Rewriting the Story-Myth: A Rehab Experience

David E. Tucker

Patients in a rehabilitation hospital enter into a world that tends to focus on their limitations as this is the primary reason for the admission. Therapists focus on weaknesses and how they can be overcome. This effort can produce a secondary effect of making other attributes of the person less visible as patients sometimes focus so much on what they have lost that they fail to notice what they still have. A key element, therefore, in assisting persons through the rehab experience is for the spiritual caregiver to help them view their circumstances through a different, less limiting, prism. This alternative view also has the potential to open up a line of sight that incorporates more of their life pictures.

The need for a new story-myth

Each of us lives with certain beliefs, certain understandings about life, or as I choose to identify them, myths. In this sense, myth does not refer to children’s bedtime stories, or even to the classics of ancient Greece. It refers to a comprehensive internally guided understanding of life that undergirds one’s sense of meaning and direction. We all possess, to one extent or another, an internal understanding, or “world view.” What I propose involves the proactive creation of a new myth, or a revising of one’s existing, but suddenly inadequate, myth that takes into account the new life events, e.g., accident, disease, which have resulted in the rehab event. This can be accomplished through an assessment of what has been lost against what remains, followed by the creation of a new story that makes the best use of both. Patients in rehab hospitals are certainly persons with weaknesses, but they also have strengths. This seemingly simplistic dualism is one that quite likely will become a primary aspect of the new myth.

David E. Tucker, DMin, BCC, serves as rehabilitation chaplain at Orlando Regional Rehabilitation Institute, Orlando, FL. He is an ordained elder in the United Methodist Church. Correspondence may be directed to dtucker@orhs.org

This article presents a rehabilitation chaplain’s approach to caring for patients in rehab hospitals. It focuses on patients’ strengths as a way of helping them to begin the process of rewriting their life stories. This approach—creation of new “story-myths”—assists them as they learn to cope with, and adjust to, a lifetime of disability. These new myths also serve as landmarks to measure their progress as they journey through and beyond the rehab event.
A foundational principle in the development of new story-myths is the understanding that health and disability are not opposite conditions. People are neither completely disabled nor completely healthy. A significant aspect of providing spiritual care in this arena is adoption of a caring posture that primarily focuses upon the person not the disability. A former patient and wheelchair user illustrated this when he said concerning his own life with disabilities, “I’m not sick, so don’t treat me like I am.”

A person with a disability is first of all a person. Using a relational approach serves to bridge the dualisms present in a particular situation and also to eliminate “either-or” type thinking, which focuses on one of the polarities in the dualism at the cost of the other. This approach moves closer to “both-and” type thinking, which produces statements such as, “The patient is neither fully weak nor fully strong but somewhere in between.”

**Developing a new story-myth**

How does this look in practice? As chaplains, we can be proactive about helping patients find adjusted ways of living that draw from both their strengths and weaknesses. Though the ways in which we accomplish this may be as varied as the situations themselves, they all need to begin with the fundamentals of spiritual care, e.g., meeting people right where we find them, addressing their immediate needs through reflective listening, and, as much as possible, maintaining a nonanxious presence.

This approach is of primary importance. As we sometimes enter into the relationship with bits and pieces of prior information about the patient’s history or way of living, we need to remember that the way one viewed life before rehab often undergoes significant change—with or without help—during the actual course of rehabilitation.

What is initially presented also can be intense. Some patients still are very angry and hurt, blaming everyone who makes a good target, including God whom the chaplain to some degree represents. Others come to rehab with more than adequate understandings of the events and people involved. What is important is finding out where individual patients are, e.g., how they are coping with the rehab process at that point. This starting place is important because if we misinterpret this aspect of the process, it colors all that follows and may result in a misguided direction. If a caregiver enters this arena having presupposed what direction patients need to go in their journeys, that caregiver has violated the caregiving process. It is the patient who must lead us.

**The “Tree of Me”**

If patients have completed “The Tree of Me,” the helping tool that we use at Orlando Regional Rehabilitation Institute (ORRI), we start there. (See facing page.) Members of the rehab team share their own trees with patients. This allows patients and caregivers to know each other on a far richer relational level than is usually present in rehab hospitals. The dynamic purpose behind this aspect of care is the desire to be transparent, which conveys a sense of availability and helps to form meaningful relationships between the patients, staff, and families.

The transparent posture of the caregiver works best when it is presented with unconditional positive regard. Persons who are becoming aware of the need to rewrite their stories often are aware also of where to start. If we listen accurately, we will be able to meet them right where they are physically, emotionally, socially, and spiritually. However, they have to write their own stories, and sometimes this writing continues throughout the remainder of their lives.
The "Tree of Me" was created by Martha McConnell, director, Organizational Development, Orlando Regional Healthcare. It was introduced to the ORRI staff by Christina McGuirk, assistant nurse manager, and is used extensively by the treatment teams. Its roots reflect that which gives the person life, foundation, and stability. The trunk bears the name s/he wishes to be called, and the branches hold the fruits that have grown out of his/her life: careers, skills, talents. Children also are often placed here. The completed tree is posted on the wall beside the patient's bed.
At ORRI, we pair new patients with those who have been in the rehab process longer, former patients, or others who have lived with disability for a number of years. These persons can provide assistance on a totally different level than those who have no such experience.

As one who has lived with disability for twenty-three years, I share my story only when asked to do so and always within a context of valuing the resources within the patient to whom I am speaking on a higher level than my own. This is not about us; it is about the person for whom we are caring. Sometimes, we may share some of the changes to our own story-myths that have proven to be the most effective when adjusting to disability, as a way of giving express permission for patients to begin to do the same.

**Living into the new story-myth**

Principally, the new story-myth provides congruency between the individual’s being and behavior, between direction and driving purpose. Common areas of adjustment can include how one sees oneself, God, the world's treatment of persons with disabilities, others in one's world. The new story-myth may incorporate an individual's purpose, hope, theology, and/or philosophy. In essence, just about anything that is meaningful to the person may need to be rewritten.

Caregiving, provided in this fashion, seeks ways to promote survival and well-being, no matter what mythological framework was previously in place. In the end, just as no two persons are alike, no two reworked story-myths turn out exactly the same, even though they may serve similar adjustment needs.

Growth of this nature tends to move toward understandings that serve as landmarks to guide patients through the remainder of their lives. Although rehab is a uniquely challenging event, patients seem in some unknown way to be prepared for, and open to, change. Sometimes nothing of the former story-myth seems worthy of defending; this leaves a vacuum in which a new story-myth can be born. Inherent in this openness is the challenge to patients to draw upon both courage and strength in order to create an understanding that adequately incorporates the events that brought them to rehab.

**Conclusion**

This process provides a revitalized sense of meaning and direction through the formation of story-myths that bring personal meaning and direction to the life journeys as shaped by the unique level of crisis-induced disharmony experienced by each individual. As caregivers, we engage patients within their evolving ontologies, being certain not to align them with some preexisting story line, either theirs or our own, and supporting them in the midst of some of the most potentially creative moments of their lives. This place, where they choose to reshape or not to reshape their life story-myths, is an awesome place indeed!

**References**

3. Jerry Wald, personal testimony from a person who has lived with quadriplegia for thirty-nine years.
5. Quoted in *Good Emotional Care*, “Seventeen items that go into providing it for patients and families in the hospital,” [http://www.groups.yahoo.com/groups/pastoralcare.html](http://www.groups.yahoo.com/groups/pastoralcare.html).