

Spiritual Care in Practice

Case Studies in Healthcare Chaplaincy

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Chapter 12

‘What can you do for me?’

— David, a mid-sixties Jewish man
with stage IV pancreatic cancer

Nina Redl

Introduction

The following case unfolded several years ago during my time as chaplain in a hospital in East Jerusalem. The medical system in Israel is full of extremes. Despite large and world-renowned medical centres, a large part of the lower-income population, and all those without sufficient access to health insurance, rely on small neighbourhood clinics. These clinics are often barely more than shacks with a few mattresses and basic field medical equipment. The country's complicated politics make it either undesirable or impossible for non-Jewish, poor or illegal people to be admitted to the bigger medical facilities found in cities such as Jerusalem, Tel Aviv and Haifa.

I am a conservative rabbi and board certified chaplain, born and raised in Germany. After finishing my academic studies in the US, I took a break and spent time in Israel, where I had taken a part-time teaching position and served as a volunteer chaplain. I had gone into chaplaincy from a background of working in underserved, underdeveloped settings. Having a background in nursing and in chaplaincy, I decided to volunteer as a chaplain (in Hebrew, *tomekhet ruchanit*, the supporter

of the soul/spirit). I had no fixed work hours, full freedom to engage pastorally in whatever way I saw fit, with the only responsibility to be available to any patient, staff member, family member and volunteer, as needed.

At the time I worked on this case, the pastoral care done in hospitals rested in the hands of community clergy and lay volunteers. On the Christian side, some hospitals were run by monastic orders, and their patients received religious support from staff and volunteers. Additionally, Christian clergy would visit their congregants in other hospitals. On the Jewish side, Jewish clergy and laypeople embraced the *halakhi* (Jewish law) commandment of visiting the sick (*bikkur cholim*) in a formalized and institutionalized way. Interfaith chaplaincy was nascent with initiatives by NAJC Israel and private initiatives such as Kashuvot. As a profession, chaplaincy was mostly unknown or unrecognised by the Israeli government and paid jobs were only available as hired a kind of 'pastoral therapist'.

The hospital I worked at was the middle ground. A small, old building with a few trained nurses, doctors and volunteers, its mission was, and is, towards chronic and end-of-life care; hence, medical treatment for acute conditions was very limited. The patient population encompassed a few dozen patients, primarily geriatric, oncology, HIV and other chronic and terminal illnesses. Patients were Christian, Christian-Arab, Jewish and Muslim, as were the staff. It was a good place to be when dying, and a place for healing, but most often not for cure. Upon meeting with the hospital's director, it was clear to me that this was a place where I wanted to work.

This is where I met David, a Jewish man in his mid-sixties, brought up Orthodox in the old city of Jerusalem. David was the oldest of three children. He grew up speaking Hebrew, Yiddish and Arabic fluently. His friends were Jewish, Christian and Muslim children alike, as is not uncommon in the old city. Even though there is the division of the quarters, while he grew up he experienced little division or separation between the people who lived there. Despite the political tensions and

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the constant struggles, David had a rather typical upbringing. Like many children that consider the old city their world, he barely ever left the old city walls.

Yet David's early adult years were interrupted by one of the not infrequent street bombings. This time his mother was killed, and it was David, as the oldest son, who had to identify her and deliver the news to his family. Shortly afterwards, his father committed suicide. From then on, 16-year-old David became the head of the family, raising his younger siblings and taking over his father's business as a shoemaker. When the business no longer brought in enough money, he was forced to close it. For a few years, he took any available job to keep himself and his siblings' heads above water. Eventually, his siblings grew up and left home. David, however, found himself unable to move on and realize his dreams. He married but never felt close to his wife. Eventually, they divorced. Finally, he became a low-paid bank clerk and occasional housekeeper, working inside a sterile and industrial environment that could not be more opposite of that to which he was accustomed.

When I met him, David had recently been diagnosed with stage IV pancreatic cancer. He had been told that there was no curative treatment for him. Since he had had to face more physical pain than he could function with while living by himself, he had decided to come to the hospice part of our hospital, primarily for palliative and end-of-life care.

