the meaning of attachment and how it related to loss and the human behaviors associated with it.[112] Bowlby's theory insists that attachments come from a need of safety and security which is developed early in life, typically directed towards a few individuals throughout most of the life cycle.[113]

The dual process model recognizes the role of attachments in grief and bereavement and the coping strategies based on attachment patterns.[114] The theory states that individuals will spend time oscillating between active grief, which is identified as loss orientation, and returning to life which distracts them from grief, which is restoration oriented.[115] Narratives may be utilized to create a new life for the bereaved, without the deceased.

The grief theoretical model of constructivism suggests an individual's reality is understood by how the individual makes sense of their experiences, perceptions, and narratives.[116] After the death of a loved one, many bereaved individuals may begin to question the reality they have constructed for themselves. Narrative therapy can organize the life of the

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[111] Elizabeth A Doughty, Adrianna Wissell, and Cyndia Glorfield, "Current Trends in Grief Counseling," *Counseling Outfitters*, no. 94 (2011): pp. 1-10, 4.

[112] J. William Worden, *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner* (New York, NY: Springer Publishing Company, LLC, 2018), 16.

[113] Ibid, 16.

[114] Howard Robin Winokuer and Darcy Harris, *Principles and Practice of Grief Counseling* (New York, NY: Springer Publishing Company, 2016), 29.

[115] Ibid, 29.

[116] Elizabeth A Doughty, Adrianna Wissell, and Cyndia Glorfield, "Current Trends in Grief Counseling," *Counseling Outfitters*, no. 94 (2011): pp. 1-10, 5.

storyteller by the stories they tell themselves and others, which may give meaning to their experience. lives by the stories we tell ourselves and others. These stories give structure and meaning to our experience, they may often be revised to express new experiences and new meanings. Narrative strategies for constructivism include writing epitaphs, journaling, recognizing how the deceased has influenced their life, and writing poetry to communicate and express the experience of grief.[117] Meaning making may result from reinterpreting negative life events to learn about oneself and life, a means of helping others, and contributing to society in a way that is related to the experience that occurred.[118]

Lastly, adaptive grieving styles reflects an individual's distinctive use of cognitive, behavioral, and affective strategies in adapting to loss.[119] Grief often reflects a person's personality and their culture. Adaptive grieving styles consist of three patterns, intuitive grieving which is a emotional desire to discuss the loss, instrumental grieving which is cognitive recognition to control emotion, and blended grieving, which is utilizing affective strategies and cognitive behavioral strategies.[120]

Pastoral Counseling in Healthcare Chaplaincy

Solution-Blessed, Brief Pastoral Counseling may also be a valuable approach to patient care. SBBPC is brief, time-limited, purposeful and collaborative in an effort to create and achieve a main goal. It focuses on the source of the problem and how to create solutions, by

[117] Elizabeth A Doughty, Adrianna Wissell, and Cyndia Glorfield, "Current Trends in Grief Counseling," Counseling Outfitters, no. 94 (2011): pp. 1-10, 6.

[118] Howard Robin Winokuer and Darcy Harris, *Principles and Practice of Grief Counseling* (New York, NY: Springer Publishing Company, 2016), 36.

[119] Elizabeth A Doughty, Adrianna Wissell, and Cyndia Glorfield, "Current Trends in Grief Counseling," Counseling Outfitters, no. 94 (2011): pp. 1-10, 6.

[120] Ibid, 7.

maintaining a problem-focused approach. It also focuses on people's strength, competence, and possibilities instead of their deficits, weaknesses, and limitations. Change is secured by the word of God, the Holy Spirit, and through the church. Homework allows the counselee to think about the issues they are facing and meditate on ways that they can overcome them. Regardless of the approach, it is important to identify the situation the patient may be facing; it may be the end-of-life, anxiety, forgiveness, or other barriers to a peaceful and purpose-filled life. The goal, then, is to return the individual to a pre-crisis level of coping patterns or provide a new blueprint for resiliency. The chaplain can attempt to either return the individual to their original comfort zone or stretch their comfort zone to current conditions. Kollar's list of guiding assumptions for SBBPC include:

> God is already active in the counselee
> Complex problems do not demand complex solutions
> Finding exceptions help create solutions
> The counselee is always changing
> The counselee is the expert and defines goals
> Solutions are co-created
> The counselee is not the problem, the problem is
> The counseling relationship is positional
> The counselor's focus is on the solution[121]

The major problem, and reason biblical crisis intervention and counseling is needed, is the effect the crisis can have on an individual. Many factors can increase the effects of a crisis. Some of these factors include unrealistic expectations or views of their strengths and weaknesses, negative personality traits, a faulty sense of identity, isolation, or faulty belief

[121] Charles Allen Kollar, *Solution-Focused Pastoral Counseling: An Effective Short-Term Approach for Getting People Back on Track* (Grand Rapids, MI: Zondervan, 2011), 190.

systems. This could also lead to further isolation and a loss of support from loved ones. The goal, therefore, of pastoral counseling is to try to reduce or decrease the significance or impact of the precipitating event and then reestablish coping mechanisms.

The first step is to determine the perceived significance of the precipitating event while establishing rapport and a relationship with the individual. To begin it is necessary to ensure an atmosphere of trust and acceptance, the counselee must be the main source of attention. It is important to be encouraging to be supportive, sympathetic, and sensitive to each individual's style and personality. Communication plays a very important role in relationships and human experience it is important to be aware of the counselee's verbal and nonverbal means of communication through active listening. Asking open-ended questions and paraphrasing can also reveal a lot about what the counselee is feeling, and it can determine the status of where they are in their coping process.

Kollar describes three types of counselees that the counselee can define during each counseling process, those in the willing position, blaming position, and the attending position.[122] Those in the willing position usually come in looking for a solution to their problems. Those in the blaming position are fully aware about the problem someone else has, and those in the attending position are the ones who come to the interview unwillingly.[123] To encourage the attending person to become a willing participant is achieved by finding out what their goals are and incorporating methods of achieving those goals, given their level of cooperation. When taking the problem-focused approach, the solution is found by finding what the counselee wants;

[122] Charles Allen Kollar, *Solution-Focused Pastoral Counseling: An Effective Short-Term Approach for Getting People Back on Track* (Grand Rapids, MI: Zondervan, 2011), 87.

[123] Ibid, 87.

focusing on what God is already doing in their lives and create change by doing something different.

Theological Foundations

Multi-faith, healthcare chaplaincy requires chaplains to have a large enough theology to hear and understand the theology of those they are ministering to and work from their belief system.[124] Chaplains accomplish this by not making any assumptions, asking questions, and listening to their conversations. Professional chaplains can move beyond their own belief system and support the theology of those they are providing care to. Chaplains must be open to the patient's theology to enable them to function within the situation they find themselves in and support them through their crisis.[125] Prior to ministering to others, the chaplain should be well grounded in their own theological understanding and practical application. Christian chaplains are the embodiment of Matthew 25:35-36:

> For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.

Chaplains are consistently utilizing faith and theology to bring peace, hope and resilience to patients, families, and staff. Chaplains operate from their personal theology, while assessing and utilizing the patient's theology. The process is a therapeutic combination of "Who am I? Who are they? And what are we about?" One method of obtaining this information is a spiritual assessment. Chaplains can utilize the FACT spiritual assessment. F – What is the patient's faith or beliefs? A – Are they active in their faith? C – How are they coping with their situation? T –

[124] Stephen Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook.* (Woodstock, VT, NY: SkyLight Paths Pub. 2014) 7.

[125] Ibid, 11.

Based on the response, what is the proper treatment plan?[126] This clinical assessment can provide vital information for the chaplain to utilize faith, religion, and spirituality. Spirituality is defined as an inner, experiential area of human life. Spirituality can occur at many levels: physical, emotional, cognitive, and transcendent. Spirituality is the inner experience and religious refers to the external experience connected with organized religion.[127] James W. Sire explains how theology and worldviews can be expressed through stories. Sire lists seven basic questions that forms our theology and worldview:

> What is prime reality?
> What is the nature of external reality, that is, the world around us?
> What is a human being?
> What happens to a person at death?
> Why is it possible to know anything at all?
> How do we know what is right and wrong?
> What is the meaning of human history?[128]

The chaplain's most important role is to facilitate and foster this growing ministry, where God is extended to people, ready and able to meet them where they are. Multiple scriptures affirm this model, painting the picture of a God desperate for His people, yearning to commune with them in trial and encourage them in times of doubt. Each day, chaplains are presented with deep theological issues and concerns. It is desperately imperative that the chaplain is grounded in a strong theological framework to meet the needs of patients, families, loved ones and staff. The purpose is to:

> Show that soul care occurs not merely in theory but in the life and death situations in which the soul's growth and happiness are risked; not merely in words but in faith the

[126] Mark A. LaRocca-Pitts, "FACT: Taking a Spiritual History in a Clinical Setting," Journal of Health Care Chaplaincy 15, no. 1 (2009): pp. 1-12, https://doi.org/10.1080/08854720802698350, 1.

[127] Robert C. Atchley, *Spirituality and Aging* (Baltimore, MD: Johns Hopkins University Press, 2009), 15.

[128] James W. Sire, *The Universe next Door* (England: Inter-Varsity Press, 2004), 20.

> becomes active in love; not merely in the church but where life is being lived out physically, sexually, habitually, interpersonally, vocationally, economically, and relationally; and finally, where life is relinquished in death.[129]

Christian faith tradition holds that our Savior came so that we might have "Life in all its fullness." (John 10:10) Life in "all its fullness," may include the endeavoring journey for holistic health: mind, body, soul and emotions. This is a life-long process of discovering the image of God (Genesis 1:27) in each person and implicating the values and unique possibilities. Wholeness can also be vital to implicating the necessity of holistic care on the healthcare team. Awareness of one's finitude, limitedness and brokenness are essential; alongside with the awareness of one's potentialities.

The most prevalent genre in the Bible is narrative, in fact, over forty percent of the Old Testament is written as narrative.[130] The Christian Bible is a canonical scripture composed of many different genres, it is largely made up of narrative accounts of God's revelation and restoration. These narrative accounts show the resiliency of God's creation, exposing the limitations of human beings and the limitless strength of God.

God's is always revealing his truth to people throughout his creation. He also choses to reveal particular things to particular people.[131] God's revelations provide a multi-generational narrative that begins at the creation of mankind, the fall of mankind, then redemption and consummation. Narrative often shapes and structures how we understand the unfolding story of theology. The Bible includes many genres includes family histories, theology, poetry, prophecy,

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[129] Thomas C. Oden, *Classic Pastoral Care: Volume 4*. (Grand Rapids: Baker Books), 2000.

[130] Gordon D. Fee and Douglas K. Stuart, *How to Read the Bible for All Its Worth* (Grand Rapids, MI: Zondervan, 2014), 89.

[131] Timothy P. Jones, *How We Got the Bible* (Peabody, MA: Rose Publishing, 2017), 8.

apocalyptic visions, letter correspondence, and more. Gabriel Fackre groups narrative theology around three kinds of story: canonical story, life story, and community story. The canonical story draws from literary analysis of scriptures. Life story explores the personal experience. Lastly, community story is the intersection of biblical and life stories.[132] It is throughout the community stories where the chaplain has the privilege and opportunity to connect the patient's story with the divine story.

According to Richard Osmer's *Practical Theology*, there are four main tasks of practical theology that invokes our ability to interpret and respond to life events. These are:

The descriptive-empirical task: this asks the question, "What is going on?" This task involves the ministry of presence, is the progression of gathering information which ultimately allows us to understand the particulars of a situation and its context.

The Interpretive task: This task asks, "Why is this going on?" This is the ministry of prudence. It is the process of utilizing personal study, research, and preparation to navigate life events. The main components are: Thoughtfulness: the ability to have deep reflection about the questions raised. Theoretical Interpretation: the ability to use theories of the arts and sciences to better understand the situation and context. Lastly, Wise Judgement: which is the "capacity to interpret episodes, situations, and contexts in three interrelated ways: (1) recognition of the relevant particulars of specific events and circumstances; (2) discernment of the moral ends at stake; (3) determination of the most effective means to achieve these ends in light of the constraints and possibilities of a particular time and place." The Normative Task: This task asks the question, "What ought to be going on?" This task involves the ministry of prophecy. The normative task is the ability to utilize theological concepts to understand life events. The

[132]Keith E. Yandell and Gabriel Fackre, "Narrative Theology from an Evangelical Perspective," in Faith and Narrative (Oxford: Oxford University Press, 2001), pp. 188-201, 189.

Pragmatic Task: This task of servant leadership asks, "How might we respond." This task creates a framework for the ministry of provision, it is an action plan that promotes healing, reconciliation, and faith. The pragmatic task is a strategy that allows both parties to enter a reflective conversation.[133]

Practical chaplaincy is being present with people during their suffering. Often, chaplains utilize their own blueprint for suffering to meet people in their own. Henry Nouwen describes this process as a wounded healer. A wounded healer is someone who utilizes a deep self-awareness of their own personal struggles, hurts and pain to be compassionate to other people who are hurting. It is sharing in the suffering of Christ as they share in the comfort and hope of Christ. Nouwen describes this intersection of the community story as a deep human encounter where the chaplain must acknowledge and put aside their own fears, doubts, hopes and despair so others may find their way and find life.[134]

Crick provides a foundation and history of the chaplaincy profession. He provides the theological framework for chaplains and details pragmatic application to help chaplains to be present and effective with the people they serve, the hurting, brokenhearted and dispossessed. "Chaplains not only behave justly, they are advocates for care recipients when injustice is present. They bring awareness to unethical policies and unfair treatment of clients, inmates, soldiers, employees, etc. They are a moral voice for the institution they serve, and they are the moral conscience amidst the daily routine of the work environment."[135]

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[133]Richard R. Osmer, Practical Theology: An Introduction (Grand Rapids, MI: William B. Eerdmans Pub. Co., 2008), 25.

[134]Nouwen Henri J M., The Wounded Healer (New York, NY: Doubleday (An Image Book), 1979), 49.

[135]Robert Crick, Outside the Gates: Theology, History, and Practice of Chaplaincy Ministries (Oveido, FL: HigherLife Publishing, 2012), 20.

The Bible records a narrative for the creation and redemption of human life. John 1:1 introduces Jesus as the incarnate Word, "In the beginning was the Word, and the Word was with God, and the Word was God." Parallels of this passage are linked to God speaking to the prophets in the Old Testament, the personification of God's wisdom, Stoic ideas of the logos as divine reason, and in Philo's writings where the word logos is utilized to denote the mind of God and the mediator between God and creation.[136] God brings the universe into being by his words. The power of words originates from the creator of all things. As mankind is made in his image and likeness, (Genesis 1:26) words have immense impact.

God's words create life. Genesis 1:2 states, "And God said, "Let there be light," and there was light. God saw that the light was good, and he separated the light from the darkness." God creates the physical world in a state of chaos, and in six days he begins to form the world into a habitable state for humankind to live in.[137] Genesis 1 describes the creation of the physical world, not the spiritual world, as God addresses the heavenly court already in existence when he creates man.[138]

Words create pain. The Eden narrative describes a conversation between a snake and a woman. Genesis 3:1 the serpent says, "Did God really say, 'You must not eat from any tree in the garden'?" The serpent deceives the first humans and man is separated from God. Thus, the doctrine of original sin is explained by the universality and primordiality of moral evil.[139]

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[136] Colin G. Kruse, *John* (Downers Grove, IL: Inter-Varsity Press, 2017), 65.

[137] John McHugh and Graham N. Stanton, *A Critical and Exegetical Commentary on John 1-4* (London: T & T Clark, 2009), 47.

[138] Ibid 47.

[139] Joseph Blenkinsopp, *Creation, Un-Creation, Re-Creation a Discursive Commentary on Genesis 1-11* (London: T & T Clark, 2011), 80.

Words create sanctification. Romans 10:9 states, “If you declare with your mouth, ‘Jesus is Lord,’ and believe in your heart that God raised him from the dead, you will be saved.” Words declare the goodness of God, Psalm 78:4 says, “We will not hide them from their descendants; we will tell the next generation the praiseworthy deeds of the Lord, his power, and the wonders he has done.” Luke 8:38-39 says, “The man from whom the demons had gone out begged to go with him, but Jesus sent him away, saying, ‘Return home and tell how much God has done for you.’ So, the man went away and told all over town how much Jesus had done for him.” Words create legacy from generation to generation. Joel 1:3 says, “Tell it to your children, and let your children tell it to their children, and their children to the next generation.” Words can comfort others. 2nd Corinthians 1:3-4 says, “Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God.”

Christian theology states that man is separated from the Divine, and because of this, mankind will inevitably endure suffering, pain and death (Romans 5:12). It is the human condition in which mankind is born into the universe and forced to find meaning and purpose, often in search of the invisible God. In the midst of our suffering, man’s theology can offer hope and coping mechanisms for survival, or at the very least, a path to the desired afterlife. When the chaplain is called to practice spiritual care, the fundamentals never change; to share the concern and look after the needs of someone’s life principles, sacred matters and religious values.

The doctrine of theodicy may be the most difficult subject that a chaplain can attempt to articulate; explaining how God has allowed pain, all while loving us. Patients may wonder where God is, where He has gone, and how to gain that intimacy back. Psalm 63:1 shows a desperate

David in the wilderness of Judah, calling out and claiming himself as the Lord's … "*O God, you are my God, I seek you. My soul thirsts for you; my flesh faints for you, as in a dry and weary land where there is no water*." In the moments when we don't feel God with us, we naturally thirst for Him, craving the communion intended for us. Practical chaplaincy is being present with people during their suffering. Often, chaplains utilize their own blueprint for suffering to meet people in their own. Henry Nouwen describes this process as a wounded healer. A wounded healer is someone who utilizes a deep self-awareness of their own personal struggles, hurts and pain to be compassionate to other people who are hurting. It is sharing in the suffering of Christ as they share in the comfort and hope of Christ. Nouwen states:

> In this context pastoral conversation is not merely a skillful use of the conversational techniques to manipulate people into the Kingdom of God, but a deep human encounter in which a man is willing to put his own faith and doubt, his own hope and despair, his own light and darkness at the disposal of others who want to find a way through their confusion and touch the solid core of life.[140]

Interventions and resources for chaplains to use at the bedside to allow the patient to establish meaning with the death and dying process. When patients' pass on the narrative of their life's events or share their personal beliefs, values and interests – they are communicating love and acceptance to deepen relationships with family and friends. Meaning is derived from two sources, global and situational. Global meaning includes our understanding of the universe, the infinite. Situational meaning is the chaplain's effort to harmoniously bring together this global meaning within the patient's life experiences."[141]

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[140] Henri J. M. Nouwen, *The Wounded Healer* (New York, NY: Doubleday (An Image Book), 1979), 49.

[141]Fred Grewe, *"The Soul's Legacy: A Program Designed to Help Prepare Senior Adults Cope With End-of-Life Existential Distress,"* Journal of Health Care Chaplaincy 23, no. 1 (2016): 1-14, 10.

Christian ethics state that man is separated from the Divine, and because of this superstation, mankind will inevitably endure suffering, pain and death. It is the human condition in which mankind is born into the universe and forced to find meaning and purpose, often in search of the invisible God. In the midst of our suffering, man's theology can offer hope and coping mechanisms for survival, or at the very least, a path to the desired afterlife. When the chaplain is called to practice spiritual care, the fundamentals never change; to share the concern and look after the needs of someone's life principles, sacred matters, and religious values.

In conclusion, chaplain's minister through a litany of issues all associated with the human condition, none of which can be accomplished without compassion. In the book, *Professional Spiritual and Pastoral Care,* one writer states, "a chaplain should recognize that he or she has the potential to be a channel between a person's vision of the good, as expressed, in part, through values and preferences relevant to what is going on in this person's life right now, and the health care professionals and systems that can help support this vision under present circumstances. Human flourishing can continue amid suffering, even when a person is near death."[142] As a chaplain, it is imperative to utilize active listening skills while being a witness to suffering; then integrating and applying the diverse fields of ethical thought to bring about the common good.

God has given mankind the freedom to make their own decisions. Romans 5:12 says, "Therefore, just as sin entered the world through one man, (Adam) and death through sin, and in this way, death came to all men, because all sinned." When sin entered into the world it sent ripple effects throughout all of humanity corrupting every person that has ever or will ever live.

[142] Stephen Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook.* (Woodstock, VT, NY: SkyLight Paths Pub. 2014) 32.

