

Spirituality and health: A narrative-pastoral approach

C J Truter and D J Kotzé¹

The Institute for Therapeutic Development and
The Department of Practical Theology
University of South Africa

Abstract

Health is much more than the absence of illness; it is rather a “high level wellness” and a life with “meaningful life-possibilities”. This article indicates how meaningful life-possibilities and a high level of wellness can be socially constructed within a process of narrative-pastoral therapy for a patient who is chronically ill and therefore cannot be cured. Pastoral care as a spiritual and religious act can play an important role in giving sense and meaning to people’s lives, and can play a preventive role in living with illness. This article furthermore shows how patients’ stories of illness can be centralised by means of narrative therapy and how a pastoral and ethical attitude of love and respect can create a climate conducive to better health and well being. We share how patients’ richer descriptions of their illness can produce a spiritual climate which can contribute to their better health.

1. INTRODUCTION

We live in a society that puts pressure on patients to go on with life (Foot & Frank 1999:168). We are not comfortable with an illness story which makes us face our own mortality and the possibility that we might become seriously ill. Weingarten (2000:400) alludes to this notion: “[H]earing the distress of others may cause one’s own psychological distress. This is so much the case that it is a natural impulse for listeners to withdraw from the conversation or to

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downplay the sufferer's pain." Patients become stigmatised and marginalised, isolated and inclined to hide themselves (Frank 1991:97) – isolated in this sense means "not feeling a real sense of intimate connection with other people" (Ornish 1993:108).

Sometimes patients have the experience that the medical world accentuates this isolation. Medical staff and patients have different interpretations of illness. One could say that medical staff would prefer to talk about "*disease*" and patients would prefer to talk of "*illness*". Frank (1991:12, 13) explains this difference in interpretation: "If disease talk measures the body, illness talk tells of fear and frustration of being inside a body that is breaking down..." In many cases "*illness*" talk expresses a life with a chronic illness, and for many patients this assumes an illness story with a downward trend.

We regard it as important for patients to find a safe haven where they can talk about their illness as an expression of their "illness-as-lived" (Toombs 1992:13), especially when it is an expression of patients' chronic illness with a downward trend. Oriah Mountain Dreamer's words in her heartfelt poem "The Invitation" are a reflection of our pastoral attitude:

IT DOESN'T INTEREST ME WHAT YOU DO FOR A LIVING. I want to know what you ache for, and if you dare to dream of meeting your heart's longing ... I want to know if you have touched the centre of your own sorrow ... I want to know if you can sit with pain, mine or your own, without moving to hide it or fade it or fix it ... I want to know if you can disappoint another to be true to yourself ...

In this article we emphasise the patient's own living worlds as his or her "illness-as-lived". We advocate a direction in pastoral therapy *with* patients that promotes not only a mere change in action but also a change in attitude ("metanoia") at a level that could be called spirituality (Isherwood & McEwan 1993:11). The theology that best describes this type of spirituality for patients is a contextual theology.

2. CONTEXTUAL THEOLOGY

Our understanding of God and his relationship with people cannot be captured by fixed and unchanged dogmas and doctrines; it should rather be explored and anchored in people's lives as expressed in their daily realities (Isherwood & McEwan 1993:9). We understand a patient's spirituality as the meaning he or she gives to or finds with God in life, in the experienced life-context of her

or his own illness. This can only happen if pastoral conversations are not intellectual conversations *about* God, but rather conversations *with* God.

From a contextual perspective it becomes impossible to do theology as though we live in some abstract realm or dead corner of history – we have to involve ourselves in the world (Isherwood & McEwan 1993:77). It is in this way that we approach pastoral therapy as a means of respecting the patient's unique descriptions and experiences of his or her own illness.

3. PASTORAL CARE

According to Pattison (1993:204), the focus of pastoral care is “gradually turning from the focus on crisis and pathology ... to a more holistic and preventive approach. This nurturing positive approach is ... a turn away from individualized problem-centredness to corporate growth in community.”

Pastoral therapy is no longer attenuated to crisis pastorate and pathology; instead it is extended to become holistic and preventive when it helps people whose lives are connected with one another to come to richer descriptions of their own situations.

The approach to pastoral care that we favour would be one that does not merely focus on pathology (with its categorising, diagnosing characteristics, the crisis at the outset and the cure), but on the patient's unique context and on care for the patient. Frank (1991:45) argues that care begins where difference is recognised. Sevenhuijsen (1998:15) elaborates on this by stating that the “ethics of care” is based on a dual commitment. On the one hand it assumes that people recognise and treat others as different and take into account other people's individual views of the world and of their place within the world. On the other hand, it does not take needs and narratives as absolute but interprets and judges them in specific contexts of action. The narratives people have of their lives cannot be interpreted as absolute; instead they should be interpreted in a specific context of conduct.