David died during my first few months working in the hospice; hence, gaining his permission to tell and publish his story was impossible. Never having met his family, and not being able to reach them even through his old hospital records, I could gain permission only from the hospital director to tell David's story under the condition that I use a pseudonym, generalize his story and leave out any details that could identify him to the reader.

Case study

The first time I saw David, I barely recognized him as a patient. My initial thought was that this middle-aged man had to be a family member who had finished a visit. There was an energy about him, a strength that was palpable, despite his slow walk. The patients around me seemed to know him quite well, and he stopped briefly to joke with some of them in Arabic. The only detail about his appearance that I could not place was that he seemed to suck on two lollipops. Given the excessive drug, tobacco and candy culture of the neighbourhood, I didn't think about it twice, even though it made me silently chuckle to see a grown man with what I deemed to be children's sweets.

Seeing him standing there, grinning through his lollipops, made me think that, despite his obvious age, he had not lost a childlike joy. Unfortunately, he was neither a relative nor visitor, but a patient suffering from rapidly growing, end-stage pancreatic cancer. The lollipops were actually narcotics. He seemed to be coming and going as he liked, not paying attention to any hospital regulations and structures other than medication times. There was a sense of fierce independence about him. I attempted several times to speak to him when I saw him passing, but to no avail. The most I would get was a searching look or a sneer before he turned around. This reaction roused my sense of curiosity. A couple of days later, I stopped him in the hallway.

Chaplain: Hi, David, I am Nina.

David: (Looking at me quizzically) And who would you be? What can you do for me?

Chaplain: I am the *tomekhet ruchanit* here, and I thought you might want someone to talk to.

David: Spiritual...you mean like religion?

Chaplain: Yes, that is one part of what I do: I have time to listen, and if you would like, we can pray together.

David: Ahh, nonsense, religion is bad. Don't you see what it has done to this country – to all of us?

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He spat on the floor, hit the wall with his fist and left without even looking at me. His blunt way of turning down my attempt to connect with him, and his strong reaction to even the mention of religion, startled me. I retreated to watching him again. I figured I needed to get a picture of him before I could attempt again to connect with him.

David clearly had an angry side to him. I witnessed several verbal fights he had with one of the doctors which demonstrated his wish to control his own medication and not follow their advice. His outbursts came suddenly, were borderline violent, but then resolved as if they had never happened.

Despite his tension with staff, David seemed to enjoy following the medical team around. At times he appeared to be the constant shadow of the nurses and doctors. Regularly, during early-morning rounds, he could be found leaning in the doorway in the nursing office, listening with concentration, positioning himself in a way that, if it hadn't been for his non-medical clothing, one could have easily mistaken him for a member of the medical team. When being denied this role, he would burst out in anger, curse and respond with very obvious gestures. When I asked my team why he was coming and going as he liked, I got the answer, 'Well, that's just him. There's nothing we can do. He knows no boundaries, and you better not come between him and what he wants – or he will rip your head off!' Over time, he had grown to be both feared and pitied by the staff.

Late one evening, when I passed by his room, I heard someone moaning. Not knowing whether it came from him, I entered only to find the curtain around David's bed drawn shut. When I carefully peeked inside, I got a furious look that communicated very clearly, 'Get out and leave me alone!' I learned from the medical team that, as he often did, he had overmedicated during the day and could not be given any more pain medication, except intravenously, which he adamantly refused.

In over a month, David had had no visitors. His trips outside the hospital had gotten shorter and shorter, and at night the moaning went on longer and longer. So far, all my attempts to connect to him had resulted in him sneering at me or simply ignoring me. Knowing I would not be able to

connect with him during the day, I started a different strategy. Due to pain and overmedication, David's nights were still the most complicated time of his day. I supposed the quiet time brought up memories and thoughts of what lay ahead of him. I started staying longer into the evenings in the hospital, sitting just outside his room, close to the little coffee and tea station where patients and families could prepare themselves something to drink. I found that at least once every evening he would come and get a strong cup of black tea. In the beginning, I was afraid he would turn around and leave the moment he saw me, but I hoped at the same time that being there, without being intrusive, allowing for a few moments of being together in the same place, without actively doing anything, might give me a way of being around David that he would find acceptable. After a few days of my being there, David actually began to take more time to make his tea, even accepting the sugar and spoon I had prepared for him on the little table so that, despite his shaking hands, he could go through his tea ritual without interruption. We never said a word, nor did we look at each other. It was as if evening by evening the language we used was the actions that went into preparing a cup of tea. Once his tea was brewed and mixed, he immediately disappeared again into his room, his moaning often slowly subsiding.

