

## **Cultivating Hope Among Medically Traumatized Older Adults: A Narrative Perspective**

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### **Introduction**

This paper takes a narrative approach to understanding pastoral practice in the context of medically-related trauma in older adulthood.<sup>1</sup> First, it examines how the problem-saturated stories told in the context of medical institutions in the United States threaten to co-opt the meaning-making and personal agency of older adults during times of illness. Next, appealing to rich imagery in the gospel story of Anna and Simeon, as well as in Pope Francis' *Evangelii Gaudium*, this paper conceives of the hospital chaplain as one who is uniquely called to stand in prophetic witness against dominant narratives that marginalize the voices of this age group. It then examines the evidence of successful narrative practice with older adults, and concludes by offering practical suggestions for Christian chaplains to better cultivate an experience of hope in the midst of darkness and to improve quality of life in this context.

### **Dominant Stories of the Medical Model**

With a careful ear and a critical consciousness, one can discover at least two stories that circulate strongly in contemporary medical settings. The first is inherent in the scientific framework itself, where biophysical markers, symptoms, and pathologies serve as the main identifiers of people. Reductionist stories about the human person are shared through diagnoses, labels, charts, and change-of-shift reports, such as, "*Mary is an 87-year-old Caucasian female diagnosed with chronic heart disease and emphysema, recovering from a fall.*" This clinical pathology-based language is geared for efficiency in treatment; however, it does not include much about patients themselves, such as their unique hopes, dreams, fears and concerns. A second major narrative found in US hospitals is related to the pressure on professionals to

recommend treatment out of a desire to minimize litigation risk. For example, in conversations surrounding falls with the elderly, these types of stories may be shared through comments such as, “*Mary’s home environment is unsafe, and we recommend she move to another facility.*”

While moving out of the home may not be the best decision emotionally, spiritually, psychologically or even physically at this point in a patient’s life, health care workers are often incentivized to make such recommendations as a way to manage risk. Risk management narratives may also surface in conversations that suggest the older adult needs further testing, increased treatment, and more expensive equipment.

While the aforementioned reductionist, pathology-based and risk management stories surrounding illnesses are difficult at any age, the elderly in our society are particularly vulnerable to having their voices marginalized in medical settings. Ageism—disguised in the form of subtle biases that implicitly question the cognitive status, ability, and right to self-determination of older adults—can affect elderly patients and leave them at increased risk for having their concerns systematically ignored.<sup>2</sup> Narrative gerontologist Raymond Grimm, for example, notes the case of an elderly widow who had been told by her doctor that he was “tired of all her complaints” of intense pain and that “if she complained one more time, he would have her admitted to the psychiatric ward of the hospital.”<sup>3</sup> Encouraged by Grimm, this woman sought the opinion of a second doctor; it turns out she was suffering from an infection that would have killed her within weeks. As disturbing as this case is, it serves as a reminder of how ageist beliefs and practices, stemming from a post-industrial capitalist Western society that generally devalues the worth of older adults,<sup>4</sup> can have a chillingly silencing effect on vulnerable elderly persons.

This environment creates a serious problem for older adults. In a society where the elderly person’s right to self-determination is often held as suspect, the voices that predominate

in medical settings are precisely those limited accounts based on physical pathology and risks. Because these narratives do not take into account the unique stories of each elderly person, it is not uncommon for major life decisions and meaning-making to be disproportionately influenced by the systematic frameworks of professional healthcare workers and not necessarily meaningful, important life circumstances and experiences. As Phillip Clark puts it, “the scientific-technocratic voice of medicine drowns out the life-world voice of the patient.”<sup>5</sup>

### **Need for Prophetic Pastoral Witness**

In his apostolic exhortation *Evangelii Gaudium*, Pope Francis evokes pastoral concern for the elderly who have been isolated, abandoned, marginalized, or “forgotten by everyone else.”<sup>6</sup> He writes, “The dignity of the human person and the common good rank higher than the comfort of those who refuse to renounce their privileges. When these values are threatened, a prophetic voice must be raised.”<sup>7</sup> In a long line of Christian tradition, today’s chaplains are called upon to bear prophetic witness, to enter into the midst of suffering, and to boldly make space for a new narrative to emerge among this age group. The gospel story of Anna and Simeon greeting Jesus in the Temple (Luke 2:21-38) offers a powerful example about making meaning in the end of life. Their proclamations at the sight of Christ are laced with a sense of fulfillment of lifelong yearning. In contrast to the suffering faced by elderly persons whose voices have been marginalized, Anna and Simeon’s story represents a triumphant moment of Christian witness, a testament to the deep hope and transformation that can be found in older adulthood. It is a scene worth contemplating in the pastoral care of older adults experiencing medical trauma.

