Published in final edited form as:

J Health Care Chaplain. 2013 ; 19(3): 99–111. doi:10.1080/08854726.2013.806119.

Chaplaincy and Narrative Theory: A Response to Risk's Case Study

DANIEL H. GROSSOEHME

Division of Pulmonary Medicine, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio, USA

Abstract

The response of a clinical chaplain to a case study of chaplaincy with an elderly African-American male with Parkinson's disease is presented. The case study offers two novel aspects: first, it explicitly describes interventions by the chaplain, and second, the chaplain's clinical approach was guided throughout by an underlying theory (narrative theory). The case study seeks to shift the paradigm from chaplains as "agenda-less" companions to clinicians with a repertoire of interventions which they should claim. The chaplain's use of narrative theory is examined. Future case studies may draw on narrative theory in chaplaincy with older males with different chronic disease, with women who have Parkinson's, and may seek to develop a theory of chaplaincy from within the profession.

Keywords

chaplaincy; case study; narrative theory; Parkinson's disease

INTRODUCTION

Like many first-unit CPE students in the early 1990s, the basic building blocks I was given for chaplaincy interactions were active listening (Bolton, 1979) and the non-directive interactions of Carl Rogers (Grossoehme et al., 2012). However, professional chaplaincy is, or should be, about more than exclusively using Rogerian sharing. Chaplain Risk writes in his presentation of the case study to which this manuscript responds that, "chaplains plant seeds" and in so doing, helps the profession enlarge our understanding of what is possible for chaplains to offer beyond active listening and simple presence. This statement is not meant to denigrate either of those activities. But there is, or should be, more to a professional chaplain's repertoire. This is a key issue, and one of the gifts this case offers for reflection is that of recognizing the legitimate interventive nature of chaplaincy. To think that chaplains enter into relationships without an agenda and with nothing to offer to the other is dishonest. When a chaplain enters a situation or a relationship, something novel is created that did not exist before. Simply showing up is an intervention, although a very low-

level one. Chaplain Risk's interventions are explicit, chosen, and go beyond "just" being present as a listener.

Chaplaincy has borrowed heavily from the realms of the behavioral sciences to understand itself. What has been largely missing from our profession is a theory to help us understand what we do, to select appropriate responses (interventions!). A theoretical basis for chaplaincy could be empirically tested and refined based on new knowledge. Chaplain Risk's case study is explicitly embedded in a theoretical foundation which clearly guided his self-understanding and his selection of interventions. This is a novel approach that deserves reflection.

Theoretical Foundations

Narrative therapy—The theoretical base out of which Chaplain Risk operates—narrative theory—is sufficiently important that it bears some explanation before examining its application in this particular case. It is also sufficiently alike, in name at least, to another use of narrative from which it is important to distinguish it. Narrative theory grows out of the initial observations and work by Arthur Frank and Arthur Kleinman with persons who experienced chronic illness (Frank, 1998; Kleinman, 1988). Their understanding of why people tell stories, and the value in facilitating the telling of those stories, is that stories are the framework through which another person may be understood. The role of the clinician listener is to reflect on why this story needs to be told now, in this way, and to facilitate the storyteller's interpretation of its meaning. Narrative theory is not to be confused with "narrative therapy" described in the seminal book by Michael White and David Epston (White & Epston, 1990). Narrative therapy is a form of marriage and family therapy, which strenuously avoids labeling people, diagnoses—or their stories. White and Epston (p. 3) draw on the work of family therapist such as Bateson and the French philosopher Michel Foucault and base their method on the idea that it is not family dysfunction that determines behavior, but, "... the meaning that members attribute to events that determines their behavior." White believes that persons live out their lives based around one or more problems, and further, that their narratives are "saturated" with examples of "the problem." The therapeutic goal becomes one of separating the person from the problem and the emergence of a new narrative devoid of the problem (White & Epston). While both narrative therapy and narrative theory focus on storytelling and constructed meaning, they are different; narrative therapy resisting the "expert" knowledge (which means power) that is inherently claimed by someone who classifies, or labels a narrative as a particular type. Power lies not as a quality internal to people who exercise it over others, but instead power resides in the jointly constructed meaning that people give to the problem in their lives.