After one long weekend that I had spent away from the hospital, the first message I got from one of my nurses was, 'David is waiting for you; you must come to the balcony right away'. It came to me as a complete surprise, but I hoped at the same time that maybe the few quiet moments we had shared in each other's presence may have shifted how he related to me – a thought that I barely dared to entertain. Walking out there, I sat next to him, and for a good while neither of us spoke a word. For the first time during the daytime, I could not feel the aura of challenge or anger around him. It was as if we continued our silent night-time conversations, but this time in broad daylight – and without tea.

David: I do not like to talk to people.

Chaplain: I could tell.

David: And I still don't like to.

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Chaplain: You don't have to. (*silence*) But you shout pretty well for someone who does not like to say anything...and you talk in other ways than just with words.

He looked at me startled. I almost feared I would now be the target for his next outburst.

David: Well said, *habibti* [my friend]. (*He turned around and smiled.*) Come!

He stood up and went to the edge of the balcony. He pointed towards the old city.

David: This is where I am from...over there. Have you been to the old city yet?

Chaplain: Yes, I have, many times.

David: Ahh, but you don't know it...not the way I do.

Chaplain: Then why don't you tell me about it?

I was incredibly relieved; he had given me an opening into his world. He had reached out, even if it was only to challenge and test me, and I seemed to have passed his initial test. For the next hour, David talked and started to share his story with me – parts in Hebrew, parts in Arabic, a few English words in between. Seeing him standing there at the edge of the balcony, looking towards his place of birth in the old city, he seemed to grow and transform into a healthier, younger and stronger version of himself. People born and raised in the old city of Jerusalem, no matter what quarter, are not just Jerusalemites. They proudly consider themselves the real inhabitants of the city, the heart of this ancient place. Listening to David, seeing his pride and love for his city and country embodied in his every word, his story and parts of the history of Jerusalem came alive.

Over the next few weeks, I spent more time with David, sometimes talking, sometimes just sitting with him. Sometimes we traded languages: I taught him some English, he taught me some Arabic. After our first long conversation, he had let me know that he would not mind my company, even if he was not ready to talk. Just like in our early encounters at night,

the silence was filled. When he got up and walked away, I often heard a whispered 'Shukran' (Thank you).

I started to realize that when David spoke about events that hurt him, his voice rose – his anger and feelings of abandonment found a very loud way out. These expressions were often accompanied by gestures and, in the beginning, by hitting objects in his way. I attributed that to his having had to hold his anger, fear and frustrations inside for decades. When talking to me about those hard times of his life, the words abandonment and loneliness were prevalent. His life experience had been one of being alone – feeling abandoned by his parents, siblings, wife, God, country and now finally by his body, which was slowly succumbing to cancer. He had experienced a lifetime of hurt to which he reacted with anger. Over time, he shared how what he was left with was nothing but anger – anger at a world where seemingly there was no place for his dreams; anger at a country so shaken by instability and conflicting politics that his fate went unnoticed and was at times almost belittled.

David was surprisingly well versed in talking about his feelings, mostly in Arabic. Under the crust of hurt, fuming anger and artificial indifference, I found self-awareness and a refined way of looking at the world and himself, as well as an overall wisdom. This became particularly clear when he talked about his family of origin and the hurt, grief and loss around his parents. With a stoking voice, hoarse and often very slow, he would tell me of that hurt, grief and loss, particularly as it related to his father's suicide, which had caused him to lose trust in all emotional relationships. As a young adult, he had decided not to trust or feel anymore – to live his life without feelings so that he would not hurt anymore. He shared how he had become intensely aware that trying to carry out this decision had not only caused him more hurt, it had also made it, over the years, increasingly impossible to connect with others.

At first, the staff kept their distance from us, only briefly interrupting at medication times; however, as the days went by, the male staff members especially started approaching carefully. Not only had the atmosphere around David started to become more gentle (in step with him growing weaker through the progression of his illness), staff also began seeing

him more as a person than an interruption and a burden. At times, while sitting on the balcony, they would join us for a cup of tea or coffee, cigarette or a water pipe. Knowing the confidence and trust David placed in me by telling me many details of his story, I supported this process by advocating for him with the staff. With his permission, I shared some facts about the development of David's life as they pertained to his reaction and his view of his illness, treatment and outlook towards the end of his life. Slowly he grew closer to some staff members as I helped him share some of his story in a safe space with them.

What stood out to me was that, while still forcefully requesting high amount of pain medication at every possible opportunity, during our times together David could go for hours without a lollipop or a pain pill. It seemed that, as much as he needed the opioids for his growing physical pain, he also used them to medicate his feelings of fear, anger and sadness. He numbed his emotional and spiritual pain at times when he was not willing to deal with it.

Over the last few weeks of his life, David's pain was out of control and almost nothing short of semi-sedation could bring him relief; however, during our time together he would demand not to be under too much pain medication so that he could converse and think straight. He shared that when talking about what really mattered to him, his physical pain would seem to ease. This helped me and the medical team realize that a considerable amount of his physical pain was existential: his pain did not only result from the cancer, but was much more from his sense of abandonment by his family and God, his loneliness and lack of purpose. When this was addressed, during our meetings he was able to let go of some of the pain that was inside his soul and thus experience ease of physical symptoms.

In his last days, a staff member would always be with him, and during his final hours, he was surrounded by the staff and volunteers to whom he had grown closer. He was minimally sedated upon his own wish; the mere presence of people who now genuinely cared for him was enough to ease his pain of dying and loneliness.

Discussion

Assessment and interventions

David had been traumatized by the violent death of his parents and by the sudden, radical onset of adulthood, and never had time to deal with, or find healing from, the trauma. The nurturing environment that teaches a young person how to become an adult had been taken away from him; instead, he was the one who had to nurture and raise his siblings. In his mind, society had failed him, and his new role isolated him from all he had known before. The bond to his siblings became all he had left, but it was complicated through his new role. When they grew up, David found himself unable to pick up his own life. Being left behind again, the only role he had known, that of a caretaker, disintegrated. Once again, he felt abandoned. Because of being unable to bear being alone, he became a husband and found himself in a marriage that he was not ready for, because he had never learned to be interdependent.

Upon the breakdown of this marriage, David withdrew into isolation. He had embraced fierce independence all his life, and paid the price in loneliness and retreat into feelings of hurt and anger. His illness became just another stroke against him, another proof that his life was not fair, yet another obstacle to tackle by himself – except that this time, he knew the cancer would win. The risk of being left or hurt meant that voluntary, lonely independence was better than taking the risk of ever getting close to someone again. It was how he had constructed his social reality. Still, it was almost impossible not to notice how much he longed not to be alone.

FROM A SILENT SAFE SPACE TO A LIFE REVIEW

From the first time we met, David's presence seemed to be filled with anger, hurt and frustration that went deep and beyond words. It was clear to me that it was not with words that the first connection needed to be formed. It was through the simple intentional coexistence of two presences in one space, what Miller and Cutshall (2001) call a 'healing

presence,' 'being consciously and compassionately in the present moment with another or with others, believing in and affirming their potential for wholeness, wherever they are in life' (p.12). And it was exactly that coexistence of another presence that David had denied, consciously and unconsciously, to everyone around him. Being amongst people, but being socially isolated and not part of a team, group or family, had been his life story (Weiss 1973, 1987). Wondering where in his life this amount of anger and hurt came from, I hoped that giving David a chance to tell his story and to do a life review would be a successful intervention. Telling his story became not just a life review, but an exploration into his emotional and spiritual history as he relived the emotions of his past. The moments of physical and emotional death and despair in his life were plenty; chances to grieve and experience moments of healthy connection were few. Helping him step out of this loneliness and see that a caring connection could be possible, without losing himself or feeling abandoned again, was one of my first goals for the pastoral relationship.

