

Atlantic School of Discipleship

Caring for Each Other in Community – The Ministry of Pastoral Care

Welcome to the 1st module of the Atlantic School of Discipleship. My name is Susan MacAlpine-Gillis, and I currently serve as the Academic Dean at AST. I was ordained in the United Church of Canada in 1985 and served in full time congregational ministry for 31 years before transitioning to a teaching position at AST. I served in Cole Harbour for 26 years and throughout that time had the privilege of working with a pastoral care team. Together, we engaged in a ministry of caring for each other in community.

It is my pleasure to be with you for 2 evenings in September.

In our time together on September 9th, I hope to cover some of the basics of Caring for Each other in Community by exploring 5 well-known questions.

- Why do we do what we do?
- What does it look like?
- Where do we do offer it?
- When do we do offer it?
- How do we do it?

On September 23rd we will have unstructured time to explore your questions and together we will look for answers.

In preparation for our time together I have gathered a few resources.

- Chapter 2 from **A Primer in Pastoral Care** by Jeanne Stevenson-Moessner, *“The Grammar of Care: Pointers and Precepts”*
- Chapter 4 from **Exploring Practices of Ministry** by Pamela Cooper-White and Michael Cooper-White, *“Companions in Healing: Practices of Pastoral Care”*
- A series of short resources collected over the years that may provide helpful tips as you seek to become more confident in Christian care giving.

The ministry of Pastoral Care, the call to look after each other in community is central to the Gospel. It is a primary aspect of Discipleship. Remember the old campfire song – *“They will know we are Christians by our love, by our love, yes they will know we are Christians by our love.”* In advance of our time together please read Luke 10:25-37, the Parable of the Good Samaritan. This is an example of love in action.

Blessings as you prepare for our time together in December

Susan

Chapter Two

THE GRAMMAR OF CARE: POINTERS AND PRECEPTS

In school, we memorized the alphabet, our ABCs. However, the grammar of care is not like that. It is not reciting. It is listening to others' words, hearing between the words, and being open to both a spoken text and an unspoken text. It involves reading between the lines.

A PRIMER IN PASTORAL CARE

JEANNE STEVENSON-MOESSNER

FORTRESS PRESS

MINNEAPOLIS

It is a natural tendency to want to “fix things” when someone is in need of our care. This seems especially true if you are a person of compassion, an individual who is responsible and conscientious, a firstborn child, or the sibling who was designated as caregiver in the family system. More often than not, we are invited to listen to a person’s sometimes painful or unhappy story. Sometimes, as we create a safe environment for a person, we actually “hear them into speech.”¹ This newfound expression comes after trust has been established, after the person feels that he or she can speak without being embarrassed or belittled, and after the person knows that what he or she has to offer will be valued. Trust and safety issues are crucial in pastoral care, particularly for those who are in minority or devalued positions in our society because of socioeconomic, gender, racial ethnic, political, or cultural factors. Persons who are mentally and physically challenged also look for places of trust and safety.

Occasionally, if we enter the caring relationship as a holy space, if we are centered spiritually, we might even hear the silence before the speaking.² One student communicated this profound truth through a poem:

Too Deep for Words
My soul’s assailed
with hurts—
Too deep for words

There's no way to let them out,
Trapped down in depths too deep to be known,
Except in darkest night or when chance encounter
With kindred life cracks wide the unfathomed orb.

Kept there for fear that letting loose will

Cause pain deeper still.

Thank God for times

when hurts—

Too deep for words,

Can speak through Spirit Holy

who moans and groans

With sighs—

Too deep for words.³

It is the Spirit Holy who prompts us to hear the silence too deep for words. Again, we are expected neither to fix anything nor to do something. We are the “kindred life” that becomes available through “chance” encounter, which we call a pastoral encounter. Trusting in God’s guidance, we realize that the encounter is not by chance but by design.

Pastoral caregivers have sometimes entered a room where the hurt was too deep for words, as in the following example. One student pastor sat quietly in the corner of a hospital room while the agonized family came to terms with the sudden death of a loved one. There was wailing and moaning and cursing as well as the dazed silence of some family members. All of these forms of shock and anger are appropriate, of course, in the presence of death. And so the student pastor sat there quietly and felt “the assaults” being made on the souls of those gathered around the deathbed. The hurts were too deep for words. He sat patiently; he prayed quietly and did not flinch with the outcries. In due time, he left without having said one single word. The next day, as funeral preparations were under way, the family member most directly affected by the death approached the student pastor. What she said amazed him. “Pastor,” she said with great feeling, “Thank you for all you did for us yesterday in that hospital room. I couldn’t have made it without you.” He hadn’t uttered one word! Their pain was too deep for words. In many cases, the “grammar” of pastoral care, ironically, may involve silence.

Here is a way to understand the grammar of pastoral care. It is not necessary to memorize the following list, but all of the items are important to include in your caregiving.

G: Get into a receptive posture.

R: Receive whatever the other person offers.

A: Acknowledge the other person’s feelings.

M: Make a holy, welcoming, and bounded space.

M: Match the other person’s needs with your caregiving.

A: Accept the other person as he or she is.

R: Reach out.

This last step—reaching out—may entail some form of guidance. However, no judgment, teaching, or preaching is involved, although there may be modeling. Reaching out may involve an action or a sacrament, such as offering Holy Communion or the Eucharist. It could also involve finding other helping professionals to help you give more holistic care to the hurting individual. Enlisting specialists to help you provide a support network is always a sign of strength, not of weakness.

These elements of the grammar of care will be illustrated in the following case study. In a way, this is a worst-case scenario because of the isolated location and the paucity of referral sources involved. However, if we go through this scenario together, you will gain confidence for other situations that are less challenging.

“THE GREAT SAVOONGA COUNSELOR”

Savoonga, Alaska, is a very remote village on an island about twenty-two miles from the coast of Siberia. The Savoonga Presbyterian Church is the only active church on the island. There are no community mental health centers or counselors on the island, only one physician’s assistant. The following story was told by the student intern who served as pastor of the Presbyterian Church.⁴

As the student pastor’s family was heading upstairs for bed, there came a knock at the door. A local young man asked to come in and talk. This young man was the relative of an active session member who had referred him to the student pastor. Let us walk through the grammar of pastoral care as it unfolded.

G: Get into a Receptive Posture

This is difficult when you have had a long day and are heading up the stairs to bed. At the sound of the knock, the student intern told his wife and young son to go on to bed. He opened the door, and there stood a young villager who wanted to come in and talk. I can well imagine that this young intern was tired. His body was unwinding for bedtime. This intern had also been trained at seminary to pace himself and to take care of himself. This self-care is an essential for continuing in caregiving. You take care of yourself, you love yourself just as you love others. We can hope that because this student intern had been eating well, getting regular sleep, exercising, and making leisure time, he was able to summon a reserve of energy for this unexpected nocturnal visit. Remember, at this point, that our student intern did not know the reason for the visit. Perhaps the student intern engaged in self-talk, such as admitting to himself that he was tired but resolving that he would call on the Holy Spirit for an extra measure of life-giving energy in this late hour.

R: Receive What the Other Person Offers

After telling the visitor that he was glad he had come, the student intern listened to what clinicians call the “presenting problem.” This is the expressed or spoken “reason” for seeking out a pastor or counselor. Often, there is more to the situation than what is presented. However, in this particular case, this nocturnal visitor got right to the core reason. The visitor said that he didn’t want to live any longer and that that night would be his last.

This is one of the most startling and frightening utterances you can receive, no matter how seasoned you become. A statement like this must be taken very seriously. The student intern did not fall off his seat, he did not jump up in shock, and he did not try to dismiss the confession. He received it calmly and genuinely.

Feeling that he was being taken seriously, the visitor began to tell his life’s story, which involved the murder of his mother and father, other family tragedies, a history of drug abuse and depression, feelings of guilt, his state of poverty, and the discrimination he had felt because he had dark skin. How, he asked, could a loving God allow this much tragedy to happen to just one person, to him?

A: Acknowledge the Other Person’s Feelings

The student pastor acknowledged the man’s feelings by admitting that he had also had times of doubt and depression himself. Here, you must be careful to keep this admission short and brief. You do not want to unload your own burdens when a vulnerable person comes to you for support. The student pastor simply made a move to give credibility to this outpouring of “irreligious” feelings. The pastor sought to acknowledge and connect; he wanted to put the night visitor at ease.

M: Make a Holy, Welcoming, and Boundaried Space

The student pastor’s living room was welcoming. He had put a pot of coffee on early in the conversation. Sometimes, drinking something hot or cold helps to “ground a person” to reality. You can prompt the person to feel the liquid slide down the throat and remind the person to stay connected body and soul. The student pastor offered a welcoming space by his relaxed body language, which said: “I have time for you. You must not hurry through your story. I am not shocked or revolted by what you say. I am with you.”

The student pastor kept his own comments brief. He told the man that he had also experienced “inconsistencies” in the nature of the omniscient, omnipotent, and loving God. He was careful to boundary or contain his stories, because he did not want to overload the hurting visitor.

M: Match the Other Person’s Needs with Your Caregiving

The visitor was in pain, and the conversation went on for several hours. The recurring question was as follows: “If we were really the children of a loving God, then how could that loving God still allow suffering and abuse?” The pastor did his best to answer this most difficult question, which theologians term the theodicy question.

At a point of verbal impasse, the pastor’s five-year-old son, Ian, came slowly down the stairs, rubbing his sleepy eyes, wearing only his underwear, and revealing a completely innocent demeanor. He said, “I have to go pee.” With that statement, both the pastor and the visitor had to smile and shared the common bond of being fathers of completely innocent children. At this crucial point in the pastoral caregiving, the student pastor used the family situation

as a point of connection. He said: "Watch what Ian does when he comes out of the bathroom."

The doorknob turned, and Ian ran straight over to the arms of his father. He crawled onto his lap and hugged him like it was the last time he would see him. With kisses and a bear hug, Ian said "good-night" to both men and climbed carefully back to the second floor of the manse. The pastor used what had occurred to ask: "What would happen if my son Ian had fallen down those stairs and died? Would that make my love for him any less?"