Narrative theory—In his discussion of what become known as narrative theory, Arthur Kleinman (1988) wrote (p. 9), "...there is evidence to indicate that through examining the particular significance of a person's illness, it is possible to break the vicious cycles that amplify distress. The interpretation of illness meanings can also contribute to the provision of more effective care" p. 9). Clinically, this means three things. First, helping persons put into words their attributions for the cause of their illness, and their experience in living with it. Such meanings are often tacitly held; the chaplain's role is to help the person tell their

story. Second, the chaplain is able to present her or his understanding, followed by a collaborative understanding of how the person's experience will be understood and explored. Finally, narrative theory calls for the chaplain's self-reflection on how the other person's story connects with his or her own story, and how the chaplain's story changes due to this encounter or series of encounters (Kleinman).

Illness Stories

Arthur Frank (1988) has described three types of illness stories as a means of understanding people's experiences of illness: restitution, chaos and quest narratives. Restitution narratives are the most commonly told stories: one becomes ill, suffers through treatment, and is restored to health. These narratives are nearly always a part of chronic illness experiences and they are easy to listen to because they have a happy ending, in which one is restored to health. Chaos stories are those which tell of ever-increasing disability or pain, and or the inability of physicians to correct the problem or understand the person. These stories lack any effective drama or action. Chaos stories are not easy to listen to, however, it's important to honor the suffering they describe without seeking an exit from it or glossing over it and at the same time to reject the idea that there are no alternatives. Frank writes that, "Compassion means just listening"—attending to the story without attempting to "fix" or treat the symptom (Frank, p. 203). Quest narratives describe experiencing illness "when restitution can no longer be imagined" and the illness is neither " 'accepted,' a word that is too passive, nor is it welcomed, a word that romanticizes illness" (Frank, p. 203). At that point, narratives shift to talk about what can be learned from the illness experience and what can be passed on to others, as well as making claims about new qualities of one's self that have risen to awareness. Frank argues that becoming aware of what one has learned from illness should never be turned into a restitution narrative; quest stories are about, "finding a grateful life in conditions the healthy self would find intolerable" (Frank, p. 205).

Clinical Use of Illness Stories

Frank's categorization of illness narratives into these three types was never meant to be diagnostic, but to be "listening devices" which provide a framework for understanding the other person (Frank, 1998). He provided three cautions about using this schema. First, all three narratives are often found in the same person, though one may dominate at any given time. The question is not so much which story is someone telling, but why they need to tell that story at this particular time. Second, they are not a form of developmental trajectory in which the quest story is the therapeutic goal. Third, listeners will have their own preferences for hearing one story more than others. Listeners need to resist urges to changing or fixing the story and instead nurture its telling and allow the teller to work through their situation by telling the story the way they need to at the moment (Frank).

Nearly twenty years after his first writings on illness narratives, Frank stated that he failed appreciate the fact that "stories are not inherently benign" (Frank, 2009, p. 162). The idea of having a protagonist (usually the story teller) requires that something or someone be forced into the role of antagonist. When death is "conscripted" into being the antagonist, then the act of dying is a failure. The very nature of some narratives requires that there be some obstacle which must be overcome. When this is so, Frank writes, "stories can trick us into