Sin is both a human condition and human action.[143] Death is the outcome of sin is not primarily physical but spiritual, relational, and in every aspect of life. The outcome of Adam's original sin is the living principle of sin in every man. The Bible calls this the "sin-nature," sometimes "flesh," or the "old man." This sin-principle in every man is something that Adam has passed on to the succeeding generations. There is an in-born predisposition within each living person to always go along the direction that is opposite to godly path. Sin is the reason why we have hospitals, nightmares, why we cry, get sad, go to funerals, are afraid, ashamed, why we lie and why we hide.

The Bible makes it clear the God hates sin, because sin is a violation of God's law, and His law is a description of his own perfect moral character, a mirror or transcript of divine holiness. We cannot separate God's law from himself.[144] Breaking God's law is an insult to the God who has created humanity and sustains life. Sin and evil did not find its' beginnings with God, James 1:13 says, "God cannot be tempted by evil, and He Himself does not tempt anyone." Habakkuk 1:13 says, "Your eyes are too pure to approve evil, and you cannot look on wickedness with favor." God has given freewill yet it "does not make sin a necessity, but a possibility." [145] Sin exists because there is a law, for something to be wrong we must first know what is good. The existence of law must come from an infinite source, the Creator God who establishes rule and authority over the subjective finite. Culture has lost its belief in sin when culture lost its belief in the sustainable infinite God. However, Paul reveals that the knowledge of God's law is available to everyone through general revelation and men are "without excuse."

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[143] John Corrie, Samuel Escobar, and Wilbert R. Shenk, *Dictionary of Mission Theology: Evangelical Foundations* (Nottingham, England: InterVarsity Press, 2007), 363.

[144]Jack Cottrell, *The Faith Once for All: Bible Doctrine for* Today (Joplin, MO: College Press Pub., 2002), 163.

[145]Ibid, 165.

Overall, the Bible is a series of narratives about God's desire to reunite His relationship with his creation. Human beings live in a world where sin and evil exist because of the consequences of freewill; therefore, God remains invisible but not unknown. Guilt is the greatest barrier between God and humanity. Those who are trapped in crisis and regrets must understand that because they are covered by grace, and their sins are forgiven past, present and future. There is a choice, just as Adam and Eve had a choice in the Garden of Eden, to remove from sin and seek God's power to overcome. We do not continue in sin, because we have a choice to follow God's Will of sanctification which will not be made perfect until the regeneration at the Lord's return when our bodies enter into eternity. Purity is a process, but at the heart of change is desire; desire to not be overpowered by sin, but to rule and overcome and make it a footstool. Salvation is not based on performance, rather disposition toward God and desire to live in his grace. Although salvation come instantly once one sincerely begins to seek it, sanctification and purity does not. There will never be a time in earthly human existence where one can say they have reached complete sanctification. In fact, sanctification is a lifelong process where we are only better than the previous day. It is only upon entering into the face of God in eternity, does restoration fully commence.

Theoretical Foundations

In theory, chaplains can utilize a conceptual framework for narrative theory and life review to spend more time at the patient's bedside and create meaning-making opportunities for coping and resiliency. The main goal of a chaplain visits is to journey with the patient and build a helping relationship. The chaplain can then direct the patient to a higher level of functioning that will prepare him or her to have higher coping mechanisms in place before the next stressor comes along. Resilient people are aware of the situation, their own emotional reactions, and the

behavior of those around them. In order to manage feelings, it is essential to understand what is causing them and why. The focus goes back to helping the counselee find "spiritual, psychological, physical, and relational health under the overarching goal of being imitators of Christ."[146] The only way for the individual to fully find acceptance and purpose is through the guidance of the Holy Spirit. There are other alternative means to cope and deal with life stressors, however they are finite alternatives. When the patient can base their lives on the infinite God who created the entire universe with his words, then they may truly find the reason and purpose for our existence. As C.S. Lewis describes it, people who put their trust in the finite are "hopes for oneself, anxieties for oneself. God is not the center… Those who love God will desire not only to enjoy Him but to enjoy Him forever and will fear to lose Him."[147]

A chaplain visit is typically brief, time-limited, purposeful, and collaborative in an effort to create and achieve a main goal; sometimes that goal may just be building relationships with patients and families. At the heart of chaplaincy is being a servant and a caregiver. Chaplains' minster to the needs of patients and families. Maslow's hierarchy of human needs builds on the basic needs that each human being needs in order to achieve the need for self-actualization. Without this need being met, discontent, anxiety and restlessness may develop. Maslow suggested "What a man can be, he must be,"[148] the opportunity of life review can tie various parts of the patient's life to form an identity rooted in self-actualization and purpose. People are storytellers at heart. It is a basic need that chaplains can tend to and help foster self-actualization at any stage in life. There are certain conditions which are immediate prerequisites for the basic

[146]David G. Benner, *Strategic Pastoral Counseling: a Short-Term Structured Model* (Grand Rapids, MI: Baker Academic, 2004), 35.

[147]C. S. Lewis, *Reflections on the Psalms* (Collins, 1962), 40-41.

[148]Maslow, A. H. "*A Theory of Human Motivation."* (Psychological Review 50 1943), 382.

need satisfactions. Danger to these is reacted to almost as if it were a direct danger to the basic needs themselves. Maslow speaks about certain prerequisites prior to basic needs being met, such as freedom to speak, freedom to do what one wishes so long as no harm is done to others, freedom to express oneself, freedom to investigate and seek for information, freedom to defend one's self, justice, fairness, honesty, orderliness in the group are examples of such preconditions for basic need satisfactions.[149]

Chaplains may struggle digging below surface level conversation, which is why the intervention of narrative theory and life review may provide opportunities to go deeper in conversation and guide the patient towards resiliency and coping in an effective way. Ultimately, change is secured by the Word of God, the Holy Spirit, and through the church. Communication involves proper balance. Communication involves actively listening to someone as well as actively talking. When people try to understand others by listening to their stories, it can be beneficial to both parties.

Chaplaincy is an ever-changing ministry. Each day, chaplains are presented with deep theological issues and concerns. It is desperately imperative that the chaplain is grounded in a strong theological framework to meet the needs of patients, families, loved ones and staff. In comparison, Thomas C. Oden's *Classical Pastoral Care: Crisis Ministries*, offers five key areas of ministry, the care of the sick, suffering, marriage and family counseling, care of the poor and care of the dying. While utilizing a framework for narrative theory and life review, it is important to take into account the whole person: body, soul, and spirit, to prioritize their needs. One of the most important elements of utilizing narrative theory and life review involves offering support,

[149]Maslow, A. H. "*A Theory of Human Motivation."* (Psychological Review 50 1943), 382.

stabilization and appropriate interventions. Active listening is critical, as well as offering unconditional acceptance and reassurance. Offering this kind of nonjudgmental support during a chaplain visit can help reduce stress, improve coping and focus on the divine.

The last step involves helping the patient re-stabilize their lives and become healthy again. This might involve helping the client explore different solutions to the problem, practicing stress reduction techniques and encouraging optimistic thinking. This process is not just about teaching these skills to the counselee, it is also about encouraging the client to make a commitment to continue utilizing and developing these coping skills in the future.

A tool for pastoral visitation and care of the sick is narrative theology. Risk's model on narrative theory details the application of narrative theory with a patient diagnosed with a terminal disease and how the disease may impact the patient's self-image.

> Narrative theory, the phenomenon that the storyteller, the patient, can develop perspective; narrative can be a construct of choice as the storyteller copes with life disrupted by illness, which is woven into a new coherence of past, present and future. In choosing to step out of the story and tell it to another, the patient experiences self as 'more' than the illness; the patient ''contains'' the experience of illness in a larger framework of self-identity. When the chaplain listens attentively and empathically to the story, she can help the patient with a chronic illness move from a denial of its effects to a new acceptance of the self as contingent and spiritual, a self which quests for meaning and purpose in the face of illness without holding out for a restitution of the life as it was before the onset of disease. In terms of spiritual assessment this narrative process of self-examination can lead to a deeper sense of God's providence.[150]

Biblical crisis intervention and biblical counseling are clinical interventions that rely on God to help an individual through a difficult situation. Using the Bible and a relationship allows the chaplain to aid the individual in coping with the precipitating events. Utilizing narrative theory and life review is an additional resource that may equip chaplains to help the patient find

[150]James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98, 85.

resilience and meaning by sharing stories. The goal of pastoral counseling is spiritual growth, although suffering is very real, there is always hope of a perfect eternity after this life. The three parts of a crisis include: 1) a precipitating event; 2) a perception of the event that causes subjective distress; and 3) the failure of a person's usual coping methods which causes a person experiencing the precipitating event to function at a lower level than before the event."[151] Each element of crises must be understood before the counselor can provide support to the counselee. The focus is on single or recurrent problems that are overwhelming or traumatic. If a trauma or crisis is not resolved in a healthy manner, the experience can lead to more lasting psychological, social and medical problems. A crisis occurs when a stressful life event overwhelms an individual's ability to cope effectively in the face of a perceived challenge or threat. First, there is a precipitating event. Secondly, the individual's appraisal of the event is distressing, confusing, or leads to a state of disorganization. Finally, unsuccessful attempts to resolve the crisis are made leading to more distress and lowered energy and a lowered level of overall functioning.[152] Crisis intervention is also defined as the provision of emergency psychological care to victims as to assist those victim's in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma.

There are many different types of grief, and they can be precipitated by specific, identifiable, threatening incidents such as accidents, natural disasters, medical problems, death of a loved one, or loss of a job, and can be due to a single event or an accumulation of small events. There are two main classifications of crises: developmental, situational. Developmental crises

[151]Kristi Kanel, *A Guide to Crisis Intervention. 3rd ed.* (Belmont: Brooks/Cole, 2007), 18.

[152] Ibid, 25.

consist of normal, transitional phases that can be expected as people navigate different life stages. Situational crises involve uncommon and extraordinary events that cannot be controlled.

At the heart of change is desire. Patient's may look within and desire to not be subdued by the world but to overcome it. Christianity is a relationship with God and with Jesus Christ and if the Christian seeks to nurture that relationship by delighting in Jesus and reflecting on His love, then one can truly begin to enjoy the Christian life. Prayer becomes communicating to the person one loves, reading the scriptures becomes listening to that person ad sharing one's faith becomes sharing exciting news of the great things happening in one's life. Romans 8:37 says, "In all these things we overwhelmingly conquer through Him who loved us." There will never be a time in our human existence where we can the patient has reached perfection and complete sanctification. In fact, sanctification is a lifelong process where we are only better than the previous day. The main objective is guiding the individual through the crisis and returning them to a pre-crisis level of coping abilities, and guiding the individual to a renewed state, or a first conversion, to Christianity. In the midst of suffering, man's theology can offer hope and coping mechanisms for survival, or at the very least, a path to the desired afterlife. When the chaplain is called to practice spiritual care, the fundamentals never change; to share the concern and look after the needs of someone's life principles, sacred matters, and religious values.

Framework for Narrative Theory and Life Review

The purpose of proving Christ-centered spiritual care to patients finds its origins in an ongoing, self-sustaining, clear vision for pastoral practice. Any fruitful and successful organization or business model must have a vision to sustain their mission and their service. Below is a list of guiding assumptions to create a missional framework for utilizing narrative theory and life review at the patient's bedside.

1. All people are created in the image of God and, as his image bearers, have infinite value and worth. All have sinned and fall short of the glory of God (Romans 3:23).

2. Everyone has the ability to accept eternal life. "For God so loved the world, that he gave his one and only Son, that whoever believes in him should not perish, but have eternal life" (John. 3:16). The Westminster Confession of faith states "The chief end of man is to glorify God and enjoy Him forever.[153]"

3. Multi-faith, healthcare chaplaincy requires chaplains to have a large enough theology to hear and understand the theology of those they are ministering to and work from their belief system.[154] The chaplain can accomplish this by not making any assumptions, asking questions and listening to their conversations. Professional chaplains can move beyond their own belief system and support the theology of those they are providing care to.

4. The most effective pastoral counseling takes into account the whole person: body, soul, and spirit.

5. Chaplains can utilize the FACT spiritual assessment do create a plan of care. What is the patient's faith or beliefs? Are they active in their faith? How are they coping with their situation? Based on the response, what is the proper treatment plan?[155]

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[153]Johannes Geerhardus Vos and G. I. Williamson, *The Westminster Larger Catechism: A Commentary* (P & R Pub., 2002), 2.

[154]Stephen Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook.* (Woodstock, VT, NY: SkyLight Paths Pub. 2014) 7.

[155]Mark A. LaRocca-Pitts, "FACT: Taking a Spiritual History in a Clinical Setting," Journal of Health Care Chaplaincy 15, no. 1 (2009): pp. 1-12, https://doi.org/10.1080/08854720802698350, 1.

6. Different approaches can be helpful with different kinds of people struggling with different kinds of problems.

7. People have various strengths and resources to help them solve their problems.

8. The problem, if the patient is experiencing one, is merely the point in which one can expect to meet God.[156]

9. Communication involves getting rid of your own agenda and trying to understand who the patient is and what they want.[157]

10. Healthcare chaplains can connect the patient with the Divine, which can be a way to escape time and space – allowing the patient to feel mindfulness and to center their thoughts. Mindfulness and present-moment awareness can also be a form of timelessness, in the sense that the present moment is key, not the passing of time.[158]

11. Narrative theory, is one of many theories in the repertoire of chaplain interventions, it is the thread or dominant story in the patient's life. Arthur Frank categorizes four types of bodies 'characters' that are present in the illness narratives: the disciplined body, mirroring body, dominating body, and the communicative body. The narrative depends on how the person experiencing the illness views the barriers of normal life, forcing them

[156]David G. Benner, Strategic Pastoral Counseling: a Short-Term Structured Model (Grand Rapids, MI: Baker Academic, 2004), 23.

[157]John C. Maxwell and Wayne Shepherd, *Everyone Communicates, Few Connect: What the Most Effective People Do Differently* (Pennsauken, NJ: BookBaby, 2014), 44.

[158]Robert C. Atchley, *Spirituality and Aging* (Baltimore: Johns Hopkins University Press, 2009), 127.

to reorient life goals and decisions. Frank describes three interweaving narratives throughout patient's stories; the narrative of restitution, chaos, and quest.

12. Narrative story-telling is a way for others to feel understood.[159] Narrative theory is the collaborative relationship within the psychosocial discipline which creates meaning throughout the illness through "catharsis, persuasion, practical problem solving, and other of the mechanism of psychotherapeutic change. [160]

13. The storyteller is someone who shares the wisdom and understanding that they gain through their suffering and illness. This rejects the idea of victimization from the illness and instead empowers those to come to terms with the illness.

14. The goal of this narrative approach is to empower the patient to achieve personal agency, responsibility, and to articulate what the patient can control in an uncontrollable situation. The goal is to enable a cognitive shift in identity by focusing on meaning making via the quest narrative. Stories allow the patient to redraw maps, have new destinations and restore what the illness has taken away from their humanity by rediscovering who they are and where they are going.

15. Robert Butler describes reminiscence therapy and life review are formed from recalling the past. He defined a structured life review as "A naturally occurring universal process, characterized by the progressive return to consciousness of past experiences and

[159]Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111, 100.

[160]Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 2020), 246.

unresolved conflicts which are surveyed and reintegrated."[161] Life review utilizes questions to identify various plot points and highs and lows of life. It is a process where time comes together for the patient. A short example of life review questions are:

Describe some of your family traditions.
What kind of work did you do? Did you have any hobbies?
What were the biggest challenges you faced?
What were the best times you experienced?
Where did you live?
What, if anything, would you change about this time?
Do you have any regrets?
What are your biggest successes?
Do you have a faith tradition?
What words of wisdom or advice would you pass to your children or grandchildren?
What do you think are the secrets of a meaningful and happy life?
If you could relive any day in your life, what would it be?
Do you have any last message you would like to leave for your loved ones?

16. The time frame to utilizing narrative theory and life review is typically one visit per week in one-hour increments. This allows enough time for the reviewers to process their thoughts between each visit. The patient can often edit and evaluate their memories as well.[162]

17. One of the main benefits of narrative theory and life review is naming and externalizing the problem. By asking questions and externalizing the problem the patient is experiencing, it enables the recipient of care to detach themselves from the prevailing stories that have been shaping their lives and their relationships.

18. Problems are solved; people are not cured.

[161]Barbara K. Haight and Barrett S. Haight, *The Handbook of Structured Life Review* (Baltimore: Health profession Press, 2007), 12.

[162]Ibid, 22.

19. When taking the problem-focused approach, the solution is found by finding what the counselee wants; focusing on what God is already doing in their lives and create change by doing something different.

20. Change is inevitable, growth is optional.

In conclusion, chaplain's minister through a litany of issues all associated with the human condition, none of which can be accomplished without compassion. Patients often respond with an exaggerated response to someone who cares for them and takes time for them. In a busy world, a little touch of humanity creates an overwhelming response. The dying patient may wish to leave a story or something they taught behind to create a sense of immortality.[163] The gift of compassion and sharing stories becomes a reciprocal gift between the chaplain and the patient. As Henri Nouwen states in his reflections on compassion:

> Through compassion it is possible to recognize that the craving for love that men feel resides also in our own hearts, that the cruelty that the world knows all too well is also rooted in our own impulses. Through compassion we also sense our hope for forgiveness in our friends' eyes and our hatred in their bitter mouths. When they kill, we know that we could have done it; when they give life, we know that we can do the same. For a compassionate man nothing human is alien: no joy and no sorrow, no way of living and no way of dying.[164]

The next chapter outlines the methodology that is utilized to address the problem of chaplains not spending enough time at the bedside and providing the best patient care. Chapter three will outline the intervention design and the implementation of the plan as it is utilized the focus group to review and apply the research from the conceptual research.

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[163] Elisabeth Kubler-Ross, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families* (New York, NY: Scribner, 2014), 262.

[164] Henri J. M. Nouwen, *The Wounded Healer* (New York, NY: Doubleday (An Image Book), 1979) Page 49.

CHAPTER 3: METHODOLOGY

The problem is that the spiritual care team at Queen City Hospice are not spending adequate time at the bedside and engaging patients and families, this is both a patient care and compliancy issue. There is a false dichotomy that chaplaincy is a ministry of presence and chaplaincy must be outcome oriented. Chaplains can learn to "think outside the box" and utilize the stories they listen as data.[165] To address the problem of inadequate time at the bedside, there was a four-week training program to incorporate narrative theory and life review into the repertoire of chaplain interventions. The four-week program included a focus group of chaplains who volunteered to be in the study. A qualitative study was utilized to gather information from the focus group. There were surveys and questionnaires before and after the four-week program to measure the efficacy of the program. The surveys were conducted through Survey Monkey. Lastly, this process includes interviews by chaplains within the focus group to gain a better perspective of their current ministry practices, the challenges they face and how these clinical interventions can help them in their ministry.

Intervention Design

The purpose of this project is to develop a framework for narrative theory and life review at Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice. The concerns of low-patient time and compliancy have prompted a need to assess the current practices of spiritual care within the healthcare agency. There was a review of current practices by surveys, questionnaires, and interviews with the focus group. A copy of the IRB approval letter is in Appendix A. The focus group includes volunteers from the current spiritual care team

[165] Steve Nolan, "Lifting the Lid on Chaplaincy: A First Look at Findings from Chaplains' Case Study Research," *Journal of Health Care Chaplaincy* 27, no. 1 (February 2019): 1-23, 2.

of twenty chaplains, a minimum of ten was preferable to conduct the four-week intervention program. The recruitment form is listed in Appendix B and a copy of the consent form is in Appendix C.

During the four-week program, the chaplain focus group received formal training by providing a framework for utilizing narrative theory and life review for longer and meaningful visits. Equipping the spiritual care department will benefit the chaplains, the agency, the staff, and ultimately patients, families and loved ones. By the utilization of pre-tests and post-tests, this project assesses the baseline knowledge of clinical skills and then measures the effectiveness of the 4-week program. The sample pre-integration survey is recorded in Appendix D. The sample post-intervention survey is captured in Appendix E. This case study will also examine the usefulness of narrative therapy as an effective tool for building resolve and resilience in the lives of those experiencing grief and loss. Interviews were also utilized for this project at the conclusion of the four-week intervention. The interviews will last for no longer than twenty-five minutes. The interviews were in person at the branch offices, or via teleconference. A list of interview questions is recorded in Appendix F.

These interventions can make a change in the stated problem by equipping hospice chaplains with a complex framework for narrative theory and life review. These clinical interventions may provide the spiritual care team with theories and practical applications that they may not be familiar with. With proper training and education, the chaplain team may utilize this framework to have longer visits with structured dialogue.