### **Practical Techniques**

As the population continues to age, thus facing an increase of pathology-based discourses related to older age, understanding techniques to help marginalized older adults access their inner

resources and cultivate hope in the context of medical trauma is of utmost importance. Quite often, hospitalizations serve as key transitions in the life course of older adults, and are therefore privileged moments for chaplains to create space for more empowered narratives to emerge. To clarify, this approach is not meant to disregard legitimate medical concerns and advice; however, it encourages pastoral agents to help the elderly patient to see that such statements are not the *sole determinants of meaning-making* in older adulthood. The prophetic role of the Christian chaplain is precisely this process of interrupting the dominant medical narrative by helping the older adult to place illness or injury in the context of a much broader and more human life perspective. While the choices for next steps in treatment may still be the same, the hope is that decisions would be made on the basis of discussions that include the patient's personal identities, values, and competencies, rather than solely his or her biological risks, diagnoses, and deficits.

How exactly might this be done? The first step in narrative therapy almost always involves the process of deconstructing problem-saturated stories with the patient, a process Michael White describes as "externalization."<sup>8</sup> Externalizing conversations in the hospital would allow people to name and contain the problem, to identify its scope, and to map its effects on their lives. It prevents the discourse surrounding the problem from becoming the totality of people's beings, thereby allowing them to better voice frustrations and articulate hopes related to a new future. According to Grimm's analysis of several case studies using narrative therapy among older adults, "When older clients participate in externalizing conversations, they have the opportunity to challenge the thin descriptors of diagnosis and labeling and explore alternative and preferred descriptions of themselves."<sup>9</sup> In practice with older adults in the medical setting, each person's definition of the problem may be different – for example, fears of decreased mobility, worries about social isolation, or grief over loss of a loved one. It is important to honor

whatever story the older adult chooses to name as the problem. Moreover, mirroring the vocabulary used by the patient is essential, as phrases and expressions take on different nuances across the generations.

Another key aspect of narrative therapy that has been shown to work particularly well for older adults is the process of re-membering.<sup>10</sup> In particular, this approach helps to empower older adults by encouraging them to tell stories about themselves that highlight their values and capabilities as noticed by others, both living and deceased. There is often a definitional ceremony, whereby the forgotten story of strength is re-integrated into one's identity.<sup>11</sup> Re-membering becomes a way to help the older adult access deep interpersonal bonds that may become essential in sustaining him or her in times of distress – a process which bears resonance to the Catholic practice of praying with the communion of saints, in which, as Elizabeth Johnson describes, “One fire kindles another.”<sup>12</sup> Such re-membering conversations can remind them of their earlier selves, which may help to re-awaken creative and hope-filled possibilities of the future selves God is calling them to become.<sup>13</sup>

An additional consideration about narrative pastoral counseling among this population is that medically-based narratives of pathology and risk often influence the whole family system. Therefore, narrative pastoral practice might consider interventions addressed to the entire family unit – however this may be defined by the patient – in order to nurture stories that support the elderly person's holistic wellbeing during and after hospitalization. Family systems theorist Froma Walsh identified several key processes related to beliefs that help foster resilience among families during crises: making meaning of adversity, maintaining a positive outlook, and appealing to transcendence and spirituality.<sup>14</sup> Helping families – who may also be burdened with caregiving stress – externalize problems and re-member their loved ones may also be critical in

order to help the whole system gain some distance from the pathology-based stories and see clearly enough to transcend the stress and sustain resiliency after a challenging medical event.

Finally, a further promising technique of narrative therapy among this population might also include using solution-focused questions, such as “the miracle question,” to invite elderly persons to imagine new possibilities outside of their medical condition.<sup>15</sup> Research suggests that narrative-based peer support groups can also be a favorable treatment modality in older adulthood.<sup>16</sup> Additionally, a mixed-method study in the Netherlands observed that life review therapy can increase quality of life for older adults experiencing distress; this narrative approach guides people through semi-structured interviews to create meaning out of both the pain and joys of life.<sup>17</sup> However, due to the time-limited nature of hospital chaplaincy, life review therapy would have to be adapted, and most likely condensed, in this particular setting.

## **Conclusion**

In conclusion, the hospital chaplain is in a sacred position, poised to prophetically interrupt the dominant problem-saturated discourses of illness and aging that threaten to marginalize the voices of older adults in the medical system. Inspired by the vision of old age as expressed in the gospel story of Anna and Simeon, and in bold response to Pope Francis’ apostolic exhortation, the Christian chaplain bears witness to the possibility of hope in co-authoring alternative endings of the human flourishing, growth, and meaning to be found in older adulthood. Understanding how narrative technique can be adapted to older adults is critical in empowering the elderly person and his or her family to be active, resilient, and collaborative agents in the face of challenging medical diagnoses and decisions. This pastoral work is an essential part of the call to Christian discipleship.

## Notes

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<sup>1</sup> In order to narrow the scope of this paper, the terms “older adult” or “elderly person” refer to persons aged 65 years old and above. Additionally, the population is further restricted to people who are not suffering from major cognitive impairment (such as Alzheimer’s disease or dementia).

<sup>2</sup> Greene, Roberta R., et al, “Assessment of Older Adults, Their Families, and Their Social Supports,” in *Foundations of Social Work Practice in the Field of Aging. A Competency Based Approach*. Washington, DC: NASW Press, 2007.

<sup>3</sup> Grimm, Raymond. “Narrative Therapy with Older Adults,” in *Mental Wellness in Aging: Strengths-Based Approaches*, eds. Judah L. Ronch & Joseph A. Goldfield (Baltimore: Health Professions Press, 2003), 251.

<sup>4</sup> As identified by critical gerontologists and noted by Grimm, Raymond in “Narrative Therapy with Older Adults,” 247.

<sup>5</sup> Clark, Phillip. “Narrative Gerontology in Clinical Practice” in *Narrative Gerontology: Theory, Research, and Practice*, eds. Gary Kenyon, Phillip Clark and Brian de Vries (New York: Springer Publishing Company, 2001), 195.

<sup>6</sup> Pope Francis, Apostolic Exhortation *Evangelii Gaudium*. 24 Nov 2013, § 75, 76, 108, 210.

<sup>7</sup> *Ibid.*, § 218.

<sup>8</sup> White, Michael. *Maps of Narrative Practice* (New York: W.W. Norton & Company, 2007), 1-59.

<sup>9</sup> Grimm, “Narrative Therapy with Older Adults,” 259.

<sup>10</sup> Meyerhoff, Barbara. “Life History Among the Elderly: Performance, Visibility, and Remembering,” in *A Crack in the Mirror: Reflexive Perspectives in Anthropology*, ed. Jay Ruby (Philadelphia: University of Pennsylvania Press, 1982), 99-117.

<sup>11</sup> White, *Maps of Narrative Practice*, 136-9.

<sup>12</sup> Johnson, Elizabeth A. “Praying with the Saints: Practices of Hopeful Remembrance,” in *Catholic Spiritual Practices: A Treasury of Old & New*, eds. Colleen M. Griffith and Thomas H. Groome (Brewster, MA: Paraclete Press, 2012), 14.

<sup>13</sup> Browning-Helsel, Philip. “Imagining Hope: Insights from Pastoral Care and Counseling,” in *Hope: Promise, Possibility, and Fulfillment*, eds. Richard Lennan and Nancy Pineda-Madrid (New York: Paulist, 2013), 79.

<sup>14</sup> Walsh, Froma. “Family Resilience: A Framework for Clinical Practice” in *Family Process* (42)1, 2003. Accessed online at [http://sw2.haifa.ac.il/images/stories/Field\\_studies/family\\_4.pdf](http://sw2.haifa.ac.il/images/stories/Field_studies/family_4.pdf).

<sup>15</sup> Browning-Helsel, “Imagining Hope,” 73-78.

<sup>16</sup> Poole, Jennifer, et al. “Narrative Therapy, Older Adults, and Group Work: Practice, Research, and Recommendations.” *Social Work with Groups* 32.4 (2009): 288-302.

<sup>17</sup> Bohlmeijer, Ernst and Gerben Westerhof. “Reminiscence Interventions: Bringing Narrative Gerontology into Practice,” in *Storying Later Life: Issues, Investigations and Interventions in Narrative Gerontology*, eds. Gary Kenyon, Ernst Bohlmeijer and William L. Randall (New York: Oxford University Press, 2011), 253-89.