feeling tested by what may be nothing more than how things are; the nature of bodies is to wear out ... a worn out body can be an obstacle but it is not necessarily a test" (Frank, p. 168). Clinician/listeners can help the teller from being "tricked" by helping them distinguish between real obstacles to overcome from obstacles they have created and on which they expend energy trying to overcome. Frank writes that institutional interests may want illness stories told in a particular manner or seek to define one form of illness narrative as "right." He concludes that clinicians' commitment is to support the teller. They do this in several ways. First, by helping persons choose well what stories to tell. Quest narratives are perhaps especially liable to having tellers be encouraged by listeners to figure out what they should be thankful for, now that they have experienced this illness. Committed clinicians help tellers avoid the danger of accepting that there is one "right" and conforming way to tell their story. Second, clinician's commitment to the storyteller is demonstrated by reminding tellers that they must make the interpretive decisions about their story; and by helping people reflect on the consequences of their story not only for themselves, but for those around them (Frank, 2009). Frank provides an example with which many chaplains are quite familiar: a person's commitment to the story that dying people should not be in pain, if acted upon by providing medication for pain relief, may have the consequence of "compromising a person's other abilities, ultimately consciousness itself" (Frank, p. 172). Living into the dominant story of dying pain free—surely a laudable goal when I consider it for myself—does have implications for those around me, namely my wife and son, and may even compromise our abilities to speak crucial words to one another at a very crucial time.

COMMENTARY ON THE CASE STUDY

The First Meeting

Chaplain Risk describes the first visit as simply, "... a time to establish an empathic relationship with Bob ..." Two things are missing for me from this section. First, Bob referred himself to the chaplain during his screening for spiritual struggle using the Rush Protocol as part of the BRIGHTEN program (Fitchett & Risk, 2009); however, the reason for his request is never explained. It is not clear if the Rush Protocol Chaplain Risk used was the original version or the revised version described in that original publication. As described, it appears that Bob referred himself through the Protocol's question, "Would you like to talk with a chaplain?" This question is included in the protocol to identify persons who may or may not be experiencing spiritual struggle and for whom a chaplain's visit might or might not be important—and yet whose satisfaction will be lower if they do not receive one (Grossoehme & Fitchett, in Press). Having a sense of what lay behind Bob's self-referral might (or might not) have influenced Chaplain Risk's initial meeting or his future care. It would also have helped Chaplain Risk reflect—either individually or with Bob—why Bob needed to tell these stories in this way at these times. The second things missing for me in the presentation of this first visit is any explicit form of religious or spiritual assessment that informs the chaplain's future plans. Chaplain Risk describes in the Methods section of his case study that the 7×7 model described by Fitchett (2002) and the categories described by Paul Pruyser (1976) are "integrated throughout this article rather than in a separate section" (Risk, 2013, p. 85). Given that this was likely to become a long-term relationship due to the chronic, progressive nature of Parkinson's disease, it would

seem important to begin some intentional assessment at the beginning. This would inform subsequent interventions. It would also be helpful to understand how chaplaincy was explained by Chaplain Risk and understood by Bob: how did this long-term relationship begin, and with what expectations and understandings? I would have appreciated reading the content and the application of these two methods of assessment, and to read how his assessment evolved over the course of the relationship.

The Second and Fifth Meetings

Recognizing that there are limitations of space that dictate how much can be included in a manuscript, I would have benefitted from both additional dialogue and self-reflection on the meetings in this case. At the end of the second meeting, Chaplain Risk briefly describes an intervention, giving Bob a copy of the book *Learning to Fall* (Simmons, 2002). Risk's metaphor for chaplaincy is "planting seeds" and that seems to be what his intervention is designed to do. It is not clear whether discussing Bob's response to the book was envisioned as a possibility, or if it was sufficient to "plant the seed" and allow it the time and space to grow in Bob however it will. One way—and an explicitly Trinitarian way—of understanding this intervention is that by coming into Bob's story and intervening, and then leaving at the end of the second meeting, Chaplain Risk created a space into which the Holy Spirit could enter and act with Bob. Such an approach is entirely consistent with narrative theory, which would never seek to rush a story's telling or force it out in a particular genre (Frank, 1998). Chaplain Risk says that he, "... suggested that the author's story was a Quest Narrative." What is missing for me is what groundwork Chaplain Risk laid either before giving the book to Bob or as he was doing so. For those who would want to intervene similarly, or make use of narrative theory, this would have been helpful for us to see how it was done in this case. How much explanation of quest narratives (and restitution and chaos narratives) did he make? Did he present them evenly and accurately? Or did he present the book and suggest that the author story is similar to how he hears Bob tell his story?