Every person experiences his or her illness as unique in his or her specific context. That is why categorising and diagnosing a disease may be an obstacle to doing pastoral care. Frank (1991:48) states we have the privilege to understand how unique individuals are: “When the caregiver communicates to the ill person that she cares about that uniqueness, she makes the person's life meaningful.”

Medical treatment and care can overlap, but are not the same – “when treatment runs out, there can still be care” (Frank 1991:101). Meaningful life-possibilities (Dill 1996:253) and a “highlevel wellness” (Clinebell 1991:211) could be socially constructed in a process of narrative pastoral therapy, even by a patient who is chronically ill.

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The research of Harris et al (1995:17-31) and Lapane et al (1997:155-162) with heart patients, confirms that the practice of religion by heart patients contributes to better health. Pastoral care as a spiritual and religious act can play an important role in giving sense and meaning to people's lives, and can also play a preventive role. Clinebell's (1991:43) description of pastoral care as "nurturing" expresses the healthy principles of prevention and healing. Pastoral care can give patients "an opportunity for growth, witnessing and deepening of faith" (Louw 1994:61).

Pastoral care is furthermore not only individual care, but also "pastoral practice" (Graham 1996:52) in a wider context – the community should also be included in caring. The pastoral care given to patients is not only care from one individual to another individual, but is also the responsibility of the religious community. From a contextual perspective, pastoral care with patients strives to find new ways to involve the religious community and medical system so that patients can be accommodated and their stories centralised and respected.

The importance of care as a social practice and the acknowledgement of the diversity of the values it embodies (Sevenhuijsen 1998:15) highlight the ethical aspects of pastoral care. Pastoral care is not care *for*, but rather care *with* people (Kotzé & Kotzé 2001:7; Kotzé 2002:18). This ethical perspective accentuates the importance of participation in the process of pastoral therapy. Participatory care is committed to the benefit of all.

Pastoral care *with* patients, regarding them as participants in their own healing process, opens the door for the social transformation that contextual theology advocates.

4. SOCIAL TRANSFORMATION

Social transformation (Ackermann 1991:108; Cochrane, De Gruchy & Peterson 1991:2) is an important way of taking action in contextual theology. Transformation goes hand in hand with action that leads to change. The verb "doing" expresses an important part of the vocabulary of contextual theology and goes to the heart of theology, "the understanding of acting the faith and not just verbalising and articulating it" (Isherwood & McEwan 1993:82). Faith is not an impersonal abstraction by people; it captures people's deepest form of existence. Therefore the emphasis on spiritual formation has to shift from: "What do we believe?" to "Who are we?" (Williams, in Rossouw 1993:901).

The pastoral therapist is confronted with patients' physical and emotional pain as a result of illness, as well as their loneliness and marginalisation as a result of the medical system and society's way of

handling of illness. This moment, when we are so intensely touched by people's distress, becomes the "moment of insertion" (Cochrane, De Gruchy & Petersen 1991:17).

This "moment of insertion" which occurs in a pastor's ministry when he or she is confronted with people's hardships and suffering, calls on the pastor to take a definite ethical stance in favour of the marginalised and the neglected, and against the disempowering and isolating discourses and practices. In this case, the marginalised are the patients who suffer exclusion and stigmatisation as a result of their illness.

Bosch (1991:356) argues that in the twentieth century there was a radical shift from a non-eschatological to an eschatological theology – a fundamental break with anything that is predictable and the introduction of the category of contingency and unpredictability. This "notion of change", according to Bosch, inspires hope in the hearts of millions, particularly those less privileged. Action that brings about change is possible but, according to Cochrane, De Gruchy and Peterson (1991:920), it calls for an evangelical perspective: "Where action is not animated by the gospel, there is mere activism; where action is lacking, there is mere sterile biblical verbalism."

An evangelical perspective in social transformation safeguards change so that it does not become activism, but deeds of love. Resistance to injustice, asserts Welch (1990:165), is an act of love. Welch (1990:175) posits that we are moved to moral action by love and hope, not by guilt or duty.

The pastoral therapy we propose is the expression of people's (Christian) spirituality and attitude through their actions of love and their respectful treatment of people. Social transformation as a deed of love is aimed at empowering the people disempowered by society to believe in their abilities and to become active participants and role players in the process of transformation. Cochrane, De Gruchy and Peterson (1991:91) comment that "those who experience themselves as 'nothing' in their society discover a new identity as 'someone' who is no longer anonymous, who is important to oneself and to others, who becomes a human subject – an active agent in history who may participate in deciding on and constructing a world to live in".