This project will inform the chaplains in the focus group with the opportunity to meet once a week for four weeks for didactic sessions on narrative theory and life review. These

meetings were conducted via Zoom, due to the unexpected nature of gathering during the Covid-19 pandemic and the chaplains who were in various locations throughout the Ohio hospices.

It is currently true that the spiritual care teams at Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice are all committed to providing the best end-of-life care. It is also true that the chaplains may not be formally educated in narrative theory and life review in the context of end-of-life care. Of the twenty chaplains on the spiritual care team, many have not completed Clinical Pastoral Education where they may have familiarized themselves with these clinical interventions. Lastly, it is currently true that many of the chaplains on the spiritual care team struggle with having short visits and how to lead conversations for deeper meaning.

Implementation of the Intervention Design

The IRB approved the interventional plan. Additional approvals for the intervention project came from the direct supervisor, which is the V.P. of Clinical Operations. Approval also came from the Director of Compliance and Education, a copy of the approval is in Appendix D. After obtaining approvals, the project moved forward with the intervention plan.

An invitational email was sent out to the chaplain and bereavement staff, inviting eligible participants to volunteer to be in the focus group. A formal process for consent from each participant with a written form that they can sign physically or electronically was sent. This is a volunteer group that met over a four-week period. It was be communicated that this is completely optional to be a part of, and it must consider the schedules and caseloads of the chaplains in the focus group. Resources included a conference room at a central location for all the area chaplains. There were PowerPoint presentations, journal articles and hand-outs to

structure the informational content. There was a survey before and after the four-week presentations to measure the efficacy of the intervention program.

Of the spiritual care and bereavement team, there were twelve participants who volunteered to be in the group. Of the thirteen, eleven were chaplains and two were bereavement coordinators. There was a list of questions for the web-based, pre-intervention survey to measure the efficacy of the program and to confirm the information with qualitative research. Next, there were invitations sent out to potential participants. The invitation will inform those involve in this project with the opportunity to meet once a week for four weeks for didactic sessions on narrative theory and life review.

A fair trial period to evaluate the intervention was held a week after the four-week training program was complete. The intervention program will start with clear and measurable objectives to build from. There was adequate time for the group to process and utilize the information received.

A successful outcome for this intervention included participation from the chaplain group throughout the four-week intervention plan. The chaplain team has twenty chaplains and two bereavement coordinators. Another criterion was seeing an increase of knowledge and understanding of narrative theory and life review from surveys, this is documented in chapter four.

The new approach to utilizing narrative theory and life review at the end-of-life may be comparable to current ministry practices. Often, chaplains are utilizing these theories and clinical interventions with being fully aware of the interventions in their entirety. This framework may allow the chaplain team to fully understand the theory behind the interventions and further guide them with leading questions, reminiscent therapy, connecting with patients and having longer,

meaningful visits. The old approach will continue to be a baseline to measure the new approach and its efficacy.

To measure the efficacy of the four-week intervention program, there were open-ended, web-based surveys. The surveys were issued one-week before the program, and one-week after the program. There were also open-ended interviews with chaplains in the group. The interviews gathered information from personal experience and reflective learning to gather information about the positive, or negative, effects of the program. The overall goal is to establish a framework for narrative theory and life review that can be utilized in individual and group sessions. It is essential to adopt a model of pastoral counseling that can be utilized and exercised on a routine basis that will establish a consistent and effective practice.

Triangulation, for gathering data, will be utilized in the form of surveys, interviews and focus groups. The qualitative research extrapolated from triangulation may develop a comprehensive understanding of the issue's chaplain's face. The research gathered from triangulation may validate the application of narrative theory and life review.

Throughout the research project, there was a reflective journal to limit any biases towards the research and its findings. The journal was utilized to capture new thoughts and feelings throughout the intervention plan. The journal was also used for analyzing ideas and for problem-solving. The journal was useful for limiting biases about the superiority of utilizing narrative theory in chaplain visits, instead of other common approaches.

This project was explained to the participant group via conference calls and handouts prior to the four-week training program. During the four-week program, there were materials to educate the chaplain team by providing them a framework for utilizing narrative theory and life review for longer and meaningful visits.

There was ongoing encouragement for the team to fully participate. The possibility existed for chaplains who did not want to participate because of heavy caseloads or lack of interest in the subject matter. It was an intentional part of the initial outreach to encourage chaplains to freely choose to be a part of the group. If a participant dropped out of the group, it would have been fully documented.

Meeting One:

The first meeting took place on Friday, May 28th, 2021, from 9:00AM -10:00AM. All thirteen participants meet virtually through Webex. During the group session, a chaplain commented about how narrative theory and life review would not apply to a dementia patient. The lack of cognitive and conversational abilities would prevent the full application of this theory. It was suggested that narrative theory and life review could be utilized with the family and loved ones to help them cope with their grief and the honor the patient's life and legacy. Furthermore, pictures, mementos, reading memoirs, could all allow the patient to recall the past. Another chaplain reflected on ministering to a patient with Alzheimer's disease who was a military veteran. The facility staff alerted the chaplain that the patient was often violent and was challenging. The chaplain sat down with the patient and began speaking about the war and serving in the military. During each visit, the patient showed no signs of conflict or difficulty.

Lastly, there was a recommendation to compile a list of readings to share at the end of the four-week group. After the first group, there was a homework assignment to read and review two journal articles outlining the concept of narrative theory: Building a New Life: A Chaplain's

Theory Based Case Study of Chronic Illness[166] and Chaplaincy and Narrative Theory: A Response to Risk's Case Study.[167]

Meeting Two:

The second meeting took place on Friday, June 4, 2021, from 9:00AM-10:00. After the introduction, there was a PowerPoint led discussion about the foundations and application of narrative theory and end-of-life care. The focus group reflected on how they have been applying narrative theory and life review in recent visits. Many suggested that they have already been utilizing various forms of narrative theory, however, they did not have an understanding of its full application. Chaplain D noted that "As a chaplain, I do not invade their (the patient's) space." Staff members come in and turn the patient and do personal care, however, Chaplain D reflected on the fact that chaplains simply come in to visit with the patient and learn from them. Chaplain S challenged the idea of guiding the patient towards a quest narrative and reflected on his CPE where he was instructed to "dig into the quest narrative," and sit with the feelings. Chaplain S was challenged by the idea of guiding the patient from a chaos narrative to a quest narrative, and explained the benefit of allowing the patient to name their feelings and to journey alongside them. Chaplain J reflected on how he has been utilizing narrative theory and life review in his visits. He reflected on a life review he facilitated with a patient and noted how there is often silence after he asks the patient a question. The silence creates time for the patient to reflect on their thoughts and articulate an answer. Many chaplains agreed that sitting in the silence can often be uncomfortable as the patient searches for words; some chaplains stated they

[166] James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 81-98.

[167] Daniel H. Grossoehme, "Chaplaincy and Narrative Theory: A Response to Risk's Case Study," *Journal of Health Care Chaplaincy* 19, no. 3 (2013): 99-111.

often fill the need to fill the silence. Chaplain M explained how he has been utilizing narrative theory, specifically with a home patient. Chaplain M expressed that sometimes there is great sadness when the patient's story begins to come out. He reflected on how the home patient was looking through family pictures with him and she reflected on her son who died from an overdose, as well as her granddaughter. Chaplain M reiterated that there needs to be space for the story to be heavy and grief care may be necessary. Chaplain D followed up with how he is utilizing narrative theory and stated that he attempted to lead a life review with a Holocaust survivor, however, she had dementia and noted the patient struggled with parts of her story. Chaplain C had worked with one of the authors of the journal articles in a previous position. He reflected on the culture of modern hospital chaplaincy and how the focus is shifting towards outcomes-based chaplaincy. The group expressed their thoughts on the importance of having a chaplain on staff, especially the emergence of private companies hiring corporate chaplains to provide spiritual, mental, and emotional care. Chaplain C also noted how he was always challenged to ask, "why am I asking the questions I am asking," and to thoroughly document the results and outcomes of his interventions.

One question the group was asked is, how could narrative theory and life review be utilized without the opportunity to have multiple patient visits? Put another way, how could this theory be utilized in an acute, crisis situation? Some of the chaplains reflected on how the patient needs to trust the chaplain prior to sharing their story; some patients come from backgrounds where they do not have clergy, or clergy has hurt them emotionally or otherwise, therefore it creates a barrier to establishing trust. Chaplain J reflected on his CPE education and how he was encouraged to utilize his pastoral authority. Others agreed that the chaplain needs to establish trust and confidence with the patient in order to hear their story. Some chaplains admitted that

patients and family often want interventions when they ask for a chaplain, such as prayer, scripture reading and anointing. It was discussed that even in these short-term scenarios, narrative theory and life review can be utilized to gather story and establish relationship building and the concluding prayer can repackage the story and the emotions. In conclusion, it was suggested that narrative theory and life review go hand-in-hand as narrative theory is beneficial for multiple patient visits while life review is most beneficial for a short-term model.

The training session concluded with a copy of the PowerPoint handouts and a "homework" assignment for the following week, also located in Appendix G. Each participant was given questions to reflect on and journal for a structured life review. Each participant was encouraged to document their personal life review and voluntary share them during the next training session. This method inspires the idea of action-reflection research. The questions for structuring a life review included:

> When did you feel most alive? What stands out in your memory are the best times in your life?
> What do you want your family to remember about you?
> What important roles have you played in life: family, work or community?
> What accomplishments do you feel most proud of?
> Is there anything you want or need to say to your loved ones? If so, what would it be?
> What are your hopes and dreams for your loved ones?
> What have you learned about life that you want to share with others, such as advice or words of wisdom about the future?[168]

Meeting Three:

The third meeting took place on Friday, June 11th, 2021, from 9:00AM-10:00. After the introduction, there was a PowerPoint led discussion about the foundations and application of life

[168] Stephen Roberts and Nancy Osborne, "Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook," in *Professional Spiritual & Pastoral Care: a Practical Clergy and Chaplain's Handbook* (Woodstock, VT: SkyLight Paths Pub., 2014), pp. 149-161, 150.

review, the focus group shared their own life review. There was an emphasis on protecting confidentiality within the group as some information was very sensitive and personal. It was referenced that chaplaincy has always been "clothed in ambiguity and protected by confidentiality." The focus group learned how life review can help patients to accept the things they cannot change. It is a psychotherapeutic proves that connects the content with the mind, and the process with the heart.

While sharing life reviews, Chaplain C critiqued the application of life review as "questions that a social worker would ask." He noted that the process is like "Charles Dickens, it was the best of times, it was the worst of times,[169]" in a patient's life. Chaplain C had strong reactions to the idea of secularizing healthcare chaplaincy by integrating psychotherapy. It was suggested that a formal life review can serve as the foundation for theoretical application for chaplains to utilize and integrate into their ministry context. Chaplain C then suggested that a rewording of the questions might sound like, "When did you feel most connected to God or a higher power?" Chaplain J included that the reverse question could be asked, "When did you feel farthest away from God?"

Chaplain M also suggested the life review questions could be reworded to initiate further discussion on spirituality and beliefs. He suggested one of the spiritual life review questions may be asked, "When did you feel most abandoned by God?" Chaplain C then elaborated on how his mother was the spiritual epicenter of his life and when she died, he felt alone. He could not continue his thoughts, for being emotionally overwhelmed. It was then introduced, that sometimes life review questions may uncover grief, despair, and dark stories. Chaplains must be prepared to sit with the emotions that come from sharing stories and then make the appropriate

[169] Charles Dickens, *A Tale of Two Cities* (Allyn and Bacon, 1966), 1.

referrals as necessary. Chaplain D noted that some of the response's chaplains receive are similar to "The Dark Night of the Soul,[170]" by John of the Cross, sometimes we "weep and we weep alone." Chaplain D then quoted A Grief Observed, by C.S. Lewis, we go to God when we are desperate, "and what do you find? A door slammed in your face, and a sound of bolting and double bolting on the inside. After that, silence.[171]" When emotions are stirred, sometimes there is unresolved conflicts the patient or caregiver may have with the divine, and chaplain must be aware of such occurrences as they respond and navigate through the narratives.

Chaplain R suggested there may often be a spiritual correlation between the highs and lows of life that are examined during a life review. He phrased a potential question as "have you been able to see/hear/feel God in the midst of your despair and joy?" A life review can provide the possibility of deeper engagement not only with the patient's "highs and lows of life," but a framework for has they have engaged the divine throughout different events in life.

During the life review exercise, often there was a long silence after a question was asked, which may be due to the personality types in the group or the vulnerability that the questions require. It was articulated that a level of trust must be present between the chaplain and the patient to share deep, meaningful conversation. During the exercise, the chaplains and bereavement coordinators shared memories, hopes, life lessons and personal reflections. The interwoven theme throughout each answer was the need to make family a priority. Bereavement coordinator T shared that her mother recently died of cancer, and that she was fortunate to hear her life review. She realized the importance of family and how she continues to make her family a priority. The meeting concluded with a quick summation of topics discussed and then shifted

[170] John of the Cross. *Dark Night of the Soul.* (New York: Riverhead Books, 2002).

[171] C. S. Lewis, *A Grief Observed* (London: Faber & Faber, 1973), 55.

the conversation to the agenda for the last meeting. The fourth meeting will layout a practical application for chaplains to utilize narrative theory and life review.

Meeting Four:

The fourth and final meeting took place on Friday, June 18th, 2021, from 9:00AM-10:00AM. The training meeting opened with a PowerPoint presentation which put together the information from the past four training sessions, to create a working framework for narrative theory and life review in the chaplain context. The framework outlined assumptions and practical application for utilizing these social theories at the bedside. After the presentation, there was open dialog about how chaplains are currently applying the information learned. Chaplain R opened the conversation marveling at the "power of narrative." He continued to tell the story of his stroke that he suffered from a few years ago and learned that it was all his fault that he had the stroke, given his life choices – the lack of exercise, taking too many medications. Chaplain R stated, "I told the story and it brought healing." He also stated that he was visited by a hospital chaplain, while recovering from his stroke, and the chaplain was the only person who did not want to "prod and poke" with needles, but instead was concerned and curious about him. It was "incredibly powerful," to simply share his story. The hospital chaplain also shared Romans 8:1, "Therefore there is no condemnation for those who are in Christ." Chaplain R reflected on the vulnerability and trust that takes place when sharing stories, and that it also provides a conduit for healing and validation. He wants to continue to reflect on the differences and similarities between a cure and healing.

Chaplain M reflected on his CPE education and utilizing narrative theory for the first time to explain a reoccurring dream. In his dream, he was in a house and the house had a secret room filled with treasure. After sharing stories of his dream, his life and his personal stories, it

was concluded that the house in his dream represented himself. He had been self-critical for years. The secret room filled with treasure was reflected the great parts of himself that each person carries within them. Chaplain M concluded that narrative theory has taught him that each person has so many gifts that we do not often acknowledge.

The question was presented to the team: What happens when the narrative uncovers a difficult story that the chaplain is not prepared to respond to? Chaplain S answered, “If I am anxious, I take a deep breath and as myself ‘what am I saying or thinking that makes me feel uncomfortable?’” He then reflected on that and names the feeling for both himself and the patient. Together they name the feeling and reflect on the story being told. Chaplain S shared a way of utilizing countertransference as a tool instead of a barrier. Chaplain D brought up the question about how many chaplains have CPE and have benefited from it. Chaplain R reflected on his pastoral ministry and that he did not take CPE. Instead, he stated that life experience and ministry experience has proved to be valuable and sufficient for chaplaincy work. Other members of the group agreed that life experience is necessary and often preferred at the bedside.

The four-week focus group concluded with a summary of narrative theory and life review. The group concluded by encouraging each other to continue learning and growing in chaplaincy skills and practical application. Lastly, the group encouraged each other to continue enjoying the ministry that they are called to as they journey with patients, families and staff throughout the end-of-life. After the training meeting, the post-intervention survey was sent out to the focus group. The pre-training, post-training, personal interviews and notes from the focus group will all serve as a means of triangulating the efficacy of the intervention program. In qualitative research, triangulation utilizes multiple sources of data to provide a complete understanding. These strategies will continue in chapter four.

CHAPTER 4: RESULTS

This chapter will record the results from the pre-intervention and post-intervention surveys. The information will be utilized to gain an understanding of the baseline clinical practices of the chaplain focus group. The information will provide insight on the educational and experience level of each chaplain. The surveys should show an increase of knowledge, understanding and application of narrative theory and life review. Graphics and charts will be utilized to share the information gathered. Lastly, the interviews will record a deeper understanding of how the chaplain team utilizes narrative theory and life review. The interviews may determine some barriers that chaplains encounter with visit duration and the efficacy of their clinical interventions.

The focus group had a total of twelve participants, ten full-time chaplains, one full-time bereavement coordinator and one full-time social worker/bereavement coordinator. The purpose and direction of this research is an attempt at quantifying the applicability of narrative theory and life review in the context of healthcare chaplaincy. With proper application, it is possible that while utilizing these social theories, and adapting them to the ministry context, chaplains could have longer patient visits with increased meaning-making opportunities. It is also possible that the information provided to the focus group could renew their desire to provide spiritual care and bolster their confidence while utilizing trending clinical interventions.

Survey Results

The first question of the survey asked the chaplain and bereavement team about the average amount of time that they spend at the bedside. This question is multifaceted; it directly asks the question of visit times while encouraging the participants to become more aware of the time they are spending with patients. It should be noted that increased time does not always

translate to more effective visits, however, production time is monitored in a healthcare agency. The expectation for a patient visit is forty-five minutes to one hour in duration. This survey question suggests that chaplains are not meeting this expectation. Other considerations such as time at the bedside and caseloads, both factor into hiring and emphasizing the need and efficacy for outcome-oriented chaplaincy.

The information obtained from the first survey suggested that 83% of the spiritual care team spends over thirty minutes at the bedside. However, after the four-week training program, the survey indicates that roughly 67% of the spiritual care team spends over thirty minutes at the bedside. This information is largely subjective and does not capture the averages for patient times, however, there are metrics in place to find these exact times within the agency's Electronic Medical Records; the same metrics which justify hiring requisitions for chaplains. The results from this question seem to indicate the possibility for increased awareness of visit durations and time spent at the bedside.