In the fifth meeting (and I discuss the meetings out of order because the interventions are similar), Chaplain Risk gives Bob a copy of an article (Cramm, 2000) which is also a quest narrative. He says he did this, "... without using the words 'Quest Narrative.'" "This is an example where additional dialogue to allow us "listen in" would have been helpful. It is unclear if Risk is showing his own preference for listening to quest narratives, or did he sense that Bob was beginning to tell one? Or was Bob's sense of isolation such that Chaplain Risk thought he might benefit from experiencing that he was not alone in his search for meaning? Arthur Frank is clear that listeners will have their own preferences for listening to one narrative form over others, and the quest form is certainly attractive. However, Frank cautions that people generally tell the story they need to tell at the time in order to deal effectively with their current situation. Therefore, listeners should neither rush a narrative toward resolution nor encourage a particular narrative form. From the information given, it is hard to understand how his understanding of narrative theory was guiding him as he gave Bob this article. The subtle giving of it, however, without mentioning that it was indeed a quest narrative, is certainly consistent with both Risk's pastoral identity of "planting a seed" and the stepping back to allow it grow as it will and narrative theory.

The Eighth Meeting

Bob gave Chaplain Risk the gift of numerous images with which to work. There are two places where Chaplain Risk might have altered his intervention by adopting the language of the metaphor he was offered by Bob, and working within it. The first of these is Bob's comment that, "I felt like the old man sitting in the corner at family Christmas gathering ... " Risk had just observed how Parkinson's disease robbed Bob and made him dependent on others. That was what Bob was responding to when he described himself as the old man in the corner: "I just don't have the energy to do what I used to do." Bob used this metaphor for being an invalid. Chaplain Risk focused instead the initial conversation topic, which was Bob's incontinence the previous night, which may have been an appropriate response. However, the image of wisdom conveyed through age, and the imagery of keen observation contained in Bob's metaphor might have been utilized by Chaplain Risk to probe more deeply. For example, a chaplain might ask Bob, "What would the wise old man sitting in the corner have to say?" What wisdom would the "wise old man" want to pass on to the children running around the family Christmas tree? Alternatively, Chaplain Risk might have personified the "old man in the corner" and asked Bob what he would have wanted to ask the "old man" or what he might have wanted the old man to say to him?

The Ninth Meeting

Glynn's narrative has aspects of a chaos story: "I don't know who this man is ... You were a superman ... " Her inability to see that she has choices is also suggestive of chaos story. Risk avoids the most common pitfalls of listening to a chaos story: being "sucked in" and attempting to fix the social (spiritual?) problems, and the desire to run from the chaos story. Frank suggests that one cannot speak in the midst of total chaos (Frank, 1998). Thus, by helping her say more about her perspective, Risk offered Glynn an escape, however transitory, from her sense of chaos. In responding to chaos stories, Frank says that listeners must avoid affirming the permanent nature of suffering, and attend without seeking to fix. It's possible that Chaplain Risk's response to her statement that she doesn't have any choices, "Yes, you do, Glynn" could be perceived as argumentative. Certainly it is didactic, and I question whether that is a pejorative expression. To what extent should chaplains *teach* in a clinical encounter? On certain occasions when child has died of cardiac issues, I have disclosed to the grieving parents that I am the surviving brother of a child who died from a congenital heart defect. Part of my purpose is didactic: I want them to learn that it is possible to have life and love again, even after such a loss. I think Chaplain Risk has offered a rich topic for reflection, and that is the educational role of chaplaincy. Is what he did different than when I respond to a 17-year old who is struggling to pray and I "teach" her some alternative ways to pray, such as writing a letter to God or drawing mandalas? Teachers are usually in an "over and above" posture to their students, which is very different from "being with" someone as equals that is more common in contemporary chaplaincy. However, Clebsch and Jaekle (1964) use the word "guiding" for teaching as one of the four actions in their definition of pastoral care: "... helping acts, done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns" (p. 4).