His prevalent anger, grief and despair were the first emotions I addressed. Despair and anger were interconnected triggers in his life. Being forced to grow up at a very early stage in his life, he survived by being fiercely independent, yet subconsciously he longed for companionship. This internal dynamic made the hospital and its staff both a desirable anchor and another unsafe space for him. Hence, my intention in being with David was to try to create an emotionally safe space that would allow for all of his emotions to be present without direct or implicit punishment; a place to let out his feelings of loneliness without being alone; a place where he could experience some continuity of spiritual and emotional care. Seeing that this was not possible by simply inviting him with words, I demonstrated it by being present and insistent, silently showing that I would not be easily scared off by his behaviour. My impression was that his aggressive outbursts expressed not just anger, but a certain kind of testing: Who would be able to stand up to him? Who would be caring and worthy enough to be with him in his worst moments? At times, I had the impression that he intentionally

exaggerated his outbursts just to see how people would react. After a lifetime of loss and of being abandoned physically, spiritually and emotionally, he would not easily be convinced that people would remain caring, especially when – in his eyes – it was their professional responsibility to care. Pushing them away meant not having to let them in; repeatedly confirming to himself that no one could pass his test, he was sustained in the only security he hung onto: that he would remain abandoned. Still, deep down it seemed that he desperately wanted someone to pass his test. In hiding, there was the need to be found.

Our 'tea ritual' helped him ease into a safe space. Night-time was David's most vulnerable time, and I knew I was taking a risk trying to connect with him at this particular time of day, given that he could very well have shut down even more. My presence in the tea area could have robbed him of the safe space of his night-time wanderings, and I hoped I would be sensitive to whether that was the case. The need for safety and connection is highest when at times of vulnerability, and I hoped that David's need for connection would outweigh my intrusion. Furthermore, I hoped that, when at night his defensive mechanism decreased due to weakness and pain, a space could open up that would normally have been blocked. Since in the beginning of our tea encounters there were no words, the sacredness of the silence and the safety of it could be allowed. I hoped my presence would communicate a simple message: 'I am here. I will not be scared off, either by pain or by anger. I will not force you to talk or engage, but I can wait until you are ready to reach out.' Knowing how precious these few moments were, that a silent connection and initial trust was being established, I left the initiative of how and whether he wanted to proceed in David's hands, and just a few days later, he did reach out, actively and with words. The safe space that started with silence could then be trusted to endure words.

After our first conversation on the balcony, I could feel his need to talk and, at the same time, his fear of letting someone into his story. I decided to check in with him whenever we ran into each other, keeping my greetings casual but offering him the possibility to talk. When he

did talk, I initially only asked factual questions so as to show my real curiosity about him, but without pushing him to reflect, feeling that he first needed to get his story out in his own way. It was when he started making eye contact, searching out my company and thanking me, that I knew that my careful approach in letting him take the lead was working. It was a great relief, since often, during our conversations, I had felt tempted to challenge and go deeper, but I decided not to go there before he was ready to share what he needed to share. It was a risk I took, knowing that maybe he would close up again after he had spoken, but the risk of alienating him by pushing too early seemed greater. I decided that, if all he needed was to tell his story his way, this would already be a success given that he had never done that before with someone else. Often, I had to differentiate between my own need to go deeper with him and his initial need of just telling what he decided to tell, so I adjusted my pace to his process.

BEING THE LESSER SIDE OF TRAGIC

David lived in a country that is filled with tragedy on an everyday basis; a country whose people are worn out by war and conflict. He lived in a sociopolitical situation where similar things happen to so many people that his story was not even recognized as tragic. There is hardly anyone who has not lost a loved one or a family member in one of the wars, fights and riots of the past 70 years. There is a good part of the population that still has vivid memories of the *Shoa* (Holocaust). There are many people who are their family's sole survivor, be that of the Second World War or of one of the many other wars and uprisings. If one were inclined to compare tragedies, David's story would fade into the background and, as he was frequently told by friends and neighbours, he was not as badly off as others – he at least still had a house and a few family members left and, before his cancer, had been physically healthy.

Having a healthy life with a 'normal' course is still something that is rather new in Israel, unless one belongs to the financially well-off immigrant population from Western Europe or the US. Being special

often means being special in a tragic way. The way David longed to be special was to be normal (i.e. trauma-free, with a predictable and regulated way of life). Lacking the 'normality' he desired, but not being sufficiently traumatized to be counted as 'special', David received no recognition or support; by the standards of his traumatized society, he was comparatively normal, but it was not 'normal' in the way he needed to be. He belonged neither to the 'larger-than-life crisis group' nor to the 'normal group'; hence, he never had a chance to find equilibrium in his life, either for his reactions or for his emotions and actions. Experiencing extreme dependence and independence were normal for him; having interdependence, or a relationship that was mutual on all existential levels, was something he had never experienced. Both his dependence and his independence put him in a space of being alone and isolated. His terminal cancer diagnosis eventually just confirmed what he had experienced all his life: tragedy, isolation and hopelessness, with the only difference being that now, all of a sudden, his body had 'betrayed' him and he could not fight through it. This triggered anger and fear. His reaction was to fight and push the boundaries he thought he was able to control: refusing the role of being a 'patient'; reaching for relationships on an equal level with the staff that were simply impossible by hospital standards; pushing everyone away who could be a resource to him. The hospital structure offered him a space for healing, but since no cure could be offered, he was not able to accept that he could experience healing in a structured environment. Recognizing this lifelong dynamic, and how it played out during his hospitalization at the end of his life, showed me the importance of helping him with his life review – making sure that what he went through was recognized as traumatic and deserving of attention and healing. Spiritual care in this situation meant treating him as not only special but unique in a healthy way.

SPIRITUALITY AND RELIGION

The English word 'spirit' is derived from the Latin *spiritus*. Its primary translation is breath, and it is used in ancient and medieval medical

writings to describe the physical activity of breathing (e.g. *spiritus lenis* = light/easy breathing, *spiritus asper* = hard/laboured breathing) (Lewis and Short 2002). However, *spiritus* has a secondary translation as 'life force', 'spirit' and 'energy', and it is this translation that has found primary place in theological literature. I define spirituality broadly, based on its primary translation as 'breath'. For me spirituality is not just religious, nor is it bound to a belief in a higher power. Rather, it entails everything that makes us breathe and breathe freely, everything that defines us and identifies us. Hence, I believe everyone has a form of spirituality, whether it be related to something sacred or something profane; even the profane becomes 'sacred' if it makes us feel alive and gives us the power to go through challenging situations.

In keeping with this definition, giving David a chance to connect, experience emotional safety and healthy relationships, to live in a safe space both physically and emotionally for the end of his life, as well as helping and allowing him to relive his life story and wrestle with it, gave him a chance for partial healing in a situation where neither a physical cure nor full emotional and spiritual healing were possible; hence, this was a long-term (almost 4 months) spiritual intervention.

For the religious aspect, the following needs to be understood: For almost anyone growing up in the Middle East, religion is a part of their lives. Most people have a much stronger background in Judaism, Islam and Christianity than in the western world, simply by living in a country that has these three religions in their strongest forms as part of its normal landscape. Even people who describe themselves as secular do so with a large cultural background in any or all of these religions. Their knowledge of, and acculturation in, any of the religions surpasses that of a western secular person. Religion is everywhere: on the street, in the politics, in the history and in pretty much every publicly discussed topic. It is impossible to escape it. Personal religiosity or spirituality still is chosen, even though many more people adopt it simply by living in this environment. David had experienced this environment from his birth. He had struggled with religious politics and political religious

fundamentalism, and with the manipulation that tears his home country apart every day. Despite not practising religion, it remained a part of his everyday life and, because of this, when the religious views of his childhood did not withstand a crisis, it became another element contributing to his loneliness.

Given how rejected he experienced himself to be by the religious communities, it is understandable that he rejected them – and their God. He never rejoined a religious community. In the light of his other, deeply existential problems, I did not focus on religion once he told me that it did not matter to him. Only towards the end of his days did he trust me enough to bring up God and allow me to bring in a Torah reading. Given the late stage of his illness, I did not push for more active religious chaplaincy work with him but instead let him choose how much he wanted to engage in, which was not a lot due to his physical and mental weakness. Still there was a sacredness and almost divine presence whenever he was in community with hospital staff at his bedside – my staff also shared in the wonder. God was present, and it was hard to doubt that David did not feel it – some things are beyond words. In a way, and even if it cannot be proven, I dare say that through some of his healing process, not just other people but *God* re-entered his life. Nevertheless, I am left wondering if I had brought up the topic of God earlier, and had more intentionally explored it with him, whether a more explicit reconciliation with his religion and God could have been reached, especially given that, to my own personal regret, a reconciliation with his family remained out of the question.

Outcomes

Even before being able to tell his story, the most important outcome of our connection was that David was able to make a connection beyond his anger. I experienced David's ability to allow himself to enter this safe space as an initial success on which we could build. It was a first sign that, despite all the hurt, he had not yet lost the ability to trust. Building

a basis of trust, first without words, and then testing this trust by telling his story and finding the trust reaffirmed, was important to David's regaining of trust: first a trust in himself; then a trust in others.

He was able to experience that not only was his story heard, but also that he was accepted as a whole person, with his strengths *and* weaknesses. It was not surprising to me that David started with telling me about his home. He started his story from a place of strength and safety: the memories of his home and his early childhood. Only after that did he allow himself to share more hurtful memories. By demonstrating his strength with pride, he could 'control' my impression of him as a strong, proud and determined man, rather than as someone who was lonely, in pain, weak and dying of cancer. Showing me who he was and how he preferred to think of himself, he could then allow his vulnerability and 'dark sides' to enter the picture. His storytelling morphed into a much deeper process that had a revealing and healing character, the story of how his life seemed nothing but a painful failure to him. It was a story that, in his experience, no one ever wanted to hear – not even David himself. He had blocked a lot of it even from himself. But importantly, he was able to look at his life without being completely worn down by resignation and despair. He was able to rebuild some self-worth that was more than just bitter pride.

The life review we did helped him struggle with the inevitability of his imminent death, given that being recognized in his sadness, grief and trauma took away some of his edge to fight everything and everyone just to get attention. Sharing some of his story with staff, through me and by himself, helped him connect and experience a few caring connections, even if they were only short term. David was cared for because of, and despite, his experiences.

This narrative journey helped him be with himself, in his past and in his present and, finally, it allowed others back into his presence. Over the last few weeks of his life he formed companionships with some staff members. Obviously, the hospital was never able to replace the home he had lost, but it did become a place where he could feel safe and at times

at home, surrounded by people whom he could trust, talk to and, once he was no longer mobile, allow to take care of him. When he died, David was surrounded by staff who took turns being with him until his last moment. His loneliness had been alleviated to a substantial degree, and his worst fear of dying as lonely as he had lived was not realized.

Conclusion

One of the most striking elements in the pastoral care relationship with David was how it seemed to influence his pain levels. Almost every pain comes with suffering, and I differentiate here between pain as the physical experience and suffering as the emotional and spiritual response to physical pain and other life-disrupting circumstances. Being an end-stage pancreatic cancer patient, it was to be expected that David would experience an increasing amount of pain. From the beginning, David advocated strongly for a high dose of pain medication, to which no one objected. In his case, it was hard to tell what caused him more suffering, the pain from his cancer or the feelings connected to his life story and current circumstances.

When David told me that he had never had a pain-free life (meaning free of physical pain), looking at it from an existential point of view, I was not surprised. He had suffered many losses and 'died several deaths' long before he was diagnosed with a terminal illness. All these losses and all his suffering had found physical outlets throughout his life, but it was not until he was diagnosed with terminal cancer that the compounded grief and suffering, accumulated throughout his life, started hitting him in the most physical ways. His existential pain had turned physical and was joined by the cancer pain. Yet, while talking to me about topics that were clearly emotionally loaded and hurtful, not only did he forget to ask for pain medication (as he would otherwise do on an hourly basis), he would often not take any medication at all during and after our sessions. The topics we talked about were clearly emotionally very difficult, and I could watch his physical reaction to them. When speaking about some

'What can you do for me?'

of his deepest feelings and fears, his body would react – his hands would clench and his body would shake; often he would hug himself and rock backwards and forwards; his stomach pain would come back – but he would not ask for medication, claiming that his physical pain was 'bearable and important'. It was important pain for him to go through in order to start healing. The suffering of his soul was reflected in physical pain, but for the first time not in a destructive way – in a healing way. A large part of the pain he was feeling was not only physical, cancer-related pain, but the physical pain caused by his emotions while remembering and processing. Alleviating his existential pain, and helping him to look at his life, suffering and pain in a safe and healing environment, helped him deal with the existential side of his pain.

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