The night visitor started crying and sobbing for many years' worth of pain. He finally said, "I get it." Evidently, nothing the student pastor had said the entire evening had made any sense to him, yet a chubby five-year-old boy had brought him back to the basic understanding of who God is: love. It was an incarnational lesson, one translated into flesh, and it brought an insight that the student pastor's theological ramblings had not done. The Holy Spirit had used the pastor's familial context and his overflowing love for his son to illustrate the love of God as Father. In this way, the visitor's need was matched with what the student pastor had to give.

A: Accept the Other Person as He or She Is

The night visitor had experienced discrimination because of his skin color. Although his mother was Siberian Yupik, his father was non-native, and he was darker in skin. For this reason, his wife's family had ostracized him.

As pastoral caregivers, we will need to examine our prejudices and move into a place of openness to differences. We will be asked to suspend judgment and to withhold our preferences. We can do this as we imagine ourselves at the foot of the cross of Christ with those from whom we differ—for Christ died for them too.

R: Reach Out

In writing up this case, the student pastor decided that his five-year-old was "The Great Savoonga Counselor," in cooperation with the Holy Spirit, of course. If the situation had not moved along as it did, the student pastor would have had to take other measures to help. An assessment of the man's suicide risk would

have been taken; the visitor would not have been left alone, and the help of the physician's assistant could have been summoned. At daybreak, transport of the suicidal person to a neighboring island could have been arranged. For a person who is genuinely suicidal, a network of professionals is warranted. We take all threats of suicide seriously, especially if the person has already made a plan to carry out the suicide.⁵

THE SUBTEXT

In pastoral care, we listen for the subtext. We assume there is more going on than is being said, so we stay attuned for the subplot, for the things that are too painful to be named or spoken. Emotional communication or emotional grammar is always going on alongside the verbal. The Holy Spirit comes to our aid if we are open to this type of intervention.

In school, we memorize the alphabet, our ABCs. However, the grammar of care is not like that. It is not reciting. It is listening to others' words, hearing between the words, and being open to both a spoken text and an unspoken subtext. It involves reading between the lines.

You have perhaps attended a meeting with a sense of something else going on in addition to the stated agenda. This might be a power play, unspoken expectations, manipulation, or other issues that have not been expressed. There is a separate agenda going on "under the table" or in the "back boardroom."

Perhaps you have been to a social event where you sense other feelings, intentions, interactions, or posturing going on beneath the surface chitchat and social niceties. For example, if people are too solicitous and too complimentary, you wonder what else is going on with them. Do they want something from you? Are they trying to manipulate you? Are they flirting with you? Trying to seduce you? Distract you? Outmaneuver you? Are they feeling guilty about something? Is there something to hide? You engage in self-talk, asking yourself these questions when you intuitively know something does not fit the situation.

This can also occur in a pastoral care situation. You discern that something is missing or is being left unsaid. The presenting problem—the "reason" the person gives for needing care—is not

at the heart of the matter. You can always honestly ask: "I have a sense that there is something else troubling you. Is there anything else you might want to tell me? I feel I am missing something." You can put this in your own words. This query may help in trying to find the subtext, which is not dissimilar from the subtext in a mystery novel. Continue to listen, for there is certainly more to the story.

COMING ALONGSIDE

In the one-room schoolhouse, the instructor would sometimes come alongside a student working over a small chalkboard or reading in a book "Coming alongside" of a person in need of our care is another way of reading between the lines, or being open to a subtext. Here is an illustration of that accompaniment in pastoral care.

Debbie had been director of Christian education in a church she had attended for twenty-four years. A couple of people were dissatisfied with her job performance and complained to the parish relations committee. The committee was quite affirming to Debbie, but the matter unsettled her. She suffered silently with doubts.

The senior pastor at the church noticed that Debbie was suffering "inner turmoil." Debbie writes: "He came along side of me, and provided me with a safe place to express my various emotions which included uncertainty, sorrow at the thought of leaving my church and friends, and anger at the 'complainers.' He allowed me to sit in his office and cry." The pastor was consistently supportive and asked questions to help Debbie think through her options and alternatives. He suggested steps to help clarify her call. Although her eventual leaving increased his workload, he stood alongside her and asked to be of help. After Debbie enrolled in seminary and received an appointment at another church, he continued to call to check on her and rejoice with her.⁶

This is "coming alongside" of a suffering person and offering attention and help when needed. It is like a teacher offering a way out of a mathematical impasse, never doing the problem for the student but instead helping to clarify possible steps toward a successful solution. Coming alongside of someone pastorally activates all aspects of the G-R-A-M-M-A-R in caring.

THE LANGUAGE OF THE CHURCH

Each culture has its own language or languages, and each language has its own grammar. The church operates with a language that includes words but is not limited to words. Prayer, song, Holy Communion, visitation, fellowship, and healing touch may involve the verbal, but these vehicles of care are never limited to words.

Kathie found this to be true when she visited Mary, a ninety-one-year-old resident of a Waterloo nursing home. Mary's angry daughter-in-law had informed Kathie, student pastor of Barclay Methodist Church, that the church had abandoned Mary.

Mary was very hard of hearing, and Kathie had difficulty communicating with her. That, coupled with Mary's short-term memory loss, made visitation a challenge. Mary's constant refrain was a signal to the student pastor: "I'm a lonely woman. So lonely."

Kathie and a commissioned lay pastor started taking communion to Mary. They included Mary's family. Mary was able to recite Psalm 23, pulling from her long-term memory. Bread and juice were shared, and a smiling Mary announced in a booming voice: "This is just like church!" Kathie, the student intern, learned to write all her visits on Mary's room calendar so the nurses could remind Mary that she had had visitors. Kathie learned to ask Mary about her seven sons; thus, there was never a lack of conversation. When Mary was distraught, Kathie put her hand on Mary's shoulder and offered a calming prayer. On days when Mary was not talkative, Kathie could always summon forth Mary's memory and strength to recite the Lord's Prayer.

When twenty-two members of Barclay Methodist Church showed up at Mary's bedside in mid-December for Christmas caroling, Mary could not be roused. Her hands, arms, and face were covered with large black bruises. She hadn't fallen; she was in the process of dying. The youngest child in the church, five-year-old Janie, held Kathie's hand. Kathie summarized: "As a church we gathered around Mary's bed and prayed the Lord's Prayer and then sang 'Silent Night.' I looked to see Janie's small little hand reach out and lay gently on Mary's gnarled bruised hand. I knew Christ was present in that room and in that touch."

On Katie's last visit, Mary did not respond well. After prayer, Mary nodded and said: "That should do it." Mary died Christmas Eve morning, the day before her ninety-second birthday. During the funeral, one of Mary's grandsons gave this image to the congregation:

"When I heard the pastor talking about Jesus coming to personally bring her [Grandma] home, I couldn't help but remember how Grandma loved to have her family come and visit. Do you all remember how she would call each of us over to her and put her hands on both sides of our face and pull us in and give us a big kiss whether we wanted one or not? All I can see now is Christ coming close to her and her reaching out to give him a big smacking kiss!"

Mary gave a picture of her faith in death.⁷

Images like this are also part of the language of the church. Sacraments, song, touch, prayer, Holy Communion, and the gathering of the priesthood of believers are certainly part of this language—a way of communicating God's presence and love and visibility. This language of the church of Jesus Christ is communicated in part through the grammar of caring.

At the close of the school year, a teacher often offers a summary of what has been accomplished. At the end of my class in foundations of pastoral care, I offer each student a black river rock and ask him or her to make it into a memorial stone. Paints and time to reflect are provided. This is reminiscent of the practice of the Israelites through the Hebrew Bible when a place or event was commemorated with "memorial stones" that were often piled up together.

One seminary student was later examined by his Committee on Preparation for Ministry and asked what he had learned about caring. The student said he had learned to walk "alongside of a person" and enter into their world, hearing them carefully. On his black rock, he had painted a big ear—to remind him of his need to *listen* to their grammar and their language.

Another student expressed himself through his poetry and used the image of the shepherd "coming alongside the sheep":

The Good Shepherd

Jesus you are the Lamb of God.

Guide me, lead me.

Help me to feed your sheep, as you have fed me.

When I was hungry, you fed me Your sacred holy Word.

When I was thirsty, you led me to the still waters.

When I was in prison, you opened the roof and set me free.

When I was afraid and broken, you walked gently beside me.

Help me to love your precious sheep as you have loved me.⁸

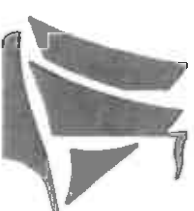
We are reminded that God listens to our language of need, even those needs unexpressed and unknown. God's grammar of care extends to us so that we might, in turn, better care for others.

• Question

Can you share an instance in which the love of Christ was communicated to you without words?

Chapter 4

Companions in Healing: Practices of Pastoral Care



EXPLORING PRACTICES OF MINISTRY

PAMELA COOPER-WHITE
MICHAEL COOPER-WHITE

And he said to them, “What are you discussing with each other while you walk along?” They stood still, looking sad.

—LUKE 24:17A

Along the Emmaus road, says Luke’s gospel, Jesus interpreted to his fellow travelers all things that the Scriptures had to say about him. Now, while the gospels had yet to be written, including those portions where Jesus’ sayings about himself were recorded, we might imagine his interpreting how various Hebrew Bible texts about shepherds (with the best-known being Psalm 23) pointed to him as the Good Shepherd. The word *pastoral* comes, of course, from *pastor*, which means shepherd. This has been the traditional metaphor or model—the pastoral caregiver as the shepherd. The shepherd tends the flock, feeds and guides the sheep, protects them from wolves and marauders, and generally steers them in the direction they are to go. And drawing on Christ’s own words, the shepherd “lays down his life for the sheep” (John 10:11b). This was taken seriously by generations of pastoral caregivers who felt a call to sacrificial love of their flock and the task of moral and spiritual guidance. But herein lies a serious pitfall—the tendency to see self-sacrifice as a defining image of ministry.

While some sacrifice is probably always necessary in a devoted Christian life, the dominance of a sacrificial image has caused numerous problems. In particular, it can lead to taking oneself so seriously that one might view one’s own pastoral ministry as so uniquely indispensable that one’s

own needs as a caregiver can be neglected indefinitely, and if the pastoral caregiver or his or her family should suffer for this, it is all within the framework of the self-sacrificial love of the shepherd. Also, the truth is, who in any congregation wants to be thought of simply as a sheep?!



The word pastor means shepherd. This traditional image, associated with Christ, has lately been supplemented by images, such as that of the Good Samaritan discussed later in this chapter, which do not encourage unhealthy self-sacrifice, or over-identification with the Savior. The image of tender care, however, continues to be one of many helpful images of pastoral care.

This paradigm of the pastor as shepherd is now shifting. In large part, this is due to the influence of two very important and interrelated strands of theological thinking and pastoral praxis: the growing presence of women in both lay and ordained leadership in many mainline denominations, and the emergence, in part through liberation theology (see chapter 1), of "Two-Thirds World" voices in theology and of at least slight growth in diversity of racial and class diversity in U.S. churches. These influences, from their own social locations and theological perspectives, have brought critiques of the Shepherd paradigm. No one, it should be noted, is trying to throw the baby (or the shepherd?) out with the bathwater. But there is an increasing awareness of the limitations of this individualistic, heroic model and a wonderful opening up of possibilities for a much wider horizon for pastoral care and pastoral theological thinking.

This opening or widening process may be seen in at least five aspects of pastoral practice: (1) listening as primary practice; (2) context; (3) content; (4) diversification; and (5) balance.

Listen, Listen, Listen!

Pastoral care involves learning to trust that silence is truly facilitative. Less is more! A lot of pastoral care simply involves getting out of the way so that the Holy Spirit can do the healing work necessary. We are not to be psychotherapists (or worse, pseudo-therapists!). A good way of explaining the



Listening is the most important skill in pastoral care. While many imagine that pastoral care implies giving wise advice, or dispensing theological wisdom, these play a relatively small role in good care and counseling. The best care depends mainly upon showing empathy, helping persons to tell and hear their own stories, and encouraging their own listening for the movement of the Spirit in their lives.

domains of pastoral care, vis-à-vis therapy, is the chart in figure 4.1, called the Johari window.²

In this diagram, areas 1 and 3 are the usual domains of pastoral care, involving conscious communication between pastor and pastoral-care recipient. Domain 1 is the social level, where what the parishioner shares is fully conscious (known to self) and easily shared with others. Domain

		Known to Self	Not Known to Self
Known to Others	1	Social Level — Pastoral Care —	Risk Level — Pastoral Care & Counseling —
	3	Private Life Space — Pastoral Care & Counseling —	Unknown/ Unconscious — Pastoral Psychotherapy —
Not Known to Others	4		

Figure 4.1 The Johari Window, adapted

Source: Adapted from Vincent D'Andrea and Peter Salovey, *Pastor Counseling: Skills and Perspectives* (Palo Alto, CA: Science and Behavior Books, 1983), 63, citing Joseph Luft, *Group Processes: An Introduction to Group Dynamics*, 3rd ed. (New York: McGraw-Hill, 1984).

3 also is fully conscious for the parishioner but involves matters of more privacy and is more carefully bounded. Issues belonging to domain 3 can be shared when the parishioner feels there is sufficient trust and rapport with the pastoral caregiver. This requires time to develop. The caregiver needs to exercise patience, non-intrusiveness (not being pushy or having an agenda for the parishioner to follow), and devotion to nonjudgmental listening. Domain 2 also is, on occasion, an area for pastoral care; it covers personal feelings and behaviors that the pastor observes in the parishioner (even if the parishioner is not fully aware of them) and on occasion, for the good of the congregation, needs to tactfully confront. This is an area of risk and requires great sensitivity and tact, because exposing to a person what others observe and know about, though the person is unaware, tends to evoke shame. Therefore, while occasionally the domain of pastoral care when gentle confrontation is required,³ domain 2 is more the purview of pastoral counseling and psychotherapy. The fourth quadrant is the realm of pastoral psychotherapy and not pastoral care. It represents the realm of the unconscious.

Transference and Countertransference

The foregoing distinctions require a brief explanation of two interlocking dynamics in all helping relationships; these dynamics are called transference and countertransference. Transference is a particular form of projection, in which we (unconsciously) project our internal emotional experiences of other persons—especially from childhood—onto the “screen” of another person and begin to treat that person as if she or he were an earlier figure in our life. For example, if one of my parents was highly critical, I might unconsciously assume that about my boss and react accordingly, even when the facts about my boss suggest otherwise. We all do this. It’s a part of our natural psychological development and a strong determinant in the formation of our personalities. It manifests itself in marriage, in friendships, and in work relationships, and as one person’s projections interact with another’s, it can also be a powerful mutual dynamic in groups, including congregations.⁴ Transference, as a subset of projection, is a natural unconscious set of feelings, thoughts, fantasies, and to some extent behaviors that occur whenever we are in the position of being cared for, taught, evaluated, supervised, and/or governed by another person. We unconsciously project or “transfer” the feelings we had as infants and children onto those who

have some kind of authority for or over us today. Without realizing it, we are reminded of the feelings we had toward our parents and other early caretakers, on whom we depended initially for our very survival and later for our physical and emotional well-being. The better our experiences of being parented, the easier our relationships to authority in adulthood will also be. However, no one has “perfect” parents, and no one escapes childhood entirely unscathed emotionally.

Extremes of abuse and neglect can cause significant suffering and damage to a person’s self-esteem, personal boundaries, and ability to trust. But even more subtle experiences of emotional neglect, rigidity, or judgmentalism can trigger unconscious expectations of those who have some kind of power over us—even in the most benign forms. For this reason, pastoral caregivers are trained to be aware of ways in which we are always on the receiving end of some kind of transference from those for whom we care. While it is only the domain of pastoral psychotherapy (domain 4 in the Johari window) to explore and in some sense rework this transference dynamic, our awareness in all the domains of care and counseling will help us not to get drawn in unwittingly to reenacting unhealthy dramas from the parishioner’s past.

Just as transference occurs in the unconscious feelings of a parishioner toward a pastoral caregiver, so caregivers also project our own “stuff”—our own unresolved emotional issues or baggage—onto those in our care. This is traditionally called countertransference in psychotherapy, but a more useful way of thinking about it is how we most helpfully can use ourselves as instruments for understanding the other person, while keeping our own



Technical terms **transference** and **countertransference** are crucial in listening to another without distortion or projection. Classically defined, transference is what parishioners unconsciously imagine about us and possibly act out toward us, based on their earliest childhood relationships. Countertransference is our own unconscious imaginings, or projections, onto them, based on our own unresolved issues. The better aware we are of our own issues and the better we appreciate that unconscious dynamics are always flowing, the more we can get beyond these to a clearer picture of the real needs of those who turn to us to listen to them and provide care.

issues from getting in the way.⁵ Many if not most seminary students will enroll not only in an introductory pastoral-care course, but also in a hospital- or community-based clinical pastoral education (CPE) program, where the importance of self-awareness as a caregiver and ways of understanding our own personal history, feelings, and habitual behaviors can be explored in the direct practice of pastoral care and in small groups of peers receiving the same training together.

Pastoral Counseling and Psychotherapy

In the Johari window (figure 4.1), notice that there is a distinction between pastoral counseling and pastoral psychotherapy. Pastoral psychotherapy, as previously stated, is the domain in which unconscious dynamics are more intensively explored through such techniques as free association, dream interpretation, and exploration of reenactments of childhood thoughts, fantasies, and emotions as they become evident in the relationship with the therapist. It is a branch of mental health counseling in which some of the deepest and most intractable emotional issues can be addressed, and it may be brief (a period of weeks or months) but is often longer-term, even two years or more. Pastoral psychotherapists are extensively trained in both theology and clinical psychology, and are normally both endorsed by a religious body and certified and/or licensed by a variety of professional organizations, such as the American Association of Pastoral Counselors, and state licensing boards. Pastoral counseling is another mode of pastoral helping that goes beyond short-term and supportive pastoral care, both in the level of risk and intimacy and in duration. Like psychotherapy, it belongs in the realm of greater training and specialization of certified and/or licensed counselors. However, in contrast to pastoral psychotherapy, Pamela has previously defined pastoral counseling as focusing mainly on *conscious* emotional and mental processes (or, at most, preconscious—that is, mental contents that may be temporarily out of awareness but are easily accessible once some attention has been paid).⁶ The goal is to help a client solve problems in his or her present situation, often by identifying and building on his or her existing strengths. Unlike psychotherapy, which primarily addresses long-term pathology, trauma, or serious and enduring patterns of emotional distress, pastoral counseling primarily addresses ways in which the client can become more self-aware and thoughtful about his or her behaviors, feelings, and life choices.

Obviously, in practice there is considerable overlap between therapy and counseling. The primary means of healing in pastoral counseling is through a cognitive, or mental, reframing of the client's current situation and the adoption of new strategies for coping, although some focus may be given to antecedents in the client's early life. Pastoral counseling, then—including cognitive, cognitive-behavioral, Solution Focused,⁷ Rational-Emotive,⁸ and many contemporary narrative approaches⁹—tends to focus on the present and future rather than present and past emotional events, and it works through various methods of reframing of negative perspectives or meanings to events in order to arrive at solutions to problems identified by clients. Much or all of what is discussed in sessions—usually about once a



Care, counseling and therapy are not the same! Pastoral care is generally short-term, focused on spiritual support and an assessment-referral model for serious or long-term problems of parishioners. Pastoral counseling and pastoral psychotherapy both require further training in clinical psychology beyond seminary. Pastoral counseling tends to focus on solving problems and self-defeating patterns of thought and behavior that are troubling the client. Pastoral psychotherapy tends to focus on unconscious dynamics in both the patient's past and present. All of these modes of helping are pastoral because they acknowledge spirituality as a central aspect of each person's life, and recognize that God/Christ/the Spirit are involved in the work of healing—and, as well, a central source of support for the pastoral caregiver him/herself.

week—involves events and feelings of the client that have occurred outside the counseling relationship, in the client's experiences with everyday living during the week. The language used to describe the therapeutic dyad in this enterprise is usually (pastoral) “counselor” and “client,” giving emphasis to the respectful, contractual nature of the professional relationship.

In real practice, this distinction between counseling and psychotherapy, and even care, is not so pure at times, and there is some overlap. The chief difference is most often seen in the focus of attention in the counseling/therapy session: counseling will focus almost entirely on the client's situation and problems outside the session, while psychotherapy will increasingly focus over time on the interaction between the therapist and

the patient in the here-and-now of the therapeutic session, in an effort to “catch” unconscious projective processes “in the act,” *in media res* (“in the midst of things”) as a mirror for understanding the unconscious processes that are likely also being enacted in the patient’s everyday life.

In Pastoral Care, Less Is More!

Another very important dimension of listening as primary in pastoral care is the issue of advice. Simply stated, giving advice is not our job! There is a lot of truth in the notion that the advice that worked for me may not work for you. I should not project my situation, my feelings, my solutions onto your problems. This is one of the more negative forms of countertransference, especially if I am doing this unwittingly. The best way I can guard against that is by listening to you, as in the popular Buddhist saying “Don’t just do something—sit there!”

This is sometimes called ministry of presence. People, young and old and in between, know when someone is really there for them. We may be tempted to feel that we should be doing more, or at least giving reassurance, but we all too often underestimate what the gift of just being there, being with, can mean to folks. Reassurance can be received as both false and toxic! Theologian Nicholas Wolterstorff, in his memoir of grief after the death of his young adult son, offers the metaphor of the mourning bench:

Please: Don’t say it’s not really so bad. Because it is. Death is awful, demonic. If you think your task as comforter is to tell me that really, all things considered, it’s not so bad, you do not sit with me in my grief but place yourself off in the distance away from me. Over there, you are of no help. What I need to hear from you is that you recognize how painful it is. I need to hear from you that you are with me in my desperation. To comfort me, you have to come close. Come sit beside me on my mourning bench.¹⁰

Wolterstorff is describing in very personal terms the difference between *sympathy* and *empathy*. Sympathy, or feeling-with, is not all bad! It’s a feeling of kindness toward the other person. But sympathy is also felt at arm’s length: “You over there are suffering, and I’m sorry that you are. But I over here am just fine.” Empathy, in contrast, means feeling-in. While we can never fully know what another person is feeling (and in fact, it is empathic



Sympathy vs. Empathy: Sympathy is feeling-with. It can be an expression of genuine kindness, but it stands at a distance. Empathy is feeling-in, stepping into the other person’s shoes and to the extent possible, trying to understand the other’s feelings from his or her own point of view. Pastoral care strives for empathy, which is healing in itself.

to acknowledge that), empathy happens when we begin to feel what the other person is feeling and experience what she or he is experiencing. To the best of our ability, we walk in the other’s shoes. The first and foremost goal of listening is empathy. And empathy is healing in and of itself.¹¹

Context: How We Are Shaped by Where We Live

The second arena in which the discipline of pastoral care has undergone some changes has to do with the increased attention to the importance of social and cultural context. As noted throughout this book, context has become one of the most foundational aspects for consideration in all practices of ministry. In pastoral care in particular, this takes a distinctive form by lifting pastoral assessment beyond merely looking for individual pathology in one who comes for help (although this can be very real and should signal a need for referral to a pastoral counselor or psychotherapist). Contextual sensitivity helps pastoral caregivers recognize that much of what ails a person is not internal to the person alone, but is caused by the economic, racial, and social burdens and pressures surrounding a person’s life. Carroll Watkins Ali, a pastoral counselor in Denver, tells this story from her pastoral counseling practice, with a client named “Lemonine”:

Truly, life was Lemonine’s presenting problem. There are no other diagnoses in the traditional sense. Lemonine was basically suffering from being overcome by her own personal life, while trying to cope with all the external social realities that affected each age group of her family members. In essence, each weekly session during our relationship served mainly to build Lemonine up enough so that she could go back out to face a hostile world for another week. A major issue that came up often in our sessions was the racism Lemonine experienced in her workplace. In fact, she experienced tremendous stress

related to the dynamics of both racism and sexism in corporate America. The glass ceiling barred heavily against her advancement before she could even get her foot in the door because she was both Black and female. She worried about being the last hired and the first fired as a result of corporate downsizing. This actually occurred twice during the course of our sessions. In retrospect, it now seems that therapy was Lemonine's last effort to find a way to overcome the many problems of her world.¹²

The Family System

Traditional one-on-one models of pastoral care, based on the medical model of psychiatry as the chief form of mental health care, tended to operate in the arena of the individual psyche. However, many pastoral theologians and professors of pastoral care have been trained in a broader paradigm called family systems theory, which was a liberative approach adopted in the 1950s and '60s to move beyond the individualism widespread in both pastoral care and mental health counseling in general. Family systems looked beyond individual pathology to understand how persons are formed in the



Family systems theory: Family systems theory is often used in pastoral care and counseling as a way of recognizing that individuals' problems are never isolated from the pulls and pressures of their entire family of origin.

interlocking dynamics and largely unconscious rules, roles, and assumptions about how to live, which are passed on from one generation in a family to the next. Utilizing systems theory from economics, engineering, science, and other social sciences, family systems theorists came to understand that families try to maintain "homeostasis"—that is, at their most basic level of functioning, families try to keep individual members from rocking the boat for fear that the family might fall apart.

Families use a variety of strategies to do this, without the members' conscious awareness. One strategy is triangulation, which occurs when two persons in conflict attempt to pull in a third person to take sides, distract, or otherwise reduce the original tension. Another strategy is scapegoating,

or assigning blame or pathology to a particular member so that other members of the family can feel innocent or whole. Family members may also divide tasks into rigid roles—for example, the perpetual caretaker, clown, star, or mess-up. Helping any individual in the family to recognize these dynamics can help the whole family, because as one member of a system changes, the rest of the system will tilt and have to find a new (and hopefully healthier) homeostasis.

The Cultural Context and Issues of Justice

Neither an individualistic nor a family systems approach, while very helpful, can fully address some of the larger dimensions and challenges of human experience, including the social, political, economic, racial, ethnic, and cultural surroundings in which any individual's life is embedded, which



Pastoral care also attends to cultural and social context! Individuals and families do not experience their lives apart from the larger social, political, economic, and cultural contexts in which they live. Carter's and McGoldrick's chart (next page) illustrates the many levels of stress that impact persons and families.

bring additional pressures, stresses, and traumas both acute and ongoing to bear on an individual's growth and the living of a life. In a helpful chart (Fig. 4.2), family theorists Betty Carter and Monica McGoldrick show how external stressors affect not only individuals and immediate families, but also extended families, communities, and entire societies in a combination of both "vertical stressors" (challenges that tend to be permanent or long-enduring) and "horizontal stressors" (challenges that occur at points in time that become life-changing for individuals and groups).¹³

The increasing awareness of these contextual realities has led pastoral theology into an awareness of the connection between pastoral care and the work for justice. In the words of Larry Kent Graham, professor emeritus of Iliff School of Theology in Denver, there has been a shift from "relational humanness" (not bad in itself) to "relational justice."¹⁴ This means that pastoral care can no longer focus on the individual in isolation from the wider context. This takes us into the arena of advocacy as well as individual care, and toward

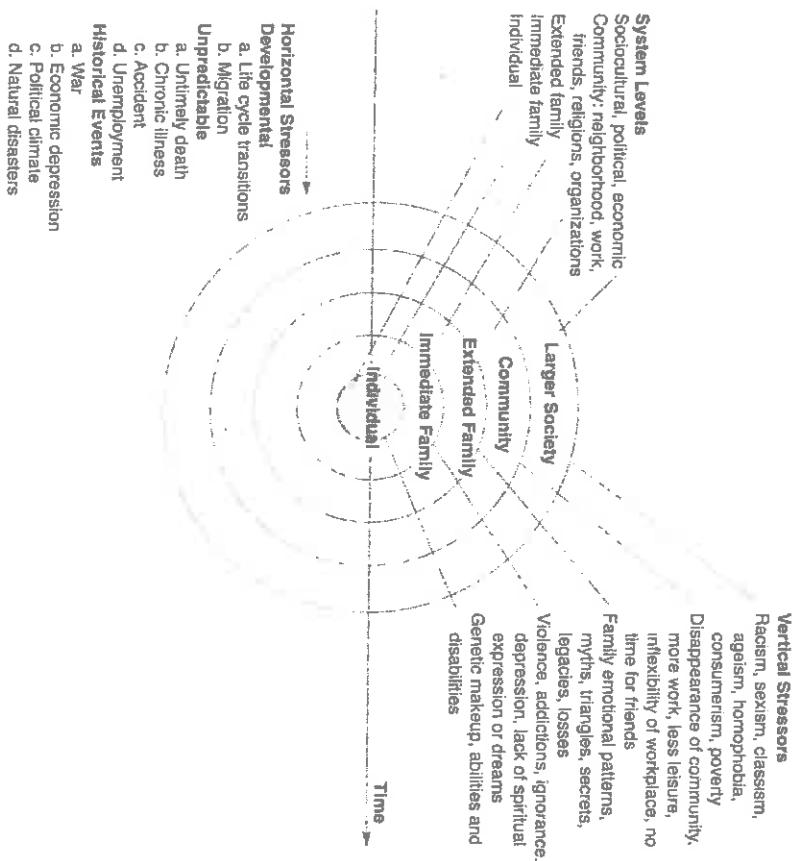


Figure 4.2 Carter's and McGoldrick's Flow of Stress through the Family

Source: Betty Carter, Monica McGoldrick, and Nydia Garcia-Preto, *The Expanded Family Life Cycle*, 4th ed. (Needham Heights, MA: Allyn & Bacon, 2010), 6.

an awareness that our own openness to the reality and the wisdom of those for whom we care can model mutuality and replace the kind of top-down, power-over expert role that once held sway. We are no longer just called to be good active listeners (listeners who speak mainly to gain better understanding and mirror back what they hear), although that never is a bad idea, but we are also called to hold in our awareness the wider contextual realities in which individuals struggle to live. Similarly, we seek to refrain from diagnosing as individual psychological or spiritual problems what are, in fact, outcomes of societal rather than individual illness and spiritual malaise.

In concrete terms, this means that the arena of care is broadened. No longer confined only to the pastoral caregiver's study, pastoral care may

include preaching that calls for empowerment and liberation of persons; offering small groups for support, Bible study, and discipleship aimed toward changing realities that stifle and oppress individuals' lives in the community; and getting out in the wider community, doing "public theology," that is, joining together with others who are working for social change that undergirds the possibility for personal change. To use an example from Pamela's specialized ministry with battered women for many years, it would mean the difference between counseling an individual battered woman about how to take responsibility for changing her life versus taking the broader approach of empowering her to identify her own strengths and options while also preaching, teaching, working collaboratively with battered women's shelters and agencies for men who batter, and advocating with others in the community for the eradication of violence against women and the social structures that reinforce it.

The traditional functions of pastoral care reflected a somewhat more individualistic and even perhaps clergy-centered approach. A kind of subliminal model of the learned, wise, and kind pastor would sit in his book-lined study with one (or perhaps at most two) parishioners, dispensing the following "basic functions of pastoral care":¹⁵

- ◆ Healing
- ◆ Sustaining
- ◆ Guiding
- ◆ Reconciling

While dimensions of each of these are still relevant, and students of pastoral care today are likely to encounter them as normative aspects of



The basic functions of pastoral care as developed by pastoral theologians are: Healing, sustaining, guiding, reconciling, nurturing, empowering, and liberating. It should be noted that none of these activities are within the pastor's capabilities alone, but depend on God and community.

what makes care "pastoral," Carroll Watkins Ali has further expanded these basic functions. Based on her contextual therapeutic stance, grounded in Womanist theology (with a focus on empowering Black women spiritually,

emotionally, and physically), as seen in her previously quoted description of her client “Lemonine,” she adds these functions:¹⁶

- ◆ Nurturing
- ◆ Empowering
- ◆ Liberating

Content: What Is the Scope of Pastoral Care?

On the Emmaus road, as we have seen, Jesus asked his fellow travelers, “What are you discussing?” (Luke 24:17a) He was seeking to understand the pressing concerns and issues that weighed upon their hearts. No less important than understanding something about the surrounding stressors that affect individuals and families in our care is the actual content of issues and problems with which people in congregations are frequently struggling. Thinking back to Aristotle’s types of knowledge identified in chapter 1, making referrals encompasses *techné* (technical how-to; knowledge or craft), *epistēmē* (scientific knowledge or knowledge of facts), and *phronēsis* (practical wisdom). Every professor of pastoral care will organize an introductory course on pastoral care somewhat uniquely; some will emphasize cultivating the *techné* of how to listen both to the other and to one’s inner impulses (countertransference); some will emphasize the *phronēsis* of theological and clinical reflection and assessment; others will emphasize the sociological and psychological *epistēmē* of responding to particular issues. (Of course, this is reductive, as all three emphases involve all three kinds of knowledge!) The following is a comprehensive template for what an introductory class will usually cover, with varying emphases:

1. Students will develop an awareness, analysis, and critique of the larger social, economic, gender, racial, sexual, and political contexts in which individuals’ and families’ pain is addressed in the pastoral-care situation.
2. Students should receive practical grounding in the fundamentals of responding to common pastoral situations (attending illness, death, and dying; home and hospital visitation; premarital preparation/brief marital counseling; spiritual support) as well as common crisis situations (such as addictions, mental illness, and family violence). Carefully chosen books, articles, and films created by experts on specific life challenges and crises will usually serve to amplify classroom discussions.

In addition, most introductory courses offer some practice in specific listening skills, through directed field work, role plays, or in-class listening exercises. Increasingly, “listening” via social media and the Internet will be addressed, as an entire generation of young adults will bring their favored forms of communication with them into pastoral situations—and to seminary!

3. Students will become acquainted with elements of the fields of counseling and psychology as they have been commonly appropriated within the pastoral-care discipline (e.g., understanding basics of couple and family dynamics, psychological health and illness, crisis and addictions, and the normal processes of grief). Some courses will also address new research findings from the growing fields of cognitive science, neurology, and human development.¹⁷ Psychology in a pastoral care course is offered mainly in order to help students learn to make appropriate pastoral assessments of what persons most urgently need, and from whom. The emphasis is on knowing when and how to refer to other professionals, and on building professional networks for more effective and holistic care.

4. Students will develop theological frameworks for understanding their own pastoral identity, the meaning of care of persons, and the pastoral role of Christian community, and for conceptualizing health and wholeness with particular reference to their own theological traditions. Students will learn one or more methods for doing theological reflection on pastoral-care cases.

5. Students will become familiar with concepts of wellness, spiritual health, and keeping good boundaries, with attention to self-care as well as care of others and of the community as an essential aspect of spiritual formation. Related issues of professional ethics will also be addressed. Use of the self in pastoral care and the concept of “countertransference” in the pastoral relationship will be introduced, with opportunities to practice countertransference awareness in both the practicum work and written assignments.

It is beyond the scope of this chapter to cover all the details of these areas of pastoral study, just as it is beyond the scope of an introductory course to cover every one of these dimensions in full depth. It should become apparent, however, that the curriculum for learning practices of pastoral care is far more than a set of skills to be mastered or even a set of psychological

theories to be applied in the pastoral setting. All five of these areas actually overlap continually in the ongoing practice of pastoral care, and theological reflection as well as reflection on the needs of the person coming for help and on our own needs and vulnerabilities are in constant interplay. This takes practice, and the guidance and wisdom of our peers and our mentors is essential for learning the art of pastoral caregiving. There are many very helpful books addressing particular issues and problems, including addiction, abuse, mental illness, and more developmental crises such as the pressures of adolescence and the challenges of aging. Part of one's pastoral wisdom is not to have all the answers but to know of books and articles to look them up! Even so, there is absolutely no textbook that can substitute for the value of supervised learning in this field.

Diversification: Expanding the Circle of Caregivers

Contextualization of pastoral care, with its commitment to relational justice, leads to the fourth aspect of change in pastoral care: diversification. This refers to diversification both of caregivers and of resources in church and community that can be made available to those seeking pastoral help. These matters of resources and making referrals are among the most important practices in pastoral care. Knowing when and to whom to refer is not only common sense—we cannot possibly provide all things to all people even in a small congregation!—but is also a living demonstration of our conviction that we do not have to be the expert in everything, and we trust in the collective wisdom of the community.

However, we do not “refer and dump.” Since at times a parishioner can feel a referral to be a brush-off, it’s important to convey that we are creating networks of collaboration in the community and widening the circle of care to include people with greater expertise in a particular issue than we ourselves have. Furthermore, it is not our role to be therapist, coach, vocational counselor, school guidance professional, evaluator for learning disabilities, or medical diagnostician. At the same time, it is our distinctive role to provide ongoing spiritual support after a referral to a community resource has been made. Hence, we do not refer and dump, but we refer and support the referral. It is important to follow up and ask how the referral worked out, and to go back to the drawing board as necessary if the first referral did not go well. It is also within the distinctive purview of our own

role as spiritual caregivers to continue to reflect together with persons about their larger questions of meaning, purpose, sin, salvation (sometimes called *soteriology*—literally the study of salvation or well-being), and perhaps the most difficult pastoral question of all: why God even allows suffering and



The reality of **suffering, sin, and evil** poses the most difficult question in pastoral theology. Why do suffering and evil exist if God is both good and all-powerful? Theologians have adopted many varying answers to this central problem, but to grapple with this question of *theodicy* (see text) is a central theme in pastoral care and counseling, and one which confronts both beginning and seasoned pastoral caregivers as life in this world entails grief and sorrow as well as joy.

evil to exist (sometimes called *theodicy*, from *theos* + *dike*, literally to justify God in light of the reality of evil). But even this we need not do alone! Spiritual conversations can take place not only one-on-one in the pastor’s study, but also in small groups, house meetings, and other gatherings where church members and friends ponder these mysteries, just as the disciples pondered the mystery of Jesus’ death and resurrection in the midst of their grief on the road to Emmaus.

Even the most casual survey of how people care for one another in cultures worldwide and across various ethnic and cultural groups within North America shows that not all pastoral care has ever been dispensed in the one-on-one setting of a professional office with a fixed appointment, nor has all pastoral care ever been dispensed solely by the clergy. The one-on-one model has all too often perpetuated a one-up/one-down expert role that tends subtly to “fix” rather than empower the one coming for help. Even access to such elite helpers has been limited to those with certain social and economic means. However, there is now a growing respect for the wide variety of resources available for pastoral care and for the clergy person as one resource—albeit an important one with particular gifts—among many. Bonnie Miller-McLemore at Vanderbilt University states that “pastoral care curriculum has focused increasingly on how congregations provide care and on clergy as *facilitators of networks of care*” (emphasis added),¹⁸ rather than sole caregivers. Similarly, pastoral counselor Margaret Kornfeld has written about pastoral care through the gardening metaphor of “cultivating

wholeness,"¹⁹ in which a variety of gardeners with a variety of expertise collaborate in the facilitation of spiritual growth and healing of individuals and communities.

Miller-McLemore has revised another paradigm that was widely circulated from the mid-twentieth century, Anton Boisen's idea of the "living human document."²⁰ In his time, Boisen was concerned that pastoral caregivers turn from an overreliance on theory and texts to a more existential respect for the life of individuals in all their uniqueness. He called for "the study of human documents as well as books,"²¹ and his phrase, *living human documents*, struck a resonant chord in pastoral caregivers who sought, legitimately, to get closer to the lived inner experience of their helpees. However, this paradigm, too, was limited by its individualistic bent. Miller-McLemore has proposed replacing the living human document with the "*living human*



We are all inter-connected! The recent metaphor of the "living human web" is a good image for the pastoral caregiver's view of care as both individual and communal. Resources for care, therefore, include both the pastor and, as appropriate, other persons and agencies—both within the congregation and in the wider community. Care for individuals and families goes hand in hand with advocacy for healing and justice in communities as well.

web" as the "appropriate subject for investigation, interpretation, and transformation."²² She advocates for "a shift toward context, collaboration, and diversity,"²³ in which the work of caregiving includes both individual and communal care, respecting the complexity and multiple contextual realities of people's lives. If we consider for a moment the view of our beautiful blue planet as seen from outer space, "this fragile earth, our island home,"²⁴ it is apparent that we are all connected!

In concrete terms, this means that the notion of care expands from that lone pastoral caregiver in the study with a lone parishioner or couple or even family to a web of resources gathered collaboratively to address the complex, multilayered needs and struggles of the helpee. It means having a list of contacts (whether in an old-fashioned well-thumbed card file or on the latest smartphone). These contacts should be personally known and trusted helpers in the community with varieties of expertise, including

spiritual directors, therapists, social workers, school officials and educators, medical professionals, lawyers, financial advisers, public agencies, and community organizers. It means sharing the responsibility and the authority for pastoral care with trained and empowered lay caregivers, such as lay Eucharistic ministers, small-group leaders, Stephen Ministers, parish nurses, and pastoral-care teams. It means hitting the pavement to identify and join with others who are working in the community to change the conditions that perpetuate suffering, and inviting those individuals into our congregations as witnesses to the wider needs of the community.

There is an added benefit to this emphasis on knowing when and how to refer, because although it sounds like a lot, in one way it is actually less taxing than the old paradigm. As we share the responsibility for providing care, we are also much less prone to burn out and therefore are more available to respond to the wide variety of requests that may come to us day by day. In this new more communal paradigm, the pastoral caregiver no longer needs to be seen as having sole responsibility for the welfare of the "flock." This becomes a shared responsibility and a collaboration of the whole body of Christ by virtue of our baptismal covenant, in partnership with the wider community.

Balance: From Shepherd to Samaritan

This leads to the fifth and last aspect of change: balance. A collaborative approach to pastoral care replaces the old self-sacrificing model of the shepherd with a paradigm of balance, exemplified in care for self as well as others and in a respect for boundaries as a positive good. The image of the oxygen mask on an airplane is a trite but true analogy. The safety announcement on every airliner instructs passengers in case of an emergency to put on one's own oxygen mask first, before assisting another person. If we exhaust ourselves in giving without taking time to replenish, if we burn out, we soon are no use to anyone. We also are not much use to ourselves; our relationships with others and ultimately even with God suffer. We may lose sight of our countertransference, as described earlier in this chapter. When we overextend ourselves on behalf of others, we are prone to falling into the trap of the martyr's self-aggrandizement: "I'm indispensable, I'm so important, everyone needs me!" We don't have time to refuel as we should in prayer and rest and personal self-nurturing activities, and pretty soon we derive

our sense of satisfaction and self-worth from those we are helping, rather than from the resources of our own personal lives—and most importantly, rather than from our own nourishing relationship with God.

Pastoral theologian Jeanne Stevenson Moessner has held up the biblical image of the Good Samaritan (Luke 10:25-37) as an alternative to the shepherd paradigm.²⁵ The Good Samaritan helped the man whom he found on the side of the road, half-dead, stripped, and beaten. But he also went on with his own journey. He did not give up his life for the stranger, but rather shared life with him. And further, he made a referral! He solicited the assistance of another helper—the innkeeper—pledging resources and support, and pledging to return, but also keeping the other commitments of his life. He kept all his commitments in balance! This story, in fact, is a useful example of the power of a good, timely referral to a trusted resource. Nor did the Samaritan refer and dump, but rather, he promised ongoing



Boundaries and self-care: The Good Samaritan serves as a helpful metaphor to place alongside the Good Shepherd. Keeping good boundaries, not losing sight of our own purpose, and caring for oneself are crucial to good pastoral care for others. We are called to nourish our own relationship with God, and to love our neighbor as ourselves, but not instead of ourselves. Keeping good balance is a crucial practice of ministry.

support for the referral. All this he accomplished without sacrificing his own plans and without becoming entangled in an enmeshed, dependency relationship inappropriate to the task of care. The message of the Samaritan is simple but poses a healthy alternative to some traditional models of care: share the caring task with other helpers, stay connected but not overinvolved, and stay whole yourself.

Moessner uses the Samaritan story also to illustrate Christ's summary of the law—"love your neighbor as yourself,"—as a paradigm of interconnection among God, self and neighbor.²⁶ The failure to care for self as well as for others can lead to a further peril beyond burnout; it is a very small step from deriving our self-worth from those we are helping, to beginning to use them to gratify other needs of ours as well—emotional, even sexual. In

this way, attention to keeping good boundaries is not withholding appropriate love and care, but rather, safeguarding that love and care within a container of trust, respect, and safety. When we begin to overvalue our own importance in tending the needs of others, and over-identify and confuse ourselves with our role—or, worse, with the Savior—very bad things can happen.

Finally, it is Christ who is the great shepherd of the sheep, not we ourselves. When we cling too hard to the shepherd paradigm, we may run the risk of confusing ourselves with the savior—a temporarily gratifying but ultimately soul-killing proposition for us and for all whom we serve. In the words of the famous doxology, it is ultimately God/Christ/Spirit "from whom all blessings flow": healing, sustaining, guiding, reconciling, nurturing, empowering, and liberating. Trying to provide all these things ourselves not only is a prescription for burnout, but also may simply be another form of countertransference—puffing ourselves up as "special carers"²⁷ indispensable to others, as a way of bolstering our own faltering self-esteem. This is not a healthy way to practice ministry, nor is it a healthy way to live! And leaning on God to provide for us as helpers is, finally, deeply reassuring and empowering as we try to offer care.

Dorothy McRae-McMahon calls for self-awareness, a certain lightness of being, and a daily vocation based in gratitude toward God and profound respect toward every other person. She writes, "Underpinning all that I do pastorally is the absolute conviction that God is at the bottom of every abyss, is the oasis in the desert, the light in the darkness that is never extinguished, and the waiting meaning in the nothingness."²⁸

We are not meant to practice our ministries alone. Jesus sent the disciples out two by two. He did not send individuals, but partners. And when those partners went forth, he foretold that they would be empowered to do great healing works in his name. This is another image that for us serves as a corrective to the paradigm of the shepherd: the image of the disciples going out as partners, without lots of extra provisions, but with the confidence of the gospel and the reliance on the hospitality of strangers that would make their mission possible. In this paradigm, we become companions to one another on the journey, and as we go, we may find ourselves, as did the disciples on the Emmaus road, walking side by side with Christ himself.



Questions for Personal Exploration

1. What obstacles or distractions might get in the way of your being a helpful listener?
2. Can you cite an example of where another person has projected "their own stuff" onto you? How did you feel, and how do you imagine yourself handling such projections as a pastoral leader?
3. Thinking back on a time when you were hurting or grieving, what did you need from others? What did others do that was helpful, and not so helpful?
4. Recognizing that pastoral care must be appropriate to culture and context, in what ways is this chapter relevant for your own cultural context? What changes or adaptations to your own practices might you make in order to provide culturally appropriate care?
5. Name some of the horizontal and vertical stressors in your personal life and cultural context. What forms of pastoral care would best address them?
6. As a caregiver, do you see yourself as more like the Good Shepherd or the Good Samaritan? Depending on your answer, what might you need to change to keep your life in healthy balance?



Resources for Deeper Exploration

- Cooper-White, Pamela. *Shared Wisdom: Use of the Self in Pastoral Care and Counseling*. Minneapolis: Fortress Press, 2004.
- Doehring, Carrie. *The Practice of Pastoral Care: A Postmodern Approach*, revised expanded edition. Louisville: Westminster John Knox, 2015.
- Hunter, Rodney, and Nancy Ramsay, eds. *The Dictionary of Pastoral Care and Counseling*. Expanded ed. Nashville: Abingdon, 2005.
- Moessner, Jeanne Stevenson. *A Primer in Pastoral Care*. Creative Pastoral Care and Counseling Series. Minneapolis: Fortress Press, 2005.
- Wimberly, Edward P. *Counseling African American Marriages and Families*. Louisville: Westminster John Knox, 1997.



Notes

1. A term that recognizes that the so-called "Third World" actually represents the majority of global citizens.
2. Adapted from Vincent D'Andrea and Peter Salovey, *Peer Counseling: Skills and Perspectives* (Palo Alto, CA: Science and Behavior Books, 1983), 63, citing Joseph Luft, *Group Processes: An Introduction to Group Dynamics*, 3rd ed. (New York: McGraw-Hill, 1984).
3. On gentle confrontation as proclamation in pastoral care, see Charles Taylor, *The Skilled Pastor: Counseling as the Practice of Theology* (Minneapolis: Fortress Press, 1991).
4. For more on congregational dynamics and the projections that occur from a family systems perspective, see Edwin Friedman, *Generation to Generation: Family Process in Church and Synagogue* (New York: Guilford, 1985).
5. For a detailed discussion of both helpful and unhelpful forms of countertransference in pastoral situations, including a related method for theological reflection, see Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004).
6. Pamela Cooper-White, *Mary Voices: Pastoral Psychotherapy in Relational and Theological Perspective* (Minneapolis: Fortress Press, 2007), 5–7.
7. Margaret Kornfeld, "Change Supported by the Solution-Focused Method," ch. 6 in *Cultivating Wholeness: A Guide to Care and Counseling in Faith Communities* (New York: Continuum, 1998), 114–46.
8. Charles Taylor, *The Skilled Pastor: Counseling as the Practice of Theology* (Minneapolis: Fortress Press, 1991), esp. 65–80.
9. For example, Andrew D. Lester, *Hope in Pastoral Care and Counseling* (Louisville: Westminster John Knox, 1995); Christie Corad Neugei, *Counseling Women: A Narrative Pastoral Approach* (Minneapolis: Fortress Press, 2001); and Edward P. Wimberly, *African American Pastoral Care*, 2nd ed. (Nashville: Abingdon, 2009).
10. Nicholas Wolterstorff, *Lament for a Son* (Grand Rapids: Eerdmans, 1987), 34.
11. An important twentieth-century psychoanalyst, Heinz Kohut, developed an entire mode of therapy based on the centrality of empathic listening, called Self Psychology. For an application of this specifically to pastoral care, see Chris R. Schlauch, *Faithful Companions: How Pastoral Counseling Heals* (Minneapolis: Fortress Press, 1995).
12. Carroll Watkins Ali, *Survival and Liberation: Pastoral Theology in African American Context* (St. Louis: Chalice, 1999), 5.
13. Berry Carter, Monica McGoldrick, and Nydia Garcia-Preto, *The Expanded Family Life Cycle*, 4th ed. (Needham Heights, MA: Allyn & Bacon, 2010), 6. (Chart reproduced in this edition from earlier editions by Carter and McGoldrick.)
14. Larry Kent Graham, "From Relational Humanness to Relational Justice: Reconciling Pastoral Care and Counseling," in *Pastoral Care and Social Conflict*, ed. P. Couture and R. Hunter (Nashville: Abingdon, 1995), pp. 220–34.

A Series of Resources

THINK BEFORE YOU SPEAK

I found this post a helpful reminder that we should always think before we speak. Please take time to read this post and come prepared to offer your thoughts.

Tips that Change Your Life (Posted On a Facebook Page November 2nd, 2024)

"Instead of saying, "I know what it feels like", let's say "I cannot imagine your heartbreak".

Instead of saying, "You're strong, you'll get through this, let's say " You'll hurt, and I'll be here.

Instead of saying, "You look like you're doing well, Let's say, "How are you holding up today?"

Instead of saying, "Healing takes time", let's say "Healing has no timeline".

Instead of saying, "Everything happens for a reason, let's say "This must feel so terribly senseless right now".

And when there are no words to say at all, you don't need to try and find some. Love speaks in silences too." (Ullie Kaye Poetry)

Yes, Instead of assuming to know the depths of another's pain, let us acknowledge the unfathomable ache in their hearts with empathy.

Instead of offering false reassurances of strength, let us stand by their side, acknowledging their hurt and offering our unwavering presence.

Instead of glossing over the struggles with superficial observations, let us inquire about their well-being with genuine concern.

Instead of imposing a timetable on healing, let us recognize its nonlinear nature, allowing space for its organic process. Instead of seeking explanations in empty platitudes, let us acknowledge the rawness of grief and the absence of sense. In moments of wordless despair, let love fill the void with its quiet, comforting presence.

PASTORAL CARE: is the “coming alongside” of a person in whatever situation they find themselves. It happens in both scheduled and unscheduled ways with people you know and people you simply encounter in daily life. It is the act of being open and responsive to the needs of another human being and offering companionship, in the moment, so that the individual knows that they are not alone.

DIFFERENCE BETWEEN A SOCIAL VISIT AND PASTORAL VISIT

SOCIAL CONVERSATION

Concentrates on:

- External Subjects –weather, World and local events
- Maintaining a congenial atmosphere
- Comforting through avoiding
- Sharing stories, experiences, mutual trading
- Being pleasant, positive
- What should be
- Generalizing, universalizing, What they say – what people do
- Being helpful by entertaining
- Religion- differences between churches, services, ministers
- People in general
- Facts, events, happenings, experiences

PASTORAL CONVERSATION

Concentrates on:

- This person
- Accepting tension areas
- Comfort through feeling
- Helping the person share self
- Being understanding, empathetic
- What is (as a step to what should be)
- Being specific –what do you think, feel
- Being helpful by intimate sharing
- God – and my/your relationship to God
- Significant relationships of the person
- The meaning of facts, events, happenings, and experiences

TWENTY-THREE RECOMMENDATIONS TO IMPROVE ONE'S LISTENING SKILLS

- 1- **SHARE TALK TIME:** Do not monopolize the conversation.
- 2- **CHECK YOUR WORRIES AT THE DOOR:** If you are preoccupied with something else you will not be listening attentively.
- 3- **GET RID OF DISTRACTIONS:** If you are fingering pencil, paper, clip card, etc., you are conveying the message that you are not really comfortable listening to whomever is speaking to you.
- 4- **ASK QUESTIONS:** It shows that you are listening attentively.
- 5- **CONCENTRATE ON WHAT THE SPEAKER IS SAYING:** If you find yourself daydreaming you are not concentrating.
- 6- **LISTEN WITH UNDERSTANDING:** Try to enter into the speaker's mind and perceive things as he/she does, from his/her point of view.
- 7- **LISTEN TO WHAT IS NOT SAID:** sometimes you can learn as much from what a speaker leaves out as listening to what he/she says.
- 8- **LISTEN TO HOW SOMETHING IS SAID:** Speaking loudly or softly, slowly or rapidly, haltingly or smoothly, are ways of expressing feelings.
- 9- **LOOK AT THE SPEAKER:** The speaker is communicating with his whole body – facial expressions, gestures, posture, nervous movements, eyes, etc.
- 10- **NOD YOUR HEAD:** You are helping the speaker by letting him/her know that you are listening. Other ways of letting him/her know that you are listening is by turning squarely toward him/her, leaning forward, saying, "Uh-uh", "yes", etc.
- 11- **LISTEN TO THE MAIN MESSAGE:** Is the speaker trying to tell you facts or share how he/she felt? Is he/she trying to persuade you or seeking your advice, approval, encouragement etc?
- 12- **SHARE RESPONSIBILITY FOR COMMUNICATION:** If you don't catch something, ask the speaker to repeat. If you are unfamiliar with names, places, time sequences, ask, "Who was that person you mentioned?" "Did you call first?" etc.

- 13- LISTEN WITH AN OPEN MIND: To listen and understand does not mean agreement or approval. While listening strive only to understand and avoid making judgment either about the speaker or what he/she says.
- 14- USE THE DIFFERENCE IN RATE: You can listen faster than the speaker can talk. Use that extra time to make relationships in what you hear.
- 15- DON'T TUNE OUT.
- 16- DON'T ARGUE MENTALLY.
- 17- CONTROL YOUR ANGER: If you find yourself getting angry, you might ask yourself, "What is there about me that makes me so defensive about that remark?"
- 18- DON'T ANTAGONIZE THE SPEAKER: When the speaker hears a hostile remark, he/she closes up like the pupil of the eye in the presence of too much light. Becoming aware of the effect your behavior has on the speaker is part of listening with both ears.
- 19- DON'T MAKE PREMATURE JUDGEMENTS.
- 20- AVOID STEREOTYPING: Labeling the speaker as young, old, retired, conservative, liberal, traditional, progressive, etc., distorts your perception of what is said.
- 21- RESPECT PAUSES. RESPECT PAUSES. RESPECT PAUSES, RESPECT PAUSES...
- 22- GIVE ACCURATE FEEDBACK: try to let the speaker know how you understand what he/she is saying, the feeling and the intensity of the feeling.
- 23- LISTEN WITH COMPASSION

Controlling the Urge to Help or "Fix"

Effective empathy requires a special skill: to control one's urge or impulse to help, and of being present with the other person in the conversation. We often reflexively respond to an upset person by giving advice, words of encouragement, or words of comfort—three common ways of trying to help. While these are well-intentioned responses, they interfere with the other person's talking because these verbalizations stem from our thinking about how to help rather than thinking about what the talker's words mean to him or her.

TWELVE ROADBLOCKS TO COMMUNICATION

The following ineffective kinds of verbal responses have two elements in common: they BLOCK the speaker from solving his/her own problems with his own solutions, and they IMPEDE the open and free flow of communication between persons.

1- Directing, Ordering, Commanding:

Examples: “You must”, “You have to”, “You will”

Effects: Fright, humiliation, resistance, rebellion, feelings of rejection, desire for revenge.

2- Warning, Threatening, Admonishing:

Examples: “You better”, “If you don’t, then...”

Effects: Invites ‘testing’, in addition to the effects of number 1.

3- Moralizing, Preaching, Obliging:

Examples: “You should”, “You ought”, “Your duty is”

Effects: Makes others feel guilty, resistance to pressure, communicates lack of trust.

4- Persuading With Logic, Arguing, Instructing, Lecturing:

Examples: “That’s not right”, “The facts are”, “Yes, but...”

Effects: Provokes counter-arguments and defensiveness, feelings of inferiority.

5- Evaluating, Judging negatively, Disapproving, Blaming, Name-calling, Criticizing:

Examples: “You are bad”, “Lazy”, “Not thinking straight”, “Acting foolishly”

Effects: Makes the speaker feel inadequate and inferior, refusal to communicate, low self-concept.

6- Advising, Recommending, Providing Answers or Solutions:

Examples: "What I would do", "If I were you", "Why don't you", "I suggest", "It would be best for you"

Effects: Dependency, hindering creative thinking, avenue for avoidance of responsibility and feelings of guilt when suggestions are not fulfilled.

7- Praising, Judging or Evaluating Positively, Approving:

Examples: "You're a good boy", "You did a nice job", "it's a very good drawing", "I approve of it"

Effects: Feelings of being threatened by too positive a picture or unreal picture, feelings of being manipulated, stops communication, embarrasses, tags praiser as superior.

8- Supporting, Reassuring, Excusing, Sympathizing:

Examples: "You'll feel better", "That's too bad", "Don't worry"

Effects: Feelings of being not understood, not accepted as is, resentment for being misled, distrust.

9- Diagnosing, Interpreting, Offering Insights:

Examples: "What you need is", "What's wrong with you is", "You're just trying to get attention", "You're don't really mean that"

Effects: Feeling of threat, being exposed, naked, trapped.

10- Questioning, Probing, Cross Examining, Prying:

Examples: "Who?", "What?", "Where?". "How?", "Why?", and "When?"

Effects: Defensiveness conveys lack of trust, being manipulated, restricts range of communications, and implies gathering information for offering the speaker a solution.

11- Diverting, Avoiding, By-Passing, Shifting:

Examples: "Let's not talk about that", "Forget it", "That reminds me"

Effects: Feelings that the listener is not interested, guilt, lack of respect.

12- Kidding, Teasing, Making light of, Joking, Sarcasm:

Examples: “You look so cute when you’re mad”, “Hey, snap out of it”

Effects: Lack of respect, feelings of hostility, not being understood.

The Eyes Have It

Perhaps more people are aware of facial expression than other examples of body language. In fact, we tend to focus our eyes on another’s face more often than on any other part of the body.

Several common rules apply to accurate eye communication:

- 1) If you want to communicate love or caring, look at the other person’s eyes.
- 2) If you want a clear, accurate communication, especially when giving directions, make eye contact.
- 3) When making eye contact, look directly at the person for several seconds, then look to the left or right, maintaining your glance at the same height. After a moment look back at the person’s face again. Repeat this process until it becomes comfortable.
- 4) If you want to tell the other person you are listening (empathetically), make eye contact (as above) and every so often gently nod your head and say, “uh-huh.”
- 5) Don’t roll your eyes – that generally means, “Oh brother!”
- 6) Don’t look down unless you want to end the communication. If you habitually look down because of shyness, you may be shutting others out!

Eye've Had It!

If the eyes give one message and the mouth another, believe the eyes.

Not only do our eyes help us give messages, but we can also better understand what others mean by knowing what their eyes tell us. Recent research suggests these facts about eye messages:

- Generally, when a person looks up while responding or contemplating a response, he or she is thinking, perhaps trying to visualize a scene or event. You might picture what you have said. Usually it is reasonable to believe this person is not convinced and is still questioning.
- Direct eye contact or side-to-side movements usually mean the person is listening.
- Looking down communicates feelings and feeling states. Be very sensitive when responding to a person who is experiencing extreme feelings.

Smile!

Have you ever realized that whenever you give a warm glance, a cheery hello, even a hearty laugh, any of these may shout your caring to those around you? Too often an assumption is made that only what one says is important. However, a research study concludes that the message people get will be influenced by: a) only seven percent of the content (the words), b) by 38 percent of the tone of voice, and c) 55 percent of the body language (facial expression, stance, etc.) Thus, the impact of facial expression and tone of voice far outweighs the contents of words.

The old saying, "Actions speak louder than words," really is true!

BEREAVED BILL OF RIGHTS

(Elizabeth J. Clark, Ph.D.)

- 1- The bereaved have a right to optimal and considerate care for their dying loved one.
- 2- The bereaved have a right to a compassionate pronouncement of the death and to respectful and professional care of the body of their loved one.
- 3- The bereaved have the right to view the body and to grieve at the bedside immediately following the death, if that is their wish.
- 4- The bereaved have a right to expect adequate and respectful professional care (both physical and emotional) for themselves at the time of their loved one's death.
- 5- The bereaved have a right (except when contraindicated legally) to not give consent to an autopsy, without coercion, regardless of how interesting or baffling the patient's disease.
- 6- The bereaved have the right to an adequate explanation of the cause of their loved one's death and to answers regarding the illness, treatment procedures and treatment failures.
- 7- The bereaved have the right to choose the type of funeral service most consistent with their wishes and financial means and not to be coerced into those which they are not supportive.
- 8- The bereaved have a right not to be exploited for financial gain or for educational or research purposes.
- 9- The bereaved have a right to observe religious and social mourning rituals according to their wishes and customs.
- 10- The bereaved have a right to openly express their grief, regardless of the cause of the loved one's death, suicide, and violent death included.

- 11- The bereaved have a right to expect health professionals to understand the process and characteristics of grief.
- 12- The bereaved have a right to education regarding coping with the process of grief.
- 13- The bereaved have a right to professional and lay bereavement support, including assistance regarding insurance, medical bills, and legal concerns.

THE TEN STAGES OF GRIEF

(Sister Teresa M. McIntier RN, MS and Nan R. Kenton, MA, MC. 1988)

- 1- **SHOCK:** This initial stage of grief is usually experienced, even if the death has been expected, as in a long, terminal illness. There is only so much physical or psychic pain which can be endured by the mind, and when that limit is reached, the mental/emotional system shuts down. There is often “numbness”, or a sense of unreality.
- 2- **EMOTIONAL RELEASE:** As the shock wears off, there is a need to release all the emotions which have been building up. This release may be verbal or physical, and while this is healthy, care should be taken to ensure the safety of the individual, others, or personal property. Some hospitals have recognized this stage of grief and have provided special “screaming rooms” where these powerful emotions can be safely vented.
- 3- **DEPRESSION:** There are often feelings of loneliness and utter isolation which come with depression. The feeling of “there is no help for me” is normal and very common. There is a push/pull situation, wanting to be alone and yet feeling a need for people at the same time. This frequently produces fears of panic and impending insanity.

- 4- PHYSICAL SYMPTOMS OF DISTRESS:** The grieving individual will often take on the physical symptoms of the illness which caused the death of the loved one. In the event of an accident, the bereaved will sometimes feel pressure in the chest or have stomach problems, and fear heart attack or cancer. This is normal and usually indicates the depth of the loss and the person wishing to “join” the deceased.
- 5- ANXIETY:** A common response to loss is for the bereaved to experience vivid dreams of the deceased, so vivid that they may believe they have actually seen or heard their loved one. Another common manifestation is that the bereaved will mistake another person for the deceased, usually on the street or in a store. This will sometimes cause great embarrassment as they may address the stranger, only to realize their mistake.
- 6- HOSTILITY:** When a loved one has died, it is very common for the survivor to feel anger at those who were involved in the situation, especially medical personnel and clergy. There is a feeling of “Why didn’t you do more?” God is a frequent target for this rage, which many people have a difficult time accepting.
- 7- GUILT:** This emotion can be imaginary or exaggerated, but should not be ignored. Following death, it is a common experience for the survivor to remember only the negative aspects of the relationship, those times of insensitivity or harsh words spoken in anger. Seldom does the bereaved pause and remember the beautiful times when all the love and tenderness were evident.
- 8- HESITANCY TO RENEW NORMAL ACTIVITIES:** There is often a fear of returning to the regular routine of living. This fear takes several aspects. There is concern about how people will respond to the bereaved; there is a desire to talk about the deceased but a fear of rejection; there is a pain that comes with hearing that “special” song, or seeing something in a store that brings back the memory of the loved one.

9- HEALING OF MEMORIES: There is a slow realization that the painful memories are part of the healing process and must be integrated into the life of the bereaved. It is a time of reaching out, however tentatively, to embrace fully all that has happened and to accept that life must change if it is to continue. The memories become less frightening, and the sky is a bit brighter as the bereaved begins to face the world with more and more confidences.

10- ACCEPTANCE OF ONE'S NEW ROLE IN LIFE: Loss brings about changes. Whether it is the assumption of single life after years of marriage, or going on through the years without a parent, there must be the realization that a new role is to be accepted and lived. The cycle of life continues, and the bereaved can finally shed the cloak of grief and take on the robe of peace and renewal.

11-

GUIDELINES TO HELP A CHILD DEAL WITH LOSS

(Brenda L. Scheatzle, M.C)

The mental health of dealing with grief is not denial of the tragedy, but acknowledgement of painful separation.

- 1- Enable the child to discuss the crisis before it strikes.
 - a) Talk in a quiet, honest, straightforward way to encourage further dialogue.
 - b) Begin at the child's level and remember your attitude is more important than your words.
 - c) Never tell the child what he will later need to unlearn.
- 2- Allow the child to give vent to his emotions of grief. Anger, tears, guilt, despair, and protest are all natural reaction to the family disorganization.

- 3- Encourage the child to discuss his innermost fantasies, fears, and feelings.
 - a) The child needs to talk, not be talked to.
 - b) Give the child every opportunity to reminisce about the absent person, and, if he or she desires, to express anger as well as affection.
- 4- Do not close the door to doubt, questioning and difference of opinion. The child's effort to find meaning in a time of acute stress can be very damaging.
 - a) Supply the child with simple facts rather than have him or her figure them out alone.
 - b) Be willing to struggle with the child as he or she tries to understand the disruption in the family unit. After all, *that's what living together involves*.
- 5- Respect the child's personality, for in the long run it is the child who must find his or her own answers to the problems of life and death.
- 6- Talking to a child about loss is often complex and disturbing. Seeking help is not an admission of weakness but a demonstration of strength and love.

The real challenge is not how to *explain* loss to your child, but how to *understand* and make peace with it yourself.

PRIVACY & CONFIDENTIALITY

The issue of Privacy relates to information or facts which the patient or resident chooses to keep to themselves. If there is something that the patient or resident choose not to share, the visitor must honour this as an inviolable and sacred choice. It is appropriate for the pastoral visitor to ask questions for clarification; probing beyond the patient's or resident's choice, is inappropriate.

The boundaries of Confidentiality are thus: No information or comments shared by the patient or resident is divulged by the visitor. Exceptions to this are: When the patient or resident has given his/her express permission. You must, for example, ask the patient or resident, "Can I include this in the church bulletin or prayers of the people?" There may be times in pastoral team meetings, when information about the patient or resident is shared, with their permission.

While it may seem harmless and within the bounds of confidentiality to speak about the patient or resident if names are withheld, or pseudonyms used, however, any information which serves as an 'identifier', is not to be divulged. Example: "I am visiting a church member who became a quadriplegic in a car accident last month". (This information potentially identifies the person to others—think 6 degrees of separation). It is inappropriate to tell others that someone is in hospital without the patient's permission (or their next of kin, if the patient is uncommunicative).

If a patient or resident has told you that they are planning to harm or kill themselves, it is your responsibility to report to their doctor that the patient or resident is in distress and ought to be assessed. If the patient or resident is unclear in their language, and you are unsure if they are contemplating suicide or self-harm, explain to them that you would like to know more. They may be 'normally' depressed due to their situation or condition.

PERSONAL BOUNDARIES

As a pastoral visitor, you must remain objective about your relationship with the patient or resident, and not become so involved, that the patient's or resident's problems become your own.

SELF CARE

"One cannot draw water from an empty well". In order to be able to enter into effective pastoral relationships, you must, above all, take care of yourself; adequate amounts of nutritious food, water, rest, sleep, relaxation, socialization, exercise, fun, and spiritual practices.