The Tenth Meeting

Not since second meeting has God been a significant part of the conversation. Chaplain Risk includes the phrase “meeting people where they are.” Sometimes where they are does not include talking about God, and chaplains should respect that. While it may be possible to question whether Chaplain Risk was a “chaplain” or a “counselor” through this series of meetings, perhaps the more important question is: how do the unique aspects of ministry to persons with chronic illness require the chaplain to adapt their approach? This is an especially vital question for those of us whose training took place primarily in acute care hospitals with lengths of stay typically less than a week. The Association of Professional Chaplains is developing Standards of Practice for different expressions of chaplaincy (acute care, long-term care, hospice/palliative care), suggesting the idea that our interventions should be shaped by our context.

This tenth meeting is the first meeting in which Bob begins to tell a quest narrative, as I read it (“... I wouldn’t have time to converse with God, if it weren’t for this,” and “I’ve learned what’s important in life”). What’s not clear to me is if this is possibly a result of the seeds that have been planted, or simple the first inclusion of them in the case study. Nonetheless, Bob tells it and Chaplain Risk speaks only enough to facilitate the telling of the story. At some future point it might have been helpful to return to the imagery of Bob fighting Satan, but perhaps Bob would not have needed to tell that story in the future.

The Fourteenth Meeting

By this time, I was in conversation with Chaplain Risk and psychologist Erin Emery, PhD, about this case study. Chaplain Risk posed a question based on some of my comments, and it led to a continuation of the quest narrative. It requires some rephrasing of the question by Chaplain Risk to find a way to word a question that draws the narrative forth, but he does. And, Bob tells his story, “with conviction.” While the persons with whom we interact may use images and metaphors for one reason, there is no reason why chaplains cannot push the boundaries of metaphors and show some curiosity as to whether they can also be applied in new ways. Bob’s image of the wise old man as a metaphor for being an invalid becomes a metaphor for expressing his wisdom—and the chaplain has acted as midwife in bringing this part of the story to birth.

The Fifteenth Meeting

Not for the first time I find myself wanting more of the dialogue of the meeting. Bob’s description of returning to work could be a continuation of his quest narrative or the emergence of a restitution narrative. Has something changed that has led him to change his narrative form? Perhaps hearing more about Bob’s anxiety would be helpful. The prayer, as related by Chaplain Risk, suggests the openness of an ongoing quest—opening to whatever new thing God is doing in Bob’s life.

DISCUSSION

On a Theoretical Base for Chaplaincy

One of the strengths of Chaplain Risk's case study is its theoretical base which makes it unique in chaplaincy literature. Chaplain Risk's case study has drawn exclusively from psychological theories, at least in part due to the lack of theoretical paradigms out of which chaplains might operate. Professional chaplaincy is just beginning to generate and publish rich, thick narrative case studies. Future cases studies should consider generating a theory of chaplaincy out of their narratives, rather than adapting or adopting theories from other disciplines. The research methodology known as "grounded theory" is particularly useful as a means of accomplishing this task. Grounded theory is the method of choice when no *a priori* theories exist in a field, and provides the framework for developing a theory out of narrative data, which can later be tested empirically. Several examples of the use of grounded theory studies exist in chaplaincy (Grossoehme, Ragsdale, Snow, & Seid, 2011; Grossoehme, Ragsdale, Wooldridge, Cotton, & Seid, 2010; Ragsdale, Holloway, & Ivy, 2009). In this way, chaplaincy will build its own theoretical base without relying on the foundations of other disciplines.

Chaplain's Use of Narrative Theory

Given that Chaplain Risk does ground his practice in this case in narrative theory, how well does he do? Frank intended his three-part distinction of narrative forms to be a listening aid, a framework, and not a diagnostic tool. He is clear that what is important is that which the other person needs to tell us now, and why—not whether or not it is the "best" or "right" form for storytelling. As such, there are times where Chaplain Risk may overstep what Frank intends, as in his Application of this Study to Chaplains, where he writes that "Chaplains can introduce patients with chronic, progressive disease to the concept of Quest Narrative and help them cope with grief and loss." Perhaps it would have been more consistent with narrative theory to say that chaplains can introduce persons with chronic disease to the concepts of different narrative forms, and invite them to talk about which form they prefer and why. Alternatively—and it is not entirely clear to me from the dialogue provided—that Chaplain Risk recognized a Quest Narrative in its telling and abided with Bob while it was being told. Then the applicability of this case is to chaplains who will recognize similar quest stories being told by the person with whom they work, and his case study presents an example of what can be done in such a situation.