Translated in terms of this article, this pastoral therapy means empowering a person as patient to see her- or himself as "someone" who is important; as someone who has the right to make decisions and to be an active participant in constructing, in collaboration with other role players, a better world for people living with an illness.

Social transformation does have an element or an "ethic of risk" (Welch 1990:68): "The fundamental risk constitutive of this ethic is the decision to care and to act although there are no guarantees of success." Pastoral care

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with patients does not guarantee instant and easy solutions. Change does not happen overnight. Many of these discourses, so destructive for patients, are deeply rooted in the medical system and require patience and perseverance.

A single person cannot achieve this kind of social transformation in the medical system and society. Corporate action is needed. “Responsible action does not mean one individual resolving the problems of others. It is, rather, participation in a communal work, laying the groundwork for the creative response of people in the present and in the future” (Welch 1990:75). “With more participants as problem solvers, it may be easier to find meaning, to define new dreams, and to consider new possibilities for action and relating” (McDaniel, Hepworth & Doherty 1992:210).

The source of this emphasis on relational anthropology, according to Ackermann (1991:108), is “in our understanding of God as ‘God in relation’”. The Abba-sayings of Jesus (Jn 15:15; Mt 23:9) describe a God who is accessible. These sayings “envisage a new social reality, one that is based on equals who lovingly interact between themselves, and with their God who is accessible and no longer remote” (Isherwood and McEwan 1994:102).

Relationships which are *inclusive* rather than exclusive, *mutual* rather than dominant or submissive, implying *connectedness* rather than separateness (Graham 1996: 28) are emphasised in pastoral therapy. These relationships are an expression of what God’s love is like – a love that adds value to the marginalised and the neglected. It is within these relations that conversations *with* God take shape.

5. CONVERSATIONS WITH GOD

In a pastoral conversation within an ethical framework, people’s conversations with God and their relationship with God are respected. The premise is that God is far greater than any understanding, experience or writing could ever describe. Therefore people’s experiences *with* God may differ from one person to another and from one situation to another.

Since God is not a creation or projection of humans, God’s existence does not depend on human constructions or conversations. God exists, regardless of how and whether people talk or do not talk to one another about God. However, when people talk *with* another person about their personal relationship and conversations *with* God, a richer meaning is constructed in that conversation.

In a pastoral conversation from a contextual approach, teaching and instruction about God will create space for people’s unique experiences *with* God and their own descriptions of what God means to them. Van Huyssteen (1987:155) comments that, in the broader paradigmatic context of the Bible

and Christian tradition, the experience of faith has always been seen as a God experience and therefore as a personal experience in the sense of a personal religious encounter.

Clients' conversations in pastoral therapy about their experiences with God could be limited if they are not handled with care. Griffith (1995:123-137) names two constraints that could limit such a conversation: *proscriptive constraints* – that this God-talk is not to be spoken of here, but only there where people worship, and *prescriptive constraints* – such conversations can be limited when it is a therapist's view that God may be spoken of, but only in a specific way. "Stories of certainty", as Griffith says, could suppress and limit the possibility of clients' conversations with God. Certainties such as: "I know what God is like for you because I know your religious denomination" or "I know what God is like and you need to know God as I do" are limiting. It is necessary instead for the therapist to move from certainty to curiosity, from certainty to wonder, to be willing to be informed by the clients about their experience with God. In this regard Griffith (1995:137) makes the following apt remark: "The Holy's other name is 'Surprise'. If one is too certain of her specifications of God, she will miss God."

In a contextual approach to pastoral therapy, it is necessary to direct pastoral conversations at people's unique ways of making meaning of their faith² within their specific situation and experience.

6. NARRATIVE THERAPY AS EXPRESSION OF A CONTEXTUAL THEOLOGY

Narrative therapy in practice is about "doing therapy respectfully – that is, promoting the construction of a client's life without enfeebling her in the process ... it is about learning to avoid ways of speaking and listening that unintentionally express disrespect for others" (Drewery & Winslade 1997:32). Respect for people is the core of narrative therapy – respect built on love. Feminist theology, as an expression of a contextual theology, has contributed to reintroducing respect and love for marginalised people – in "a world where individual dignity and integrity are honoured in mutual relating, where life-giving power replaces life-denying power and people are enabled to accept their humanity joyfully" (Isherwood & McEwan 1993:134).

A narrative approach is combined with ethical values when it emphasises people's life-giving power and potential, instead of their life-denying power. This life-giving potential can only be revealed when people who feel excluded are treated with respect, love and inclusion. As a form of

² Dill (1996:253) calls it "mense se unieke geloofsbetekenis", or people's unique meanings for faith.

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pastoral action, a narrative therapeutic approach fits well with a contextual theology. Narrative therapy gives expression to a contextual theology by centralising clients' and patients' stories, and by not reducing these people to being the passive recipients of expert professionals' theoretical and classification systems, be they medically or theologically based.

The storytelling of clients and patients in their own voices and according to their own experiences centralises their own contexts and does not confine them to external theoretical and classification systems. Narrative therapy that centralises people's own contexts through their storytelling is therefore a meaningful way of giving expression to a contextual theology: "The more we participate in such a way that the voices of all, especially those who have been previously silenced, can be heard, the more we can research and co-construct, in an ethical manner, an ethical, just and ecologically sound world to live in" (Kotzé 2002:30).

To conclude this article, we give an example of how God's voice can create a spiritual climate conducive to richer descriptions in the conversation of a heart patient, and then describe the outcome of narrative-pastoral therapy with heart patients.

7. AN EXAMPLE OF GOD'S VOICE IN A CONVERSATION WITH A HEART PATIENT

In narrative-pastoral therapy, it is important to give God's voice a prominent place in our conversations with clients/patients. In this research project, the participants (heart patients and their families) brought God into their conversations from the outset of the first session. In most of the conversations reported in this research project, God's voice resonated strongly during the pastoral conversations. These conversations played an integral role in giving sense and meaning to these heart patients' lives. The example given of God's role in the richer descriptions of a heart patient is therefore only one of many conversations.

The following conversation took place between the researcher and therapist (Trix), and one of the heart patients participating in the project (Stephan):

Trix: "If you reflect on the year following the operation, are you satisfied with the way in which you handled it?"

Stephan: "Yes, I believe I am."

Trix: "Are you able to give Stephan credit?"

Stephan: (smiling) "I think he deserves a few marks."

Trix: "For which aspect?"

Stephan: "Oh, he made a change to his diet. I try to cope with the stress, but I'm not very successful, although it feels as if it is improving slightly."

Trix: "Do you feel that there was a sense of spiritual enrichment following your operation?"

Stephan: "Yes, definitely. One must be aware of the grace that allowed you to have coped with it. You are thankful, for the daily improvement. As time passes, your outlook improves and is more positive. At this stage I have no negative emotions."

Trix: "What does the fact that Stephan could manage all this, say about him?"

Stephan: "Yes, I would like to compliment him, but it is God's grace, as well. He must surely receive the greatest appreciation."

Trix: "Do you think the Lord would acknowledge Stephan for what he has achieved?"

Stephan: "Yes, at least."

Trix: "Which aspect would the Lord acknowledge, according to you?"

Stephan: "The total change of quality of life. You have more daily appreciation. Tomorrow when you awake, you are grateful for the blessing of a new day."

In accordance with the narrative approach, the therapist tried to tie in with ethical values that emphasise Stephan's life-giving power and potential, instead of his life-denying power. Emphasis was placed on what he has achieved. The therapist created a context for richer descriptions when he gave Stephan the opportunity to see himself through the eyes of God. At the outset, Stephan found it difficult to give recognition to himself. When he saw himself through the eyes of God, he found it easier to validate himself in the light of what he had already achieved. This conversation is a true example of how God can give new meaning to a person in his or her specific context, if viewed through the eyes of the person and not those of pro- or prescriptive theologians. This spiritual conversation is also an expression of a contextual theology which is open to describing the new situations that may occur as part of the social constructions of believers, in a language that makes God accessible to people in their specific context.

8. THE OUTCOMES OF NARRATIVE- PASTORAL THERAPY WITH HEART PATIENTS

Pastoral care as a spiritual and religious act can play an important role in giving sense and meaning to people's lives, and can play a progressive and preventive role in living with illness.

The findings of this study (Truter 2002:262) indicate the following progressive results for heart patients: due to a better support system, heart patients feel less isolated and lonely; they changed their life style; no longer feared death; less angina; their self-centredness changed to reaching out to people in need; families and heart patients talked more openly about heart illness-as-lived; some of the participants became more active and creative; these patients' medical doctors witnessed better cholesterol and blood-pressure levels, better heart function, less anxiety and worries about heart function, a greater motivation for important medical tests, and better co-operation with medical treatment (for example the regular use of medication).

9. CONCLUSION

Narrative pastoral therapy from a contextual approach wants to establish a process through which the pastoral therapist and the patient can in their joint conversation co-construct richer descriptions and meaning that can be applied in their life contexts. A patient's richer descriptions of his or her illness can indeed produce a spiritual climate which may contribute to better health.

The implication of pastoral therapy from a narrative approach is that the crisis should not merely be prevented and handled at the outset, but should also be preventive against deterioration and enriching in conduct by increasing meaningful life-possibilities (Dill 1996:253).

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