Figure 1. Pre-Survey Question One

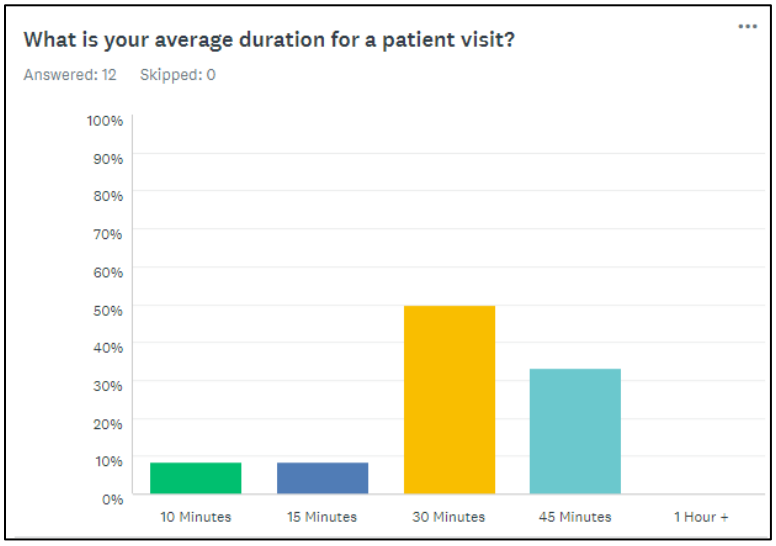
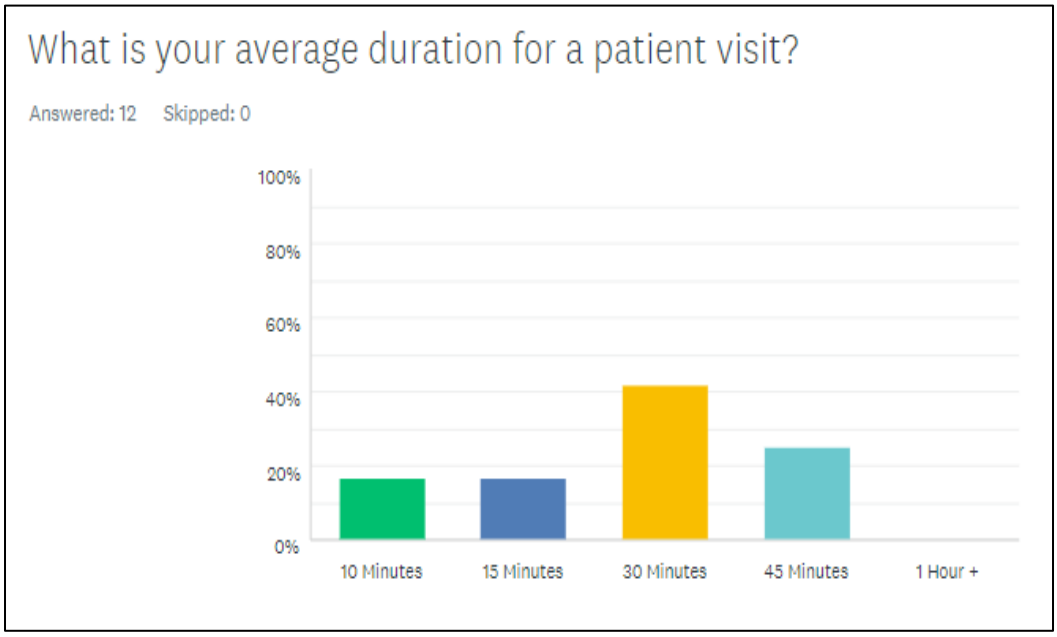


Figure 2. Post-Survey Question One



The second survey question is directly linked to the first survey question and moves from quantifying the average amount of time at the bedside to a personal reflection of whether the spiritual clinician is concerned about the time they spend at the bedside. The first survey suggested that 58% of the focus group was not concerned with the amount of time they spend at the bedside; the number jumps higher in the post-intervention survey to 75% of the group stating they are not concerned with visit times. It is possible that throughout the intervention program, the spiritual care team became more aware and confident about their clinical times and interventions. It is also possible that with education and training, the expectation of visits lasting forty-five minutes to one hour will be upheld. A question that was not asked in the surveys could ask what barriers or factors stand preclude the chaplain from having longer visits? It is likely that barriers include patient responsiveness, visitors, time of day, etc. Even so, chaplains can learn to adapt to challenges poised to meeting the expectations of hour-long visits and engage the patient is therapeutic spiritual care with the appropriate level of clinical interventions.

Figure 3. Pre-Survey Question Two

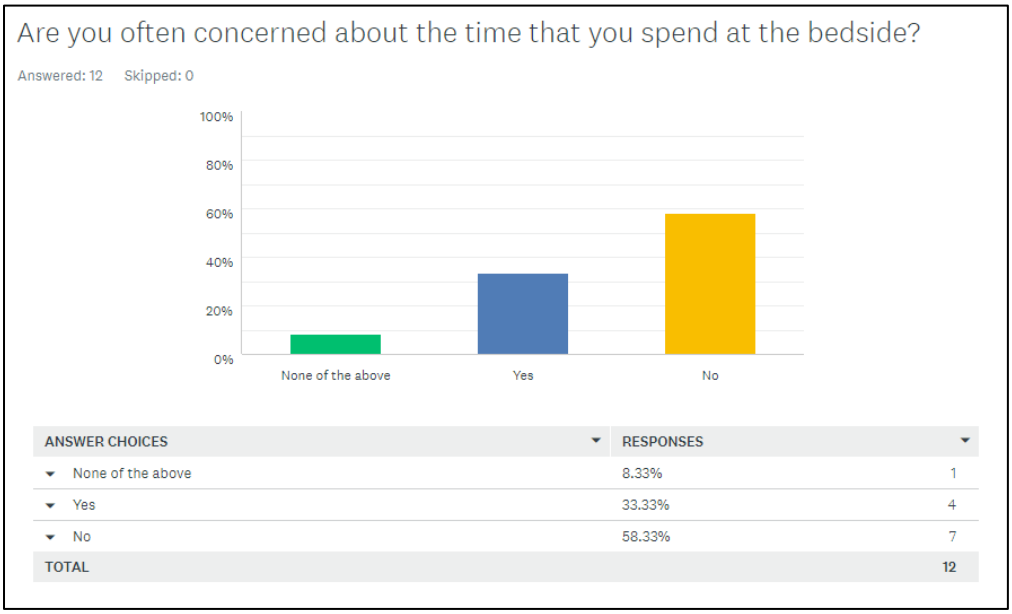
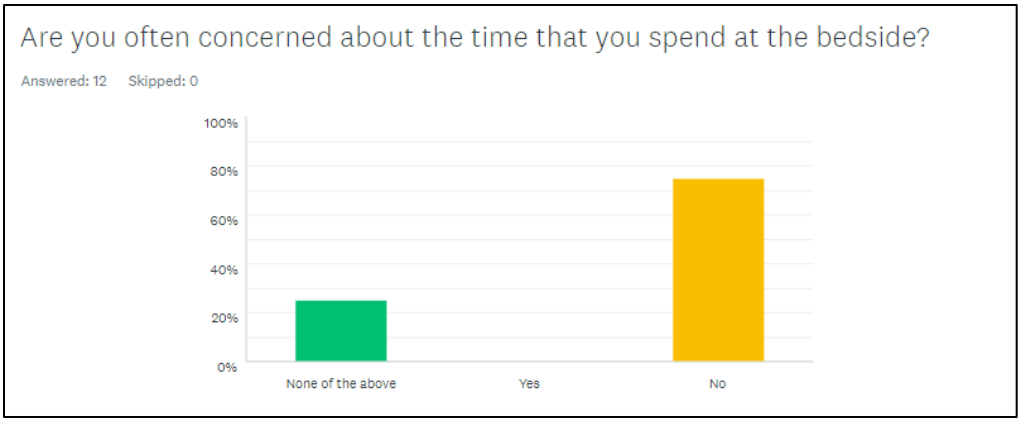


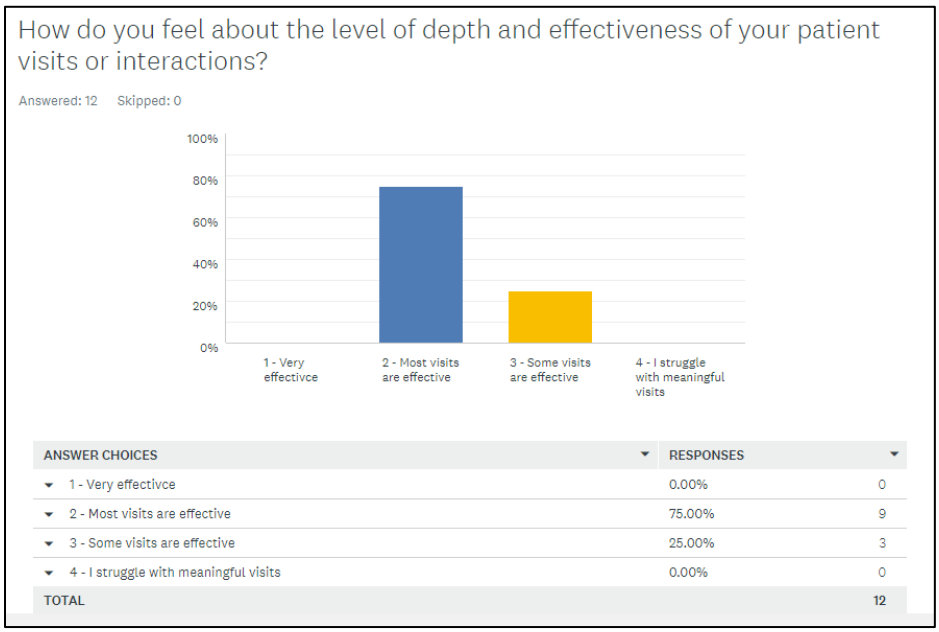
Figure 4. Post-Survey Question Two



The third survey question goes a step deeper into how the spiritual care department feels about the efficacy of their patient visits and interactions. Again, this question is highly subjective, however, it attempts to reveal what each chaplain perceives about themselves. The pre-intervention survey suggested that 75% of the focus group believes that most of their visits are effective, with 25% believing that some of their visits are effective. The statistics jump dramatically in the post-intervention survey, where 91% of the focus group believes that most visit are effective. The reason for the 16% increase can only be assumed, however, it is possible

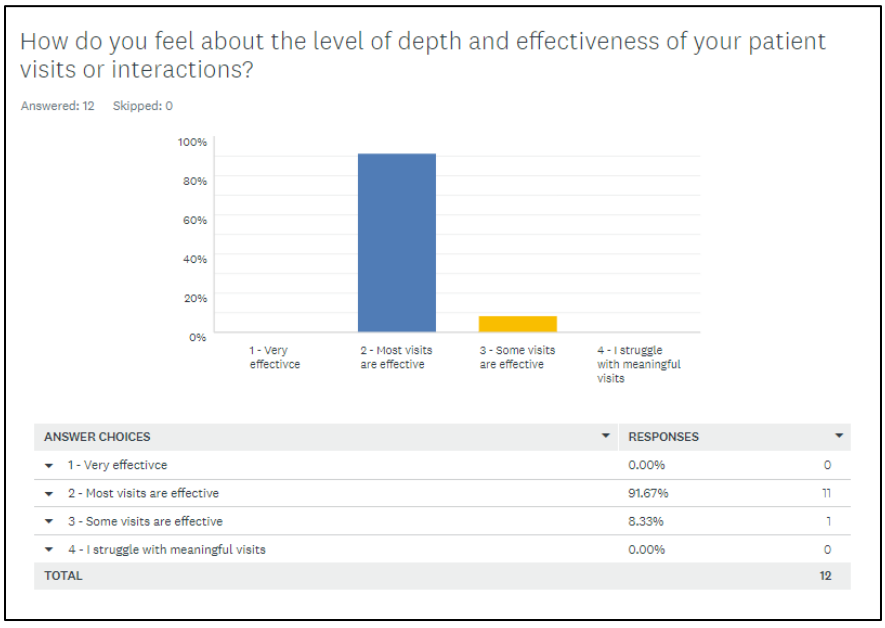
with personal reflection, and the focus group may feel more confident in their skills and abilities performed at the bedside.

Figure 5. Pre-Survey Question Three



ANSWER CHOICES	RESPONSES	
1 - Very effectivce	0.00%	0
2 - Most visits are effective	75.00%	9
3 - Some visits are effective	25.00%	3
4 - I struggle with meaningful visits	0.00%	0
TOTAL		12

Figure 6. Post-Survey Question Three

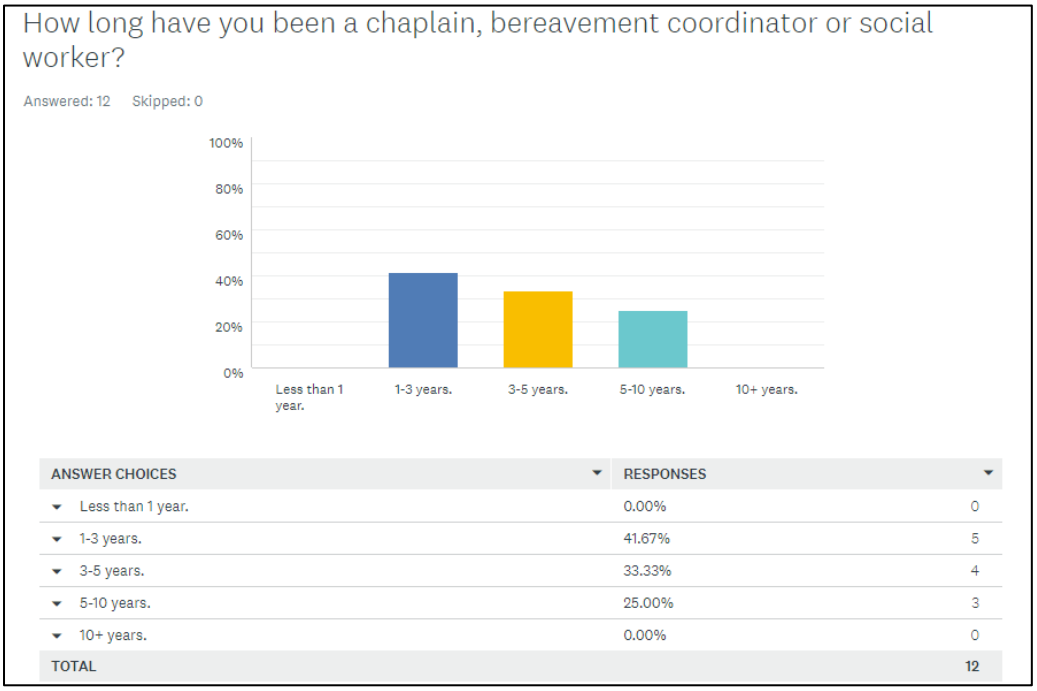


ANSWER CHOICES	RESPONSES	
1 - Very effectivce	0.00%	0
2 - Most visits are effective	91.67%	11
3 - Some visits are effective	8.33%	1
4 - I struggle with meaningful visits	0.00%	0
TOTAL		12

The fourth survey question measured the length of time that each participant has been in their occupation. The question asked how long they have been a chaplain, bereavement

coordinator or social worker. Within the focus group, a large number of the participants were relatively new to the healthcare chaplaincy and bereavement field, with 41% being in their position for 1-3 years; 33% were in their role for 3-5 years, and 25% of the group had served in their capacity for 5-10 years. It is noted that no one had been in their position for less than a year, or over ten years.

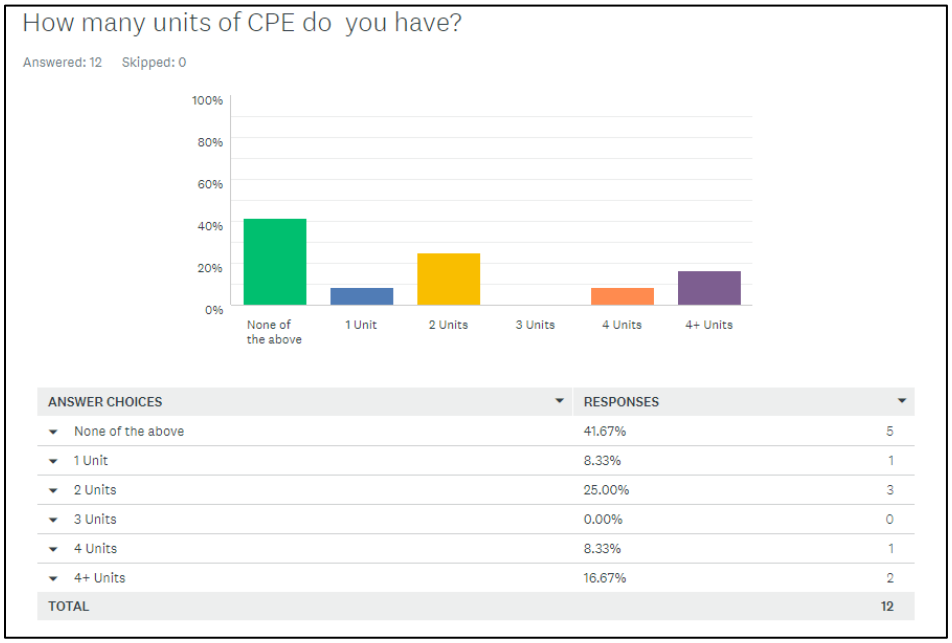
Figure 7. Pre-Survey Question Four



ANSWER CHOICES	RESPONSES	
Less than 1 year.	0.00%	0
1-3 years.	41.67%	5
3-5 years.	33.33%	4
5-10 years.	25.00%	3
10+ years.	0.00%	0
TOTAL		12

The fifth survey question also inquires of experience and education related to how many units of clinical pastoral education each participant had. It should be addressed that chaplains are not required to have CPE in hospice; however, it is highly encouraged. CPE is based on the idea of action-reflection, and it vital for clinical chaplaincy. Within the focus group, 41% of the participants did not have formal CPE training; 8% had one unit, 25% had two units, 8% had four units and 16% had over four units. This information provided insight on the clinical background of the group.

Figure 8. Pre-Survey Question Five



ANSWER CHOICES	RESPONSES	
None of the above	41.67%	5
1 Unit	8.33%	1
2 Units	25.00%	3
3 Units	0.00%	0
4 Units	8.33%	1
4+ Units	16.67%	2
TOTAL		12

The sixth survey question examines whether the spiritual care and bereavement team are currently utilizing narrative theory and life review in their clinical context? Prior to the start of the training program, 50% of the focus group stated they were already applying narrative theory to their clinical work. The initial baseline assessment showed that this theory is already widely adopted as a clinical practice and intervention. In the post-survey, the number of those utilizing narrative theory, at the time of this survey, jumps 25% to 75%. Again, it is possible that equipping chaplains with the intervention of narrative theory may lead to performance-based outcomes such as increased time at the bedside and providing excellent patient care with new clinical interventions.

Figure 9. Pre-Survey Question Six

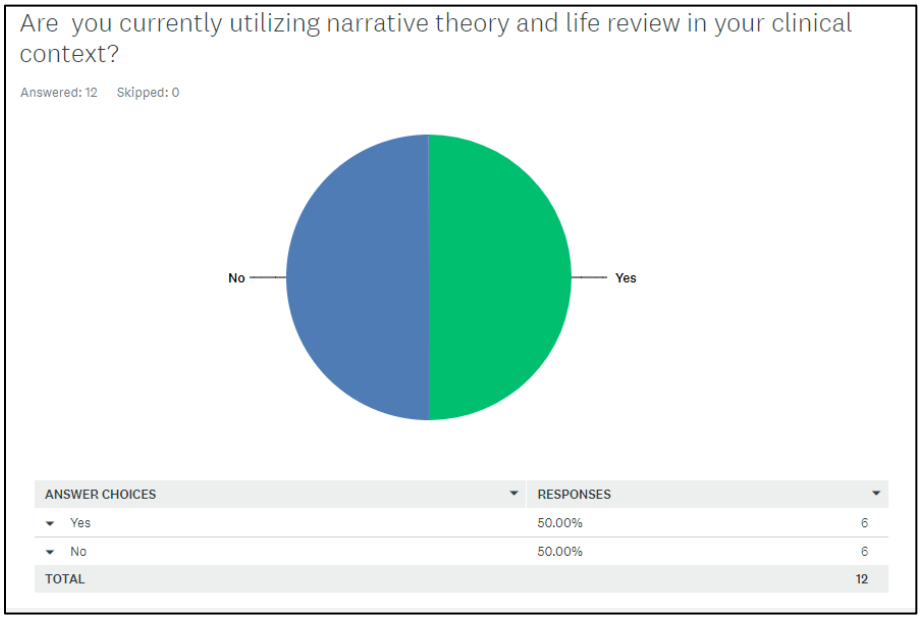
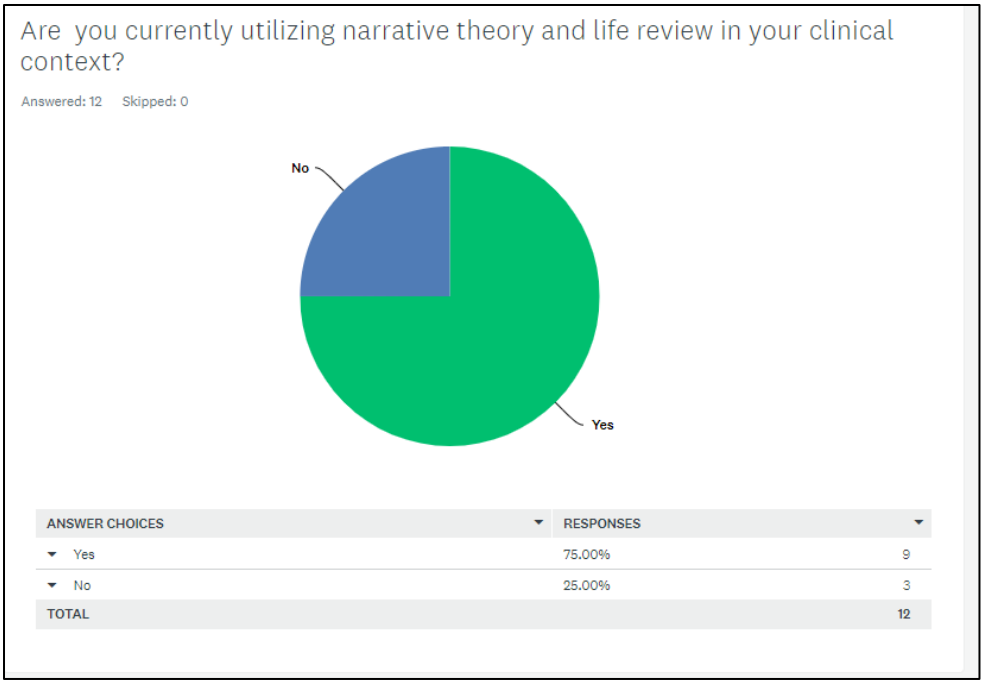


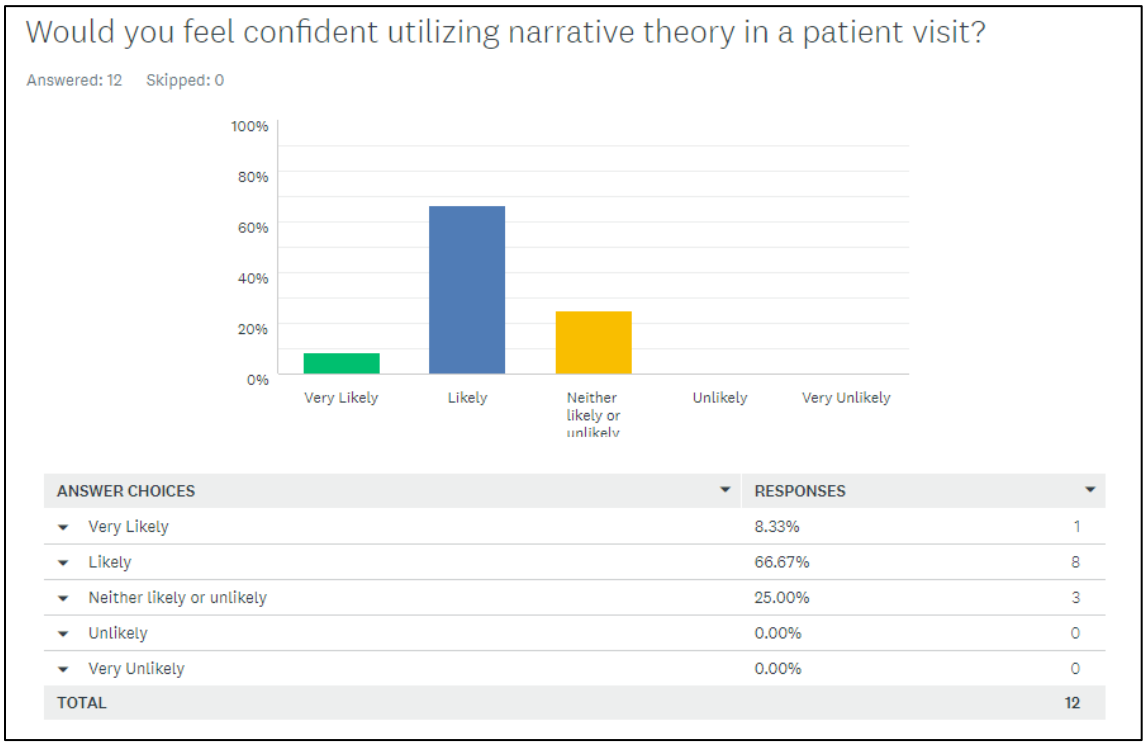
Figure 10. Post-Survey Question Seven



The seventh survey question build from question six and asks if the participant would feel confident utilizing narrative theory with a patient. The pre-survey results suggest that 8% of the focus group would feel "very confident" leading a life review, with 66% saying they would

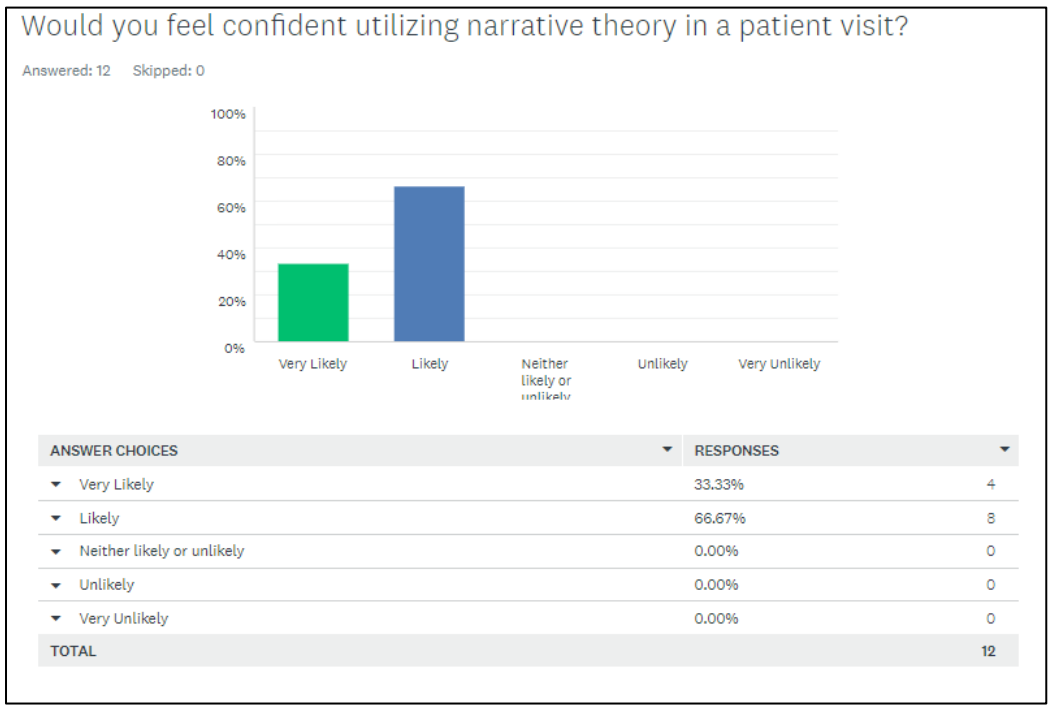
"likely" feel confident, and 25% reporting they would feel indifferent. In the post-survey, the numbers shift to 33% feeling "very likely" and 66% feeling "likely." These indicators reveal the possibility that education and awareness can lead to clinicians using therapeutic interventions and feeling confident about their skills. Also, there may not be clinical opportunities for these interventions to be utilized. For example, bereavement coordinators may not have the allotted time necessary to utilize these interventions with every interaction they have with bereaved family members and loved ones. Often, bereavement counselors offer support over the phone and therefore do not have the opportunity to sit down, face-to-face with those whom they are offering support. Lastly, there may be a personal lack of preference to utilizing this theory. It is within the functioning autonomy of the clinician to utilize the practices and theories in which they deem as effective.

Figure 11. Pre-Survey Question Seven



ANSWER CHOICES	RESPONSES	
Very Likely	8.33%	1
Likely	66.67%	8
Neither likely or unlikely	25.00%	3
Unlikely	0.00%	0
Very Unlikely	0.00%	0
TOTAL		12

Figure 12. Post-Survey Question Seven

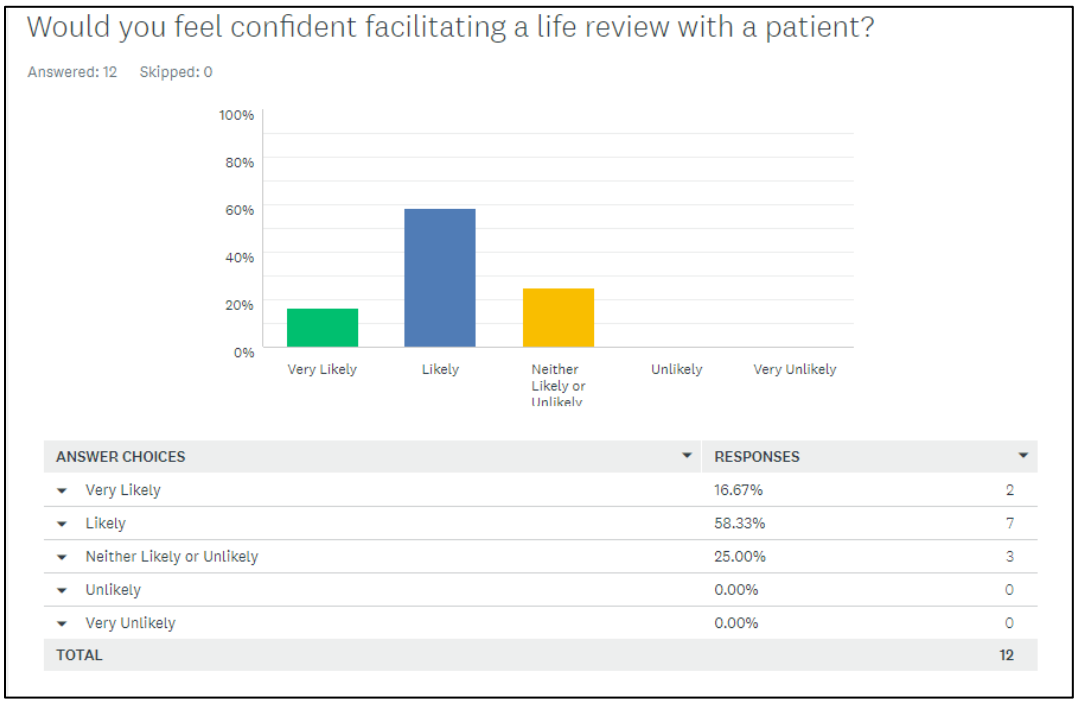


ANSWER CHOICES	RESPONSES	
Very Likely	33.33%	4
Likely	66.67%	8
Neither likely or unlikely	0.00%	0
Unlikely	0.00%	0
Very Unlikely	0.00%	0
TOTAL		12

The eight-survey question is similar to the seventh question. The focus group was asked if they would feel confident leading a life review with the patient. Those who answered, "very likely" were 16%, those who answered "likely" were at 58% and lastly 25% reporting "neither likely nor unlikely." In the post-intervention survey, the numbers change to 41% answering they would feel "very likely," 50% as likely and 8% "neither likely nor unlikely." Much like the aforementioned survey question, it can be assumed that education and reflection may have led to overall confidence and application of utilizing new clinical methods. A four-week training period for action-reflection based material is ideal for equipping chaplains with the clinical intervention of narrative theory. Throughout the duration of the training period, the focus group demonstrated enthusiasm for learning narrative theory. The conversations after the lectures were fruitful and it seemed that most participants reviewed the journal articles and reflected on applying them to

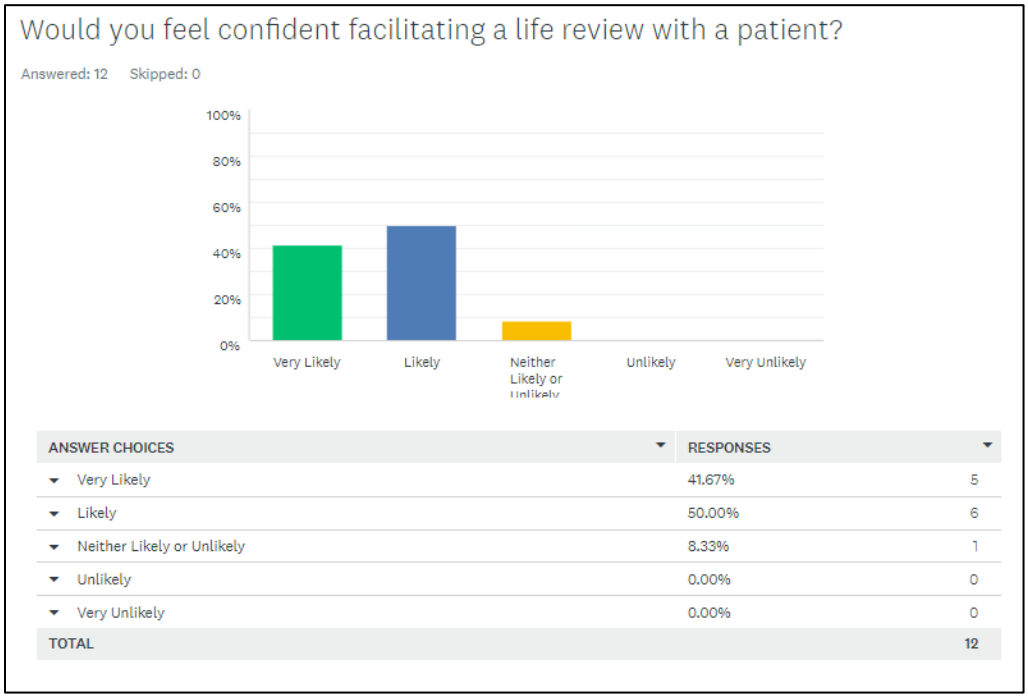
their patient visits. It could be, that it just requires time for confidence to grow with the application.

Figure 13. Pre-Survey Question Eight



ANSWER CHOICES	RESPONSES	
Very Likely	16.67%	2
Likely	58.33%	7
Neither Likely or Unlikely	25.00%	3
Unlikely	0.00%	0
Very Unlikely	0.00%	0
TOTAL		12

Figure 14. Post-Survey Question Eight



ANSWER CHOICES	RESPONSES	
Very Likely	41.67%	5
Likely	50.00%	6
Neither Likely or Unlikely	8.33%	1
Unlikely	0.00%	0
Very Unlikely	0.00%	0
TOTAL		12

The ninth survey question asks if the focus group has previously utilized narrative theory in their clinical work. A third of the participants said they were utilizing the social theories prior to the start of the intervention training. In the post-survey responses, the number of those actively utilizing narrative theory grows from 75% to 83%. This survey indicates some familiarity with narrative theory and life review, the slight increase from the pre-survey to post-survey indicates the possibility that the participants are utilizing the theory as a result of the education provided.

Figure 15. Pre-Survey Question Nine

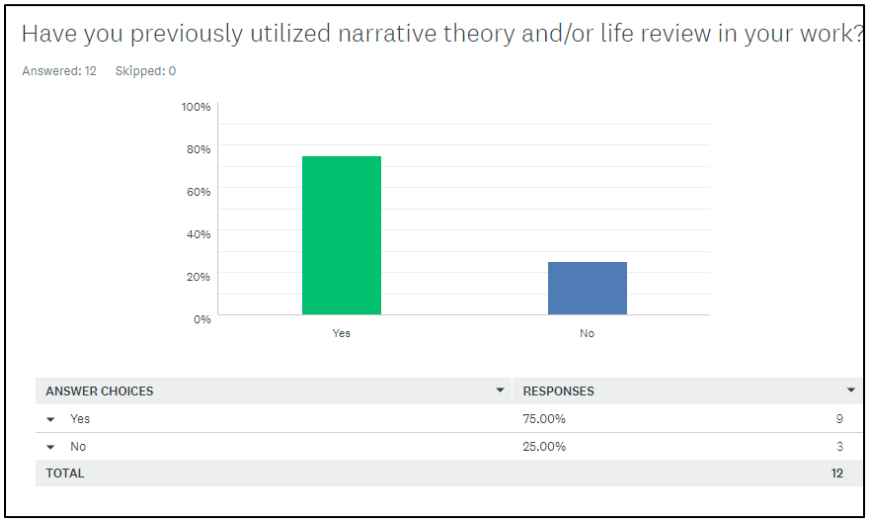
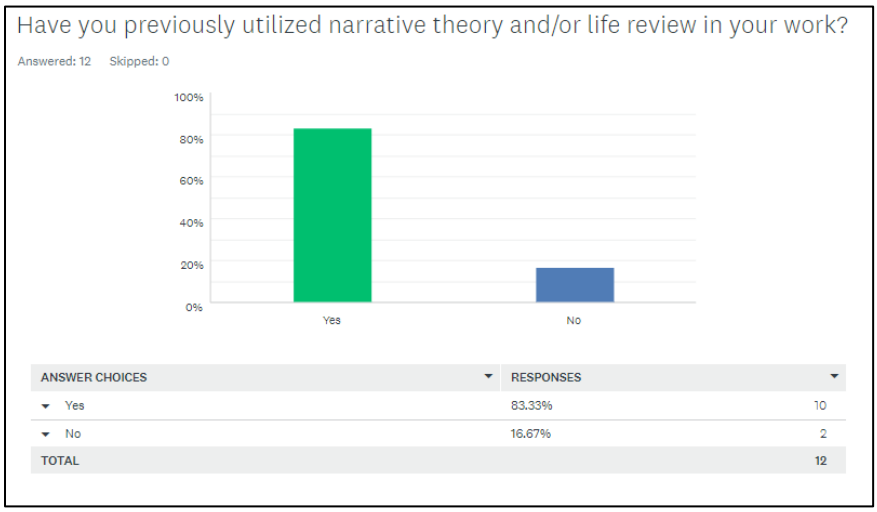


Figure 16. Post-Survey Question Nine

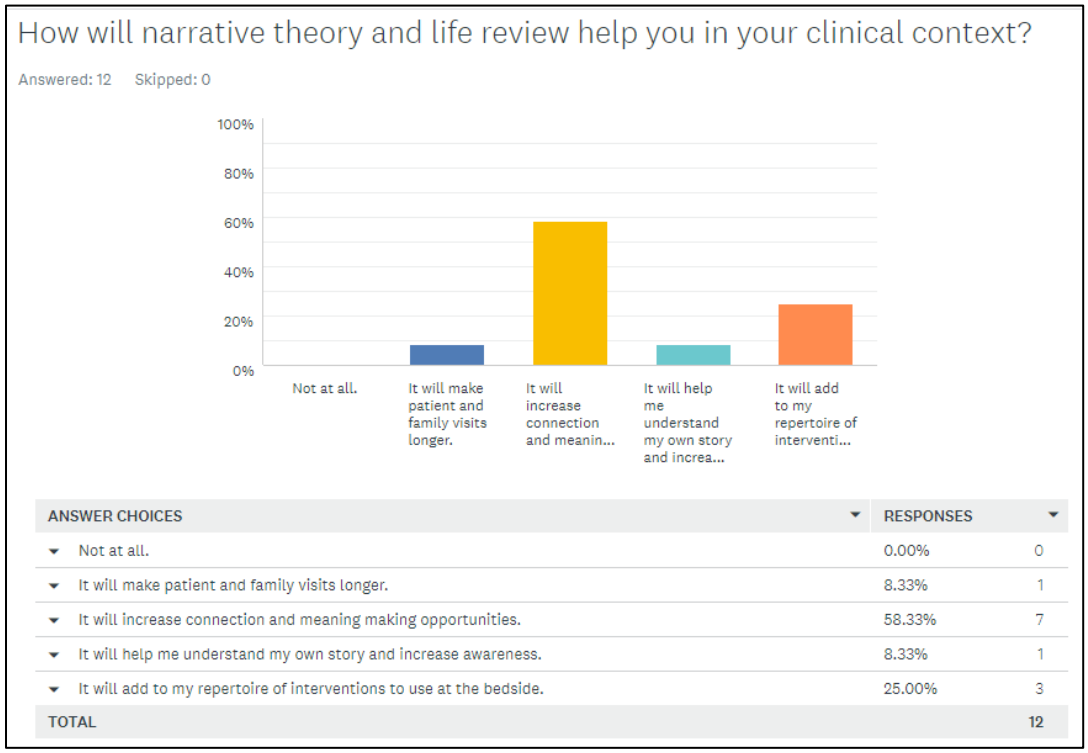


The tenth survey question asked the participants of the focus group "how will narrative theory and life review help you in the clinical context?" In the pre-survey, 8% report that it will make their patient visits longer, 58% suggest that it will "increase connection and meaning making opportunities," 8% state that it will help them understand their own story and increase awareness, and 25% say that it will add to their repertoire of interventions at the bedside. It is interesting to note, in the post-survey results 75% of the participants state that narrative theory and life review will increase connection and meaning making opportunities; 8% of the group stated that it will help them understand their own story and increase awareness, and 16% suggested that it will add to their repertoire of interventions.

The question reveals the priority of the spiritual care team to increase how they connect with patients and create meaningful dialogue. The members of the focus group seem to not be concerned with their visit time as their priority is to connect with the patient and provide ways to establish meaning and purpose within the patient visit. This is not entirely a disconnect from the expectations established by the healthcare agency, the business exists to serve patients and to become a financially stable enterprise that centers expectations on compliancy. There must be justification and guidance for the work that chaplains provide.

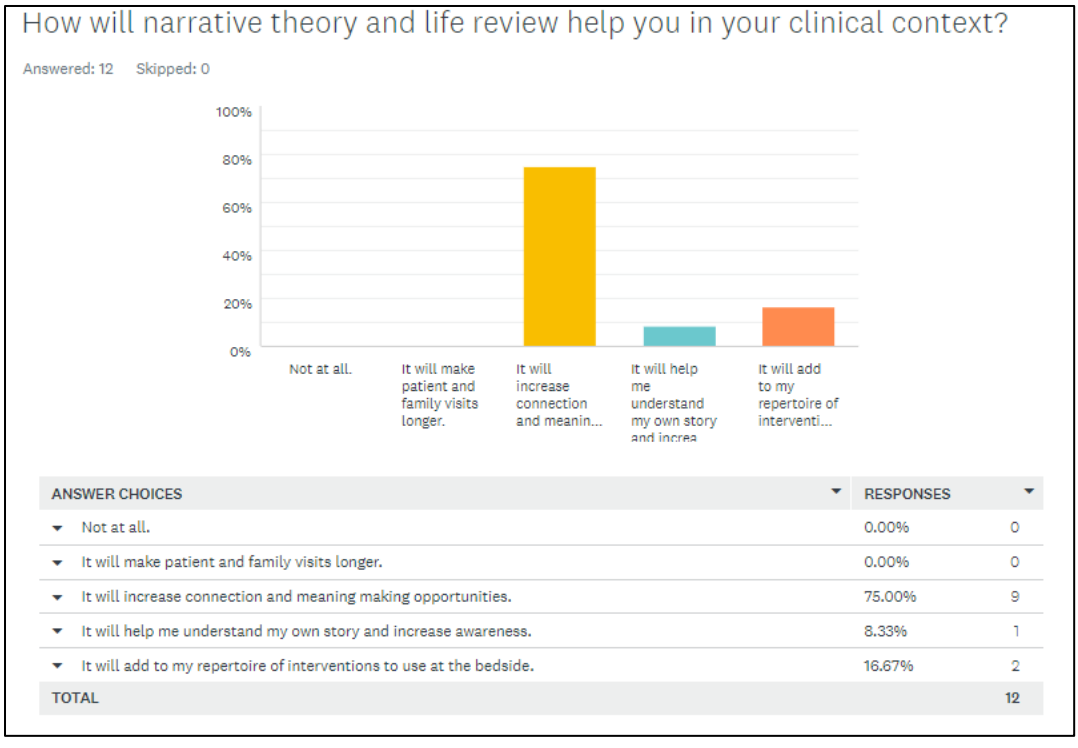
While this intervention certainly has the opportunity to add to the skillset of each participant, assist in understanding their personal life story and prolong visits times, it seems that the greatest outcome for learning narrative theory and life review is creating a meaningful visit between the chaplain and the patient. There is a social exchange with each pastoral visit where the questions are asked, "Who are they, who am I and what are we about?" Inside the visit, there are unlimited avenues and directions that each conversation may take, therefore equipping chaplains with additional skills may produce therapeutic outcomes.

Figure 17. Pre-Survey Question Ten



ANSWER CHOICES	RESPONSES	
Not at all.	0.00%	0
It will make patient and family visits longer.	8.33%	1
It will increase connection and meaning making opportunities.	58.33%	7
It will help me understand my own story and increase awareness.	8.33%	1
It will add to my repertoire of interventions to use at the bedside.	25.00%	3
TOTAL		12

Figure 18. Post-Survey Question Ten



ANSWER CHOICES	RESPONSES	
Not at all.	0.00%	0
It will make patient and family visits longer.	0.00%	0
It will increase connection and meaning making opportunities.	75.00%	9
It will help me understand my own story and increase awareness.	8.33%	1
It will add to my repertoire of interventions to use at the bedside.	16.67%	2
TOTAL		12

In the post-intervention survey, questions eleven and twelve asks the focus group was asked if they were more likely to utilize narrative theory and life review in their clinical context. With both questions, the participants answered “yes” 100%. Concluding that the four-week intervention plan created a sense of understanding and confidence with the application of narrative theory and life review. The participants of the focus group within the spiritual care and bereavement team were also asked a set of interview questions.

Figure 19. Post-Survey Question Eleven

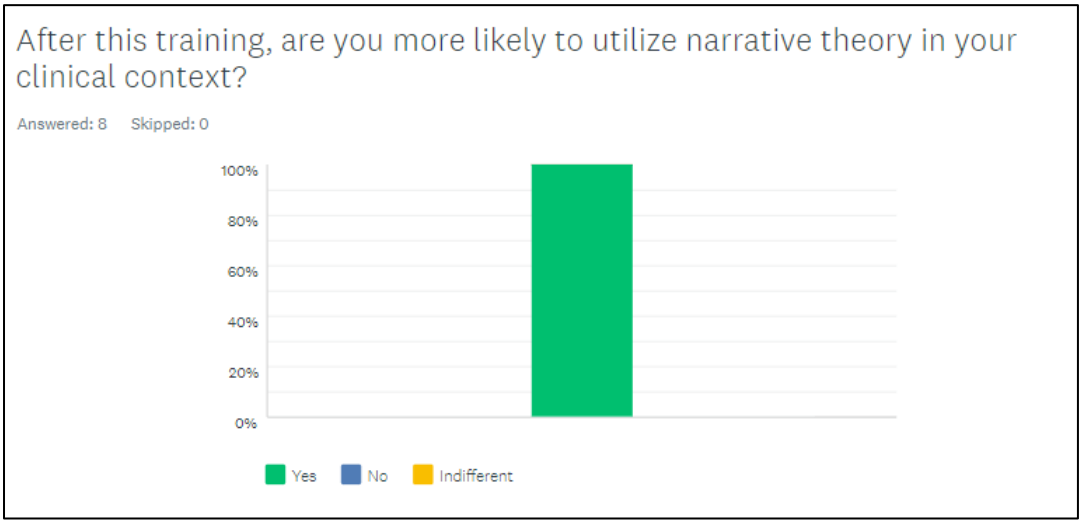
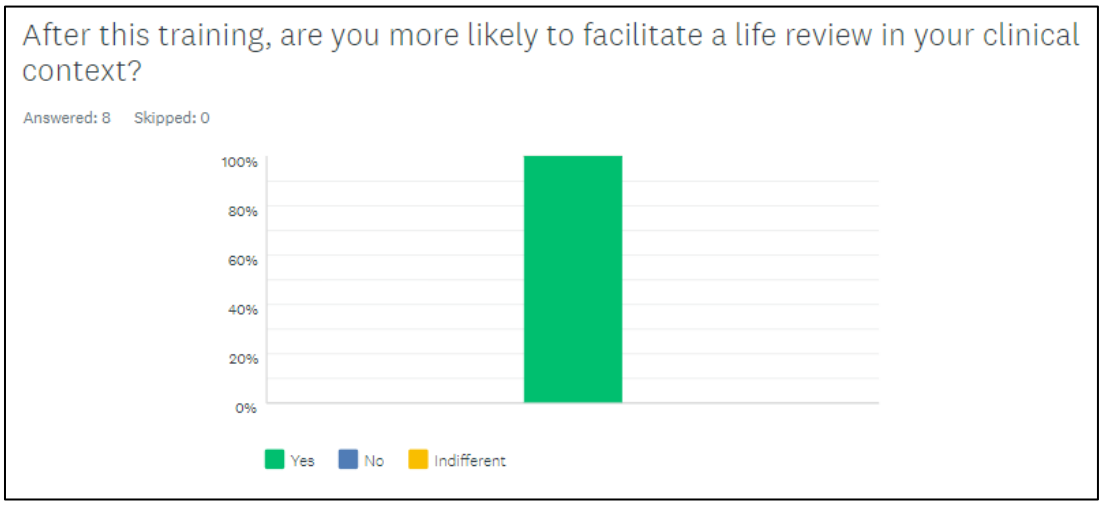


Figure 20. Post-Survey Question Twelve



Interviews

After the four-week training session, interviews were conducted to further create triangulation. Questions were asked by members of the focus group who volunteered information they reflected on and processed. The initial interview questions started out with personal reflection about their journey to chaplaincy and bereavement. Many chaplains have started their chaplain career after working in congregational ministry for many years; others have served in congregational work in a part-time or volunteer capacity. One chaplain commented that came into chaplaincy right after seminary training and knew that is the ministry context, he wanted to serve in. The chaplains in the focus group are motivated by their own personal theology which guides them through the highs and lows of healthcare ministry. Many view their work in ministry as a "gift" they are given, being able to journey with those who invite them into their homes while they talk about their faith. A bereavement coordinator shred that she often reflects on the PIE theory, Person-In-Environment, where each person is unique and has been shaped by their environment. It helps helped this bereavement coordinator to keep an open mind when meeting people and to respect where they are at.

The next interview question asked how the personal story affects ministry. One chaplain commented that "life has value at every stage," our family of origin has created a blueprint for how we respond to situations. How we respond to illness, suffering and death is, largely, how we were raised and nurtured. The more the chaplain is aware of these internal dynamics, the more they will be aware of it in others. This awareness creates opportunity for a helping relationship to come alongside and offer support. Another interview question encouraged the participant to define narrative theory and life review in their own words; Participant T reflected, "Encouraging life reflection and creating other viewpoints of their situation."

The next question asked was: How can chaplains and bereavement coordinators utilize narrative theory without the opportunity for multiple visits and interactions? One chaplain replied that more interaction with family members would be beneficial to building the patient's story. Chaplain M responded, "From my perspective one visit that helps a person grow in awareness of their story, patterns in their life, sacred memories to draw upon for strength/comfort can be very effective." Another participant responded, "It is important to engage with the patient to determine what life experiences might provide the patient comfort." Other chaplains commented by saying they could become familiar with patient's chart before visiting, speak with family members. build rapport with the patient, ask questions and learn to take time to listen to what is being communicated, utilizing caregivers to highlight the "main events" of patients' lives if the opportunity for multiple visits/interactions is minimal and encourage the patient to share highlights of their story, because people respond when they know you are genuinely interested. Lastly, it was discussed that even utilizing a partial life review can be comforting to families.

The second question asked, what other forms of questioning can be used to facilitate learning and spiritual growth for the patient? This question allowed the opportunity to investigate how these social theories can evolve with the spiritual discipline. One response stated that they were interested in learning more about the patient throughout the span of their life and development stages. Another participant added that "asking open-ended and reflective questions may provide the patient the opportunity to express his/her true feelings and give the chaplain additional information to assist in the assessment." Others suggested that systems theory and motivational interviewing would be beneficial, as well as questions such as, "What is your greatest desire"? Have you been a church going person? Tell me about a time when you felt most

close to God. Have you felt God's presence in difficult seasons? If not, how would you attempt to incorporate His Presence?

The next question asked, does the goal inevitably become shifting the patient's story to a quest narrative and therefore limiting organic conversation? Narrative theory implies that a healthy mindset tends to focus on the quest narrative and what the illness has taught the person. Those interviewed, disagreed that this would be the inevitable goal. One chaplain vehemently disagreed, "No. Never impose an artificial narrative. The chaplain must take time with patient & family and never impose his/her agenda." Another responded, "It seems like chaplaincy is part art, part science. We should have an agenda to be effective healers in the spiritual realm. This involves multiple interventions, such as moving to a quest narrative. However, it also requires 'art' that is harder to define or measure, organic conversations, rapport building, etc." Another chaplain responded, "I believe open dialog will produce the information necessary to accomplish the goal of a successful narrative life experience. One must listen as much as speak; we learn more from listening." Other participant responses suggested that the answer is both/and rather than either/or. The best quest narratives would be organic in nature and that each person is an expert of their life. The key is to facilitate "organic conversation to occur with quest narrative a goal for the overall relationship."

The following question asked, what happens if a narrative or life review uncovers a difficult story that the chaplain or bereavement coordinator is unprepared to respond to? Undoubtedly, there will be conversations that arise from storytelling that uncovers a traumatic event that the chaplain may not prepared for. One participant noted that the patient still needs to tell their story. "Half of all healing begins with the telling." Chaplain D stated the need for silence and wait to see if the patient will share more on the topic and find healing through

sharing the story. Others noted the need to honor the importance of the story being told but ask the person to pause so that the right people can be there to hear the important story, this may offer the opportunity for deeper reflection and lead to patients to consider forgiveness or understanding how the difficulty can be turned into a positive spiritual experience. One chaplain responded, “Stay calm, admit to the patient that you are not quite sure how to respond, ask for more info, tell the patient you need time to ponder this and when you get back with them, ask permission to share with the story with another trained professional.” Lastly, there was an awareness of knowing when to refer to someone more equipped and reach out to possible peer or supervisor if needed. Overall, there is opportunity for growth in both the patient and the clinician.

The next interview question asked how chaplains and bereavement coordinators can utilize narrative theory without the opportunity for multiple visits and interactions. Some responses included more interaction with family members, reviewing the patient’s chart and medical record prior to the visit, another participant commented that “one visit that helps a person grow in awareness of their story - patterns in their life, sacred memories to draw upon for strength/comfort - can be effective on its own,” that even utilizing a partial life review can be comforting to families. It is important to engage with the patient to determine what life experiences might provide the patient comfort. The greatest skill that that one participant shared is how to simply learn to ask questions and learn to take time to listen to what is being communicated. Providers can help highlight the "main events" of patients' lives if the opportunity for multiple visits and interactions is minimal. Lastly, a participant noted that people respond when they know you are genuinely interested.

The next question asked, how might a life review evolve and be more therapeutic and integrative? One chaplain noted, “It may allow the patient to see God's role in their life and perhaps bring them comfort and peace through the review.” Other responses included ideas such as creating new questions and guided interviews. Others observed the benefits of multiple visits, “If multiple visits are available this gives the Chaplain the opportunity to engage and encourage the patient to share their thoughts with those who are most important to them. Also, the Chaplain can use what is learned to plan future discussions.” Chaplain D stated, “Trust is established over the long haul. If a chaplain appears rushed, hurried, or disinterested, patient will recognize it and withdraw.” Humor was also noted as being a good mechanism for integrative a life review. Another participant shared, “As rapport increases, the depth of conversation is most likely to increase which can lead to a more therapeutic relationship and opportunity for more in-depth life review and healing.”

The next interview question asked, what was the most helpful aspect of the training on narrative theory and life review? There were a variety of answers of how this training was beneficial, one participant shared how life review has the potential to “spark new memories and could shift the conversation into a deeper spiritual reflection.” Others remarked on how a life review could evolve into being explicitly spiritual instead of a social theory. A chaplain noted how they enjoyed “listening to others who have more experience and training so that I can integrate with my pastoral background.” Another participant shared the greatest thing they took away from the program was “The encouragement to engage, to listen, and to be honest.” Others were affirmed in their clarification of the interventions they currently practiced. One participant noted how they enjoyed the case review in the journal article that was shared. Lasty, a participant concluded that chaplain visit is a picture in time. Chaplain, J surmised, “We go into a visit, and

we are taking a picture, a snapshot of them. Then we analyze it and articulate it." Another participant responded, "That's the wonderful thing about people. If you want to know something about someone, just ask. We are wired to talk about ourselves. If you open the door, people will share."

The overall findings from the four-week intervention to equip chaplains with a framework for utilizing narrative theory and life review shows a genuine interest in learning and applying these social theories. The focus group was willing to commit to the four weeks of training, reading journal articles, applying a personal life review, and reflecting on the research. Ohio chaplains and bereavement coordinators from Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice have been fully equipped with new clinical interventions to share at the patient's bedside to foster spiritual and emotional support. This program allowed the spiritual care team to take a respite from ministry work and spend time in an action-reflection module that encouraged self-awareness and personal growth.

The qualitative research findings show that there was a need to spend more time at the bedside, however, the findings also revealed the motivations that drive chaplains to serve in this capacity. While compliancy and outcomes are central to justifying the need for chaplains to serve on the IDG teams, chaplains are generally concerned with their own personal competence to meet the needs of those whom they serve. These two values have a unique opportunity to merge within the area of chaplain performance. If chaplains are meeting the spiritual and emotional needs of patients, families, and staff, then the healthcare agency will continue to be successful and compliant at the same time. These findings ultimately indicate the need for hiring chaplains, maintaining appropriate and balanced caseloads and wage justification and raises. Spiritual care leadership must be an advocate for their profession and of those in whom they lead.

CHAPTER 5: CONCLUSION

The purpose of this action-research thesis is to create a working framework for utilizing narrative theory and life review in the context of healthcare chaplaincy. It has been observed and noted that chaplains at Queen City Hospice LLC may sometimes struggle with creating longer visits and engaging patients and families on a deeper level. With proper application, it is possible that while utilizing these two social theories and adapting them to the ministry context, chaplains could have longer patient visits with increased meaning-making opportunities. Ultimately, the goal is to encourage chaplains to utilize emerging spiritual care interventions to provide excellent patient care to humans who may be suffering from a terminal diagnosis.

This chapter will compare the results of this project with the research in chapter two. Good theology and good theory require practical application. Therefore, this chapter will utilize the information to provide a pragmatic approach to utilizing narrative theory and life review at the patient's bedside. Everyone has stories to share, and stories become data to advocate the need for chaplains in the healthcare setting. The research could be replicated with a larger group of chaplains in all fields of ministry. This research can also be utilized with other clinical disciplines.

Lessons Learned

In chapter 2, "Conceptual Framework," research regarding spiritual care at the end of life, ethical issues at the end of life, narrative theory, life review, externalizing of the problem communication and life stories and pastoral counseling in healthcare chaplaincy was performed. The information gathered will be compared to the information garnered from the research performed with the focus group at Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice.

The immediate benefit of this project was equipping chaplains and bereavement coordinators with the knowledge and awareness of emerging social interventions which may enhance their patient care. With the wide range of education and experience that compose a spiritual care department, it is essential to have continuing education opportunities to train and develop teams with interventions that can be immediately applied at the patient's bedside. The four-week intervention training provided the focus group information and application in which the survey results show is already being incorporated into their ministry practices.

Further research into narrative theory and life review would be beneficial to the psychosocial disciplines, particularly in the field of spiritual care. Some areas of interest for further research are evaluating the efficacy of narrative theory and life review in a clinical setting. Other possible areas for further research may include how various positive and negative events throughout a patient's lifetime affected their future course of life. Other areas of potential research may include work with dementia experts to determine the best methods of reaching into a patient's memory; narrative theory in group discussions; Life review/narrative theory for medical providers (hospice, hospital, firefighters, EMTs, police). Lastly, it may be beneficial to research a potential connection between life review and nature of healthy and toxic relationships. Did the healthy/toxic relationships encourage or impede a relationship with God?

Integration also seems to be a fundamental avenue for proper utilization of narrative theory and life review in chaplaincy. Chaplains are continuously finding new ways to integrate family into better spiritual care. This framework could also be adapted to provide support to healthcare workers and first responders who encounter trauma and suffer from compassion fatigue.

It is also possible, that diverse chaplain settings may produce different results with its application and use. Hospital chaplains, prison chaplain, military chaplains and other fields of ministry may find additional ways to utilize and equip their spiritual care team with narrative theory and life review. Previous research typically utilizes case studies with patients over the span of multiple visits. Appendix H details a long-term case study for utilizing narrative theory and Appendix I examines a short-term model. The research used in this thesis focused on equipping chaplains with a working framework for utilizing these social theories.

The Empty Seat

Everyone has a story to tell, a life of stories that bring laughter, tears, healing, and hope. There is a richness in a reciprocal relationship between a speaker and a listener, a storyteller, and an audience. That richness is a lasting gift that could give life and encouragement when someone needs it the most. There are endless stories to be told, stories of early childhood memories, high school years, college life, the day they met their future spouse, their wedding day, starting a family, work life, war stories, the day their children graduate and leaves to create families of their own, and life in the retirement years. Stories have the ability to reveal a person's purpose and mission in life, what drives them and motivates them. Storytelling can also reveal grief, loss and fear. Having a framework for encouraging therapeutic dialog can encourage stories to evolve into means of resiliency, identity, and encouragement – all it requires is a working framework and an empty seat.

Often, when a patient is experiencing a life-limiting injury or illness, there is a new challenge they may confront, one of loneliness. Perhaps, the acute nature of the news brought in friends and family from nearby and out of town, however, families and loved ones cannot always commit to being at the bedside throughout someone's end-of-life journey. Hospitals, nursing

homes and independent living may be difficult for loved ones to visit. Children, grand-children and great grandchildren may have difficulty overcoming the things that are seen while walking back to the patient's room. Visual and olfactory senses may pick up on the difficult realities of life. One must acknowledge, even on a subconscious level, the fragility of human existence and ultimately mankind's finite nature. Also, there are some patients who may not have the luxury and privilege of having loved ones to accompany them on their journey. Isolation and loneliness are devastating to endure as one approaches the threshold of mortality. What do patients want the most at the end of life? To remain wherever they call home and to be comfortable. The hierarchy continues, most patients then want to have their faith honored, share their memories and traditions; patients want respect and dignity, and patients want autonomy in the decision-making process.

When chaplains arrive to the patient's room, they may be invited guests or "cold-calling," by offering a spiritual care visit. Upon initial observations, the chaplain may quickly survey the room and gauge the emotional temperature. The patient then has the autonomy to accept or decline the visit. Typically, there an empty seat next to the patient. The empty seat could be an open invitation, although the chaplain must not assume that it is. The chaplain may ask to sit down next to the patient at eye level. Patients often perceive that visits are longer when chaplains take the time to sit down with them, giving them attention and are not in a hurry. Patients require a calm, non-anxious presence. The patient needs to know if you are going to be the advocate or adversary.

Go to the Bedside

It is the chaplain's duty and privilege to go to the bedside. Regardless of the situation, whether the patient is surrounded by visitors or alone, the chaplain's mission is to go to all

people. Opening the conversation with a patient takes genuine interest and reflective nonverbal communication. If the patient is dejected, it would be unwise to walk in smiling and laughing. This does not mean that the chaplain should completely shy away from humor, there may come an opportunity for light-heartedness once trust is established and the patient knows that the chaplain cares for their well-being. Mirroring the patient is a way to step inside their space and give them full attention. Superficial conversation could be the key to "breaking the ice," topics such as weather, sports and news often provide opportunities for the patient to become comfortable with the chaplain, a conduit to deeper engagement if the patient allows for further conversation. The patient's surroundings provide many clues to piecing together a picture of who they are and what they are about. They may be pictures of loved ones that draw a story, they may be images of faith, medals and patches from the service, or a lack of keepsakes. Once the chaplain completes the observations, a formal spiritual assessment can begin. When the story is shared, the chaplain can muster ideas on faith, theology, and life experience. The chaplain may also utilize social psychotherapeutic interventions to complete wholeness in the approach to spiritual and emotional wellbeing. This framework could be anchored in the words of the Apostle Paul in his letter to the church at Colosse in Colossians 3:16-17, NLT:

> Let the message about Christ, in all its richness, fill your lives. Teach and counsel each other with all the wisdom he gives. Sing psalms and hymns and spiritual songs to God with thankful hearts. And whatever you do or say, do it as a representative of the Lord Jesus, giving thanks through him to God the Father.

It is the chaplain's responsibility to provide great physical, emotional, and spiritual care to every person that we meet with. Chaplains begin visits by being simply present with a patient, the chaplain must be mindful of creating new meaning with the one who suffers. The chaplain, through his or her presence can help restore to the patient the opportunity to feel some control, a sense of power, and a sense of transcending purpose, to experience being loved and to express

love. Being authentic, compatible; being positive and accepting; and being empathic can influence the effectiveness of chaplain work.

Chaplains have responsibility to distinguish times when objective pastoral care is required. They have the responsibility to discern the boundaries of the pastoral relationship, to offer professional pastoral care when it is required, and to discern when their relationships overstep the appropriate level of friendship and intimacy, or when they are exercising power inappropriately in relation to others in the pastoral relationship. Each interaction is usually a privilege for the chaplain; it is of great significance to journey with someone during a time of need; and as such, the chaplain must bring respect, integrity, and a sense of curiosity to each interaction.

It is always imperative that chaplains practice inclusivity to all persons. In professional pastoral care there is no tolerance for exclusion, discrimination, and disrespect. The chaplain will help others to sort through emotions and conflict. The chaplain must also respect the fact that some may not be in the right frame of mind to process such events, or perhaps, they may be ready to engage in deep and meaningful conversation. The chaplain is able to enhance the quality of care for our patients and their families through end-of-life preparation, crisis intervention, family conflict resolution, and many other topics which concern patients, families and staff.

Chaplains are witnesses and facilitators of a person's life and values. Often, when a person comes into a healthcare setting, they are being fundamentally stretched within their personal theological beliefs and understandings. The healthcare field is largely patient-centered, holistic and wellness focused; incorporating care for the patient's social, emotional, and spiritual concerns as well as their physical concerns. The chaplain is in a unique position to see the patient working through their situation and offer opportunities for the patient to reflect on their beliefs

by asking open-ended, non-offensive questions that may bridge the divide between the illness/crisis and the patient; it is possible that the patient will receive a reorientation of their beliefs in light of their circumstance.

From the Christian theological understanding, a chaplain may approach patient care with the belief that everyone is created in the image of God; this understanding guides the chaplain to respect each person's uniqueness and perspective. Each person being served must have their cultural, spiritual, religious, and personal values respected. The chaplain must always be assessing and re-assessing the boundaries that other's present and to make sure that those boundaries are respected. The chaplain will help others to sort through emotions, cultural norms, personal desires, and community preferences; the chaplain must also respect the fact that some may not be in the right frame of mind to process such events, or perhaps, they may be ready to engage in deep and meaningful conversation.

The most important aspect of the chaplain's role is also the most privileged aspect; chaplains are witnesses and advocates of a person's life and values. The chaplain must recognize the opportunities to speak up and to be silent. Often, the chaplain can be a quiet companion for others to find active listening and reflection; the chaplain can utilize the space to work inside the theology of those we serve. However, there are occasions when the chaplain must recognize his/her position and assert their authority in a respectful manner. For example, when a chaplain is visiting a patient, it is a sacred time and space to be directed by the chaplain with little interruption. If such an interruption occurs, the chaplain must respectfully assert his/her position and complete the visit in a timely manner. The chaplain can also serve as the patients advocate around family members and medical staff. Pastoral authority must be used to protect the person(s) the chaplain is working with and to uphold their values.

The chaplain should be aware of their own limitations. The chaplain's goal is to provide spiritual and emotional support to whom they serve. This could be developed through deep spiritual conversation, reading scriptures, prayers, and blessings. Whether they are short-term or long-term encounters, chaplains possess the professional skills to journey with others and to be a resource to them. A strength and a limitation often come from working long and often arduous hours. Also, the nature of pastoral care can often be burdensome with the number of stories and experiences one may encounter; chaplains may often be confronted with their limitations, in this regard, when weighing the emotions of those whom they visit with. These limitations must be acknowledged and respected whenever they occur; the chaplain find means of processing my weaknesses with a mentor, peer, or counselor.

As narrative arises in conversation, it is often necessary for the chaplain to understand when a patient needs someone to advocate on their behalf. When a chaplain decides to be an advocate, it is important to help an individual or group find and effectively use their own voice. The chaplain can encourage the patient to utilize autonomy and advocate for themselves. It is also important to not engage in what is known as the "trauma triangle," and vilifying another individual or group of individuals. The chaplain is a respected member of the healthcare team, and if there is a need to speak on a patient's behalf then it must be done in the appropriate manner with thoughtfulness. In any and every situation, the patient's rights and wishes must be respected and upheld.

The Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students[172] establishes principles that should inform our relationship with patients, clients,

[172] "Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students" (Association of Professional Chaplains), accessed September 9, 2021, https://www.professionalchaplains.org/files/professional_standards/common_standards/common_code_ethics.pdf.

supervisors, students, and faith communities, other professionals including those within the community, with colleagues in providing spiritual care, in advertising and in research. The Common Code is a means of encouraging one to practice ethical reflection and compliance. Dilemmas often arise, and situations may compete between the best interest of the patient and the organization; in these situations that chaplain must be present and not passive. Great chaplain work is connected to other professions, teams, organizations, patients and loved ones. Chaplains must be informed of the various ethical dimensions and be available for ethics consultation, education and examination.

A significant function of the chaplain is to be able to do great patient care by working from within; being able to connect with others by providing the basic human needs is essential. It is necessary for a chaplain to be connected but autonomous, this can become a difficult task at times because chaplains are always spending their efforts physically, emotionally, and spiritually. It is also necessary to practice self-awareness and understand when there are times that the chaplain is being stretched.

Taking time between stressful visits can prove to be very beneficial; also, finding ways to regularly decompress can provide dividends for the chaplain. It can also be beneficial for the chaplain to have an outlet, such as a counselor, sometimes provided by the employee assistance program, to meet with on a regular basis. The chaplain can also arrange to meet with other chaplains and clergy to process events and build relationships. The chaplain can enjoy outside hobbies such as exercise, writing, painting, music, poetry, etc. The chaplain can also promote self-care within the organization and become a role-model for others to follow best practices. Spiritual care and spiritual leadership are not mean to be a vocation of isolation. The integration of community resources is essential to providing the best care to patients, families, and staff.

This is accomplished by the simple task of reaching out to the diverse faith group's leaders within the community being served and providing the proper introductions. When there is community connectedness, ownership of the facility or agency is increased. The presence of professional pastoral care helps the community feel good about the institution, which could lead to greater market share. Ultimately, it is often the interpersonal environment of the patient's support system to help ensure an atmosphere which lends itself to healing and health.

The chaplain's role in the interdisciplinary team is to be the primary leader for spiritual and emotional care. Just as any good leader would do; the chaplain allows opportunities to further the spiritual and emotional growth for all of those around them. As a member of the interdisciplinary team, the chaplain must own their role and bring pertinent information to the team to further patient care while maintaining patient confidentiality. The chaplain must always continue to build trust within the interdisciplinary group and support the group needs; this is achieved by fulfilling chaplain responsibilities to the best ability and supporting and encouraging others and going the "extra mile" with teammates.

A Final Word

Narrative theory and life review may create a framework for exploring the interchange between spirituality and identity over the course of a patient's life. Each spiritual journey is distinctive. When patients share stories, often they share their spiritual journey – which are sources of data of spiritual development and the interplay between spirituality and other parts of their life. Chaplains can utilize a spiritual assessment, gained from these shared stories, and create an individualized plan of care for each patient. The plan of care is updated after each visit and includes the patient's diagnosis, planned interventions, and goals for personal and spiritual growth. It is a way to articulate, and potential quantify, outcomes of patient care.

When utilizing narrative theory and life review, the chaplain can effectively use documentation within the electronic medical record by providing a snapshot of each visit. It is always a best practice to document everything that occurred during the visit; at times it is necessary to remain ambiguous to protect patient confidentiality. Unless it is of the utmost necessity, the chaplain should never share personal information that was shared in confidence with the chaplain. There are scenarios in which personal information must be communicated; the chaplain must use discretion in deciphering such information. It is also necessary to document the extent of the work in which the chaplain performed; this additional information informs the staff and the agency all of the specialized work that the chaplain performs which ultimately adds value and increases the awareness for having an effective spiritual care department. For better or worse, modern healthcare chaplaincy is actively trending towards outcome-based care, therefore, the chaplain should document any outcome from their clinical interventions.

Narrative theory and life review are practical interventions for healthcare chaplains and clinicians. When patients and families are admitted to hospice or the hospital, they may be overwhelmingly overcome with their immediate crisis and thoughts of mortality. The chaplain can encourage the patient to reclaim the story they are telling and allowing the opportunity to rewrite the narrative that is shaping their experience. At the end of life, it is possible that patients may be preoccupied with ideas such as the meaning of life, questions of death, the need for forgiveness, the desire for hope and a longing for healthy relationships. With guided questions from the chaplain, the patient can compose from within, and through the life experience, the patient can construct a quest narrative that shifts the focus to what they are learning about themselves, and what has been revealed.

The purpose of this project is to create a framework for narrative theory and life review for healthcare chaplains. The problem presented in this thesis project is that the spiritual care team at Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice appears to not spend adequate time at the bedside and adequately engaging patients and families. The concerns have prompted a need to assess the current practices of spiritual care within our agency. To address the problem, there was a four-week training program to incorporate narrative theory and life review into the repertoire of chaplain interventions. The four-week program included a focus group of chaplains who volunteered to be in the study. A qualitative study was utilized to gather information from the focus group. There were surveys and questionnaires before and after the four-week program to measure the efficacy of the program. The interviews by chaplains within the focus group gave a perspective of their current ministry practices and how these clinical interventions can help them in their ministry.

Chaplains may find themselves with patients and families struggling to go beyond superficial conversation and walk away from the bedside potentially feeling dejected. The clinical intervention of narrative theory and life review may provide opportunities to go deeper in conversation and guide the patient towards resiliency and coping in a way that brings peace, acceptance, and healing. There are certainly times when chaplaincy is a ministry of presence. There are times when a chaplain must simply be available to sit with a patient and be silent, with contemplative prayer. Conversely, there are pastoral visits when the chaplain must utilize pastoral care theories, theology and growing social concepts.

Ultimately, healthcare chaplaincy must be making the difficult move to becoming outcome-oriented, to justify the art and science of this ministry occupation. In a culture where less people are going to church, yet more people are becoming spiritual, pluralistic healthcare

chaplains are needed now more than ever. When patients suffer from a life-limiting injury or terminal illness, it is imperative to address the reality of our finite nature. Chaplains may draw on their own experiences and faith to articulate an understanding of such spiritual and existential concerns, however, it is the faith and theology of the patient that must be tapped into to give them true peace that will last long after the pastoral visit. Healthcare chaplains may also incorporate a working knowledge of psychological, philosophical, ethical, and social theories to be well-rounded in their skills and abilities. Ongoing education and creating a space for action and reflection for the spiritual care department will benefit the chaplains, the agency, the staff, and ultimately patients, families and loved ones. The spiritual care team at Queen City Hospice, Day City Hospice, Capital City Hospice and Miracle City Hospice are all committed to providing the best end-of-life care in Ohio.

This thesis illustrates a training program to equip chaplains with these social theories and to increase time and meaning-making opportunities with patients, families, and staff. With hospice patients, and those experiencing a terminal or life limiting illness, chaplains can direct individuals with a quest narrative to providing coping skills as their identity is challenged from their decline. Chaplains can frame conversations with themes of questioning to encourage reflection, identity, autonomy, and empowerment. Thus, the crux of the chaplain's clinical interventions is to hear stories so that they may better understand those who are ministered to.

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Appendix A: IRB Letter

May 10, 2021

Joshua Fagin
Brent Kelly

Re: IRB Application - IRB-FY20-21-818 A Framework for Utilizing Narrative Theory and Life Review in Healthcare Chaplaincy

Dear Joshua Fagin and Brent Kelly,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study is not considered human subjects research for the following reason:

Your project will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B: Recruitment Form

Dear chaplain team,

As a student in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to measure the time and efficacy of patient visits and to incorporate narrative theory, and I am writing to invite eligible participants to join my study.

Participants must be a member of the spiritual care team. Participants, if willing, will be asked to be a part of a focus group to learn and apply narrative theory and life review to their repertoire of chaplain interventions. It should take approximately four weeks to complete the procedure listed. Participation will be completely anonymous, and no personal, identifying information will be collected.

Sincerely,
Joshua Fagin
Regional Director of Spiritual care
[redacted]

Appendix C: Consent Form

Title of the Project: A Framework for Utilizing Narrative Theory and Life Review in Healthcare Chaplaincy
Principal Investigator: Joshua Fagin, MDiv., B.C.C.

You are invited to participate in a research study. In order to participate, you must be at least 18 years of age, and a current healthcare chaplain. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

The purpose of the study is to measure the time and efficacy of patient visits and chaplain interventions. This study will also equip chaplains with a narrative theory and life review to engage with patients and families and to have longer visits.

If you agree to be in this study, I would ask you to do the following things:

1. Commit to meeting four one hour each week for four weeks.
2. For those that opt to be interviewed at the end of the four-week training sessions, the interviews will be audio recorded.

The direct benefits participants should expect to receive from taking part in this study are learning and implementing narrative theory and life review into their patient interventions.

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Participant responses will be anonymous. Participant responses will be kept confidential through the use of pseudonyms/codes. Interviews will be conducted in a location where others will not easily overhear the conversation. Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Interviews/focus groups will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher[s] will have access to these recordings. Confidentiality cannot be guaranteed in focus group settings. While discouraged, other members of the focus group may share what was discussed with persons outside of the group.

Participants will not be compensated for participating in this study.

The researcher serves as a supervisor at Queen City Hospice. To limit potential or perceived conflicts the study will be anonymous, so the researcher will not know who participated. This disclosure is made so that you can decide if this relationship will affect your willingness to

participate in this study. No action will be taken against an individual based on his or her decision to participate in this study.
Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or Queen City Hospice. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

If you choose to withdraw from the study, please inform the researcher that you wish to discontinue your participation, and do not submit your study materials. Your responses will not be recorded or included in the study.

The researcher conducting this study is Joshua Fagin. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted]

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record/video-record/photograph me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Appendix D: Permission Form

April 3, 2021

Jennifer Cotterell
V.P. of Clinical Operations
[redacted]

Dear Mrs. Cotterell:

As a graduate student in the School of Divinity at Liberty University, I am conducting research as part of the requirements for a doctoral degree. The purpose of my research is to measure the time and efficacy of patient visits and chaplain interventions. The title of my research project is A Framework for Utilizing Narrative Theory and Life Review in Healthcare Chaplaincy, and the purpose of my research is to equip chaplains with a narrative theory and life review to engage with patients and families and to have longer visits.

I am writing to request your permission to conduct my research at Queen City Hospice.

The data will be used to publish the results in my thesis work for the School of Divinity. Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, respond by email to [redacted] A permission letter document is attached for your convenience.

Sincerely,

Joshua Fagin
Regional Director of Spiritual Care

Appendix E: Pre-Intervention Survey

1. What is your average duration for a patient visit?
    1. 10 minutes.
    2. 15 minutes.
    3. 30 minutes.
    4. 45 minutes.
    5. 1 hour +
2. Are you concerned about the time you spend at the bedside?
    1. Yes
    2. No
3. How do you feel about the level of depth and effectiveness for your chaplain visits?
    1. Very effective.
    2. Most visits are effective.
    3. Some visits are effective.
    4. I struggle with meaningful visits.
4. How long have you been a chaplain?
    1. Less than 1 year.
    2. 1-3 years.
    3. 3-5 years.
    4. 5-10 years.
    5. 10+ years.
5. How many units of CPE do you currently have?

    1. 1
    2. 2
    3. 3
    4. 4
    5. 0
6. Did you learn narrative theory in CPE or graduate studies?
    1. Yes.
    2. No.
7. Did you learn life review in CPE or graduate studies?
    1. Yes.
    2. No.
8. Are you currently utilizing narrative theory and/or life review in your current ministry practice?
    1. Yes.
    2. No.
9. How will narrative theory and life review help you in ministry?
    1. It will make patient and family visits longer.
    2. It will increase connection and meaning-making opportunities.
    3. It will help me understand my own story and increase awareness.
    4. It will add to my repertoire of skills and interventions at the bedside.
    5. This will not help me at all.

Appendix F: Post-Intervention Survey

1. What is your average duration for a patient visit?
    1. 10 minutes.
    2. 15 minutes.
    3. 30 minutes.
    4. 45 minutes.
    5. 1 hour +
2. Are you concerned about the time you spend at the bedside?
    1. Yes
    2. No
3. How do you feel about the level of depth and effectiveness for your chaplain visits?
    1. Very effective.
    2. Most visits are effective.
    3. Some visits are effective.
    4. I struggle with meaningful visits.
4. How long have you been a chaplain, bereavement coordinator or social worker?
    1. Less than 1 year.
    2. 1-3 years.
    3. 3-5 years.
    4. 5-10 years.
    5. 10+ years.
5. How many units of CPE do you currently have?

1. 1 Unit
2. 2 Units
3. 3 Units
4. 4 Units
5. 4+ Units
6. None of the above

6. Are you currently utilizing narrative theory and life review in your clinical context?
    1. Yes
    2. No
7. Would you feel confident utilizing narrative theory with a patient?
    1. Very Likely
    2. Likely
    3. Neither likely or unlikely
    4. Unlikely
    5. Very unlikely
8. Would you feel confident utilizing a life review with a patient?
    1. Very Likely
    2. Likely
    3. Neither likely or unlikely
    4. Unlikely
    5. Very unlikely

9. Have you previously utilized narrative theory and/or life review in your current ministry practice?
    1. Yes.
    2. No.
10. How will narrative theory and life review help you in your clinical context?
    1. Not at all
    2. It will make patient and family visits longer.
    3. It will increase connection and meaning-making opportunities.
    4. It will help me understand my own story and increase awareness.
    5. It will add to my repertoire of skills and interventions to use at the bedside.
11. After this training, are you more likely to utilize narrative theory in your clinical context?
    1. Yes
    2. No
    3. Indifferent
12. After this training, are you more likely to utilize a life review in your clinical context?
    1. Yes
    2. No
    3. Indifferent
13. How could chaplains utilize narrative theory without the opportunity for multiple visits?

14. What other forms of questioning can chaplains and bereavement coordinators use to facilitate learning and spiritual growth for the patient?

15. Does the goal inevitably become shifting the patient's story to a quest narrative and therefore limiting organic conversation?

16. What happens if the narrative uncovers a difficult story that the chaplain or bereavement coordinator is unprepared to respond to?

17. How might a life review evolve to be more therapeutic and integrative?

18. What was the most helpful aspect of the training on narrative theory and life review?

19. What future research in narrative theory and life review would be interesting to you?

20. Are there any topics or ideas that you would be interested in learning in the future? If so, what are they?

Appendix G: Questions for Focus Group Interviews

1. Tell me about your journey to become a chaplain.
2. What scriptures motivate you when you visit patients?
3. What theories do you currently use in your ministry practice?
4. Have you received CPE training?
5. How long does a typical patient visit last for you?
6. What are some barriers to having meaningful and longer visits?
7. How does your personal story affect your ministry?
8. How would you describe narrative theory in the context of hospice chaplaincy?
9. How would you describe life review in the context of hospice chaplaincy?
10. How can you use narrative theory and life review in your current ministry practices?
11. How will these interventions increase visit times and create meaningful conversation?
12. How can chaplains and bereavement coordinators utilize narrative theory without the opportunity for multiple visits/interactions?
13. What other forms of questioning can be used to facilitate learning and spiritual growth for the patient?
14. Does the goal inevitably become shifting the patient's story to a quest narrative and therefore limiting organic conversation?
15. What happens if a narrative or life review uncovers a difficult story that the chaplain or bereavement coordinator is unprepared to respond to?
16. How might a life review evolve and be more therapeutic and integrative?
17. What was the most helpful aspect of the training on narrative theory and life review?
18. What future research into narrative theory and life review would be interesting to you?

Appendix H: Group Homework – Structuring a Personal Life Review

When did you feel most alive? What stands out in your memory are the best times in your life?

What do you want your family to remember about you?

What important roles have you played in life: family, work or community?

What accomplishments do you feel most proud of?

Is there anything you want or need to say to your loved ones? If so, what would it be?

What are your hopes and dreams for your loved ones?

What have you learned about life that you want to share with others, such as advice or words of wisdom about the future?

Appendix I: Case Study One: Long-Term Model for Narrative Theory

This case study represents the pastoral care provided for a hospice patient suffering from congestive heart failure. The chaplain's interventions were directed by application of narrative theory and life review. The case study will attempt to demonstrate how narrative theory enabled the chaplain to move beyond relationship and provide coping strategies for the patient

John S. (patient's name and other information has been changed to protect confidentiality) is a 62-year-old Caucasian male with a terminal diagnosis of end stage cardiovascular disease. The patient has a medical history of 2 myocardial infarctions with stent and pacemaker placement, irritable bowel syndrome, chronic obstructive pulmonary disease, (COPD) major depressive disorder and anxiety. John is frequently short of breath, during normal conversation and with small exertions such as brushing his teeth. He exhibits anxiety and has difficulty sleeping at night. He is dependent on oxygen, via a nasal cannula, and remains ambulatory at this time, however, he has fallen multiple times and remains at a high risk for falls. John is on many medications such as cardiac medication, diuretics, anxiety medication, and pain medication. He is alert and oriented to person, place and time; he is verbal and able to make his needs known while requiring minimal assistance for showering and mobility.

John is a homosexual; he was partnered for nearly 30 years to Keith. Keith was nearly ten years older than John and was well-known in his field of antique restoration. Shortly after John left his hometown, he met Keith in New York City through a mutual friend. Keith introduced John to the business of appraising and restoring antiques; from there they would literally travel the world for work projects and antique shows. They eventually settled down and opened their business in the south. One morning, Keith suffered a major heart attack and passed away in their home with John, and EMS, performing CPR. Keith's family did not acknowledge their

relationship and took the business away from John; their relationship was not recognized as a legal marriage and therefore the family had rights to Keith's belongings. After Keith's death, John moved back to his childhood area. John found ways to cope with the grief of his loss with drugs and alcohol. His first heart attack, as he lost consciousness on a downtown sidewalk. John has been in and out of homeless shelters and rehabilitation facilities. John claims that he has received his "death sentence," and initially he expressed a very intense fear of dying. After months of working through his illness he states that there is relief in death.

Visit One: The patient lives in a one-bedroom apartment. John lives alone with his cat. His apartment is very well decorated with many antiques placed throughout his home. The chaplain met with John on a frequency of one visit every week. The majority of visits take place at his bedside; if he is feeling well the chaplain sometimes has conversations in the living room over coffee. John is often neatly dressed upon arrival, although there are times when he is very tired and does not have the strength to get out of bed.

C: Hi John, is this a good time?

P: No, not really.

C: Oh, I'm sorry, I can come back another time if you prefer? Can I ask what's wrong?

P: I'm dying. I know that I'm getting close. Could you come back in a few days? I would really like to talk to you about something... I would like to go out better than I came in.

C: Ok, I will come back in a few days when you are feeling a bit better.

P: I hope I'm still here.

C: I hope you are too.

P: (They shake hands) I may give you a call.

C: Please do.

Visit Two: During this visit the patient discussed some of his past. The patient referred to his childhood as a "toxic soup." He described being raised in a Catholic family, although he would occasionally attend a primitive Baptist church with his aunt. John lived in a family where his family would act a particular way around church members and a completely different way at home. John's parents would argue constantly, and he and his brother would hide in their rooms. John also shared being sexually abused by his father, although he did not spend much time on the topic.

During this visit, the chaplain began to utilize some life review techniques. The chaplain asked the patient how he would want his family and loved ones to remember him. John reluctantly answered that he does not have a family to be missed by. His brother is the only surviving blood relative and his partner's family disregarded him many years ago. He has not talked with his brother in over ten years, even though he only lives a few hours away. The patient has a close friend, Greg, who comes by occasionally to check on him.

Towards the end of conversation John mentioned that he would like the chaplain to facilitate his memorial service after he passes. He also mentioned that he would like to "get some things together," different pieces of his life to record. He talked about marching for the civil rights movement earlier in his life and showed a picture of him in a magazine. The chaplain affirmed that social justice has been a key value to him throughout his life.

Visit Three: Patient was very frustrated upon arrival. The previous day his apartment was full of medical professionals, and a nurse practitioner was present and discontinued some medications. The patient wanted to end hospice care, and the chaplain educated the patient about his rights as a patient; if he wanted to change physicians, or people on his care team then it is his right to do so.

P: He was very disrespectful, and I knew he was looking down on me. I know that I am not an educated person, I didn't go to college, but I surrounded myself with educated people. Last night I couldn't sleep, and well I won't go into that.

C: You can tell me if you would like.

P: I was having suicidal thoughts. I felt like William Capote, that I could just will myself to death.

C: How do you mean will yourself to death?

P: You know how when older couples have been married for such a long time, one passes and then a few days late the other passes? I just want to will myself to death. Its people like this nurse practitioner that make me lose my faith.

C: How does it cause you to lose your faith?

P: That's a good question. I feel like there are so many bad things that happen to me and it outweighs the good. I feel like Dorothy at the end of The Wizard of Oz, there is nothing in that bag that is going to help me. I know that I have a death sentence. I am just tired, would it be ok if we met another day?

C: Of course, would it be ok if I said a prayer before I leave?

P: Yes, I wish you would.

C: Almighty God, we thank you for John and his friendship. We come together today to lift him up to you. We know that it is so easy to lose faith in ourselves and each other and we ask that you strengthen him. We know God that you are our ultimate healer and physician. We pray this in your name, Amen.

Visit Four: Emergency Room. Patient was taken by ambulance from his apartment to the Emergency Department. The patient had fallen in the shower, and he thought that he had a

broken hip. Patient called the on-call nurse and asked to see the chaplain. I arrived at the facility and went into his room; patient appeared to be very anxious and pale in color. During visit the patient talked about how his condition seems to be getting worse. At one point the patient looked at the chaplain and asked, "Is God doing this because I'm gay?" The chaplain talked at length about his faith and worked through his theology to affirm that the loving God that he believes in would not cause him to suffer in any way. The visit holding hands in prayer.

Visits five and six: During these visits, the conversations were focused on John's relationship with Keith and the places that he has visited in the past. John's caregiver, Tiffany, sat with us throughout both visits; the patient seemed reluctant to express himself further, and was very lethargic. Both visits ended with prayer.

Visit Seven: The patient had called the chaplain the previous night and communicated that his home health aide was emotionally abusing him and not following the proper policies. After talking to the patient on the phone, the chaplain contacted the social worker and explained what the patient expressed. Upon arrival the chaplain found the patient sitting in his chair and the hospice social worker visiting with the patient. The social worker requested to visit the patient alone, so the chaplain waited in the hallway with the home health aide. After the social worker left, the chaplain went in to visit the patient alone, and continued the discussion from the previous night. John expressed a new sense of trust with in the pastoral care relationship. During this conversation, John said, "I just want to go." He explained how he was being visited by deceased loved ones in his dreams. This brought John a sense of peace and longing for the afterlife. John's father was also in his dreams, which seemed to indicate a new orientation in his feelings towards his father. John did not seem suicidal, also there was mention of wanting to die sooner rather than later.

Following these events, the care team (consisting of the RN case manager, the social worker and chaplain) had to sign an incident report. The incident involved the firing of the patient's home health aide, as well as a signed contract with behavioral health contract. It was reported that the patient was taking more medication that what he was prescribed. A new system for tracking his medications was put into place.

Visit Eight: Upon arrival the chaplain was introduced to the patient's new home health aide, Dominique, and he seems to be a good fit as the patient is adjusting. During the visit the patient appeared to be very lethargic; he had been sick and vomited this morning after taking his medications. The patient was aware that he could not take more medicine because there was no way to tell how much was already in his blood stream. The chaplain noticed a tattoo on his upper forearm that was not noticed before, with the name "Jeffery," after inquiring about it he shared a story of when he first moved to New York City he met a waiter who became his first friend in the new city. Jeffery was in the World Trade Center on 9/11 and his body was never found, although it is known that he was there because he had clocked in to work that morning. His partner, Keith, was very accepting of his desire to memorialize their friend with the tattoo.

Due to the patient's lethargy the chaplain continued to initiate conversation about what he is learning about himself throughout his illness. The patient reflected on his journey of resiliency. The chaplain asked about the red ribbon that has been tied around his wrist for months; he explained that it is a Jewish practice to wear the ribbon as a bracelet, the bracelet would detox his body and when the bracelet had collected as much as possible then it would fall off on its own. After a few moments, the chaplain had realized that the patient was much too tired to continue the conversation and we agreed to conclude the visit and meet next week.

Phone call: John was very distressed. The chaplain talked through issues of guilt, anxiety and fear; then ended the phone conversation with a short prayer and a scheduled time to meet.

Visit Nine: During this visit the patient talked about his upbringing in the Catholic faith, and the chaplain read a few prayers from his prayer book. The patient also reflected on his life and did not mention Keith. The chaplain brought up stories of resiliency from previous visits and attempted to connect them to the current situation.

Visit Ten: Patient was very lethargic and did not wish to have a long visit. Conversation was very surface level and the patient did not want to go further or offer reflection. A new home health aide had started, Dominque was asked to leave after not showing up for several shifts.

The patient seems to be suffering from a tremendous amount of religious guilt. His strict upbringing in the Catholic faith did not permit him to live his life as a homosexual. The patient also has manipulative behaviors that has been experienced by other staff members as well. Often, the patient attempts to talk about other staff members during our visits; I try to encourage the patient to reframe how he experiences them and not involve myself in any triangular relationships. Throughout the ten visits, the chaplain tried to build the relationship and the patient's sense of trust in the chaplain. John seems to value the insight and companionship from the chaplain. The chaplain was always mindful of thinking about how to word responses with John. The primary focus for the visits was to support him pastorally and to gently meet him where he is. The patient is mentally declining, it is noticed in his inability to keep his thought process in conversation. He is also becoming very forgetful and unable to remember names and who came to see him on certain days. The patient also seems to isolate himself and not want to have visitors; this seems to be a way of protecting himself from getting hurt and having others

see him in his condition. John also has difficulty sleeping at night, which is due to his anxiety and his fear of dying in his sleep and not waking up.

The main theological issues that were reflected with John is that of acceptance. John seems to express a sense of rejection from God, his family, his partner's family, and even staff members who are trying to care for him. John often perceives God to be a vengeful God, although there are times when he accepts God's grace for him. The patient grew up in a working middle class family. There was a period in his life where he was very prosperous and lucrative in his field of work. After his partner passed and he lost the business, he became homeless and struggled to get by. The patient currently lives on government assistance. The patient comes from the Catholic faith, there are times with his faith seems to comfort him and times when his faith hurts him and becomes a source of stress. Given the patients upbringing in an environment where faith was not lived out in action or deed, the patient had a misunderstanding of his religion. At times, his faith helps him to cope through situations. The patient utilizes prayer, scripture readings, and pastoral visits to grow in his faith. He has a priest that comes to visit with him occasionally, and the priest normally brings him communion. The patient's faith becomes a conflict at times; especially when he is challenged b issues of injustice and acceptance of himself. The priority during the visits attempted to focus on fostering a trusting relationship; it is my hope to provide the patient with adequate spiritual care and to help him find hope and strength in the death and dying process. The chaplain also worked through the religious guilt that he often refers to and allow him to find a new understanding of his faith. Overall, the objective was to encourage the patient to learn from his illness and move forward with his story.

In each visit with the patient, the chaplain documented in a manner that did not break the confidential information that the patient may have provided. This became challenging at times

because the patient would often make statements about his mental well-being. A standard note in his chart would read as:

"Chaplain visited with the patient and provided spiritual and emotional care. The patient was seemingly comfortable and without pain. Sat with patient and engaged him in conversation; validated the patient's feelings and utilized active listening skills. Utilized patient's faith and theology to provide support. Followed-up with care team to be of support. Chaplain will continue with the patient's plan of care."

Appendix J: Case Study Two: Short-Term Model for Narrative Theory

Ms. Betty is a 62 Caucasian female with a hospice diagnosis of COPD. She has comorbidities of bipolar disease, depression, anxiety, and a history of Skin Cancer. The patient is showing over all signs of decline; she is having increased shortness of breath at rest and with minimal exertions. She uses pursed lip breathing. She is oxygen dependent (via nasal cannula) and housebound. She is having increased anxiety and depression. She has lost most of her appetite and has increased weakness and fatigue. The chaplain made a connection with the patient, her daughter, and other family members. When Ms. Betty first came on to hospice service she asked to be baptized, and the chaplain facilitated the baptism in her front yard during the first visit. She has her baptismal certificate framed and placed in her living room. She lives at home with her daughter who is 37; her daughter works full-time, and therefore cannot be at home during the day with her mother. The patient was married for a short amount of time; she divorced her husband when she found out that he has issues with pedophilia, he was later taken to prison for a relationship he had with a child. A few years later he passed away with heart disease. Ms. Betty also lost her youngest daughter due to heroine. She keeps the ashes of her late ex-husband, daughter, and two dogs, in her house. Her daughters' ashes are in a box next to her bedside.

Upon arrival for the second visit, the chaplain knocked at the door and walked in; the patient leaves her door unlocked for hospice staff to let themselves in. The patient has two dogs and they have a place in the living room to relieve themselves until the daughter comes homes to clean up. The chaplain walked to her bedroom and knocked on the opened door. Ms. Betty was resting with the tv on; she woke up easily and sat up. There was an empty chair at the bedside.

C1: Hi Ms. Betty. I didn't mean to wake you. Is now a good time?

P1: Yes, please sit down.

C2: How have you been this week?

P2: Not good. I got over the virus I had, but my medications are off because I have been throwing them up. I am trying to get back into a rhythm with my bi-polar medicine. When I am manic I am up, even when I shouldn't be, I get up and cook and clean the house; but when I am depressed, I am really depressed. I started yelling at Ashley the other night, and I think I made her upset. She hasn't talked to me since. I also hit KC (one of her dogs) on the head, he was trying to reach for my food, and I got so mad at him.

C3: You seem really upset.

P3: After I hit KC, I felt really guilty and I started thinking, what if God doesn't forgive me? I don't want to die and go to Hell; I don't want to have any of those visions that I had at the hospital.

C4: Well Ms. Betty, I know that we have very similar beliefs; and I believe that when you ask forgiveness from God that Christ's sacrifice covers your sins, past, future and present. There is nothing that we can do to limit the grace that he gives us.

P4: I know, it just doesn't feel that way sometimes. I am getting to the point where I am ready to die. I think it would be a relief, and to Ashley as well.

C5: I think that Ashley, and a lot of other people, including myself, will be very heart-broken.

(Patient smiles and begins to cry.) What do you want the most from the rest of your time left?

P5: I just don't want to be remembered this way. I feel so tired, all I want to do is sleep. I don't have any energy to do anything.

P5: I think that your family will remember you be all the wonderful things you have done for them. You have been the rock for your family, and now they get to be there for you.

(Patient spent some time talking about her family and catching the chaplain up on some life events.)

C6: What have you learned about yourself while struggling with your illness?

P6: (Patient paused) I find that I have it in me to do whatever I need to do, even when I'm exhausted like I am now. I know that God is with me through this and that it will get better.

C7: Ms. Betty, it sounds like you are a very strong and resilient woman. This illness may limit you but it does not define you. (She nodded and smiled.) I heard you say that you are tired, I will let you go back to resting if you would like.

P6: I really enjoy your visits. I know when you leave, I will go right back to sleep though.

C8: Rest is good. Would you like me to say a prayer for us?

P7: Yes I always do.

C9: (Holding both hands) Gracious God in heaven, we thank you for this time that Ms. Betty and I have had to share; we know that when two or more are gathered together in your name that you are present, and we ask that would continue to surround Betty with you love and presence. God we know that she has been through so much and at times she feels so far from you; your Word says that you will never leave us or forsake us. Jesus, we thank you for your sacrifice on the cross for our sins; we thank you for the promise of eternal life. Your Word says that there will be no more sickness or death, that you will wipe away our tears; and that we will all take freely from the tree of life. We thank you for these images of hope during such uncertain times. God, we lift up Betty to you, and we ask for your blessing over her. In Jesus Christ's name we pray. Amen

P8: Amen. Thank you, thank you. I started crying and I just hope I can stop.

C10: It's ok to cry. I will see you this time next week, if you need to talk to me before then just give me a call.

P9: Ok, I will.

The chaplain gave the patient a hug before walking out. The chaplain called the daughter, Ashley, to check in with her. She stated that her mother has been very difficult this week and that she has been very depressed. The chaplain talked for a moment and then ended the conversation. The patient is going through a very difficult time, particularly this week due to her inability to take her medications properly. The daughter is also taking her mother's decline very hard. Ms. Betty was placed in the ICU and discharged from hospice care. She was found minimally responsive by her daughter and was taken by ambulance to the hospital to pursue aggressive treatment. While the patient was in the ICU, she had a traumatic experience. The patient reported having visions of demons. The visions were thought to be induced from her medications, although the patient disagrees. The visions she experienced have had a lasting impact, she is still anxious to fall asleep and will not take certain medications.

The patient is seeming to struggle with her faith at times, and even doubts her salvation due to guilt. Ms. Betty and the chaplain have a similar faith background, therefore, the chaplain felt very comfortable offering pastoral support and reaffirming her faith and salvation. The patient has lived her life as a working-class mother, and now she is dependent on government assistance. Her daughter works and supports them as well. Throughout the visit, the chaplain looked for opportunities during the conversation to ask how she distinguishes herself from the illness and from exhaustion. The patient was able to articulate her areas of strength and resiliency. These two case studies reveal how narrative theory and life review can occur in long-

term and short-term visits. After the visit was complete, the chaplain documented the visit in the electronic medical record:

"Chaplain visited with the patient and provided spiritual and emotional care. The patient was seemingly comfortable and without pain. Chaplain sat at the bedside with the patient; the patient was very pleasant and engaged in conversation. Chaplain validated the patient's feelings and utilized active listening skills. Chaplain also utilized patient's faith and theology to provide support. After the visit, the chaplain followed-up with care team to check-in and be of support. Chaplain will continue with the patient's plan of care."