I do not see, in the dialogue provided, evidence that he rushed the telling of this narrative nor that he cut off the telling of other forms. In fact, the silence and space he created after his reading interventions suggests consistency with helping a story come along on its own time scale. Never does Chaplain Risk relate that he brought up the book or manuscript or followed up on whether or not Bob read them, which might hurry a narrative, any narrative, to come out so as to "satisfy" the chaplain, nor does it induce guilt in Bob if he has not yet, or chooses not, to read them.

What is missing for me is what Arthur Kleinman describes as the, "... self-reflective interpretation of the interests, biases, and emotions that underlie ..." (p. 243) the clinician's

own model for illness and healing. What is Chaplain Risk's perspective (theology?) of chronic illness and how did that influence his care and interventions? Does he have a preference for hearing quest narratives over the other two forms? What effect has hearing Bob and Glynn's stories had on him and how is he different because he has heard them? There seems to be this point of connection between narrative theory and professional chaplaincy: the ability of the chaplain to self-supervise, to be aware of one's motivations, biases, and feelings and the ways in which they influence our clinical practice. These often tacitly held concepts should be made explicit, especially if one uses narrative theory (although perhaps not only then).

Chaplain as Interventionist

Chaplain Risk's commentary on the chaplain as interventionist states that it is an example of a chaplain taking the opportunity to "... help the person with a chronic disease frame illness in the context of a Quest Narrative ... " As far as that goes, it is accurate and a helpful contribution to the literature. The danger is that this case might be generalized, and it is too soon in the process of presenting cases for reflection to generalize. Risk comes close, at times, to implying that the quest narrative is the preferred narrative form over restitution or chaos forms, and that is not my reading of Frank (1998, 2009) and Kleinman (1988). However, this case makes a valuable contribution, in my opinion, on its own merits: here is an example of chaplaincy when one encounters a person with a chronic illness who tells us a quest narrative.

In a recent guest editorial in the *Journal of Health Care Chaplaincy*, Grossoehme (2011) argued that asking an open-ended question is itself an intervention. While the editorial is based on asking questions in a research context, there is no reason to presume that asking open-ended questions in a chaplaincy is markedly different. Asking a question creates the opportunity for someone to explore multiple options. In the silence after a question is posed, there is the possibility for the hearer to find something divinely revealed. Asking a question is an intervention, and chaplains "intervene" in relationships all the time. And it is possible for chaplains to go even further. Examples from Chaplain Risk's work is giving Bob a copy of the book, *"Learning to fall"* and the Cramm (2000) manuscript that was also a quest narrative. Risk's case study raises the idea that chaplains can intentionally "intervene" based on their analysis of the other person's needs. The time may have come for professional chaplaincy to claim its interventionist nature and move beyond the fictional concept of the chaplain as an "agenda-less" listener.

Future Directions

Chaplain Risk takes his place amongst the limited, but hopefully growing number of chaplains willing to put their clinical practice "out there" for scrutiny and comment. I have not seen my role as respondent to applaud everything Risk has done but instead to offer critical review and raise questions. That being said, I think Chaplain Risk has done the profession a service in setting this case study before us. He has opened new grounds for conversation about chaplains' role as interventionists, and presents what is probably the first case study to have, *a priori*, a theoretical basis. He has described how responding to quest narrative has provided positive coping skills for Bob. A future direction for case studies

would be to attempt similar responses to a quest narrative and see if the outcomes are different—perhaps first with another man suffering with Parkinson’s and broadening to women and to persons with different chronic illnesses. How much is similar and how much is gender- or disease-specific? Another direction is to present case studies that detail chaplains’ responses to restitution and chaos narratives and the ways in which they are similar to or different from, the case study presented by Chaplain Risk. Developing a grounded theory of chaplaincy would be a significant contribution to the field and decrease our reliance on other disciplines. Such a theory could be developed from cases already extent if the entire dialogue were available. Future case studies should consider the amount of narrative necessary to present their intervention and outcome within a limited allocation of space for publication. Developing such rich, thick narratives will enable professional chaplains to be better listeners to the stories we have, and intervene more appropriately for the benefit of those to whom we listen.

References

- Bolton, R. *People Skills*. New York, NY: Simon & Schuster; 1979.
- Clebsch, WA.; Jaekle, CR. *Pastoral Care in Historical Perspective*. Englewood Cliffs, NJ: Prentice-Hall; 1964.
- Cramm, D. *Ten Things Every Parkinson’s Patient and Caregiver should Know*. Omaha, NE: Addicus Books; 2000.
- Fitchett, G. *Assessing Spiritual Needs*. Lima, OH: Academic Renewal Press; 2002.
- Fitchett G, Risk JL. Screening for Spiritual Struggle. *Journal of Pastoral Care And Counseling*. 2009; 63(1–2) Retrieved from <http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/71>.
- Frank AW. Just Listening: Narrative and Deep Illness. *Families, Systems & Health*. 1998; 16(3):197–216.
- Frank, AW. The Necessity and Dangers of Illness Narratives, Especially at the End of Life. In: Gunaratnam, Y.; Oliveiro, D., editors. *Narrative and Stories in Health Care*. New York, NY: Oxford University Press; 2009. p. 161-175.
- Grossoehme DH. Research as a Chaplaincy Intervention. *Journal of Health Care Chaplaincy*. 2011; 17(3–4):97–99.10.1080/08854726.2011.616165 [PubMed: 22029503]
- Grossoehme DH, Fitchett G. Testing the Validity of a Protocol to Screen for Spiritual Risk Among Parents of Children with Cystic Fibrosis. *Research In The Social Scientific Study of Religion*. In Press.
- Grossoehme DH, Ragsdale JR, Cotton S, Meyers MA, Clancy JP, Seid M, Joseph PM. Using Spirituality after an Adult of Diagnosis: Cognitive Reframing and Adhernece Motivation. *Journal of Health Care Chaplaincy*. 2012; 18(3–4):110–120.10.1080/08854726.2012.720544 [PubMed: 23094612]
- Grossoehme DH, Ragsdale JR, Snow A, Seid M. We Were Chosen as a Family: Parents’ Evolving use of Religion When their Child has Cystic Fibrosis. *Journal of Religion And Health*. 2011; 51(4): 1347–1358.10.1007/S10943-011-9477-5 [PubMed: 21409481]
- Grossoehme DH, Ragsdale JR, Wooldridge JL, Cotton S, Seid M. “We Can Handle This”: Parents’ Use of Religion in the First Year Following their Child’s Diagnosis with Cystic Fibrosis. *Journal of Health Care Chaplaincy*. 2010; 16(3):95–108.10.1080/08854726.2010.480833 [PubMed: 20658424]
- Kleinman, A. *The Illness Narratives*. New York, NY: Basic Books; 1988.
- Pruyser, P. *The Minister as Diagnostician*. Philadelphia, PA: Westminster Press; 1976.
- Ragsdale JR, Holloway EL, Ivy SS. Educating CPE Supervisors: A Grounded Theory Study. *Journal of Pastoral Care And Counseling*. 2009; 63(3–4):10-11-14. [PubMed: 20306939]
- Risk JL. Building a new life: A chaplain’s theory based case study of chronic illness. *Journal of Health Care Chaplaincy*. 2013; 19:81–98.10.1080/08854726.2013.806117 [PubMed: 23844842]

Simmons, P. Learning to Fall: Blessings of an Imperfect Life. New York, NY: Bantam Books; 2002.
White, M.; Epston, D. Narrative Means to Therapeutic Ends. New York, NY: W. W. Norton & Company; 1990.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript