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CREATING CONGREGATIONAL CARE TEAMS AT ST. STEPHEN’S UNITED METHODIST CHURCH IN ALBUQUERQUE, NEW MEXICO

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ABSTRACT

Creating Congregational Care Teams at St. Stephen’s United Methodist Church in Albuquerque, New Mexico

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The purpose of this project is to create congregational care teams to serve the emotional and spiritual needs of the parishioners at St. Stephen’s United Methodist Church (SSUMC) in Albuquerque, New Mexico. Congregational care should be done by clergy and laity primarily to address and assuage those who suffer from emotional and spiritual distress. This paper will focus on three key areas.

In Part One, the historical contours of SSUMC’s past and its overall congregational care ministry will be explored. The importance of holistic care—body, mind, and spirit—will be examined within the church context. Currently, all congregational care is clergy-centered and focuses inwardly, stifling growth on all levels. However, one of the strengths of the congregation is its willingness to offer care, albeit on a limited basis.

In Part Two, theological literature and teachings relevant to this specific ministry challenge will be explored. The literature reviews will reflect the central and important role of clergy and laity in the long tradition of Christian soul care. A theology of congregational care from a biblical perspective will be introduced. This theology will be examined through a lens of cross-cultural compassion, applying tradition and experience through a narrative approach. Clear and concise communication is essential to ensure that all those who need spiritual care are not neglected.

Finally, in Part Three of this study, a ministry strategy that incorporates a pilot care team will be discussed. At SSUMC, the best practices of other pastoral care ministries will help form the foundation of the congregational care teams. The objective is for care teams to be transformed on a personal level, so that the tasks that they must perform become opportunities to release the power of prayer, healing, nurture, listening, and compassion. This ministry strategy will be assessed to determine its effectiveness.

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PART ONE

MINISTRY CONTEXT
INTRODUCTION

The purpose of this project is to create effective congregational care teams at St. Stephen’s United Methodist Church (SSUMC) in Albuquerque, New Mexico to serve the spiritual and emotional needs of the congregation. Serving as the associate pastor at SSUMC and the person in charge of congregational care has made me aware of the urgent need for improvements in our pastoral care ministry. There are two significant issues the congregation currently faces. First, pastoral care is primarily centered on the clergy, because the clergy is obligated by the orders of ordination in the United Methodist Church to be responsible for pastoral care. Second, the congregation lacks a clear and effective communication system. For example, some of the parishioners who need spiritual care are unintentionally neglected because of a lack of good communication.

My experience as a healthcare chaplain is at the heart of my conviction that SSUMC is in urgent need of improved congregational care. For two years I served as a board-certified hospital chaplain in Presbyterian Hospital in Albuquerque, New Mexico. I worked mostly in the Emergency Department (ED) as well as the Short-Term Surgical, Intensive Care, and General Medical Units. This experience as a caregiver has aided me in becoming acutely aware of the crucial nature of providing adequate pastoral care.

Like spiritual care in a hospital environment, pastoral care must relate intimately to the spiritual and emotional needs of each individual. For instance, the birth of a child requires sharing joyful moments with family members. Likewise, the loss of a loved one and the sorrow and suffering associated with it demand a minister’s participation in feelings of pain and grief with affected individuals.
My collective years of experience as a church pastor and tenure as a hospital chaplain contribute to the framework for this project.¹ Those who walk alongside the suffering play an important role as spiritual caregivers. Maintaining a positive attitude enables them to view the complex nature of the patient population not as an impediment but as a welcoming challenge. My perspective as an experienced pastoral caregiver has raised my awareness that the parishioners at SSUMC are not receiving the same level of pastoral care as those who are hospitalized.

In order to provide quality healthcare for every patient, EDs and hospitals in general rely heavily on the services of chaplains and other spiritual caregivers. Healthcare chaplains often find themselves helping to lay the foundation for the cultural bridge that the clients need. Then they join hands with all the medical staff and other spiritual care providers to complete the construction of the bridge. Chaplains accept responsibility for cooperating with all providers to ensure that the healthcare facility focuses on trust, inclusion, and reconciliation. The experience is both rewarding and fulfilling and is not just for the professional pastor or chaplain. Lay people in the Body of Christ can be mobilized to discover and train in these same gifts, so that they can care for others in their church.

In my present role as the associate pastor at SSUMC visiting and praying with congregants are of utmost importance. Those at SSUMC with hearts to comfort and a firm foundation in their walk with Christ can come alongside hurting people and be

¹ I have been a pastor for a total of eleven years, serving for the past two years as associate pastor at SSUMC. In addition, I have four years of experience as a chaplain.
present to listen to their stories of emotional and spiritual suffering. This is what provides the impetus to launch a congregational care ministry project at SSUMC.

Ostensibly offering an effective ministry of care will require decentralizing SSUMC’s current pastoral care ministry. In other words, caring for the congregation will be more effective if volunteers are recruited from the church body and trained in clinical pastoral education in order to minister to the emotional and spiritual needs of the congregation. The pastoral care department will be managed by me, as the associate pastor. Understanding the church’s current state and the potential for a vibrant spiritual care plan provides the catalyst for unraveling the existing structure in order to involve the laity more in congregational care.

Historically, the Methodist system of pastoral care was organized at the margins and not at the center of authority. Within the United Methodist Church, class meetings were the conduits for members of the local church to fellowship and care for one another. Class meetings provided a safe and sacred place for visitors and newcomers seeking to know more about the UMC and the local church to obtain adequate information to make a decision for Christ. From its inception, the Methodist movement grew with the institution of the class meetings. At SSUMC, like most UMC congregations, the class system has warped into small groups. However, the focus is no longer on conversions. This is coupled with the fact that churches rarely extend open invitation to discipleship after each sermon, so the number of conversions has diminished.

The class leaders and the members cared for one another and subsequently provided the pastor with information about parishioners’ emotional and spiritual well-being. Class meetings are currently nonexistent. However, the small groups at SSUMC
do not have the historical mandate of the class meetings. Consequently, the need to incorporate the best practices in developing effective congregational care teams at SSUMC has become quite pressing.

This ministry project seeks to meet this challenge. Part One of the project presents the need to develop a relevant pastoral care ministry that focuses on the spiritual and emotional needs of the parishioners at SSUMC. The current history of SSUMC and its overall congregational care ministry are examined. A study of Christian soul care also forms the foundation of the discussion and explores certain schools of thought regarding a congregational care ministry that just offers palliative comfort to parishioners. In particular, this study identifies and analyzes the forces that press parishioners on all sides and opens the door to discovering how to break the power that holds them down. It is important to move parishioners from an enslaved stance to a position of power and freedom. A basic church assessment will be conducted to identify salient historical factors that have contributed to the founding of SSUMC in Albuquerque, New Mexico in 1973.  

Since its founding, SSUMC has tried to live out the true meaning of the profound faith of St. Stephen, the first martyr in Christian history (Acts 6:34-36). St. Stephen had a deep spiritual walk and was very dedicated to faith in service (Acts 6:34-36). The fledgling mission church was forged on the anvil of risk with a foundation that was based on faith in service. The naming of SSUMC comes from Acts 8:54-60. Those who planted

\[\text{Molly Emkes, interview by author, Albuquerque, NM, 2018. Emkes is a founding church member. All historical information has been taken from this source, unless otherwise indicated.}\]
the church valued a clear sense of identity, a well-focused sense of mission, and the faith and desire to blaze the trail in the power of God’s Spirit and love.³

Currently, the parishioners enjoy pastoral care on a limited basis that is clergy centered. A healing service is conducted by one of the certified lay ministers (CLM) every quarter. However, more attention from leadership needs to be given to invigorate the miniscule participation and attendance. Congregational care ministry steadily evolves, like church members, on the way to perfection (Hebrew 6:1). Presently, there are opportunities to create new ways in which compassionate and culturally competent care can take place. This ministry is crucial since it informs discipleship and evangelism programs at SSUMC. In Part Two, the best practices of congregational caregiving will be examined. It conducts a literature review of key sources written to offer guidance and investigates best practices deployed by caregivers in the field of pastoral care ministry. This portion of the discussion seeks to understand how effective congregational care contributes to the overall pastoral care ministry of the local church. The section concludes by setting forth an informed theology of congregational care that is biblically grounded and calls for culturally competent and compassionate leadership that applies both tradition and experience.

In Part Three, a ministry plan will be presented. In this plan a pilot care team will be created, implemented, and sustained for six months. This project will lay the building blocks for actual congregational care teams to provide relevant, culturally sensitive, and competent spiritual care to the parishioners of SSUMC in Albuquerque. The pilot team will be comprised of three lay ministers, lay members, and the associate pastor. This pilot

³ Ibid.
team will be trained and then assigned teams of their own, consisting of lay members who have been screened and affirmed for spiritual care ministry. The team leaders will be responsible for shepherding and leading the individual members of their team.

There will be ongoing training in the initial six months of the implementation of this project. Thereafter, quarterly training sessions will be held to sharpen the skills and knowledge of the congregational care ministers. As the church grows and the demand for more congregational care ministers ensues, it will be necessary to provide more training on the delivery of spiritual and emotional care.

SSUMC is blessed with a vast array of resources. Its strengths include local and global missionary projects. SSUMC was publicly lauded for its missionary endeavors at the 2011 gathering of the New Mexico Annual Conference of the United Methodist Church. The church has maintained successful stewardship campaigns, steady decline in membership notwithstanding. Although the congregation has thirty-five active and functional small groups with an average of ten people in each that provides limited congregational care, it is necessary to impart knowledge to establish an organic congregational care ministry.

Establishing congregational care teams can provide a powerful catalyst for diversity and systemic inclusion in discipleship and evangelism on one hand and spiritual and emotional care on the other. The church has a sustainable outreach to the city of Albuquerque through its various ministries. However, these ministries do not coincide with the mission of discipleship and evangelism, which focuses on reaching across ethno-cultural and socioeconomic boundaries. The need for cultural competence and humility has

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never been more necessary at SSUMC, where the benefits for congregational care can be immeasurable.

Currently, SSUMC can be described as a predominantly Anglo, aging, and female congregation. However, if the congregation is to intensify its ministry of evangelism and discipleship, cultural sensitivity must be a vital component of the church. True vitality of a church, according to Jorge Acevedo, “is not an institutional survival but what Jesus described to his followers as Kingdom life.”\(^5\) The current vital signs at SSUMC do not reveal a lack of institutional vitality, but there is lackluster disposition amongst some parishioners when it comes to evangelism and spiritual growth. Hence, there is a need to foster congregational vitality and transformation in the life of SSUMC.

The present discussion will focus on how best to develop a plan for responding to the congregational needs of SSUMC. Successful models and best practices of other ministries will be used as an informational springboard to create the strategy for meeting the needs of SSUMC parishioners. Selective methodologies will be deployed to launch the congregational care project at SSUMC. This project also will look for opportunities to partner with other areas of ministry to provide ongoing pastoral and lay leadership.\(^6\) The roles of the pastors and the congregation will be clearly delineated. Finally, an assessment will be conducted to consider modifications in the plan.

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\(^6\) Ibid., 12-13.
CHAPTER 1

SOUL CARE AT ST. STEPHEN’S UNITED METHODIST CHURCH

Since SSUMC was founded, there has been a lack of systemic congregational care teams. The last attempt at implementing a care team was initiated by a retired Lutheran pastor, who was recruited by the senior pastor of SSUMC to serve as his associate.¹ Both of these ministers have been gone for more than a decade. Presently, there exists a great need to develop a pastoral care ministry to serve the emotional and spiritual needs of this congregation of approximately 600 members.² The difficulties in parishioners’ lives plead for care, counseling, and spiritual direction because no one can avoid the challenges of life. This chapter offers a brief overview of the founding of SSUMC and its present pastoral care ministry. The congregation’s current strengths and weaknesses also will be examined.


² Holly Sikorski, SSUMC Leadership Council Reports: 2005-2017 (Albuquerque, NM: St. Stephen’s United Methodist Church, January 30, 2018); Holly Sikorski, interview by author, Albuquerque, NM, 2018. SSUMC archives are maintained by Sikorski, who serves as executive assistant and director of SSUMC’s Data and Communications.
Brief Overview of St. Stephen’s United Methodist Church

One of the most important aspects of St. Stephen’s history is found in its beginnings. SSUMC is the result of a gift—actually, several gifts. The Methodist churches in Albuquerque contributed in one way or another to the planting of this new congregation. Members of various congregations went door to door in the area near the proposed church location to tell people a new congregation was coming; and fellow churches donated furniture, altar equipment, hymnals, and Sunday school materials. In fact, a communion set which is still in use today was donated by the youth group at First United Methodist Church.\(^3\)

The new congregation of fifty members first met at the Mountainside YMCA in the northeast area of Albuquerque, until their new building was completed in the month of November in 1974. The original building is now a part of the current fellowship hall.\(^4\) Even the land was a gift. A young congregation of approximately fifty worshipers depended on the generosity of others to be able to afford the church’s five-acre plot of land in the sprawling and expensive far northeast area of Albuquerque. Nearly two years later, the congregation received another generous gift in the form of a building, which became affectionately known as the Yuko Stucco. The building provided much needed classroom space. It still sits in the same place where the old worship center now is located.\(^5\)

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\(^3\) Emkes, interview.

\(^4\) Ibid.

\(^5\) Ibid.
Over the years various capital campaigns added a sanctuary, an education wing, staff offices, and classrooms. The final building program saw the addition of the current sanctuary. In the last forty years the worship services have increased from one service to three services on Sunday morning. In addition, on Saturdays an outreach ministry for the unchurched is held. This outreach is known as the Solid Grounds Coffeehouse.6

The history and founding of SUMC also included a strong emphasis on local and global missions and service. SSUMC has participated in and supported many missionary projects at local, national, and international levels. There have been trips to the Ukraine, excursions to the Four Corners area of New Mexico, and even outreach into the Navajo Nation. Congregants have taken several trips to Nicaragua to build a training school for construction students and have visited Mexico, Peru, India, and Kenya to assist in the education of youth—with a particular focus on female students. SSUMC continues to support various local and international missionaries.

The leadership of SSUMC has served the congregation well in the last four decades. The pastors who have served at SSUMC and the ministry of the congregation have made a big difference in the local community and even in the world. It has been the gift of service, time, and resources from individuals who have provided a place for the church to grow spiritually, within community, and in service to the Lord. In general, congregants appear to be satisfied with the ministry at the church.

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In examining SSUMC over the decades, one thing is clear. The church is intentional about missionary activities as a result of the generosity experienced from various local churches in the Albuquerque vicinity. The initial fervor for missions and for making disciples of Jesus Christ for the transformation of the world established a foundation for spiritual formation and church growth. In 1973 SSUMC was founded in response to the need for a Christ-centered church in the far northeast heights in order to help people find new meaning, purpose, and direction for their lives. The residents who live in the vicinity of the church readily responded to the congregation. Consequently, by 1980, the church was experiencing growth and grew from 50 to 320 members, with over 260 adults.\footnote{Kenneth Thiel, \textit{SSUMC Annual Reports} (Albuquerque, NM: St. Stephen’s United Methodist Church, 1975-1980).}

However, the late 1990s brought a wave of change to Albuquerque. The affluent landscape of the northeast heights continued to attract people and new church plants, creating an unwelcomed competition for SSUMC. The northeast side has become oversaturated and growth can only go east over the Sandia mountains or west across the Rio Grande river. New home construction and more affordable housing have shifted to the Westside of Albuquerque. This shift has resulted in a gradual decline in membership and shrinking attendance at SSUMC.

The economic and demographic changes of the last twenty-five years also have brought significant religious influx to the community. Sixty-three other churches planted
after St. Stephen’s in the same community created a competition for membership.\textsuperscript{8} SSUMC was not prepared for this.

Paradoxically, the geometric growth in membership that has been enjoyed by SSUMC has come largely from other UMC members who chose proximity to SSUMC over loyalty to their former congregations. The growth was not entirely due to the influx of new converts. Consequently, the church needs to generate sufficient enthusiasm for evangelizing all the people. The leadership council has made several attempts to infuse new life into its evangelistic activities, yet the congregation continues to express a desire to look inwardly and disciple existing members. The leadership council, however, cannot afford to ignore change and just maintain the status quo.

While the church currently is holding its own, people are not flocking to join. The congregation has not added any new converts in a while. It has gone from a watermark of 700 members in the early 2000s to a current membership of 525.\textsuperscript{9} Hence, there is a deep need for due diligence in creating and adopting strategies to explore avenues for growth.

\textbf{The Need for Healing}

Currently, there is a strong need to expand healing services at SSMUC that will include more congregational care ministers from amongst the laity. A healing service is conducted by one of the certified lay ministers on a quarterly basis. Unfortunately, only a small number of parishioners attend. The congregation at SSMUC needs to be reminded

\textsuperscript{8} Will Steinsiek, \textit{New Mexico Annual Conference Report of Local Churches} (Albuquerque, NM: The United Methodist Church, May 2011), 12-13.

\textsuperscript{9} Sikorski, \textit{SSUMC Leadership Council Reports}; Sikorski, interview.
that Christ set an example for Christians by devoting a great deal of his time to healing. His healing ministry included not only his followers but also strangers (Luke 7:2; 13:24; Matthew 12:15). Healing for me is the process by which a person experiences physical, emotional, and spiritual wholeness. Essentially, there are two key areas in which congregants at SSUMC demonstrate a need for healing. These areas consist of emotional and spiritual healing. Currently, parishioners’ hunger for emotional and spiritual balance. However, when the congregation become more diversified, ethnocultural healing might become a key component of congregational care.

**Emotional Healing**

Emotional healing helps congregants overcome feelings of anger, anxiety, and fear. Since SSUMC is an aging congregation, requests are often made for physical and emotional healing. Many members of the congregation undergo surgery for various reasons. So the need for emotional healing is frequently on their minds as they face physical limitations, due to the reality of aging. In addition, the congregants at SSUMC experience their share of grief due to multiple funeral services throughout the year.

Some of the congregants also have shared their concerns of broken relationships with parents and children. There appears to be aloneness, depression, and lack of forgiveness. These unresolved emotional experiences have caused congregants to become stagnant. This calls for a ministry of reconciliation, as instructed by the apostle Paul in 2 Corinthians 5:18.10

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10 A theological perspective regarding healing and soul care is presented in Part Two of this discussion.
C. E. Izard declares that “the influence of emotional experience on perception, cognition, and action has been demonstrated in a number of investigations.” According to behavioral experts, the impact of emotion on empathy, sadness, and grief are critical in maintaining family and community cohesiveness. Regarding the “experience” of emotion, Izard asserts the following:

There is substantial empirical support for the assumption that each of the emotions of human experience has adaptive, motivational functions. For example, interest motivates learning, exploration, and creative endeavors. Joy facilitates social interaction and alleviates stress. Anger mobilizes energy for action against frustrating barriers which may include insults to personal integrity and oppression. Anger’s power to energize and activate can prevent the sadness from becoming totally immobilizing and overwhelming. Shame motivates development of skills and competencies that strengthen the self and make it less vulnerable to humiliation. Shame can ameliorate depression by motivating self-protective and self-strengthening behaviors, counteracting the loss of self-esteem that often figures in the etiology of the disorder. Guilt, believed by some to be a fundamental emotion despite its lack of characteristic expression, fosters reparation and the development of a sense of personal responsibility.

Emotional healing, therefore, consists of normalizing the emotional concerns of the congregants. This type of healing is supported by empathic listening. Currently, many SSUMC congregants lack a proper understanding of the adaptive and motivational functions of emotions and the power of healing. The laity who are called to function as caregivers can offer a valuable ministry to the congregants with intense emotional concerns.

**Spiritual Healing**

For the purposes of this discussion, spiritual healing is viewed as healing that is accomplished through prayers and the faith of congregants and clergy. “The agent of

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12 Ibid.
healing is perceived to be the Spirit of God . . . and usually to take the form of a religious experience. Access to the spiritual realm is potentially open to everyone.”

People who need spiritual healing are in danger of developing unhealthy mental attitudes. A strong relationship with God depends on a healthy mind that dwells on positive thoughts rather than on unwholesome concepts. Ralph Waldo Trine sheds light on the relationship between spiritual and mental health. He posits: “Full, rich, and abounding health is the normal and natural condition of life. In the degree that we live in harmony with higher laws of our being, and so, in the degree that we become better acquainted with the powers of the mind and spirit, we will give less attention to the body—no less care, but less attention.”

While parishioners can benefit from participating in a spiritual healing service, attendance at such a service does not guarantee they may experience healing or that they will maintain a personal relationship with God. These services usually last thirty to forty-five minutes. Interested congregants gather in the sanctuary and, depending on the number of attendees, the two other certified lay ministers and members of the prayer team are included in the service as caregivers. Attendees are paired with caregivers. Caregivers create a safe space for the attendees, on one-on-one basis, to cast their cares on the Lord, for He cares about them (1 Peter 5:7). Spiritual healing is believed to be bestowed by having faith in God.

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13 Ibid., s.vv. “Faith Healing.”

14 Ralph Waldo Trine, In Tune with the Infinite or Fullness of Peace, Power, and Plenty (Indianapolis: Bobbs-Merrill Company, 2015), 89.
SSUMC congregants demonstrate spiritual distress and a need for spiritual healing when they articulate concerns of theodicy, that is when they attempt to reconcile suffering with the idea that God is both all-loving and all-powerful (Hebrews 1:3). Some congregants question their faith and even perceive their illness to be a punishment for disobeying God’s laws (Romans 13:4; 1 Chronicles 21:10). Others remark that they must have fallen from God’s grace, because God has not answered their prayers (Galatians 5:4). A sense of powerlessness on occasion is manifested by congregants prompting a need for them to reach out for new meaning and frame of reference to experience faith, hope, and love. Congregants in need of spiritual healing as an intervention usually will request a meeting with clergy to share their stories and facilitate intense and continuous prayers in order to start on the path to healing. The ministry of presence is a vital intervention for spiritual healing. Consequently, it is important for congregational caregivers to embody the presence and compassion of Christ (Ephesians 5:2), as they seek to understand the suffering of others.

A broad definition of spirituality describes how people find meaning, purpose, and direction for life. For the members of SSUMC, God needs to equal life, because he lives in believers now and forever (1 Corinthians 15:46). “Jesus’ act of healing reveals his compassion for the sick and his perception of sickness as a symptom of evil in the world. In the healing work of Jesus he himself becomes a sign of God’s presence in the midst of disease and death.”¹⁵ This type of healing involves improving the health of the human spirit by means of prayer or other “extranormal states of consciousness, usually

occurring apart from orthodox medicine and considered miraculous.”

Central to the understanding of spiritual healing for the congregants at SSUMC is the passage in James 5:13-16:

Is anyone among you suffering? He is to sing praises [to God]. Is anyone among you sick? He must call for the elders (spiritual leaders) of the church and they are to pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will restore the one who is sick, and the Lord will raise him up; and if he has committed sins, he will be forgiven. Therefore, confess your sins to one another, and pray for one another, that you may be healed and restored.\(^{17}\)

For this reason, SSUMC healing services include the anointing of oil and the laying of hands. Prayers of comfort are offered along with pastoral counseling. Congregants place their faith in the transforming power of God to forgive their sins and heal their diseases. Improved health and wellness of body, mind, and spirit is a matter of radical dependence on God. The congregants at SSUMC need to become more aware of how spiritual healing impacts their mind and body. In the same way, caregivers at SSUMC should enhance their ability to do spiritual assessment.

Caregivers at SSUMC should try to understand the existential concerns of congregants before developing an appropriate spiritual intervention. As with any relationship, the building and the maintenance of trust is critical from the outset and throughout the relationship. It is not necessarily what is said in the encounter but what happens that predetermines the trust level and engenders healing.

\(^{16}\) Ibid.

\(^{17}\) All Scripture is taken from *The Holy Bible: Amplified Version* (Grand Rapids, MI: Zondervan, 1987), unless otherwise noted.
Beliefs formulate the worldviews by which congregants ascertain the meaning of their illness. Some of these worldviews emphasize the divine principles that can lead those who are hurting into fresh dimensions of meaning and the power of the Holy Spirit within them. These worldviews also provide congregants the understanding of how spiritual laws govern spiritual health and well-being. However, the prevailing assumptions of modern scientific interventions are constantly at odds with spiritual healing, because the physical and tangible have become the new reality. In 2 Corinthians 5:7, the apostle Paul encourages believers to live by faith and not by sight. Many SSUMC congregants need prayer, visitation, meditation, and other appropriate spiritual disciplines to overcome total dependence on scientific reasoning. It is important that believers stand on their faith and hope in Christ to embrace their own spiritual healing.

Ethno-cultural Healing

Another type of healing that is related to the needs of SSUMC’s parishioners is ethno-cultural healing. Ethno-cultural healing may be defined as healing that focuses on issues that are intertwined with the way the dominant culture deals with people of different races, religions, social classes, and gender.\(^{18}\) The demographics of the communities surrounding SSUMC warrant serious consideration for implementing a congregational care ministry that is sensitive to ethno-cultural differences.\(^{19}\)

\(^{18}\) This definition has been adapted from Dictionary of Pastoral Care and Counseling, 1990 ed., s.vv. “Cultural and Ethnic Factors in Pastoral Care.”

\(^{19}\) Details regarding specific demographic information are provided later in this same chapter.
Typically, the leader of pastoral care at SSMUC has been a male member of the mainstream culture who speaks only English. Most of the people who recently have moved into the area where SSMUC is located are of diverse backgrounds. Many are multilingual and appear to be strongly influenced by a wide range of cultural beliefs and faith traditions. As SSUMC congregants approach the church building, they can hear neighbors who recently have moved into the community speaking Spanish, Chinese, Vietnamese, Russian, and various African languages. Many tend to be religious, as attested by the presence of churches, temples, synagogues, and mosques in the area. However, SSUMC has stayed and continues to remain monolingual and monocultural. Existing plans for church growth and evangelism hardly mention cultural diversity. Most congregants at SSUMC are more likely to shy away from people who do not look, dress, or sound like them.

To reach out to those who are culturally diverse in the community, SSMUC congregational care ministers need to consider developing an ethno-cultural healing ministry. Ethno-cultural healing requires mastery of active, empathic listening. If people send and receive messages that have different meanings, the purpose of the communication will be diminished. Therefore, care ministers at SSUMC will need to prepare themselves by learning to recognize, understand, and accept cultural differences. This process involves caregivers identifying their own biases and cultural differences. "While it may be clear that communication is enhanced when there is a similar worldview, this similarity in itself is not sufficient, due to intercultural and intra-ethnic diversity and
other factors such as race, social class, sex, gender, religion.” Currently, SSUMC congregants lack specific information about various ethnicities and cultures to avoid stereotyping. SSUMC has been in existence for forty-five years and never has reflected a diversity beyond the dominant church culture. Generally, whenever congregants bring visitors to services at SSUMC, the visitors tend to look and behave like the congregants. On the rare occasions when visitors from other races and cultures visit SSUMC, many congregants are at loss on how to interact with them.

SSUMC congregants need to learn about differences between ethnic and cultural groups, in order to remain relevant and active in present-day ministry. The training of congregational care volunteers also will include the value of cultural diversity and cultural sensitivity, respectively. This aspect of congregational care might appear daunting, but it is unavoidable in light of the reality of the growing diversity within the surrounding community. Cultural competence and humility should be a standard curriculum in preparing congregational care ministers in a congregation located in a multicultural community.

**Current Strengths of SSUMC**

SSUMC has been endowed with tremendous potential and possibilities. On March 24, 2018, at a regularly scheduled leadership council meeting, a request to identify the strengths and weaknesses of the church was made by the associate pastor. The leadership council identified the following strengths of the church: outreach, missions,
small groups, pastoral care, great location, great music ministry, church-wide events, Vacation Bible School (VBS), and vibrant worship services. The leadership council is comprised of the chair of the leadership council, the senior pastor, the associate pastor, and the chair of the staff parish relations council. Other members of the council include the directors of lay ministry, youth and children ministry, worship and music, the chair of the finance committee, the finance administrator, the lay leader, and six members at large. At each meeting, one of the at-large members serves as secretary. The leadership council and the congregation support both the vision and the mission of the church.

SSUMC has one of the prime locations in Albuquerque. It is flanked by a high school and is located in a high per-capita income section of Albuquerque, with an average household income of $73,943 per year.\(^{21}\) Within a mile of the church is the Tanoan Country Club along with exclusive golf courses and a private subdivision populated with luxurious and expensive homes. The church is also close to schools, mixed-use housing, expensive residences, businesses, shopping centers and strip malls, and various supermarkets. All of these are within a five-mile radius of the church. These features attract highly educated residents into the community, with 92.1 percent of the population aged twenty-five and over having graduated from high school and 39.7 percent of the same age group having graduated from college.\(^{22}\) Consequently, all of this provides for a steady supply of new people into the area.


\(^{22}\) Ibid., 8.
Three worship services offer a variety of worship styles from which to choose. All Sunday services last for one hour. The 8:00 a.m. and 9:30 a.m. services target early risers and the millennials, while the 11:00 a.m. service caters to traditional parishioners. Daycare is provided for families in a modern facility, where nursing mothers have a private room in which to provide nurture for their babies. People with disabilities are accommodated as well.

The children’s ministry offers biblical curriculum and programs tailored to all age groups. The youth have ongoing spiritual formation classes as well as social outings and activities. Youth Sundays are held every fifth Sunday. On these days, the youth plan and conduct every aspect of the service with guidance from the director of youth ministries. More active youth in the youth ministry would contribute to a much-needed variety in speaker selection and a youth choir, respectively.

The music ministry, under the talented leadership of the worship leader, offers a spiritual and uplifting worship experience for all attendees of the different services. The praise band is filled with great talent and resources. There is a vocal choir as well as a hand bell choir. The presence of all these components in the worship services generates a rich worship experience.

The pastoral staff diligently prepares relevant sermons that speak to the needs of the worshipers and challenges them to move into a new and different reality in their relationships with God and one another. Most sermons align with the vision and mission of the church, while aiming to meet the existential and spiritual needs of the congregation to make disciples of Jesus Christ for the transformation of the world. The Book of Discipline defines what is expected of UMC laity and clergy as they seek to be effective
witnesses in the world as a part of the whole Body of Christ, which is essentially to demonstrate faith and love in action.

Pastors provide counseling to parishioners as needed and coordinate their efforts with a volunteer team. As a board-certified hospital chaplain, in addition to being associate pastor, I provide insights on dealing with parishioners who are experiencing pain, suffering, or the loss of a loved one. Subsequent counseling sessions may be scheduled with the associate pastor and/or the senior pastor, when and if requested.

Various Bible study classes meet throughout the week at different times at the church as well as in the homes of small group leaders. Under the direction of an able and talented coordinator, Sunday school is organized around thirty-five functioning small groups with an average membership of ten. The dialogue may be described as candid, constructive, friendly, and centered on what really matters to the group. Their focus involves faith development and fellowship as well as service to the church, community, and the world. Small groups also engage in discipleship, shared special interests, and recreation and serve as ministry team.

Vacation Bible School has selected a strong team of volunteers under the capable leadership of the director of youth and children ministries. Jo Lynne Anderson, the director of VBS posits that “VBS averages a little over a hundred children and a team of enthusiastic volunteers.” Attracting more families to the church could increase the

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24 Ibid., 54.

numbers of youth and children. All the young people who attend VBS seem to enjoy their participation.

**Areas in Need of Improvement**

When the leadership council met on March 24, 2018, a verbal survey on the strengths of SSUMC was conducted. In addition, a discussion followed on the four areas of the church in need of improvement. These four areas included membership and attendance, the budget, discipleship, and congregational care.

Due to the decrease of 225 members in the church over a twelve-year period, the council is naturally concerned that membership will continue to spiral downwards because attendance has been declining steadily. Average attendance of all three services has dwindled from 400 to 270.26 The council has yet to identify the factors contributing to shrinking membership and attendance. There is great interest in finding the cause and addressing it. The leadership of the church could focus more on discipleship and the effectiveness of our evangelistic efforts.

According to the finance administrator, although the church budget is fairly healthy, it is somewhat burdened with a bond debt of $250,000 with no plans to retire the debt.27 A $250,000 debt against a million-dollar budget makes it rather difficult to recruit and retain great talent for running the various aspects of the ministry at the church.

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27 Finance Administrator, *SSUMC Financial Records* (Albuquerque, NM: St. Stephen’s United Methodist Church, 2018). Records are maintained by the Finance Committee, under the leadership of the administrator.
Consequently, the limited staff is overworked, making it difficult to even recruit and sustain volunteers for the different church ministries.

Youth and children ministry is operating with a part-time director, who handles the many operational demands of both youth and children, as a cost-cutting strategy to mitigate the relatively large size of the church’s payroll. The church appears to be solvent on paper—however, not solvent in membership and attendance. Each ministry needs its own full-time director in order to fulfill its mission. Today VBS is serving dwindling numbers of children. The youth ministry is experiencing a similar fate.

One of the primary concerns is that currently SSUMC’s membership is predominantly female, Anglo, and aging. If the church is to intensify its ministry of evangelism and discipleship, cultural sensitivity must be deeply rooted in the DNA of the congregation. In spite of the steady decline in membership, SSMUC continues to enjoy a successful stewardship program. The thirty-five functional small groups provide limited congregational care, despite the lack of knowledge to launch an organic congregational care ministry. It is anticipated that the creation of the congregational care teams could serve as a catalyst for diversity and systemic inclusion in discipleship and evangelism as well as spiritual and emotional care. Thus, the teams must be able to transcend all barriers in order to connect with the surrounding community.

Of the total population in the surrounding community, between 2010 and 2015, the White population decreased by 1,767 persons, a 2.3 percent decrease of the total population. In contrast, the total Hispanic population increased by 4,971 persons, which

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represents 1.4 percent of the total population. The Asian/Other population increased by 2,069 persons, a 0.8 percent increase; and the Black population increased by 652 persons, a 0.2 percent increase of the overall population. Based upon the total number of different groups present, the racial/ethnic diversity in the area is extremely high—and this trend is projected to continue.29

SSUMC should be intentional about discipling all congregants regardless of ethnicity or culture. This means motivating the congregation to care for one another and then going beyond the four walls of the physical church building to get to know their neighbors. By learning from them, SSUMC can become equipped to disciple their neighbors from different cultures.

One’s body and spirit are affected by decisions and deeds. In order to offer proper congregational care, the ministry must be scripturally sound and the caregivers must be imitators of God, as the apostle Paul exhorts believers to be. In Ephesians 5:1 he writes: “Imitate God, therefore, in everything you do, because you are His dear children.” Additionally, incorporating spiritual and emotional dimensions in the practice of pastoral care becomes necessary, since every person expresses and experiences crises differently.

Such spiritual and emotional dimensions are important for church vitality. As an author and UMC pastor of three churches in the Florida Annual Conference of the UMC, Acevedo can help SSUMC to fully understand the benefits of congregational vitality. His

29 Ibid.
research reveals that a congregation that has good vital signs vibrates with excitement. He observes:

[Such] measures of fruitfulness [are] evident in church attendance and number of converts, faith and spiritual formation; ministry activities through small groups and other auxiliaries for the implementation and sustainability of church growth and transformation of the church; and stories that are being told about transformed lives and ministries through the congregation. The combination of all three vital signs indicate high vitality and kingdom life.\(^{30}\)

Acevedo goes on to point out that a vital congregation lives out its creed to make and equip disciples, who in turn will “make and mature disciples, grow over time, and engage disciples in community and world ministry that is transforming lives and addressing social issues. Vital congregations not only practice the Wesleyan means of grace but become the grace of Jesus Christ in the world.”\(^{31}\) Experiencing and effectively communicating “the grace of Jesus Christ in the world” is what SSUMC seeks to do.

Chapter 2 considers how this can be done effectively through congregational care.

\(^{30}\) Acevedo, *Vital*, 11.

\(^{31}\) Ibid.
PART TWO

THEOLOGICAL REFLECTION
CHAPTER 2
LITERATURE REVIEW

This chapter will review a variety of literature to explore and understand how effective congregational care contributes to overall pastoral ministry of the local church. The traditional marks of pastoral care ministry will be reviewed in Charles V. Gerkin and Jeanne Stevenson-Moessner’s works. This discussion will introduce a case for the rediscovery of congregational care in The Caring Congregation by Karen Lampe and Spiritual Care in Practice by George Fitchett and Steve Nolan. Finally, the last two reviews will explore books on listening and pastoral counseling by James E. Miller and David G. Benner, respectively. Ultimately, the chapter will seek to understand how best practices of existing pastoral and spiritual care practices can help church leaders to equip the laity in offering holistic care to the rest of the congregation. Furthermore, this chapter will demonstrate a clear and strong justification for the selected resources and how they relate to the ministry project.
The Caring Congregation: How to Become One and Why It Matters
by Karen Lampe

Lampe has become well known for developing some of the best practices for helping to improve congregational care ministries. The thesis of this project has a meaningful connection with the author and the title of the book, The Caring Congregation: How to Become One and Why It Matters.¹ Lampe is an executive pastor at the United Methodist Church of the Resurrection in Leawood, Kansas. She has created a model pastoral care ministry at her church and offers valuable insights that can help not only in the creation but implementation of a care ministry at SSUMC. In the Introduction of this present discussion, it was made abundantly clear why developing a caring congregation matters at SSMUC. The UMC instructs all its churches to offer emotional and spiritual support to parishioners. Essentially, creating a congregational care ministry is a mandate in the United Methodist Church.²

Lampe makes a strong case for developing care teams. She points out that many congregations rely only on pastors for counseling and care. However, pastors often are limited by time constraints and can be overwhelmed by the range and the extent of congregational needs. She refers to clergy-centered pastoral care as “Lone Ranger Care” ministry and asserts that this approach invites failure, even in small congregations.³ Churches, regardless of their size, should reach out to the membership and encourage

² United Methodist Church, Book of Discipline, 159-160.
³ Lampe, The Caring Congregation, xii.
them to serve as caregivers. Instead of caregivers functioning as individuals in ministry, Lampe advocates creating care teams.\textsuperscript{4}

In her discussion of creating congregational care teams, Lampe stresses the importance of screening and training volunteers and recommends clergy conduct a needs assessment.\textsuperscript{5} The assessment should take a snapshot of the emotional and spiritual needs of the church to ascertain how to care for the congregation. Based on the church’s specific needs, the right people then can be recruited and trained. Not every congregant is suited to provide pastoral care, even if the person means well. For this reason, the screening process is extremely important. It is vital for the pastoral team to ensure that the volunteers are intelligent, receptive to training, and have the capacity to lead and serve their fellow Christians with compassion.\textsuperscript{6}

After the selection has been made, the important task of training the volunteers begins. Lampe advocates focusing on four key areas: prayer ministry,\textsuperscript{7} support ministry,\textsuperscript{8} hospital visitation,\textsuperscript{9} and grief and death ministry.\textsuperscript{10} In particular, creating congregational care teams for hospital visitation and grief and death ministry would be useful at SSUMC. Since the church has a high number of aging congregants, more parishioners

\textsuperscript{4} Ibid.
\textsuperscript{5} Ibid.
\textsuperscript{6} Ibid., 23.
\textsuperscript{7} Ibid., 1-14.
\textsuperscript{8} Ibid., 15-40.
\textsuperscript{9} Ibid., 41-56.
\textsuperscript{10} Ibid., 57-72.
would have their unique emotional and spiritual needs met. Lampe identifies hospital visitation as crucial to the authenticity of pastoral care ministry at the local level. She also offers clear instructions for carrying out hospital visits. Lampe indicates that every hospital visit should always be bathed in prayer, due to its complexity. In addition, she stresses the importance of clear and effective communication channels to ensure all the people are receiving pastoral care when needed.

Lampe highlights the importance of empathic listening and defines it as walking in the shoes of people who need care, so they feel they have been heard. Her resources include training on active listening, and she underscores an empathic ear. The caregiver has to be able to walk intimately and in an understanding way with the person who needs the care. This means being there for the needy, instead of merely performing tasks. Lampe also highlights the importance and benefits of pastoral counseling in the overall pastoral ministry of the church. She stresses the need for creating boundaries and offering a safe space for empathic listening. Empathic listening offers compassion and sympathy. Lampe says that listening creates a sacred place for pastoral response.

Congregational care is crucial, because life is replete with suffering on all levels and requires a healing shoulder for those needing spiritual care as well as direction and comfort in their darkest moments. Lampe agrees and states, “Life is messy and painful and no one can avoid the grief and loss that happens in all of our lives at some point.” She is convinced that the volunteers can provide continuous and compassionate care because, as

11 Ibid., 28-30.
12 Ibid., 26-32.
13 Ibid., ix.
Christians, they can understand how compassion and healing emanated from Jesus’ earthly ministry when he healed the sick (Luke 4:40), saved the lost (Luke 19:10), and comforted the wounded and the sorrowful (2 Corinthians 1:5-6). Therefore, anyone who is a Christian caregiver must always look for “ways to be transformed into a Christ-like healer.”

Lampe advises Christians to review their own experiences as a means to equip them to acknowledge the humanness of other people and to offer pastoral response. This means teaching SSUMC caregivers how to minister out of their own lives. Lampe’s book supplies concrete stories that illustrate how experiences can be used in delivering care. She explains how to transform congregational care ministries from simply performing tasks into seizing opportunities to release the power of prayer, healing, nurturing, and Christian community.

Additionally, she offers useful tools that are needed to connect with people who are crying out for healing and compassion. These tools include setting ethical boundaries, providing clarity, offering sympathy, reflection, comfort, and making certain the person feels heard. Lampe strongly feels that healing deals with the entire body and all of its aspects: mind, body, and spirit. She asserts that healers have to learn to be contextual in order to determine the people’s physical, emotional, and spiritual health.

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14 Ibid., xi.
15 Ibid., 28-30.
16 Ibid., xiv.
17 Ibid., 28-32.
18 Ibid., 42.
It is recommended that exceptional caution be exercised to ensure that volunteers do not feel somewhat rejected, if they are not selected as caregivers. The plan should always inform volunteers that they may serve the needs of congregants in other ministries in the church if they are not selected for the congregational care ministry. All volunteers should be made to feel that their services are needed and appreciated.\footnote{Ibid., 22-24.}

Moreover, Lampe suggests that each volunteer selected for a care team be required to write a spiritual biography and to include it in the application form.\footnote{Ibid.} Upon selecting the qualified volunteers for the care ministry, the church should submit the applicant to a background check and complete an ethics training titled “Safe Sanctuary” policy in the UMC.\footnote{Ibid., 25.} This fits easily within SSUMC’s framework, as applications and specialized training could be offered during the fall to prepare volunteers to attend to congregants by the spring.

Lampe points out that a major result of congregational care is church growth. Previously, it was mentioned that the quest for help was largely tied to the current concern about the decrease in membership and shrinking attendance. Deploying the tools and best practices offered by Lampe in this book and making them a permanent part of SSUMC can help jumpstart evangelism and membership growth over time. A fair amount of confidence can be harnessed to begin addressing some of the congregation’s current caregiving problems.
*The Caring Congregation* is a particularly useful resource for St. Stephen’s United Methodist Church, as Lampe’s step-by-step instructions on how to offer outstanding pastoral care through congregational care teams are affirmed by UMC theologians. The testimonies of respected leaders like Adam Hamilton and Bishop Scott J. Jones provide a valuable guide and encouragement for embarking on this ministry project.\(^{22}\) Additionally, Lampe suggests valuable resources and tools for mitigating the ministry challenge at SSUMC, because her book draws from relevant and current UMC polity and doctrine. The book provides pragmatic instructions on how SSUMC can develop its congregational care, so all parishioners are adequately served and membership and attendance can increase. The only limitation of Lampe’s resource is the absence of features regarding clinical pastoral education—such as spiritual screening and assessment as well as theory of pastoral care and practice—although these topics were not the stated focus of her resource.

*Spiritual Care in Practice: Case Studies in Chaplaincy*

*by George Fitchett and Steve Nolan*

In *Spiritual Care in Practice: Case Studies Chaplaincy*, Fitchett and Nolan offer pragmatic information and practical recommendations for equipping congregational care ministers at SSUMC. This valuable resource is basically a report on the viewpoints of healthcare chaplains. The authors posit that a professional chaplaincy should employ research to examine and improve both its interventions and outcomes.\(^{23}\) Similarly providing spiritual care in a congregational setting should also employ research.

\(^{22}\) Ibid., back cover.

When spiritual caregiving in a congregation is built on the principles of clinical pastoral education, the benefits are numerous. The ministers learn how to collaborate with healthcare professionals and hospital chaplains. These healthcare professionals include physicians as well as nurses, psychologists, technicians, therapists, and others. In addition, the ministers are introduced to the art of listening as a healing agent; they gain valuable insight into the power of relationships and develop the capacity to appreciate the narrative approach.\(^{24}\)

The narrative approach involves being present for the person who needs care, instead of busily performing tasks. By listening carefully to the experiences of those who are suffering, the ministers can be fully present and prepared to engage in meaningful dialogue. So in the midst of pain and grief, a sacred space filled with understanding and hope can be created.\(^{25}\)

The curriculum and clinical contacts enable the participants to process the difference between spiritual screening and spiritual assessment. A spiritual screening involves taking a spiritual or faith history. A spiritual assessment helps caregivers develop an effective spiritual care plan that leads to specific outcomes. Thus, hospital chaplains have the opportunity to share their clinical acumen not only with other healthcare professionals and hospital administration but also congregational care ministers that they may encounter.\(^{26}\)

\(^{24}\) Ibid., 9.

\(^{25}\) Ibid.

\(^{26}\) Ibid., 10.
The case studies Fitchett and Nolan provide are significant, because they offer a valuable resource for integrating spiritual care into healthcare. They demonstrate the importance of spiritual issues in clinical care and describe how to identify and address a patient’s spiritual needs. The cases are especially useful to hospital chaplains and demonstrate their essential role in delivering effective clinical care. Fitchett and Nolan challenge chaplains to develop theories about how to provide effective spiritual care in a hospital setting. Chaplains can do this by allowing the patient’s story to unfold within the relationship. They also can function as ambassadors of Christ, serving as the symbolic presence of God’s provision.\footnote{Ibid., 59-68.} The cases also inspire chaplains to function as leaders in clinical research in spiritual care.\footnote{Ibid., 10.}

Fitchett and Nolan augment the case studies with critical reflections and responses from professionals within chaplaincy,\footnote{Ibid., 25-306.} such as nursing,\footnote{Ibid., 195-272.} psychiatry,\footnote{Ibid., 107-186.} and psychology.\footnote{Ibid.} The diverse case studies provide an honest, detailed look into how hospital chaplains actually work with people in their care. Also, readers get a clear picture of the vital role that narrative approach plays in bringing about internal transformation. The cases also educate other healthcare professionals about chaplaincy and how patients’ spiritual issues impact the case for appropriate care and result in a greater awareness of the spiritual
needs of the patients. This skill can help SSUMC congregational care ministers provide appropriate care to parishioners.33

It is important for chaplains to learn how case studies can play an important role in training new chaplains. Cases written by experienced chaplains can deepen the learning of trainees. Even the continuing education of experienced chaplains can be enhanced by case studies. The chaplains can use the studies to compare perspectives about best practices in specific clinical situations. Finally, case studies can help other health professionals develop a better understanding of what chaplains do.34

Fitchett and Nolan would agree that case studies do more than train and develop chaplains; they also edify them. The authors disclose the satisfaction that comes from nurturing a trusting relationship between chaplains and those in need of care.35 They advocate the writing and sharing of reports as a way to expand their influence beyond the relatively small world of healthcare in a particular context.36

Fitchett and Nolan are intentional about introducing diversity in their selection of the cases and clinical contexts. This is revealed particularly through the religious and the cultural backgrounds of the patients and families they choose to discuss. The key themes in the cases are also diverse.37 The authors show the extent of the diversity of the case studies. It ranges in variety from a sixteen year old believing God for a miraculous

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33 Ibid., 11.
34 Ibid., 12.
35 Ibid., 16.
36 Ibid., 14.
37 Ibid., 18.
healing from paralysis, to an African man with a history of psychosis and depression whose cultural belief in witches complicated his treatment, to a dying Jewish man aggressive and isolated due to his traumatic life experiences. Each case includes insight into the patient’s needs and chaplain’s perspectives, discussion of spiritual assessments and spiritual care interventions, and accounts of significant encounters and dialogues.38

Fitchett and Nolan point out that the benefits of chaplaincy case studies encourage more chaplains to train in the art of research, so more case studies can be published. This is extremely important for healthcare chaplaincy to become a more scientific and research-informed profession. Many chaplains could start publishing their stories, which essentially are their case studies.

In addition to writing its own reports to be shared at monthly meetings, SSUMC’s congregational care ministry project can use what is learned to train others and insist on congregational care ministers writing their stories as case studies to educate one another at the lay level.39

The book is a useful tool in providing effective pastoral care in a congregation. It offers numerous resources including empathic listening, bringing compassion and comfort to grieving individuals, and being culturally fluent. However, the extensive research advocacy proposed by the authors as essential to the delivery of spiritual care by professional chaplains in healthcare is currently not necessary at SSUMC. These case studies may be germane to the training of professional chaplains, but they do not apply to

38 Ibid., 107-242.
39 Ibid., 20.
this specific ministry challenge. However, when spiritual caregiving in a congregation is built on the principles of clinical pastoral education, the benefits are numerous.

*An Introduction to Pastoral Care*

*by Charles V. Gerkin*

In *An Introduction to Pastoral Care*, Gerkin gives a general description of what pastoral care entails. As the title of the book infers, the author introduces the reader to pastoral care instead of delving deeply into various theoretical viewpoints. According to his interpretation, pastoral care communicates the inner meaning of the gospel. Therefore, pastors should develop a relationship with their flock that entails connecting with the internal history of each person in a way that is potentially transforming.

One area of discussion for Gerkin is pastoral care in hospitals. He states that in the hospital the primary focus of pastoral care should be the holistic care of all patients. This means chaplains should not only focus on the physical ailments but also the mental, emotional, and spiritual conditions of the people. Caregivers should also relate to people in such a way that they and the people may experience what the theologian H. Richard Niebuhr calls “moments of revelation.” In other words, what is communicated in the relationship makes a connection with the person in a new and potentially transforming way. Gerkin offers two important interventions: the art of listening and the art of

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41 Ibid.


43 Gerkin, *An Introduction to Pastoral Care*, 89.
observation. According to him, listening involves caregivers not just hearing the words people say but also being attentive to the emotions that accompany the words. Caregivers should carefully observe people in order to be able to make an assessment of their spiritual condition. Both the ability to copiously listen and observe are the underpinning of spiritual assessment of the individual.

Proper assessment of a person’s spiritual state can help the hospital chaplain develop practical interventions. These interventions eventually may lead to an effective outcome for the individual. The assessment also can reveal a person’s mental and physical distress and equip the chaplain with the language that can be uttered to start the person toward healing.

Proper assessment of a person’s spiritual history can contribute to the development of not only practical but ethical intervention, which eventually engenders an effective outcome. Proper spiritual assessment can reveal a person’s distress from mental and physical conditions. In other words, spiritual assessments by pastoral caregivers provide the language to be spoken to cause a person to break free from a paradigm of spiritual or emotional paralysis and help arm the person with the readiness to review present belief systems, idiosyncrasies, or worldviews that may be impeding them.

This section of Gerkin’s book is relevant to the project at SSMUC, since the church utilizes police chaplains as well as hospital chaplains. It might be worthwhile for the congregational care teams to not only review the information about spiritual

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44 Ibid., 91.
45 Ibid., 89.
46 Ibid.
assessments and discuss the merits of the viewpoints but to develop strategies that will assist in alleviating the spiritual distress of parishioners. While this resource is useful in providing practical training for pastoral care through empathic understanding of people’s needs, the primary focus is on professional chaplaincy in healthcare. Hence, some of the practical tools may not apply or may need to be adapted to be useful to the ministry challenge at SSUMC.

*A Primer in Pastoral Care*
by Jeanne Stevenson-Moessner

Stevenson-Moessner describes pastoral care as dynamic and varied, because it is a way of being in a relationship with others. She takes a general approach towards pastoral care and maintains that the many different experiences in relationships render it impossible to connect with a specific biblical paradigm. Rather, it is a blend of several paradigms reflecting the unique gifts God has given to each person. She asserts that the blend of paradigms reflects the varied situations Christians encounter in giving pastoral care as well as each person’s diverse individuality.

According to Stevenson-Moessner, prior reflections on previous pastoral care experiences, whether recalled or not, tend to form the center of most pastoral caregivers. The author asserts that presuppositions about pastoral care inform one’s theological task for pastoral care. However, some caregivers might argue they are not influenced by their

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experience and that they came to pastoral care ministry with a *tabula rasa* or a blank slate.\(^{48}\)

Stevenson-Moessner stresses that the pastoral care profession emanates from Jesus’ healing ministry.\(^{49}\) As caregivers, Christians represent Christ in the “archives of grief or the antechambers of joy” \(^{50}\) as the extension of the God of Comfort who promises to be with us in all of our circumstances. It is gratifying to know that believers have such a divine assurance and are not functioning alone in caring for those who might be experiencing emotional and spiritual distress. Drawing on her personal experiences in offering pastoral care in the hospital setting, the author has developed the pastoral authority that collaborates with Christ and with other helping professionals.\(^{51}\) According to the author, “We enter holy spaces never before imagined to engage and to listen.” \(^{52}\)

Stevenson-Moessner draws attention to a model for caregiving that informs her theory of pastoral care. That model was promulgated by the late Henri J. M. Nouwen and termed “the wounded healer.” She agrees with Nouwen’s thesis that a “caregiver is both the wounded minister and the healing minister, binding his or her wounds while still prepared to heal others.” \(^{53}\) Stevenson-Moessner informs the reader that the concept is

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\(^{48}\) Ibid.

\(^{49}\) Ibid., 10.

\(^{50}\) Ibid., 14.

\(^{51}\) Ibid.

\(^{52}\) Ibid., 15.

based “on an old legend in the Talmud, taken from the tractate Sanhedrin. In short, pastoral care is an outreach of compassion often accompanied by an action of care.”

The author advocates for caregivers to be compassionate and to value individuals as legitimate authors of their own stories. No one should be made to feel humiliated in their vulnerability, which means accepting their narrative without suspicion or critique. It is paramount to honor the questions that surface in times of loss and transition. Respect is of the utmost as the other is offered spiritual care, whether at the church or in the hospital setting. “In the rare instances that people express suicidal or homicidal thoughts or expose sexual abuse, we do respond appropriately,” says Stevenson-Moessner.

Empathic listening means listening for the nuance, because there could be more going on than what originally presents itself on the surface. Caregivers should listen for the things that are too painful to be named or spoken. Naming these things can expose the underlying concerns and foster reflective conversation. “The Holy Spirit aids our discernment if we are open to this type of intervention.”

The author reviews the basic steps that caregivers should take in order to maintain good health. She points out that sufficient sleep, regular exercise, hobbies, sound family

54 Stevenson-Moessner, A Primer of Pastoral Care, 55.

55 Ibid., 24.

56 Ibid., 23.

57 Ibid., 31.
relationships, and a rich prayer life are the keys to a healthy lifestyle. Taking care of the self is as important to the pastoral caregiver as taking care of another person.58

In her book, Stevenson-Moessner presents a theological task based on three loves: love of God, love of neighbor, and love of self.59 The three loves are interconnected and pulsate with virtuous dependence. They require a healthy balance. Without a healthy balance, the amount of suffering and trauma encountered in pastoral caregiving can be overwhelming and devastating.60

Of the three loves, the most difficult for many caregivers is love of self. This self-love should not be viewed as selfish nor narcissistic. Taking care of one’s own body, mind, and spirit is an essential part of responsible pastoral intervention. Pastoral caregivers need to see themselves in the way that God sees and loves them. This awareness then frees them to appreciate themselves and to love themselves in the same way that God does,61 which in turn empowers them to love others.

Stevenson-Moessner holds that love of self is a commandment that Jesus has emphasized. She refers to Luke 10:27. This commandment requires followers of Christ to “love God with all your heart, soul, and strength, and love your neighbor as yourself.” Learning how to love oneself may be a lifelong task for some caregivers. The effort may involve getting to know and accept the inner child within. Acceptance of one’s inner

58 Ibid., 15.
59 Ibid., 47-53.
60 Ibid., 47.
61 Ibid., 53.
child includes looking at areas of hurt that may be unfamiliar to the caregiver. Invariably, these are the aspects of life that may need further healing.62

Certain sections of Stevenson-Moessner’s book will be of interest to SSMUC’s pastoral team. While general observations about pastoral care may invite only a cursory glance, the sections that deal with the theory of pastoral care and the three loves may be of sufficient interest to fuel discussion. Furthermore, these sections can forge a foundation with the necessary prerequisites for the creation of healthy teams to facilitate spiritual care at SSUMC.

*The Art of Listening in a Healing Way*
*by James E. Miller*

In *The Art of Listening in a Healing Way*, Miller makes a strong argument for the need of pastoral caregivers to develop the ability to provide listening in a healing way. This book explores the difference among various forms of listening with an emphasis on listening to heal. The author points out the difference between merely hearing and listening. He posits that while hearing is a normal function of the human auditory system, listening takes the system into new dimensions and requires special skills. Hearing is automatic. Listening is a chosen activity.63

Miller goes on to explain that from an early age human begin to learn how to master the art of listening. In other words, listening begins at home.64 Very young children are trained to listen to orders from parents, teachers, and other adults who are authorized

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62 Ibid.
64 Ibid.
to give those commands. As children begin to grow older, they figure out that it is necessary to listen carefully in order to make sure that they have a correct understanding of what is heard. These children realize that they will be tested on the information that has been provided by their instructors, so they need to take relevant notes. They consider that their knowledge of the information is constantly being assessed, so their progress and grades become dependent on their ability to listen effectively. It is interesting to note that listening is not usually offered as a course in elementary and secondary schools.

Miller asserts that different situations in life require different forms of listening. Essentially, one style of listening may not be suitable for all encounters and engagements. For instance, casual listening will not guarantee comprehension, nor is listening appreciatively the same as listening critically and listening therapeutically is different from engaging in healing listening.

Miller contends that healing listening is different from all other kinds of listening. Healing listening focuses more on a person being present for the speaker rather than on performing actions. The root word for “heal” means to make whole, so listening to heal affirms the stories of other people and enables them to experience a feeling of acceptance and validation.

Miller explains that listening to heal involves both unconditional regard and empathic understanding for the other. Both of these attributes are prerequisites for

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65 Ibid., 11.
66 Ibid., 12.
67 Ibid., 13.
healing listening. This type of listening requires the willingness to bring all of oneself to engage completely with the other. The highest goal of a healing listener is to show the utmost respect for the speaker. This respect for the other should be powerful enough for the other to freely express concerns both verbally and non-verbally. Consequently, listening to heal involves looking at the other internally as well as externally.

Miller offers the following observation:

Choosing to listen—to really listen—is the most caring, affirming gift that can be offered. By creating an open space in which the other person is free to express whatever matters most could facilitate healing and growth. By relating to the one who is speaking as a whole person, and by bringing our whole self as a listener to this experience, puts us in touch with life at a very deep level. This book reveals the art of being a healing listener as both a promise and a reward.

Such healing listening requires special attributes, including patience and humility. However, when people serve as listening healers, their primary purpose is to hear fully. Healing listeners should listen carefully, respectfully, and by paying attention and trusting the healing power of all the verbal and nonverbal expressions uttered by others. Healing listeners also should listen for the resilience expressed by those who need healing.

According to Miller, listening empathically is the most caring gift one person can present to another. The listener facilitates healing and growth by enabling the speaker to feel free to express whatever is of the utmost importance in the moment. Simultaneously,

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68 Ibid., 21.

69 Ibid., back cover.

70 Ibid., 21.

71 Ibid.
the speaker is regarded as a whole person who has the listener’s entire attention. This kind of listening is so demanding that those engaged in this profession need to take special care of themselves. Consequently, those engaged in this profession must make a special effort to maintain their practice of self-care.

Miller seems to invoke the love of self as an essential ingredient for listening in a healing way. On that point, he is in agreement with Stevenson-Moessner. Love of self is necessary for delivering effective pastoral care. There are various ways by which the caregiver can engage in self-care. Listening first to oneself is a starting point. For example, this might mean taking time to de-stress, relax the mind, or engage the body in exercise. Going to a museum, playing a sport, or enjoying a hobby or a music recital are all forms of self-care. Such diversion is not a waste of time. Consequently, the responsible caregiver may take care of self by deciding to do absolutely nothing.

Miller’s book emphasizes the importance of empathic listening and can be linked to the ministry challenge that SSUMC needs to confront. The information on empathic listening coupled with what was provided by Lampe may be particularly useful. In addition, Miller’s guidance on developing a healing ministry may lead to serious discussion among members of the congregational care team.

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72 Ibid., 25.
73 Ibid.
Strategic Pastoral Counseling: A Short-Term Structured Model
by David G. Benner

In Strategic Pastoral Counseling, Benner’s overarching thesis is that strategic pastoral counseling should be at the very heart of soul care. Strategic pastoral counseling is a short-term and unequivocally Christian counseling model. It is structured around five sessions; however, it could be less, depending on the needs uncovered. It avoids the technicalities and jargons of psychology and counseling theory. The seven essential characteristics of this model include its limited scope, holistic and structured nature, use of assigned homework, presentation as a church-based resource, spiritual focus, and explicitly Christian quality. To make his point he does a cursory review of church history to ascertain how soul care, one of the main missions of Christianity, has been practiced in several ways.

However, often pastors do not feel adequately prepared for their counseling responsibilities, so Benner uses this book to develop a strategic pastoral model to assist

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74 David G. Benner, Strategic Pastoral Counseling: A Short-Term Structured Model, 2nd ed. (Grand Rapids, MI: Baker Academic, 2005), 12.

75 Ibid., 47.

76 Ibid., 47-54.

77 Ibid., 55-56.

78 Ibid., 56-58.

79 Ibid., 58-60.

80 Ibid., 62-67.

81 Ibid., 67-70.

82 Ibid., 12.
pastors in counseling more effectively. His model is highly focused and consists of five sessions in response to the maximum amount of time most pastors say they spend in their counseling responsibilities. “In addition, strategic pastoral counseling is positioned as integral to and necessarily consistent with these broader pastoral roles.”

Benner’s review of church history also affirms that spiritual counseling has been part of the overall soul-care responsibilities since the earliest days of the Church. However, juxtaposed alongside general psychological counseling, pastoral counseling has often experienced tension between the pastoral and the psychological. Still, Benner insists, “Pastoral counseling can be both when it takes its identity from the rich tradition of Christian soul care and integrates appropriate insights of modern therapeutic psychology in a manner that protects both the integrity of the pastoral role and the unique resources of Christian ministry.”

Benner goes on to say that “the Christian church has understood pastoral counseling to involve nurture and support as well as healing and restoration of the soul.” Healing the soul is healing the body, because the soul is not just part of a person. It is his or her total being. There are four primary areas of care: healing, sustaining,
reconciling, and guidance.\textsuperscript{90} Benner asserts that these areas of healing help people overcome their present ailing reality—which may be mental, physical, or spiritual—and moves them to a healthy reality.\textsuperscript{91} He comments: “These health-giving efforts can involve physical healing as well as spiritual healing, but the focus is always the total person, whole and holy.”\textsuperscript{92} Caring for souls thus can be understood as validating and healing the essence of the whole person: body, mind, and spirit. The concept dovetails with Miller’s healing listening model of affirming the stories of people to enable them to experience a feeling of completion and validation.\textsuperscript{93} This is useful for SSUMC’s ministry of care, because it seeks to offer healing of the whole person.

Sustaining focuses on helping people overcome a situation that on the surface appears to be insurmountable.\textsuperscript{94} Soul care underscores the need to be resilient and reach into the inner self to summon strength and hope to forge ahead in their quest to experience wholeness. This is similar to Miller who suggests that the caregiver must be the healing shoulder people need to overcome. SSUMC can recruit and train volunteers to encourage people to develop the fortitude to weather the existential storms of life.

\textsuperscript{90} Ibid., 15.
\textsuperscript{91} Ibid.
\textsuperscript{92} Ibid.
\textsuperscript{93} Miller, \textit{The Art of Listening in a Healing Way}, 13.
\textsuperscript{94} Benner, \textit{Strategic Pastoral Counseling}, 15.
Reconciling engages all the members of the designated congregation and repairs relationships that have been damaged. Christians have a spiritual imperative to pursue and implement a ministry of reconciliation. They are commanded to forgive and to love, to respond graciously to people’s mistakes and deeds. Similarly, Miller recommends creating an open space in which the other person is free to express whatever matters most. Both authors advocate facilitating healing and reconciliation. Relating to the one who is speaking as a whole person and bringing one’s whole self as a listener to this experience puts the caregiver in touch with life at a very deep level. Forgiving others is not easy, so SSUMC’s ministry of care has to be intentional about restoration and reconciliation of broken relationships within and beyond the church.

Finally, guiding helps people to make choices that eventually result in their attaining spiritual maturity. Some aspects of soul care foster reflective conversation. The caregiver needs to respond with empathetic understanding, in order to open the door to opportunities to guide in a fruitful way.

Benner emphasizes a highly focused approach to pastoral counseling in the dispensation of pastoral care to a congregation. Strategic pastoral counseling assumes pastoral ignorance and has developed what can be construed as basic training in pastoral care and counseling for clergy, seminarians, and laity. More importantly, this model “takes its form and direction from the pastoral role that it will be of value to those pastors

95 Ibid.


97 Benner, Strategic Pastoral Counseling, 15.
who seek to provide counsel that is congruent not only with their theological commitments and biblical understanding but also with their primary role as ministers of the gospel of Christ.’

Caring for souls is the core of any meaningful pastoral care ministry. Consequently, SSUMC caregivers need to learn how to attune to the spiritual and emotional needs of parishioners. It is necessary to develop a pastoral care ministry that utilizes congregational care teams that foster the four ingredients identified by Benner: healing, sustaining, reconciling, and guiding.

Benner emphasizes that soul care never focuses on a single aspect of one’s being nor only on one’s problems. Rather, the goal is to have a positive impact on the whole person—mind, body, and spirit—as a living and vital whole. Hence, soul care is totally supporting the restoration of the inner life of the whole person.

Benner goes on to note that there is a school of thought that advocates five forms of soul care that should be an integral part of every Christian church. These are Christian friendship, pastoral ministry, pastoral care, pastoral counseling, and spiritual direction. This theory is based on a “continuum of specialization—moving from broadest and least specialized to narrowest and most specialized.”

Life patterns are extremely difficult to break. Childhood patterns do not conveniently evaporate with age. There is a strong chance for such tendencies to

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98 Ibid., 11.
99 Ibid., 14.
100 Ibid., 16-29.
101 Ibid., 16.
resurface, unless one pursues an intentionality to follow new and different patterns. In other words, sincere desire and determination would not be sufficient to alter present lifestyles. Benner posits that though the term “counseling” may evoke images of information exchange and/or advice in another profession, as it certainly requires a relationship of listening and discovery, the goal is to “aid the spiritual growth of the one seeking help.” Benner concludes by pointing out that God’s framework of attending to the total needs of the congregation requires effective listening.

He asserts counseling is being present as well as being with the other and “therefore is not reducible to telling a person what to do or what not to do, whether it be the counselor’s opinion or the counselor’s opinion of God’s opinion.” To summarize, pastoral counseling is not executed in the halls of the church due to the sensitive nature and privacy required in such a relationship. It requires the establishment of formal boundaries to accommodate the specialized purpose. Ultimately, Benner contends that “if pastoral counseling is to be distinctively and authentically pastoral, it must be returned to its proper place with pastoral care and ministry. It also must be understood in relationship to the other forms of Christian soul care that form part of the life of the church.” This will no doubt form the basis of soul care at SSUMC.

102 Ibid., 25.
103 Ibid., 26.
104 Ibid.
105 Ibid., 28.
106 Ibid.
Conclusions

Generally, healing is a broad concept with room for varied perspectives. Healing conjures up the need for balance and homeostasis in health and wellness. It involves relief of the distress of body, mind, and spirit. Moreover, healing comes from the inside. Pastoral care is generally designed to support and assist those in need of healing. It should never be perceived as fixing the problems of believers. Pastoral care should remind people of their own internal resources of strength, because all healing is ultimately self-healing. Men and women will seek different types of healing, solace, sustaining, guidance, and reconciliation depending on their existential and ontological concerns.

Medically, healing does not necessarily mean cure. Healing for Christians begins with their faith in the power of God to heal them. Christian modes of healing always have distinguished themselves by achieving spiritual transformation in connection with the healing process. For Christians, spiritual healing is healing of the total self. This belief has roots in both the Old and the New Testaments. 107 Jesus provided opportunities for human faith and divine power to unite in creating a new order to restore emotional and spiritual transformation.

The need for healing requires caregivers to come alongside others and offer a listening ear to help them on their journey towards health and wellness through emotional and spiritual reflections. Their support and guidance assuage the rough spots of life, which plead for healing. Caregivers can be more effective by the degree of empathy they

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107 To be explored more at length in Chapter 3 of this paper.
bring to bear in a particular circumstance. As caregivers enter into difficult situations, bringing themselves into existential encounters as fully needed, they can help others deal with the challenges of life. This is an essential condition for all that subsequently follows. Chapter 3 will utilize these concepts derived from the literature review to develop a theology of congregational care that undergirds the ministry project at SSMUC.
CHAPTER 3

THEOLOGY OF CONGREGATIONAL CARE

This chapter reviews traditional UMC standards for pastoral care. It also offers a biblical perspective of congregational care and discusses how to create a compassionate and culturally sensitive ministry. SSUMC’s view of pastoral care includes meeting people at their point of need and offering healing, hope, and redemption. As people of faith committed to healing and wholeness, sometimes those offering soul care can just show up and reach out. Other times, a word of comfort and/or a simple listening ear is needed. The role of listening will be underscored to lie at the root of pastoral care; however, pastoral care challenges the concept of passive listening. For this reason, the power of the narrative approach in the evolving relationship between the minister/volunteer and the parishioner is seen as essential in how spiritual care is dispensed. The essence of congregational care requires caregivers to bear witness with those they serve.

A Brief Overview of Congregational Care

The theology of congregational care is based on the theory of pastoral care. According to the *Dictionary of Pastoral Care and Counseling*, “the term pastoral stems from the metaphoric etymology of the Jewish scriptures and from God’s care of Israel”
(Psalm 23:80).\(^1\) The word “pastoral” also refers to the church providing care for its members.\(^2\)

The theology of congregational care requires acts of discipline, support, and celebration as well as acts of comfort and compassion. Paul reflects on the importance of discipline when he writes in 1 Corinthians 14:40 that “everything must be done in a proper and orderly way.” He also asserts that “every athlete in training submits to strict discipline, in order to be crowned with a wreath that will not last; but we do it for one that will last forever” (1 Corinthians 9:25; 2 Timothy 4:2; Ephesian 5:10). God commands believers to reach out, accept, and affirm one another. This means that authentic congregational care consciously resists the strong current of the stream that dictates excuses and suggests that congregants are too busy to be “our brother’s keeper.” Although rugged individualism might be considered fashionable or sophisticated, and the busy time pressures and demands of life can prompt scheduling uncertainties, love and support within the Body of Christ is demonstrated through the diligence of God’s people to focus on others.

This is seen clearly in Scripture. Luke writes in Acts 5:20: “Go and stand in the Temple, and tell the people about this new life.” James advocates support for the sick when he says, “This prayer made in faith will heal the sick; the Lord will restore them to health, and the sins they have committed will be forgiven” (James 5:15; Matthew 14:35). Answered prayers and the sick being healed gives cause for celebration. Luke reflects on

\(^1\) Dictionary of Pastoral Care and Counseling, 1990 ed., s.vv. “Congregational Care.”

\(^2\) Ibid.
the importance of celebration when he records Jesus’ parable on the lost sheep, lost coin, and lost son (Luke 15:23; Matthew 22:9; 1 Thessalonians 5:19; John 10:22).

Such discipline and support require comfort and compassion. Paul and others affirm the importance of the Lord’s comfort and compassion (Philippians 2:1; 1 Corinthians 14:3; 2 Corinthians 1-6; John 11:19; and James 3:17). To live out this priestly ministry and congregational care, some people become therapists and counselors. Others become chaplains, pastoral counselors, and ministers in specialized settings. Still others become spiritual directors or spiritual guides. Each of these ministries seeks to administer grace to people in their different stages of life development and in their crises. They offer comfort and compassion for the sick, the homeless, the grieving, and the dying. All of these are priestly ministries of grace just like caring for widows and orphans (Psalm 68:5; James 1:27), those who are persecuted, and refugees (Deuteronomy 10:19; Leviticus 19:34).

Congregational care can be both personal and a team effort. Every congregant is a priest before God and therefore can offer grace to others (1 Peter 4:10). Caregivers may not be professionally trained, but they can listen compassionately to a grieving friend. Caregivers can practice hospitality (1 Timothy 5:10) and open their hearts to strangers (3 John 1:5). They can visit the sick or dying (James 5:14). They can support institutions devoted to the ministry of grace among those considered forgotten or failures. Hospitals and hospices, orphanages and retirement homes, rescue missions and community centers, clinics, shelters, and relief organizations are only some of the institutional expressions of
priestly ministry where the presence of Christ can be manifested. This Christian ministry of care is guided by the New Testament which clearly charges the members of the congregation to care for one another (Matthew 25:36). Consequently, God’s people are identified by the caring that they extend to one another and to those beyond the Body of Christ.

A Traditional United Methodist View of Pastoral Care

Traditionally, pastoral care is the umbrella for all aspects of pastoral ministry in the UMC. United Methodists share a vision of life for all humanity and work toward a society where each person’s value is recognized, maintained, and strengthened. A nurturing community is viewed like a family that nurtures its members and people in general in mutual love, respect, and fidelity. The UMC acknowledges complete dependence on God in birth, life, health, sickness, and death. God calls the Church to affirm the goodness of life and to become the people of God in their dealings with one another. The UMC believes that God’s grace is available to all and that nothing can separate believers from the love of God, which is in Christ Jesus (Romans 8:38-39).

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5 United Methodist Church, *Book of Discipline*, 141.

6 Ibid.
Since the early historical paradigm of pastoral care in the UMC was geared toward the clergy, ordained elders of UMC are implored to affirm the inestimable worth of each congregant in their pastoral contacts and pastoral care ministry. The UMC established an order of ordained ministers to personify servanthood. Those called to this form of ministry are called to witness to the Word in their words and deeds for the sake of enacting God’s compassion and comfort. Ordained elders also are charged with celebrating the sacraments as well as guiding and caring for the church’s communal life. They are given to proclaiming and teaching the Word in their pastoral encounters with the congregation. Clergy are trained to do visitation and provide supportive care in a professional manner. In discharging these duties, they are to create a sacred space for the presence of God in any pastoral encounter and contact. The clergy as a representative of God brings healing, guidance, nurturing, and reconciliation to bear on the pastoral contact and care. One aspect that is quite important is how pastors have been clinically trained in listening, respecting, caring, and empathizing.

In the 1980s, this clergy-centered paradigm was changed to include the laity. Currently, both the laity and ordained clergy offer regular visitation, care, and spiritual oversight. They provide the necessary activities and opportunities for spiritual care through individual and family worship as well as individual and group study to connect

7 Ibid., 163-164.
8 Ibid., 182.
9 Ibid., 147-148.
10 Ibid., 16-164.
with faith and daily living. Laity and clergy have the moral and spiritual imperative to nurture every congregant regardless of church attendance.\textsuperscript{11}

The UMC encourages pastors and churches to provide for the nurturing of congregants into the full potential of their humanity. The UMC follows its understanding of the gospel that all persons are important, because they are created by God (Genesis 1:26-31) and loved through and by Jesus Christ (Ephesians 2:4 -10) and not because they have merited significance. Consequently, they support social climates in which human communities are maintained and strengthened for the sake of all persons and their growth. Clergy and laity also are encouraged to remain sensitive to others by using appropriate language when referring to all persons.\textsuperscript{12} The UMC applauds the efforts of advanced medical science to prevent disease and illness, with treatments that extend the meaningful life of people. However, the United Methodist Church also recognizes that every mortal life ultimately will end in death and therefore encourages the faithful to care for dying persons. Regardless of the circumstances and type of death, the UMC believes that death is never a sign that God has abandoned his people.

For this reason, care for dying persons is an integral part of the UMC’s stewardship of the divine gift of life, when a cure is no longer possible. When life-sustaining treatments do not support the goals of life and when they have reached their limits, then the use of medical technologies to provide palliative care at the end of life are encouraged. However, there is no moral or religious obligation to use these technologies when they impose undue

\textsuperscript{11} Ibid., 163-164.

\textsuperscript{12} Ibid., 110-118.
burdens or only extend the process of dying. UMC believes that dying persons and their families are free to discontinue treatments when they cease to be of benefit to the patient. Both laity and clergy of the church are to extend comfort and compassion through prayers and service. The personal and moral decisions faced by the dying, their physicians, their families, their friends, and their faith community can be agonizing. Hence, the UMC urges that decisions faced by the dying be made with thoughtful and prayerful consideration by the parties involved along with medical, pastoral, and other appropriate counsel. Dying persons may discuss with their families, their physicians, and their pastoral counselors their wishes for care at the end of life and provide advance directives when they are not able to make decisions for themselves.

Even when one accepts the inevitability of death, pastoral caregivers must continue to provide faithful care—including pain relief, companionship, support, and spiritual nurture for the dying person in the hard work of preparing for death. The concept of hospice care, whenever possible, at the end of life also is encouraged and supported by the UMC. Faithful care does not end at death. It continues through bereavement as grieving families are offered comfort and a supportive presence. The traditional view of the UMC’s pastoral care rejects euthanasia and any pressure upon the dying to end their lives. Consequently, laws and policies that protect the rights and dignity of the dying are affirmed.13

In light of these precepts, the UMC believes that suicide is not the way a human life should end. Congregational caregivers have an obligation to see that all persons have

13 Ibid.
access to needed pastoral and medical care as well as therapy—especially in those circumstances leading to loss of self-worth, suicidal despair, and/or the desire to seek physician-assisted suicide. Hence, education to address the biblical, theological, social, and ethical issues related to death and dying (including suicide) should be provided as part of pastoral care. The UMC instructs its seminaries to offer courses that focus on these core issues of death and dying, including suicide. This perspective on suicide begins with the affirmation of faith that nothing, including suicide, separates believers from the love of God (Romans 8:38-39). Therefore, the condemnation of people who complete suicide and the stigma that so often falls on surviving families and friends are considered deplorable and unjust. Pastors and churches are encouraged to address this issue through preaching and teaching. In addition, pastoral care should be offered to those at risk, survivors, and their families as well as to those families who have lost loved ones to suicide—all while seeking always to remove the oppressive stigma around suicide.

Healing, Hope, and Redemption to Those in Need

A traditional United Methodist view of pastoral care necessarily involves offering hope, healing, and redemption to those who are in need. This was often done through the Wesleyan practice of Wesleyan societies and class meetings. A meaningful way in which the UMC offers healing, hope, and redemption has been through direct care provided by the clergy.

Methodism derives its practice from the biblical life of John Wesley, who emphasized the practice of societies and class meetings. According to D. Michael Henderson, societies were organized to minister to the psycho-social and spiritual needs of
the members. Historically, the class meetings laid the foundation for the basic structural means of Christian spiritual formation in the early Methodist societies. Class leaders provided the lay pastoral leadership. Class leaders were commissioned, and classes were organized within local congregations for the purpose of forming persons as faithful disciples of Jesus Christ through mutual accountability and support for witnessing to him in the world and for following his teachings through acts of compassion, justice, worship, and devotion under the guidance of the Holy Spirit. There were about twelve persons in a class. The leader was responsible for seeing each person in the class at least once a week to ascertain their spiritual formation and to advise, reprove, comfort, or exhort as needed. The class leader also was required to inform the pastor of anyone who was sick or of anyone living in sin and was unwilling to be reproved.

In the United States, Francis Asbury, Wesley’s spiritual heir traveled constantly and was always ready to offer emotional and spiritual care to the faithful. Asbury insisted on maintaining the standards in *The Book of Discipline*. “Our Society,” he writes, “may be considered a spiritual hospital, where souls come to be cured of their spiritual diseases.” In this way, Wesley’s class meetings were described as a channel for care. The theological assertions underscoring the pastoral care tradition of the UMC stem from Wesley’s

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15 Ibid. See also United Methodist Church, *Book of Discipline*, 187.

16 Henderson, *John Wesley’s Class Meetings*, 77-78.
theology of God extending grace to every person, since all are created in the image of God.17

Another dynamic way that care is provided in the UMC is through the direct efforts of the clergy and lay leaders. As indicated in Chapter 2 of this paper, healing may be defined as the means to experience physical, emotional, and spiritual wholeness by the Holy Spirit through prayer. For Christians, healing is derived from biblical teachings. The New Testament reveals Jesus as the repository of divine healing. The four Gospels disclose his healing ministry on earth. Jesus attended to the emotional, physical, and spiritual diseases of the people (Matthew 8:16, 12:15, 14:14, 15:30; Luke 4:40, 5:17, 9:11; 3:10, 6:56; John 5:11, 6:2). He modeled this healing ministry for his disciples and instructed them to do likewise. “Jesus called his twelve disciples to him and gave them authority to drive out impure spirits and to heal every disease and sickness” (Matthew 10:1).

The Christian life is hope experienced. Without hope, there is no yearning for tomorrow, no desire for a better tomorrow, no belief that the next cast will bring the big strike. In Pavlov’s Trout, Paul Quinnett writes that fishermen are chronically optimistic because to be optimistic in a slow bite is to thrive on hope alone.18 Believers can learn a lot about Christian hope from fishermen. Quinnett posits that fishing is hope experienced. Without hope, there is no wonder, no mystery, and no reason to fish. Essentially, it is

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17 United Methodist Church, Book of Discipline, 67, 74, 101-199.

better to fish hopefully than to catch fish.\textsuperscript{19} In a similar way, Christian hope is built on the firm foundation of the promises of God. In Matthew 7:24-27, Jesus explained that when the rains came down, and the storms raged violently, the house built on a rock did not fall because it had an unshakeable foundation.\textsuperscript{20} Unconquerable hope can always be found in the Scriptures (1 Peter 1:3-6). No matter what mind, body, or spiritual trials one suffers, hope in Christ is assured. Hence, a hopeless Christian is a contradiction in terms.

The Bible says redemption is the means by which Christ delivered us from the curse of the law (Galatians 3:13). The curse of the law understandably is the source of the physical, emotional, and spiritual circumstances experienced by all. In \textit{Sacred Pace}, Terry Looper explains that circumstances—including decisions, actions, or events that are typically outside one’s control—may prove to be providential.\textsuperscript{21} In this way, circumstances require us to pay attention to the unfolding story.

George Muller thoroughly believes those who follow Christ should take circumstances into account and consider them providential. He posits, “These often plainly indicate God’s Will in connection with His Word and Spirit.”\textsuperscript{22} Redemption is an unfolding story of how God delivers his people from physical, mental, and spiritual distress. This deliverance involves the work of the Holy Spirit who directs and

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\textit{\textsuperscript{19} Ibid.}
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\textit{\textsuperscript{20} Max Lucado, \textit{Unshakeable Hope: Building our Lives on the Promises of God} (Nashville: Thomas Nelson, 2018), 7-8.}
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\textit{\textsuperscript{21} Terry Looper, \textit{Sacred Pace: 4 Steps to Hearing God and Aligning Yourself with His Will} (Nashville: Thomas Nelson, 2019), 87.}
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\textit{\textsuperscript{22} George Muller, quoted in \textit{Living with Power}, vol. 3 of Operation Timothy Classic (Chattanooga, TN: CBMC, 1995), 36.}
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orchestrates redemptive healing and wholeness. The people of God are implored to trust
God to direct their paths. Caregivers as well as care recipients will do well by submitting
to the direction of the Holy Spirit during sessions of pastoral/congregational care
(Proverbs 3:5-8). When a daily connection with Christ is wholly established, a
transforming experience with Jesus Christ is not far behind. Believers can expect it, look
for it, and even anticipate it just as anyone/anything they long to see. Norman Vincent
Peale urged his audiences that, according to Matthew 9:29, they would not receive a
blessing from God greater than their expectations.23

Still, God calls his people to live with the tensions of redemption. In other words,
believers live with a fair amount of ambiguity of the in-between. There is redemptive hope,
but there is also suffering in this life. There is a deep groaning and sighing for what is yet
to come. Paul writes that creation itself is groaning for redemption (Romans 8:22-23).
Caregivers may assure parishioners that “for those who love God all things work together
for good, for those who are called according to his purpose” (Romans 8:28). Certain kinds
of suffering do not seem to have a sense of meaning or purpose unless that suffering is
understood in the context of God’s redemptive and eternal work in Christ. According to
John Lindell, not all suffering is redemptive insofar that it immediately yields value or
lesson that makes it seem worthwhile. If the vicissitudes of this life ended in the cemetery,
and there was no redemption beyond the grave, many trials would seem to be without
meaning. However, if these trials are juxtaposed against the larger picture of redemption,

then suffering, sickness, and hardships take on a sense of purpose it could not have had previously. This is how God redeems and continuously renews us.²⁴

Trained in the art of caring and compassion, clergy and laity should be able to ascertain the most important concerns of parishioners in order to offer care that is desirable and relevant. However, in the case of death and dying the pastor ought to be directly and/or indirectly involved. Education on death and dying for the congregation can mitigate the associated anxieties and confusion so that families are more accepting when death occurs. While it is beneficial for the congregation to understand that God is always in the business of healing, healing might come through death (Romans 8:18). Healing is the responsibility of God and the results are left up to him (1 Peter 2:24). Hope comes in the awareness of who God is in Jesus Christ (1 John 3:1-3; 2 Corinthians 4:16-18). To be aware of the genuine and sincere hope in Jesus as the resurrection and the life eternal gives hope to the living and the dead. Death is imminent for all but since death has been overcome by Jesus, victory is the inheritance of the people of God. Hope emanates in a way that edifies believers physically, emotionally, and spiritually. Hope helps to fulfill self-will as well as the will of God (1 Peter 1:3-6).

Within the UMC, one important way in which the clergy offers healing, hope, and redemption is through weekly preaching. Redemption offers hope when parishioners are able to connect with the Scripture in a moment of proclamation from the pulpit. Preaching moments offer opportunities for transformation. Proclamation is also a key opportunity for clergy to care for the souls of the congregation. The Word of God resonates with the

assembled congregants who are then graciously moved by the Holy Spirit to do something concrete about their lot in life (Ephesians 6:17). The Holy Spirit brings love and grace. Through love and grace, the Holy Spirit makes possible self-awareness, vulnerability, confession, forgiveness, and continuous growth (John 14:15-27; 18:8; Romans 8:26).

Transforming Tasks into Opportunities to Release the Power of Healing

Theology is the human effort to reflect upon God’s gracious action in one’s life. In response to the love of Christ, it is imperative to be drawn into a deeper relationship with him as the pioneer and perfecter of faith (Hebrews 12:2). United Methodists are called to identify the needs both of individuals and of society and to address those needs out of the resources of Christian faith in a way that is clear, convincing, and effective.25

This theological task is both individual and communal. It is a feature in the ministry of individual Christians (Ephesians 2:8-10). It requires the participation of all, both lay and ordained, because the mission of the Church is to be carried out by everyone who is called to discipleship (Matthew 11:28-30; 28:19). To be persons of faith is to hunger to bear witness to the Christ (John 5:39; Acts 10:43). Communally, this theological task unfolds in conversations open to the experiences, insights, and traditions of all United Methodists. This dialogue belongs to the life of every congregation. It is fostered by both laity and clergy. All 43,000 United Methodists congregations around the globe are urged not only to make a difference in the world but also to build a different kind of world. Theology serves the Church by interpreting the world’s needs and

25 United Methodist Church, Book of Discipline, 80-82.
challenges to the Church and by interpreting the gospel to the world.\textsuperscript{26} For example, the Bible teaches us to bear each other’s burdens (Galatians 6:2). United Methodists live this out through local and global missions. For example, schools and hospitals are built to educate and heal people, respectively.

Wesley believed that the living core of the Christian faith was revealed in Scripture, illuminated by tradition, vivified in personal experience, and confirmed by reason.\textsuperscript{27} It is incumbent on Christ-followers today to be the presence of Christ to one another and the world. It is a simple yet profound truth that can revolutionize both individual lives and the world (John 1:12; 1 Timothy 3:16). It is the concept that each believer in Jesus can be a sanctuary where Christ lives. The Church, the bride of Christ, is the dwelling place of God (1 Timothy 3:15), because each member is a living temple of the Spirit of God (1 Corinthians 3:16, 17; Ephesians 2:18-22). Every place where the Spirit of God is manifested is a sanctuary, because sanctuary signifies holiness. For example, when God appeared to Moses in the burning bush, he was ordered to remove his sandals because he was standing on holy ground (Exodus 3:1-6; Luke 20: 35-38). When the angel confronted Joshua before Jericho, he was also ordered to remove his sandals, for the space had become God’s sanctuary (Joshua 5:14-15). Therefore, if believers are in Christ and Christ is in God, then believers are the repository of the sanctuary of Christ.

\textsuperscript{26} Ibid.

\textsuperscript{27} Ibid.
Spiritual and pastoral caregivers can be a continuous embodiment and incarnation of Jesus Christ in the world (John 1:14). This involves various tasks—such as acts of prayers (James 5:15), listening (1 John 5:14; 1 Peter 3:12), respecting (Matthew 7:12; Romans 12:10), hoping and guiding (James 1:5; John 16:3)—that are carried out during their encounters, which can be sacramental and incarnational, because caregivers are the presence of Christ. To be the presence of Christ means to serve others (Titus 2:17), ministering to their needs and helping them in the same way Christ did (1 Corinthians 10:33; Philippians 2:3; Romans 12:10). This is what it takes to engage in transformational acts of healing for oneself and others.

UMC pastoral care is centered on the ministry of Christ. The ministry of Christ encompasses not only words but deeds as well. When John the Baptist inquired whether Jesus was indeed the Christ, the answer pointed to what was seen as well as heard. Jesus said, “Go and report to John what you hear and see: the blind receive [their] sight, and the lame walk, the lepers are cleansed [by healing] the deaf hear, the dead are raised, and the poor have the gospel preached to them.” (Matthew 11:4-5). Daniel Vestal explains that the signs of the kingdom are acts of compassion and justice. Healing brokenness, overcoming human bondage, and alleviating suffering validate the presence of God’s kingdom (Isaiah 35:5-6; Matthew 4:23). Christ’s ministry restored the beauty and perfection of creation (Romans 12:2), and people engage in his ministry whenever Christ’s works of compassion and justice are performed. Jesus’ ministry of reconciliation, restoration, and redemption is extended through those who become his disciples. His

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disciples become the temple of his Spirit (1 Corinthians 3:16-17), his living presence continuing to perform his works (1 Peter 2:5).

These are the works of mercy and kindness, works of healing and help, works of peace and pardon. Such works can be as simple as taking a meal to a homebound friend (Colossians 1:9-12) or as complex as negotiating peace between warring nations (Colossians 3:15; Ephesians 2:14-22). They might take shape as spontaneous aid to a homeless person or organized as a community development project. They can be done alone or in cooperation with others. They can be done close to home or in places far from home. Whenever and wherever these works occur, they are to be performed in the Spirit of Christ and with the mind of Christ (Philippians 2:5-11; 1 Corinthians 2:16).

Additionally, these acts are offered with an attitude of humility. Jesus said, “Whenever you give alms, do not sound a trumpet before you as the hypocrites do in the synagogues and in the streets, so that they may be praised by others. Truly I tell you, they have received their reward. But when you give alms, do not let your left hand know what your right hand is doing” (Matthew 6:2-3). For this ministry of deeds, some become social workers and community organizers. Others become doctors, nurses, and healthcare professionals. Still others use their personal gifts and professional training to perform acts of compassion and justice. All believers can advocate for the powerless and work for the reconciliation of all people. Time, energy, and resources can be given to care for people who are suffering. There are two key acts that help transform simple tasks into opportunities to release the Holy Spirit’s power of healing: prayer and listening to people’s stories.
The Transformational Act of Prayer

God is always present with his people (Matthew 28:20). He loves and pursues humanity (Romans 5:6-10). He is always blessing and drawing near to those he created, inviting them into relationship. Prayer is simply living in response to God’s presence and engaging in actions that keep us responsive and attentive. It is literally abiding in Christ and allowing his Word to remain in us (John 15:7-8). Essentially, prayer is a relational conversation with God.

When people frame a thought or construct a mental image in response to God, they engage in mental prayer. This mental process becomes an act of prayer when it is God-directed and God-conscious. Often someone will say, “You are in my thoughts and prayers,” as if the two are not necessarily the same. One can have a thought of concern that is not a prayer, but a prayer is also a thought. Some contend that this kind of mental process is only that, a mental process, where one is simply thinking and imagining to oneself. While some people may follow this superficial line of reasoning, Christians affirm that prayer is an act of faith. Hebrews 11:1 says, “Now faith is the assurance of things hoped for, the conviction of things unseen.” There may be good evidence that “prayer changes things,” or people may have witnessed “answered prayer.” However, in the final analysis, prayer is not a scientific exercise. It is a faith exercise.29

C. S. Lewis offers the following explanation:

Some things are proved by the unbroken uniformity of our experiences. The law of gravitation is established by the fact that, in our experience, all bodies without exception obey it. Now even if all the things that people prayed for happened,

29 Ibid., 45.
which they do not, this would not prove what Christians mean by the efficacy of prayer. For prayer is a request. The essence of request, as distinct from compulsion, is that it may or may not be granted.30

Prayer has to do with the God one cannot see, prove, or explain. Prayer has to do with a reality for which people yearn and hope. In this way, those who pray walk forward with their thoughts directed towards God, as an act of faith.

Hebrews 11:6 states that “without faith it is impossible to please God, for whoever will approach Him must believe that He exists, and He rewards those who seek Him.” Consequently, in prayer both the caregiver and recipient think and talk as if God is there. They yield to the divine reality of God’s presence. They act as if God is personal, caring, and responsive—because God is (1 Peter 5:7), although they may not be able to see it quite clearly with human, finite eyes. In the difficult context of suffering, they embrace the incarnation and sacrament of prayer.

The Transformational Act of Listening to Stories

Listening to stories means empathically offering to others a chance to accept their present condition and thus initiate a form of personal transformation. It is done through the receiving of words, instead of the speaking of words. A central aspect of Jesus’ earthly ministry was his sensitivity to the needs of people. For example, his feeding of the five thousand demonstrates his sensitivity to both the physical and the spiritual (John 6:5-15; Matthew 14:13-21; Luke 9:10-17). His sensitivity consoled the bereaved (2 Corinthians 1:4-5), healed the sick (Matthew 4:23), and saved the lost (Luke 19:10). In Jesus’ earthly ministry he demonstrated active and empathic listening. These are the same listening skills

currently used by pastors, laity, and professional chaplains in offering pastoral and/or spiritual care. The Bible shows that when Jesus listened, he did not listen to judge or condemn. The Lord actively listened to people, demonstrating how deeply he cared about them and their situations. He listened in a healing way. Listening to heal affirms the stories of other people and enables them to experience a feeling of completion and validation.

Jesus asked informative questions to help people get in touch with the hidden places of their lives they had never encountered. Jesus listened without being judgmental; he created a sacred space for people to process their issues without fear. Jesus listened not only to the words of people but also to their nonverbal cues. While scattered biblical references allude to the value of listening as a spiritual reflective discipline (Ecclesiastes 5:2; James 1:19; Galatians 6:2), numerous texts portray listening as inherent in the nature of God (Genesis 21:17; Psalm 61:1; Daniel 10:12). The Gospels assume Jesus’ sensitivity to individual conditions (Matthew 9:36). The apostle Paul, who was committed to carrying out Jesus’ earthly ministry, underscores the value of listening when he wrote: “Carry one another’s burden and in this way you will fulfill the requirements of the law of Christ [that is, the law of Christian love]” (Galatians 6:2).

Jesus was an effective listener because he worked within the religious frame of reference of the people he encountered. By sharing their beliefs and presenting alternatives, Jesus facilitated a person’s theological self-reflection; this approach helped


32 Ibid., 13.
them to repent and live a new life, as in the case of the Samaritan woman (John 4:7-26),
the blending of the polarities of acceptance and confrontation notwithstanding. The
blending of the polarities of confrontation and acceptance places emphasis on Christ’s
humanity and upon Christ as the one who reveals to people their own “essential
humanity.” Christ fully lived out his humanity, and as a result he was able to empathize
with the needs of the people.

Jesus placed the stories of the people within the larger and encompassing story of
God’s redemption. Pastoral/spiritual caregivers do the same as they listen to the stories of
parishioners. As ambassadors of Christ in a caring relationship, congregational caregivers
seek divine guidance to do their ministry in the presence of Christ (Matthew 7:22; Mark
9:38; Luke 10:17-20). Consequently, caregivers give all the credit of any success they
might achieve in their ministry to God, because both the care recipient and caregiver have
been sustained, healed, redeemed, and loved by God.

In Being the Presence of Christ, Vestal explains that faith in Christ does not shield
believers from pain and problems, difficulties and disappointments. The present is a
strange mixture of suffering and pleasure. Successes and failures can happen
simultaneously. Joy and sorrow are often concurrent. The present can bring on the desire
to laugh and cry in the same moment. Perhaps it is not what was expected or chosen, yet it
is one’s story—and regardless, the presence of Christ is in the middle of it. The presence
of Christ works in stories that are still unfolding. Stories actually can become a song and

34 Dictionary of Pastoral Care and Counseling, 1990 ed., s.vv. “Pastoral Identity.”
create a greater space for the presence of Christ to make transformation. Some examples of this are contained in the Psalms (Psalm 1:1-3; 23:1-6; 27:1-14; 34:1-8; 63:1-11).

Christ’s presence compels and creates love (2 Corinthians 5:15-19). It reorients and renews the human spirit toward compassion and kindness (Colossians 3:12). That presence creates a whole new capacity to overcome. Receiving the presence of Christ and practicing the presence of Christ, offered by the caregiver, are inward realities and internal experiences. Christ’s presence alters one’s thoughts and feelings, strengthens the will, awakens the conscience, enlightens the imagination, creates motivation, inhibits destructive tendencies, and purifies motives (1 Peter 1:22-25; 1 John 2:28 - 3:2-3). This transformation occurs in a way that is totally non-coercive and coherent with people’s identity and distinct individual stories.

A Biblical Perspective of Congregational Care

In the Ante-Nicene Church, pastoral care was a clerical function assigned to the bishops (Hebrews 13:20; 1 Peter 2:25). Subsequently, the responsibility for caring, nurturing, and protecting the church members was passed on to pastors. In later years pastoral care became synonymous with congregational care, which relied on the teachings of the New Testament. In the Gospel of John and in the Johannine Epistles,

35 Vestal, Being the Presence of Christ, 66.

36 Ibid., 61-75.


38 Ibid.
church members are exhorted to love one another in such a way that the world would recognize them as Jesus’ disciples (John 13:35). Parishioners are to give priority to the needs of others. They may rearrange their schedule to accommodate the other; they may respond graciously to infractions of others. In other words, they are to bear one another’s burdens and so fulfill the law of Christ (Galatians 6:2). They are also to love one another, as Christ has loved them, because God is love (John 13:34; 15:17; 1 John 3:23; 4:7, 12; 2 John 1:5).

One of the highest expressions of congregational care is to faithfully follow Jesus’ example of ministering to his disciples. A solid theology of congregational care must be mindful of Jesus’ call for believers to care for one another as He showed us in John 13:1-17. This passage requires a reciprocal and sensitive system of care. The outline of this passage includes the following: Jesus washes the feet of his disciples (13:4-5); Jesus models spiritual cleansing (13:6-9); the essence of Discipleship is servanthood (13:12-17). In other words, Jesus saves us to build bridges of service and love. In the United Methodist doctrine, faith and works are equal parts of our salvation. John’s gospel is divided into seven parts. ‘Part 4” covers chapters 13 through 17 which focus on the preparation of the disciples by the Son of God. Washing of feet is included in chapter 13:1-20 which is the subject of this exegesis. Feet washing was culturally acceptable in Jesus day because most people travelled by foot on dusty roads. However, this was the primary responsibility of servants. It was rare that the master of the house would wash the feet of his guest except to convey deep love and affection. It was a menial task and beneath the stature of rabbis, high priests, Sadducees and Pharisees and perhaps the reason Peter tried hard to stop Jesus from carrying out what he considered to be
demeaning and a cultural anathema. As it was Jesus’ usual practice, he used the prevailing traditions and cultural nuances to prepare his disciples for kingdom service. This Passover was epochal. Jesus essentially became the Passover lamb to be sacrificed for the sins of all humanity.

Jesus used foot washing to offer spiritual and pastoral care in advance of his passion and crucifixion. He came alongside the disciples and offered comfort. He also modeled spiritual cleansing and humility. Through this act, he taught his disciples how to create wholesome relationships, and to build bridges of love and service, in the hopes that they might ultimately become conduits of comfort, compassion, and grace. According to Pope Gregory the Great, priestly authority should be exercised with humility by one who acts as a compassionate neighbor. The pastor is always involved in balancing the healing power of distance with the redeeming power of intimacy in the critical situations of pastoral/spiritual care. Choosing one over the other is to miss the essential calling of being a pastoral/spiritual caregiver.  

The functioning of the body provides a striking example of this complex interdependency. This is the nature of organic functioning. In Christian pastoral care of the sick, the organic functioning of the Body of Christ is vital. Acts 2:44-47 and 4:32-5:16 give an idealized but theologically significant picture of how early Christian communities practiced interactive pastoral care among themselves. The epistles perhaps give a more realistic view—for example, Romans 12:10, John 13:34-35, and Galatians 6:10. In Romans 12:9-16, Paul points out the need for a broad-based ministry. He writes: “Let love

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for our brotherhood breed warmth of mutual affection. . . . With the joyful be joyful, and
mourn with the mourners. . . . Care as much about each other as about yourself.”

This emphasis on imitating Jesus’ loving care for his disciples is supported in the
Gospel of John (John 13:31-34). The focus here is on loving action instead of loving
feelings. In other words, love is an outreach of compassion often accompanied by an
action of care. That action can be as ordinary as offering food to someone who is isolated
and lonely or as complicated as intervening in a medical crisis. A group of men
volunteering to reroof a family’s house due to limited finances is love in action. That
action is living out love as commanded by Jesus. When parishioners end up in the hospital
and care is extended to them through hospital visits, this is an expression of loving action
engendered by loving affection. If Christian love is to be understood, it is important to
look to Jesus’ life and actions. In other words, believers must learn and live the life and
actions of Jesus. The foot-washing that Jesus exemplified in John 13:1-20 sets the tone for
the humble service that Jesus expects his disciples to render to one another. Jesus repeats
it as a commandment, saying, “This is My commandment, that you love and unselfishly
seek the best for one another, just as I have loved you. No one has greater love [nor
stronger commitment] than to lay down his own life for his friends” (John 15:12-13). In
his own life, Jesus translates love into action that benefits the beloved. He calls Christ-
followers to do the same. Christian witness can take many forms, from street preaching to
solemn liturgy, but it always involves love. Ignoring this new commandment is not an

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41 Ibid.
option. Paul warns, “If I speak with the tongues of men and of angels, but have not love [for others growing out of God’s love for me], then I have become only a noisy gong or a clanging cymbal [just an annoying distraction]” (1 Corinthians 13:1-3).

Congregational care refers to all Christian acts of love that congregants offer to one another. For example, in contemporary times, simply phoning a fellow member of a church to cheer up someone who is homebound would qualify as an act of congregational care. Special events such as acknowledging major achievements, sending birthday cards, and reading the names of deceased members on the anniversary of their deaths also would be perceived as acts of love.42

A biblical perspective centers on God, who not only enters into human troubles (Psalm 91:13-15) but listens to their language of need, even those unspoken and unknown needs. God’s language of care extends to his people so that they, in turn, might better care for others (2 Corinthians 1:1-5). The predominant image of pastoral care is the Good Shepherd, which is primarily centered on Psalm 23. The outline of Psalm 23 includes a hymn of confidence (23:1-6); God protection and comfort (23:4); and the everlasting presence of God (23:6). This Psalm helps us discover a lot about ourselves, God, and our relationship with God. Psalm 23 is a hymn of confidence that pictures the Lord as the Provider, Protector and Comforter. David uses common imagery of his era to unveil his personal relationship with the Lord. This hymn contains some of the most profound and vital teachings about the Lord Jesus Christ in the entire Bible. This understanding of Christ helps us to follow His examples. According to the psalmists, God’s provision and

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42 Dictionary of Pastoral Care and Counseling, 1990 ed., s.vv. “Congregational Care.”
protection are available to those who have a relationship with Him. The psalms genuinely reflect real life experiences. Though the most culturally acceptable psalm, Psalm 23, talks about greener pastures and still waters it also uses trails and triumph to convey the sensitivity of God to our needs. For Christians, the concept of Jesus as the good shepherd is a unifying theme though not a practical function in our present context.

“Pastor” is the Latin word for “shepherd.” 43 This conveys the image frequent in both the Old Testament (Psalm 80; Isaiah 40:11; Jeremiah 23:1-4; Ezekiel 34) and New Testament (Hebrews 13:20; 1 Peter 2:25), which discloses God’s loving protection and guidance of God’s people, the flock. Jesus Christ, the Good Shepherd (John 10:1-18), apparently preferred this metaphor as a figure of self-designation (Mark 6:34; 14:27; Matthew 25:32; Luke 12:32; John 21:16).

According to Carroll A. Wise, the marks of the shepherd that draw on biblical material as well as the development of pastoral care through the years are instructive for contemporary ministry. 44 The shepherd knows the flock and is known by the flock (John 10:14). This statement underscores the significance of trusting relationships. To truly be a pastor or congregational caregiver, there is the necessity for significant involvement in the life of the people of God. By the same token, those who offer care and shepherd God’s flock demonstrate an openness that ultimately bears witness to human strengths and weaknesses and the power and grace of God to transform and renew (Romans 12:2).

43 Ibid., s.vv. “Pastor (Normative and Traditional Images).”

Some pastoral care interpreters have called for a new image, feeling that the biblical notion of the shepherd feeds dependency needs on the part of the parishioner and triggers countertransference tendencies in the pastoral caregiver.\textsuperscript{45} However, the caring, compassionate love and concern of the caregiver for the people of God affirms the value, the dignity, and the integrity of the people of God. Pastoral shepherding occurs wherever and whenever the people of God are supported in their pilgrimage toward wholeness.\textsuperscript{46}

Pastoral care is rather dynamic and varied since people are different, and thus requires different levels of care. While Psalm 23 is useful in understanding the concept of how God cares for his people, the shepherd image may no longer be a normative one.\textsuperscript{47} Presently caregiving is only distantly related to the original imagery of shepherding. Different life situations and experiences make it rather impossible to draw on one specific biblical paradigm; rather, Jesus as a servant, brother, and companion probably has more meaningful impact in the ministry of care.

In this vein, the normative and traditional images of pastors have three important aspects of pastoral care: leading, healing, and nurturing. Each aspect has images other than shepherd associated with it. Different situations encountered in pastoral care may require the caregiver to use all or a combination of these three aspects. For example,

\begin{itemize}
\item \textsuperscript{45} Carroll A. Wise, \textit{The Meaning of Pastoral Care} (Bloomington, IN: Meyer Stone Books, 1989), 223-224.
\item \textsuperscript{46} \textit{Dictionary of Pastoral Care and Counseling}, 1990 ed., s.v. “Shepherding.”
\item \textsuperscript{47} Ibid., s.vv. “Pastor (Normative and Traditional Images).”
\end{itemize}
leading takes shape as a form of guiding. Healing is seen as restoring, nurturing as sustaining with the Word of God.\textsuperscript{48}

The parable of the Good Samaritan in Luke 10:25-37 gives still another paradigm for pastoral care. Historically, Luke provides the most meticulous treatment of the Christ. The main thesis of the gospel of Luke is Jesus’ compassion for the poor and outcasts. He portrayed Jesus as the Great Physician who ministered to the physical and spiritual needs of all the people without exception (19:10). Jesus uses the Samaritan paradigm to inform patterns of pastoral care by Jesus. Luke 10:29 reveals man’s self-righteousness character; the scribes and Pharisees saw only the righteous people as their neighbors. They hated Gentiles, especially Samaritans, because they saw them as the enemies of God. They used Psalms 139:21,22: “Do I not hate those who hate You, O LORD? And do I not loathe those who revolt against You? \textsuperscript{22} I hate them with perfect and utmost hatred; They have become my enemies” (AMP) to justify their position, where hatred of evil is the result of loving righteousness. Yet Jesus taught that godly hatred is marked by a broken-hearted grieving over the condition of the sinner and is tempered with genuine love (Matthew 5:44 – 49). In Luke 10:33, the Samaritan is described as having compassion. The verb “having compassion” is shown to be the basic and decisive attitude in humans and hence in Christian acts.\textsuperscript{49} In Luke 10:34,35, the parable stresses the importance of teamwork in caring for the wounded. In this context team consisted of the Samaritan, the innkeeper, and the beast of burden. The Samaritan used his donkey to transport the wounded man to the

\textsuperscript{48} Ibid.

inn; and then recruited the innkeeper and paid him to care for the victim while he went on his journey and took care of his business. He promised to reimburse the innkeeper for any additional expenses incurred in caring for the victim upon his return. In other words, the Samaritan learned to find another helping professional, the innkeeper, to tend to the needs of the wounded. In this way the Samaritan engaged in teamwork and activated a community of caring professionals using the inn. As pastoral/spiritual caregivers, we shall at times confront situations that warrant specialized helpers or referrals. For example, persons suffering from major depression, bipolar disorder, suicidality, sexual abuse, rape, or incest must be referred to trained professionals. Referring a “traveler in need” to one of these professionals is an act of strength and a sign of wisdom. The parable also models the importance of self-care. The Samaritan finished his journey, thus demonstrating a balance between care of the wounded and care of self. If the Samaritan is seen as a representation of Christ, surely the wounded person experienced the loving gaze of God. Love of God, then, becomes interconnected with love of neighbor and love of self in this parable.  

The distribution of responsibility, the teamwork, is what Jesus, the Great Samaritan, desires. No one person, no sole minister, should be burnt out. This model of caring offered by Jesus demonstrated the importance of self-care. Pastoral/spiritual caregivers must take self-care seriously to mitigate overload and burnt out.

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Role of Senior Pastor and Associate Pastor

Many times, congregants in crisis first will go to their pastor because they hope to have a safe, confidential place to navigate a difficult situation. Due to this dynamic, pastors need to be careful not to fall into the savior syndrome. However, employing the grace to be sensitive and empathic can offer deliverance and healing. The UMC has a long tradition of calling the faithful to service in the world and in the Church. The Church understands that ordained and licensed ministers offer themselves to serve as “set-apart minsters” in ways that are different than laity. These roles have been re-shaped by time and circumstance and have evolved into their present form. In the UMC tradition, pastors are called by God and are authorized as leaders by the Church. They are ordained by a bishop to a ministry of Word, Sacrament, Order, and Service. They pledge to serve wherever they are sent. Elders preach and teach the Word of God, provide pastoral care and counsel, and administer the sacraments of baptism and Holy Communion. The servant leadership of the elder is expressed by leading the people in worship, prayer, and making disciples of Jesus Christ for the transformation of the world.

The majority of the elders serve in local churches as pastors. Pastors oversee the ministry of the church in its nurturing ministries and in fulfilling its mission of witness and service in the world (Matthew 28:16-20). This includes administrative oversight, evangelistic leadership, and disciple formation. Spiritual nurture and pastoral care in the congregation are central to the ministry of elders.

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51 United Methodist Church, Book of Discipline, 223.
52 Ibid.
Associate pastors model the theology and practice of care for those around them. They also encourage and help caregivers increase their confidence in praying aloud. With that confidence, the people can develop and encourage others to pray. Praying aloud classes may be offered by the associate pastors for congregants, key volunteers, and staff members using resources, including a book by Laurence Hull Stookey called *Let The Whole Church Say Amen! A Guide for Those Who Pray in Public*. The main goal of such a class is to imbue people with confidence and comfortableness when praying in public or when praying one on one. Associate pastors also may be responsible for the pastoral care ministry.

Role of the Laity

God bestows on his people the gift of calling (Romans 11:29) and the gift of work (Ephesians 6:5-6; 1 Peter 2:12). Work has both an external and internal character. Its external character is made up of acquiring tools, skills, and knowledge. Its internal character is that of creativity and inventiveness. The call to follow Christ in ministry is at the root of every calling and work. Christian service embraces everything done to make the world more what God intends it to be. Compassion, kindness, humility, gentleness, and patience are part of God’s work (Colossians 3:12).

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The UMC affirms that God calls all people and that the work of the laity is as equally valuable as that of the licensed or ordained. The laity, under the direction of the pastor(s), may develop and lead the congregation, establish community ministries, develop small groups, and engage in congregational development into the local community. The different levels of lay responsibilities and participation include the certified lay minister (CLM), certified lay servant (CLS), and certified lay speaker (CLSP).\(^{56}\)

CLMs are lay members who are called and equipped to conduct public worship, care for the congregation, assist in program leadership, develop new and existing faith communities, preach the Word, lead small groups, or establish community outreach ministries as part of a ministry team with the supervision and support of the pastor(s). This concept of certified lay minister serves to enhance the quality of ministry, much like a class leader did in early Methodism, through service in the local church.\(^{57}\)

The CLS serves the local church in ways in which leadership and service inspire others to a deeper commitment to Christ and effective discipleship. The CLS, through continued study and training, prepares and gives primary attention to service within the local church. This includes providing leadership, assistance, prayer meetings, training, study, and discussion. In addition, the CLS assists in conducting services of worship, preaching the Word, and working with committees and teams that provide congregational care and community leadership. The CLS also helps in distributing the elements of Holy


\(^{57}\) Ibid.
Communion and teaching the Scriptures, doctrine, organization, and ministries of the UMC.  

“The Certified Lay Speaker (CLSP) is a certified lay servant (or equivalent as defined by his or her central conference) whose call has been affirmed by the conference committee on Lay Servant Ministries or equivalent structure to serve the church in pulpit supply in accordance and compliance with paragraph 341.1. The CLSP serves by preaching the Word when requested by the pastor, district superintendent, or committee on Lay Servant Ministries, in accordance with paragraph 341.1. Recognition as a CLSP may be renewed annually by the conference committee on Lay Servant Ministries (LSM), or equivalent structure, after certain requirements have been met. ACLSP is a volunteer but an honorarium is appropriate.”

The Laity in the ministry of pastoral care can fill any number of roles in providing the best care for congregants. Some of the laity may be very relational and capable of doing hospital visits, telephone calls, and sitting with people who need encouragement and prayer. Other laypersons with administrative capacities may provide administrative support. Those who are skilled in finance, counseling, or medicine may be mobilized for ministry in those areas. The benefits of having the laity involved in congregational care are immeasurable. Most of the laity work in a voluntary capacity without compensation, hence alleviating the usual financial pressures churches face while enabling the pastoral team to focus primarily on Word, Sacrament, Service, and Order. Mobilizing the laity for

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58 Ibid.

59 Ibid., 217 – 218.
ministry provides a deeper level of care to all congregants, both members and non-members, and even those beyond the Body of Christ. Once they are trained, these laity meet regularly with their pastors. In this way, caring for the congregation is not a solo task; rather, it is a way of living together in community as the Body of Christ.

**Cultural Intelligence and Compassionate Leadership**

Sensitivity to the spiritual needs and individual differences that congregants manifest helps to foster the humanity of each congregant regardless of cultural, socioeconomic, ethnic, or religious differences. Understanding people as spiritual beings necessitates care for not only the body and mind but also the spirit. Providing spiritual/pastoral care is a significant aspect of treating the whole person, especially during a health crisis or trauma. Moreover, any effort to initiate spiritual assessment of congregants and attend to the spiritual and emotional needs and differences of parishioners through congregational care teams must demonstrate cultural competency and compassion.⁶⁰

Any emphasis on a quick intervention can run counter to efforts to foster a listening presence and a truly compassionate cultural perspective. A healthy cultural perspective is fostered through patience: a hesitancy to rush to conclusions, careful listening to the narrative of congregants, and withholding premature interventions that might be unduly influenced by the specific culture of a caregiver that might be different from that of the parishioner. Taking time to listen and to understand any congregant’s

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⁶⁰ Ibid.
spiritual orientation, even when the spiritual orientation of the caregiver and the parishioner fall within the same tradition, is crucial when working toward a goal of cultural competency.61

Competent and compassionate congregational care is marked by Cultural Intelligence (CI). CI requires caregivers to respect viewpoints that differ from their own and to refrain from trying to impose their values on others. A caregiver who is culturally intelligent has the ability to interact positively with people from an array of backgrounds.62 Competent and compassionate caregivers accept the reality that acquiring Cultural Intelligence is a process that takes time and focused effort. To understand another person’s point of view, caregivers have to temporarily set aside their own narrow cultural perspective to make space for another.63

Usually, a lack of cultural intelligence is unintentional. Sometimes it is caused by a simple lack of the knowledge needed to understand another person’s outlook. Other times, it results from a fear of the unknown or perhaps is due to attempts to deny the existence of cultural differences.64 Various cultures hold their own beliefs about the cause and treatment of diseases and about life and death. These beliefs may extend to unusual

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64 Ibid., 19.
approaches towards pregnancy, birth, and infant care. Often caregivers and those they care for are separated by a cultural gap from the very beginning of their relationship. Competence in the area of cultural intelligence leads to compassionate leadership.

Compassionate leadership is hardwired to offer empathic listening in an emotional and spiritual crisis or trauma. Medically, compassionate leadership leads to fewer hospitalizations for serious complications of chronic conditions. It also leads to brisker immune response and shorter duration of acute viral illness. It is purported to improve emotional and spiritual conditions.

Due to abuse of leadership, which can happen because of the fallen nature of humankind (Romans 5:12-14), spiritual/pastoral leadership must turn its back on authoritarianism and be tempered with love in order to offer compassionate care. The UMC encourages its pastors to balance the strength of their convictions with grace and love when dealing with congregants. The concept centers on Jesus’ earthly ministry of compassion, love, respect, and forgiveness in which the spoken Word and compassionate deed constituted a single unified expression of divine love and compassion (Luke 17:13-19). Therefore, in its deepest meanings compassionate leadership may be said to point toward God, in whom there is perfect, full, holistic communication of divine grace (John 1:14-17). In Jesus, the person and message became one, because he entered fully into the human

\[\text{Ibid.}\]

\[\text{Dee Borgoy, 28 Ways of Compassion: A Guide to Transformation and Leadership for a Relationship-Centric Healthcare Culture} \text{ (Austin, TX: River Grove Books, 2019), 11-23.}\]

\[\text{United Methodist Church, Book of Discipline, 110-119.}\]
condition to hear as well as to speak with accuracy and effectiveness to the existential human predicament (Romans 5:5-8).

When Moses and God met on Mount Sinai, the Lord declared that God is compassionate (Exodus 3:4-6; 33:19). The Gospels reveal Jesus as having a heart of compassion for the people (Matthew 20:34; Luke 7:13; John 11:34-38; Mark 6:34), using biblical paradigms that demonstrate that God is deeply compassionate and empathic yet not given to perpetual sympathetic companionship. In this way, caregivers must shed pointless kindness and opt to compassionately use their biblically informed voice to help people engage the powers and principalities that have a hold on their lives. The apostle Paul wrote: “For our struggle is not against flesh and blood [contending only with physical components], but against the rulers, against the powers, against the world forces of this [present] darkness, against the spiritual forces of wickedness in the heavenly (supernatural) places” (Ephesians 6:12; 1 John 5:19). When caregivers encounter powers against which cordiality and good cannot change the current crisis, they must help people to forgo their old reality in order to embrace what is new in Jesus Christ (Colossians 3:12; Philippians 2:1; James 5:11). This is impossible to do, if they do not have a sense of cultural intelligence, biblical wisdom, or specific guidance from the Holy Spirit revealing where the stronghold or lie might be taking root.

To be culturally intelligent and compassionate in pastoral care ministry, congregational caregivers must be aware that God is responsible for human diversity. This reality calls on all caregivers to view people from different cultures as creatures of the Creator, made in the image of God (Genesis 1:27; John 4:24), just like them. Sometimes monocultural people can regard diversity as an intrusion into their lives, due to a lack of
interaction with those whose traditions and cultures and even languages are different from their own. Interacting with those who are different presents many challenges, which can require modifications to everyday patterns and speech and even behavioral adjustments. However, responding to these challenges is rewarding and can contribute to important insights about the attributes of God.\(^{68}\) Despite cultural differences, all believers are found in Christ and believers in general are exhorted to be imitators of God (Ephesians 5:1), who is sovereign above all. The Holy Spirit can help congregational caregivers to embrace multicultural understanding and teach them to care for parishioners from different cultures.

**Multicultural Understanding**

Caregivers who function with multicultural understanding are able to engage more deeply in congregational care. After God created the world, he reviewed the “vast array” (Genesis 2:1) and declared that “it was very good” (Genesis 1:31). Such celebration of creation was a celebration of diversity. Cultural diversity cannot be celebrated unless those whose appearance is different, whose language is atypical, whose beliefs and customs are noticeably distinct are appreciated. Therefore, the notion that others who are different are somehow inferior in any way needs to be discarded. It is a spiritual imperative for congregational caregivers to see people of different cultures as reflections of the Creator just like themselves.\(^{69}\)

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\(^{69}\) Ibid., 24.
All human beings are reflections of the *imago Dei*, the image of God (Genesis 1:27). When caregivers allow themselves to learn from other cultures, they can start to see how God shows himself to people through those cultures. In this way, caregivers can catch a glimpse of God’s grace that may not be revealed so clearly or easily in their own culture.\(^{70}\) Consequently, there are not only logical but divine reasons for making a commitment to understanding and appreciating other cultures. That commitment can enhance the knowledge of God’s character, as it is revealed through diversity. As caregivers learn about diverse cultures, they will continue to expand their appreciation for the Creator. By creating diversity, God is telling people about himself—who is three distinct Persons in one God as Father, Son, and Holy Spirit (Philippians 1:2; 2 Corinthians 3:14; Colossians 2:9; 1 Corinthians 8:6). When caregivers acknowledge and honor people who are different from them, they are emulating God and celebrating the cultural diversity that he created in Genesis.\(^{71}\)

God wants the whole world—in other words, all people—to be loved (John 3:16), because love does not have cultural boundaries. It is not confined by the limitations of self-centeredness and/or cultural differences. Therefore, to love people of diverse cultures, caregivers need to know the people for whom they are providing care; and they can do this by learning about their beliefs and customs, respecting those beliefs and

\(^{70}\) Ibid.

\(^{71}\) Ibid.
customs, and celebrating their shared humanity as creatures of God, made by a loving Creator.\textsuperscript{72}

In \textit{Increasing Multicultural Understanding: A Comprehensive Model}, Don C. Locke posits the following: “Although thousands of publications have advocated increased understanding of multiculturalism, no step-by-step guidelines have been provided to suggest how that understanding can be accomplished.”\textsuperscript{73} This statement may be viewed as the reason that Locke developed his comprehensive model. The author points out that the role of caregivers needs to be expanded to accommodate the increasing diversity of the population. Caregivers should hold themselves responsible for developing their own cultural competency, so they can improve their services to people of various cultures.

Consequently, caregivers have a responsibility to increase their overall knowledge and understanding of multicultural groups within their sphere of ministry from the viewpoints of the groups themselves. This knowledge and understanding can equip caregivers to accurately evaluate the behaviors of these groups and respond with the right intervention, at the appropriate moment.\textsuperscript{74} Ethnic identity extends beyond race to include language, religion, socioeconomic status, culture, customs, and country of origin. This identity may be described as a relational phenomenon which deals with cultural and social differences.\textsuperscript{75} If caregivers ignore the reality of diverse populations and their

\textsuperscript{72} Ibid., 14.


\textsuperscript{74} Ibid., xi.

\textsuperscript{75} Ibid., xiv.
accompanying needs, any spiritual guidance that they offer may be of limited benefit or even cause damage unintentionally.

Caring for Parishioners from Different Cultures

It is essential for caregivers to evaluate and, if necessary, revise their traditional practices and approaches by researching how and why the experiences of culturally different groups within their sphere of ministry differ from one another. They also need to research how and why the experiences of culturally different groups are somewhat alike and yet different from the dominant culture. This research can help caregivers to develop strategies and interventions that are based on the cultural characteristic of the group and reflect their customary behaviors. It is imperative and incumbent on caregivers to determine the emotional and spiritual needs of the care recipient in order to be able to offer the appropriate interventions. It is important to ascertain one’s current reality and its ramifications before guiding those receiving care into a new reality.76

The earthly life of Jesus of Nazareth began and ended with a worldview and mission that were inclusive. Jesus’ life story displays the message of the Gospels and provides a framework of inclusion for the congregations that were receiving and reading these first-century documents.77 God wants those who follow him to love all people. Love does not have cultural boundaries. It is not confined by the limitations of self-centeredness and/or cultural differences. Therefore, to love people of diverse cultures is to know them

76 Ibid., 1.

and to learn about their beliefs and customs (cf. 1 Corinthians 13:4-8). To respect those beliefs and customs is to honor the Lord of diversity (Revelation 5:9).

**Application through Tradition and Experience**

The story of the Church reveals the most basic sense of tradition, which is the ongoing activity of the Holy Spirit in transforming human life. All Christians are united by this shared tradition. Scripture moves Christ-followers toward the principal manifestation of that tradition. The UMC openly follows the unity of both the practice and authority of Christian tradition. Tradition reveals that the Church communicates its unique experience and culture by using its own language, which extends beyond the mere use of words. Stevenson-Moessner points out that each culture creates its own language and grammatical structures.\(^7\) The Church is no exception. Christianity does not spring from New Testament times to the present as though nothing were inherited from the great cloud of witnesses in between. For centuries Christians have pursued the authenticity of the Gospel and Jesus’ ministry of care and compassion, as they responded to the needs of God’s people. In these pursuits, tradition has been a vital component. These traditions abound in different cultures in the world.

In addition to words, the Church traditionally has used specific tasks including giving Holy Communion, attending the sick, extending fellowship to the lonely and alienated, providing healing services to the needy, and using prayers and sacramental

\(^7\) Stevenson-Moessner, *A Primer in Pastoral Care*, 33 - 34.
listening to offer care. Embarking on care for multicultural congregations in the Body of Christ demonstrates a commitment to practice loyalties to friends, community, and ultimately to God.

The UMC’s theological task is centered on Wesley’s practice of examining experience, both individually and collectively, for the scriptural validation of the truths of God’s grace in the lives of people. When experience works together with God’s precepts, then Scripture ostensibly shapes both human identity and experience. Spiritual experience affects human experience; and human experience affects one’s worldview of spiritual experience. Experience confirms in a believer’s life the realities revealed in Scripture and in tradition and helps to chart one’s personal Christian witness.

The Christian experience is also corporate. Theological reflection is informed by the experience of the Church and by the mutual experiences of all people. God’s redemptive love embraces all of his creation (Genesis 1:26-28; 1 John 4:8). The human experience can include seasons of fear, depression, hunger, and loneliness. In this way, the Bible constantly reminds people not to be afraid (Matthew 28:5-6), to guard against depression (Philippians 4:8), to seek Jesus to satisfy their hunger, to congregate (John 6:28-29), and to stay in authentic relationship with people (Colossians 3:23; Hebrews 10:24-25). Paul reflected on this and wrote: “God has not given you the spirit of fear, but has given you the spirit of power, of love, and of a sound mind” (2 Timothy 1:7; Romans 8:15).

79 Ibid.
80 United Methodist Church, Book of Discipline, 80-83.
Experiences of healing and care and of progress belong to a solemn spiritual and emotional reflection (Matthew 9:35; John 9:6-7). As a powerful catalyst for theological reflection, experience encourages believers to pursue both words and deeds of love in carrying out the scriptural promises. Just as experience informs one’s understanding of scriptural norms, one’s experience also informs the caregiver’s task of offering pastoral care. Thus, Scripture remains pivotal in anchoring one’s efforts to remain faithful in Christian caregiving.

Commitment to the Narrative Approach

A narrative approach draws together the difficulties and the cultural meanings of an existential distress by gathering and exploring the stories of the whole person in a ministry of pastoral care. Through a narrative approach, cultural aspects of healing can be revealed by listening to the stories of parishioners, because the foundation of narrative inquiry is based on storytelling. Jean Clandinin and Michael Connelly posit, “The stories of one’s experiences—past, present, and future—provide an avenue to understand the experiences of stories lived and told as a partnership between storyteller and receiver.”

The complexities of serious illness require a narrative approach. Illness stories have been shown to provide rich details of the multiple complexities of one’s beliefs, values, emotions, and attitudes. Through a cultural focus, stories describe how human beings

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understand experiences of illness in their lives giving the receiver a view of how the storyteller expresses and organizes these experiences into a meaningful whole.  

Storytelling is a prominent and highly valuable ritual in many cultures. Thus, listening to others tell their stories of pain and joy can create a sacred place for them to encounter parts of their culture and themselves that they have spent years hiding, perhaps unbeknownst to them. Consequently, they are able to talk and relate gently to the images that show up in their stories. When parishioners feel totally received and heard, a mysterious power often is felt in moments of listening. Something shifts when a caregiver looks into another’s eyes, accepting even the broken or unsavory aspects without judgment. It evokes a deep and abiding hope.

Listening has a sacramental dimension. The apostle Paul reminds believers to remember that current suffering is not the end of the story (Romans 8:8-25). In her article, *The Art of Listening: Paying Attention*, Deborah van Deusen Hunsinger says that “the practice of listening to others is God’s love for humanity.” God demonstrates his love for people by listening to them when they pray. In listening to others, pastoral caregivers need

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82 Ibid., 19-22.


84 Ibid.

85 Ibid.

an empathetic imagination and the willingness to set aside their own preoccupations. They must seek to empty themselves in order to be fully present to the other.  

By attending to the stories of others, pastoral caregivers aim to create a bridge of understanding. Since the objective is to intercede on the other’s behalf, caregivers strain to hear the inarticulate longings beneath the needs that are expressed. They endeavor to deepen the other’s connection with themselves to bring all of the suffering self—joys and sorrows, fears and doubts, gratitude, regret, and lament—before God.

Bearing Witness

As caregivers bear witness to Jesus’ earthly ministry they become the repository of spiritual care to address the physical, emotional, cultural, and spiritual needs of parishioners without assumption, bias, or discomfort for either person. Bearing witness in spiritual care can invoke varied images or models. Beyond the model of the shepherd is that of the clown. This image was promoted by Heije Faber from Holland and by Seward Hiltner from Princeton. These authors assert that the clown reminds people with a tear and a smile that all share the human condition, the same human weaknesses. This powerful image helps to understand the role of pastoral caregiving in contemporary society. Of the clowns, it is surmised that “they are like us.” A third model for caregiving was

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87 Ibid.
88 Ibid.
89 Dictionary of Pastoral Care and Counseling, 1990 ed., s.vv. “Congregation, Pastoral Care of.”
90 Ibid.
promulgated by Nouwen and termed “the wounded healer.”

91 This presents a caregiver as both the awareness and transcendence of loss as “he or she is able to convey, as much by presence as by the wounds used.”

92 The empathic healer binds his or her wounds, while still prepared to heal others.

93 Bearing witness in the context of pastoral care is tantamount to an intentional act of compassion in Christ’s name to those in need. Caregivers offer basic tasks that can transform into holy actions, when they collaborate with Christ. Caregivers can visualize Christ at their side, as they deliver a hot meal to the family of a newborn or shop for a parishioner recovering from surgery. These devotional moments further deepen relationships with the Christ in whose name care and compassion are bestowed.

A caregiver’s willingness to enter into the uncertain circumstances of the other and even share in the awkward silence is tantamount to offering incarnational presence. This is emulating what Christ modeled in the incarnation. In the incarnation, Christ shared our human nature and dwelt among us (John 1:14). Jesus showed respect to others by his actions. He loved people for who they were. Paul writes: “While we were yet sinners Christ died for us” (Romans 5:6-8). Jesus’ compassion was always moved by the downtrodden, the sick, the poor, and sinful (Luke 4:18; Proverbs 9:17; Mark 2:17; James 5:13-16). He offered forgiveness (Ephesians 1:17), compassion (2 Corinthians 1:3-4), love (1 Corinthians 16:14), respect (1 Peter 2:17), and healing to the people (Luke 6:19). Even

91 Nouwen, The Wounded Healer, 98.

92 Alastair V. Campbell, Rediscovering Pastoral Care (London: Dartman, Longman and Todd, 1993), 42.

93 Stevenson-Moessner, A Primer in Pastoral Care, 55.
on the night of his passion, he modeled love and compassion for his disciples by washing their feet and breaking bread with them (1 Corinthians 11:26; Revelation 19:9; John 6:53). Jesus forgave sins and healed the multitudes (Luke 5:20; 8:46; 9:1; 13:12; John 4:47; 5:15; Matthew 8:3). In a similar manner, in pastoral care the care recipients can be respected and accompanied in their need. Christian companionship with compassion is offered to others, as caregivers choose to remain faithful to Christ.

Like Jesus, spiritual caregivers also need to honor the questions that surface in times of loss and transition. In his discussion on Pediatric Chaplaincy, Dane R. Sommer, asserts, “Whenever there is an interface of children and suffering there must be a discussion of theodicy.” In other words, theodicy is the intersection of grief and suffering. At this intersection, those whose lives and homes have been struck suddenly by tragedy invariably raise theological questions. Today’s world reflexively causes questions, because many people are steeped in traditional theism, believing that God is all-loving, all-knowing, and all-powerful. Hence, a formulaic response to loss has been developed. This formula finds expressions in varied ways but usually manifests itself in sadness, guilt, and anger. For example, since God is all-loving, all-knowing, and all-powerful, God could remove the present suffering and chase death away if he wanted. So whenever tragedy strikes, the focus is God’s inattentiveness, capriciousness, and God’s punishment for disobeying his commandments.

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94 Ibid., 24.

The great challenge is that often people are taught to respond to suffering with these formulaic responses, due to these images of God. The challenge in pastoral care is caregivers extending themselves to those who believe that they are unworthy of care from God and not much from anyone. Caregivers try to be present for those who have given up on God and in crises that are both emotionally and spiritually draining.

This is where actively listening to the stories of others can be an act of cultural intelligence and compassionate care. Simply expressing respect, openness, acceptance, and tenderness through one’s presence reminds others that they have not been completely abandoned by God in the midst of their crisis.

While presence makes a difference, presence alone is not enough. Through prayers, rituals, explanations, and leadership, caregivers have an opportunity to deploy their Christ-centered, incarnational calling through the Holy Spirit to help others shift paradigms and embrace a new reality. Caregivers, therefore, honor the questions of others by their presence and their words to help others rethink the manner in which they justify God’s presence or lack of presence in their lives and in their suffering.

Jesus loved questions. He honored the questions of the people with his presence and his words (Luke 20:1, 26, 40; Acts. 19:32). With Jesus there was no dunce corner. Of the 186 questions that were asked of him, Jesus most often answered with a question. This was the common way he helped people understand their spiritual functioning, including an awareness of the holy, a sense of divine presence, the nature of faith, the sense of divine grace, the sense of remorse for sins, the sense of communion with others, and the sense of vocation. According to H. Newton Malony, these seven broad
dimensions of experience are relevant for practical daily living. Jesus wept with those who wept and mourned with those who mourned; and he comforted them as well, just as when he returned to Bethany to comfort Mary and Martha when their brother Lazarus died (John 11:23-26). Part Three of this project will present a ministry plan that embodies these concepts for biblically based congregational care in the UMC that applies cultural intelligence and compassion.

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PART THREE

MINISTRY PRACTICE
CHAPTER 4
MINISTRY PLAN

This chapter develops a ministry plan designed to create congregational care teams at SSUMC to provide a structure for pastoral care and counseling. The teams will be indoctrinated in a culture that focuses caregivers on being present and relational, instead of simply performing tasks. The training and support of the team will be pragmatic and active, in order to keep the team from engaging in old habits that tend to promote information rather than transformation.

Lampe points out that once volunteers are selected, training should be offered in the fall and the spring and include the following topics: “Praying Out Loud, Pastoral Care through Crisis, United Methodist Polity and Doctrine, Preparation of Sacred Spaces, Funerals and Weddings, Hospital Visitation, and Care for the Elderly.”1 Accepting this recommendation, SSUMC’s core content will provide guidance regarding prayer, spiritual direction, pastoral care and counseling, and the safe sanctuary policy of the UMC. In essence, SSUMC’s congregational care plan will involve creating a toolbox for care and

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1 Lampe, The Caring Congregation, 25.
equipping those who feel called to this ministry with the resources and leadership needed
to give Holy Communion, attend to the sick, extend fellowship to the lonely and alienated,
provide healing services to the needy, and offer prayers and sacramental listening.

**Synthesizing Theological Conclusions for a Congregational Care Plan**

People at SSUMC generally assume that healing of the sick in pastoral care
ministry is merely task-oriented, something that the pastor does to or for someone.
However, the main focus of the caregiver is to stand alongside care recipients and offer
hope and compassion. Such a perspective closely approximates the pastoral principles
and practices seen in the life of Jesus and in the early Christian communities.²

The care recipient’s beliefs and understanding may be known or unknown to the
caregiver. Therefore, it is incumbent on caregivers to become familiar with such
underlying worldviews to guide care recipients in identifying their spiritual distress. As a
result, the caregivers can be equipped in comprehending the connection between
spirituality and informed healthcare decision making. For this reason, SSUMC caregivers
will be trained to acknowledge and address the existential needs of the congregants.

SSUMC caregivers also will be trained in the “art of listening in a healing way.”³
Unconditional regard and empathic understanding are prerequisites for healing listening.
It involves caregivers’ willingness to bring all of themselves to bear on the encounter
with the care recipient. A healing listener shows respect, love, and compassion to the
other. This creates a safe space for others to unpack their stories both verbally and

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² *Dictionary of Pastoral Care and Counseling*, 1990 ed., s.vv. “Pastoral Care of Sick, Toward a
More Comprehensive Approach.”

nonverbally. This skill will help caregivers at SSUMC to identify the emotional state of mind of the congregants they serve in order to foster deep conversations. Training of the caregivers will include learning to analyze people’s behaviors and conversations in order to ascertain their emotional expressions. When problems are recognized, the SSUMC caregiver will need to encourage the person with the emotional problem to seek emotional healing.

Responsible caregivers at SSMUC will need to reach out to congregants and encourage them to take a careful inward look at themselves and then decide if they need to participate in a specially designed spiritual healing service. At SSUMC, caregivers will be trained to provide spiritual care through empathic listening. This will require the caregiver to initiate a spiritual assessment to help direct the care recipient to available spiritual resources to begin the healing process.

The *Dictionary of Pastoral Care and Counseling* provides solid guidance on the practice of pastoral care and counseling. Based on this information, caregivers at SSUMC will be trained on how to successfully interact with congregants who are in need of spiritual and emotional healing. This kind of healing usually deals with assumptions, metaphors, meanings, values, and causal norms which define the problems and guide the practice of pastoral care and counseling. Consequently, this training will take the narrative approach and teach caregivers how to learn to observe people’s actions and words and link them to their spiritual and emotional well-being. An implementable and sustainable congregational care ministry at SSUMC requires congruent cultural

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4 *Dictionary of Pastoral Care and Counseling*, 1990 ed., s.vv. “Research in Pastoral Care.”
competence, humility, and sensitivity, in order to bear witness to the presence of Christ amidst the ministrations of the Holy Spirit during a congregant’s deepest moment of need.

Congregational care teams at SSUMC will work with parishioners in their care using the narrative approach to maintain a practice of spiritual transformation. This brand of congregational care includes insight into the parishioners’ needs as well as the perspectives of the Congregational Care Ministers (CCMs). According to Health Insurance Portability and Accountability (HIPAA) guidelines, discussion of spiritual assessments, spiritual care interventions, accounts of significant encounters and dialogues should always be confidential except when it becomes medically necessary to disclose.

Benner emphasizes that caring for souls involves caring for a person’s entire being. He points out that soul care never focuses on a single aspect of one’s being or problems. Instead, it involves interactions between two or more persons with the goal of contributing to the development of the whole person.\(^5\) Caregivers at SSMUC will be encouraged to consider reading his book and discussing his insights for possible use in delivering emotional and spiritual healing.

Benner also identifies and advocates five forms of soul care that should be an integral part of every church. These are Christian friendship, pastoral ministry, pastoral care, pastoral counseling, and spiritual direction. This theory claims a continuum of specialization that moves from broadest to most specialized, rather than a continuum of importance.\(^6\) As SSUMC embarks on its challenging journey of providing soul care to the

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\(^6\) Ibid.
congregation at SSUMC in Albuquerque, New Mexico, the ministry will be centered on various biblical paradigms including the Good Shepherd, Good Samaritan, Wounded Healer, Micah, Ruth, and Job.\(^7\)

### Creating the Toolbox for Care

A toolbox for care will serve as a useful guide for CCMs. In 1 Thessalonians 2:8, the apostle Paul wrote: “Having such a deep affection for you, we were delighted to share with you not only God’s good news but also our own lives, because you have become dear to us.” Stories of redemption where people are healed, restored, and even completely transformed are numerous in the ethic of Congregational Care. God has worked and continues to work in ways that are loving, mysterious and wonderful. According to Judith Lewis Herman, “Incarnating the tenderness of God’s compassion is important in an ethic of care.”\(^8\)

In the same way, the authenticity of SSUMC’s tenderness relies on respect for the people in its care. Respect includes an awareness that some people suffer unimaginable pain and distress. Thus, they deserve the sort of fierce tenderness parents afford their vulnerable children.\(^9\) Honesty requires that caregivers acknowledge and normalize their distress and help care recipients move into a new reality. Herman describes this process

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\(^7\) These paradigms were previously discussed in Chapter 3.

\(^8\) Judith Lewis Herman, *Trauma and Recovery* (New York: Basic Books, 1992), 33.

of validating people’s experience of suffering as “bearing witness,” for it is impossible to remain aloof through empathic listening. This theme of bearing witness is an important one, because healing includes truth telling and accountability. When our witness validates the suffering of people, then the possibility for meaning and hope return. The power of tenderness does not turn away from the distress of the sufferer. Rather, by respectfully bearing witness to those in crisis, our tenderness offers its own testimony of hope. The tenderness of compassion helps to restore the relational bridge between the caregiver and the care recipient and among the caregiver, care recipient, and God. Beverly Harrison has described this tender power as “the work of love.”

The ministry plan when implemented and sustained will provide valuable training for the CCMs to inculcate the balance between pastoral counseling and spiritual care. Lampe asserts that CCMs should be instructed in United Methodist polity and doctrine on how to offer spiritual and emotional care. They should also go through the UMC’s Safe Sanctuary training, a three-month course on discipleship, prayer, listening, and compassionate leadership.

In the SSUMC ministry context, the “Toolbox for Care” will be grounded in the empowering love of God and the possibilities of our love for one another. In this paradigm of care, however, congregational caregivers will adapt less to given circumstances and instead attend in a focused way to the emotional and spiritual climate.

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10 Herman, *Trauma and Recovery*, 5.


Therefore, pastoral care is the work of leading people from what is old into what is new. This necessitates a radical cultural shift in perspective from taking care of others to genuine caring for others, which summons them to take new responsibility for the well-being of their own lives.

The Toolbox for Care will involve engaging the principalities and powers and spiritual wickedness that hold both the care recipient and caregiver in bondage. Pastoral care for others entails challenging and confronting them by naming the patterns responsible for their disease and their broken relationships. It requires living by faith and not by sight, abandoning false compassion, and claiming the power to name clearly the prevailing dynamics to unmask the reality of “stuckness” and challenge others to become authentic selves.

According to Craig L. Nessan, the God behind this paradigm is not a commodity for sale to consumers of pastoral care. God does not allow the sufferer to remain stuck in the position of a helpless victim. The God of the Beatitudes and the Sermon on the Mount does not heap pity on those who are suffering. Rather, this God calls all people to a new reality in the power of the resurrected life of Christ as those liberated by God. A fundamental understanding of the theology of the cross underscores this paradigm. Salvation happens when the congregational caregiver moves beyond cordiality and shame to relate to other persons as representatives of God who have been set free by the reality
of justification by grace through faith alone. Only through the Holy Spirit and the power of the Word can all those involved in pastoral care be liberated and transformed.\textsuperscript{13}

The purpose is to set grace-filled guidelines and directions for the CCMs. The basic guidelines for anyone in congregational care will include setting boundaries, volunteer recruitment, ongoing training in clinical pastoral education, self-care, pastoral counselling, and pastoral response. In setting boundaries, CCMs may never put themselves in uncompromising situations. CCMs may meet in offices with glass windows, whereby people can see who is in the room but cannot listen in. CCMs need to understand that they are in positions of power when they are caring for parishioners. Consequently, they must never set a “date” for a meal or coffee or travel with a person of the opposite sex with whom they are counseling, never counsel someone alone in the church, and never go to a home visit alone if it may put them in a dangerous situation. Moreover, all CCMs must enroll and take a course in the UMC’s “Safe and Sacred Spaces.” This course also allows the church to do a legal background check on all potential CCMs.

CCMs will adhere to a dress code. When parishioners are in a vulnerable situation, the clothing of caregivers should not detract from the sacred moments where they are entrusted to provide incarnational tenderness and compassion. Moreover, CCMs should be aware of any sexual feelings they may have for a congregant, staff member, colleague, and for that matter anyone in their care. CCMs should acknowledge these feelings for themselves and keep these feelings private. They should never share these

feelings with the person who is the object of these feelings. They are encouraged to
debrief with someone safe.

CCMs should keep personal and family relationships healthy. They should pray
and pay attention to the needs of their soul. They should find their professional
counselors outside the church. They should avoid burnout by taking days off and finding
ways to play.

Basic Guidelines for Care and Support Ministry

CCMs will learn the basic SSUMC guidelines for congregational care. These will
involve a theology of spiritual care that is integrated with the present theory of SSUMC
pastoral care. They also will entail learning and/or further developing the present skills of
CCMs. The following topics will be covered in the CCM training: “Praying Out Loud,”
“Pastoral Care through Crisis,” “United Methodist Polity and Doctrine,” “Preparation for
Sacred Spaces,” “Funerals and Weddings,” “Hospital Visitation,” and “Care for the
Elderly.”

The first area of training is Praying Out Loud. This is the basic curriculum on prayer.
These classes will be offered to CCMs and other key volunteers. CCMs will learn how
prayer lifts us up out of the chaos of the moment to a different reality. That reality is where
we connect with God and where restoration can happen. CCMs will be trained to boldly
speak their conversation and petitions to God. Many times, people are reluctant to pray
aloud. However, CCMs must be able to pray with people on the phone, through an email or
other written correspondence, or in person. The main goal of the class is to give people tools
to be comfortable when praying aloud for groups or when praying one on one.
CCM trainees will acquire the skills to write and pray the different prayer types in the Psalms. They also will learn to always ask God to give them a right heart and words before they engage parishioners. In addition, they will learn to name God according to the situation, such as “Healing God” or “Gracious God.” Finally, CCM trainees will be taught to help people with their confessions so they can release their guilt, make petitions appropriate for each situation, and pray out loud when they are alone or in public. To learn this, participants will be provided with Laurence Hull Stookey’s resource, *Let the Whole Church Say Amen! A Guide for Those Who Pray in Public.*\(^\text{14}\) This book comes highly recommended for UMC laity. It is an excellent resource for preparing public prayers, although it may be short on making room for those who might embark on different forms of prayers.

The second area of training is Pastoral Care through Crisis. Crisis can be defined as times of “dis-ease,” challenges, confrontation, pain, or suffering. According to Wayne J. Menking, when people enter into these times, they expect God to offer sympathetic protection as well as a return to a homeostatic condition of stability.\(^\text{15}\) The entire biblical story gives testimony to God’s compassion. When God’s compassion is stirred, God always acts by calling forth a new creation and a new reality. God took notice of the deplorable conditions of the Hebrews in Egypt and brought them out of the house of bondage to the promise land (Exodus 1:8-22; Deuteronomy 34). Hence pastors, act first as representatives of the church, the community made by God, which authorizes the


\(^{15}\) Menking, *When All Else Fails*, 30-32.
pastor to convey on its behalf its redemptive experience to persons in crisis. In this way, CCM trainees will learn to uncover the particular meaning in the crisis at hand. CCM trainees not only will offer instrumental help but will work with those involved to interpret the present situation according to their ultimate concern.

To learn this, the training will lead participants to develop an ethos for a more helpful scriptural and theological perspective of suffering and practice of care for survivors grounded in the empowering love of God and the possibilities of human love for one another. CCM trainees will be issued Lampe’s *The Caring Congregation: How to Become One and Why It Matters* with it accompanying workbook. Here Lampe offers some of the best congregational practices and instructions on how to provide outstanding pastoral care. While Lampe has written a thoughtful, practical, and helpful book that offers concrete pastoral interventions, it fails to challenge the concept of pastoral care as passive listening or making people comfortable. So Menking’s *When All Else Fails: Rethinking Our Pastoral Vocation in Times of Stuck* will offer CCM trainees the skills needed to change their pastoral care approach when sympathy sabotages recovery and a failure of nerve leaves everyone stuck. In addition, the book offers relevant concepts of pastoral care interventions.

The third area of training is United Methodist Polity and Doctrine, as offered through *The Book of Discipline*, also known as “the Discipline.” The Discipline is a product of over two hundred years of the general conferences of the denominations that now form the UMC. The Discipline as the instrument for setting forth the laws, plan, polity, and process by which United Methodists govern themselves remains constant. The Discipline defines what is expected of its laity and clergy as they seek to be effective
witnesses in the world as a part of the whole Body of Christ. The UMC is structured for ministry through the continuing development of the Discipline and other formal documents. The focus was on practical ministry with an emphasis on the heritage, polity, and doctrine of the UMC. Emphasis was placed on the interrelationship of beliefs, mission, and practice. This book clarifies denominational governance and organization to UMC beliefs as well as UMC mission. It frames governance practices and organizational structure within a Wesleyan theology of connection. This approach will assist current and future CCM trainees to understand the importance of their roles and participation in polity as a UMC theological endeavor and key component of their UMC ministries.

At first glance, polity and not the Bible constitutes the basis of authority of the UMC. A newcomer to the UMC and/or for that matter someone joining the UMC from a non-denominational tradition might misconstrue UMC practices to be one that supplants the Bible with the Discipline. Due to this potential misunderstanding, it is imperative that the dichotomy between the Bible and the Discipline be clarified during the training of CCMs. People need to understand that the Discipline is what binds together United Methodists. It serves as a memorandum of understanding of our connectional structure. In other words, the Discipline is not intended to replace the Bible or to add additional requirements for salvation.

It is intended to provide a working and practical document for United Methodists “to dwell together as brethren” with one structure of the Church on a mutual path toward salvation (John 11:52; Hebrews 10:35). United Methodists affirm both that “the Holy Scripture contains all things necessary to our salvation” and that the Bible is “the true rule
and guide for faith and practice.”16 Official United Methodist doctrine is that anything not in the Bible is not necessary for salvation. The Discipline sets forth the theological grounding of the UMC in biblical faith and affirms that members go forth as “loyal heirs to all that is best in the Christian past.”17 Although the Discipline delineates roles of pastoral care for both clergy and laity, it lacks a training apparatus for pastoral caregivers on how to deliver care. For this reason, CCM trainees will be introduced to Mark A. Maddix’s *Pastoral Practices: A Wesleyan Paradigm*.18 This book will not only produce spiritual growth in CCM trainees but help them reflect the spiritual imperative to truly impact the cultural context—persons and community in need of God. According to Wesley, the Church should effect change in the surrounding community (Acts 2:5-6; Revelation 7:9).

The fourth area of training is “Preparation of Sacred Spaces.” Without audible words, a sacred space says, “Come to Me, all who are weary and heavily burdened [by religious rituals that provide no peace], and I will give you rest [refreshing your souls with salvation]” (Matthew 11:28). The act of creating a sacred place is one of courage, judgment, imagination, and intellect. According to Curtis W. Hart:

> The creation of sacred space partakes of an aesthetic vision sculpted out of prayer, conversation, study, and hospitality. The creation of sacred space is a venture encompassing a collection of voices, talents, and perspectives. It is a place where beauty and the holy embrace each other. Sacred space is a temporal location. And

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16 United Methodist Church, *Book of Discipline*, 83.

17 Ibid., v.

yet it also exists outside the bounds of time and history. Sacred space opens out into
the world while at the same time remains safe for the inner life and its secrets.\textsuperscript{19}

The purpose of this is to get CCM trainees ready to engage parishioners. They
will learn to be prepared and be sensitive. They will learn to always bathe their roles in
prayer. They will remember to get themselves in the right frame of mind that God really
might work through them and that the light of Christ might shine through them. CCMs
will learn to have parishioners sign the appropriate paperwork indicating how much the
caregiver respects the confidential nature of their situation.

Parishioners will always be informed at every pastoral encounter that whatever
transpires in the meeting is confidential, unless it needs to be shared with clergy but
always with their authorization. Additionally, in cases of suicide, abuse, and/or violence
caregivers would inform parishioners of their obligation to report it to the authorities.
CCM trainees will become versed in reporting regulations so as to communicate with
clarity to the right authorities. CCM trainees also will learn how to communicate and set
the appropriate boundaries in each pastoral contact with regards to the duration of the
conversation. They will learn how to conduct their sessions with grace and without
judgment. This will help parishioners share without fear or coercion. Skilled CCM
trainees will know how to ask leading questions and make reflective statements that help
parishioners to open up.

Key resources will be used in this portion of the training. One is Miller’s \textit{The Art
of Listening in a Healing Way}, and the other is Lampe’s \textit{The Caring Congregation}. Miller

offers the trainees a guide and explanation regarding the significance of healing listening. However, he fails to incorporate the need for spiritual assessment. To fill this gap, Lampe offers the import of spiritual assessment but lacks a step-by-step listening strategy. Together the two books will provide CCMs a balanced roadmap for creating a sacred space.

The fifth area of training is Funerals and Weddings. Planning a funeral service is one of the most important elements of pastoral care that can be offered to a family. Although funeral planning is usually reserved for ordained clergy, CCM trainees may offer care by providing food, transportation, and care for children and pets. CCMs will be trained on how to interact with the family, walk the journey with them by being alert to where they are, and gradually open their hearts and minds to the peace that is possible in the Lord. CCMs will be trained in how to offer a calming presence by reminding the family that this is not the end by representing the hands, feet, voice, and presence of the God of comfort. CCMs will be trained on how to assess the emotional and spiritual needs of the family, and to create a safe space for the family to share. CCMs will learn how to prepare a worksheet to collect information for the service to be later given to the pastor. Suggested reading and resources may include Lee Franklin’s *A Pastor’s Guide to Funerals*, Andy Langford’s *Christian Funerals*, Cynthia Danals’ *Just in Time!* and the *United Methodist Hymnal*.20

The sixth area of training is Hospital Visitation. Hospital visitation is one of the most important elements that can be offered through the church. First, it is essential to

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have permission to visit the sick. There are times when the patient or family does not want any visitors except the immediate family. As CCMs attempt to do this type of ministry, the objective for this training is to equip them with skilled eyes and intuitive hearts so that they can understand the multiple dimensions of life that connect all human beings. When people suffer from physical ailments, they also are affected spiritually and emotionally. When people become ill, their family and friends also may need care. Pastors and CCMs should be prepared to attend to the family and friends of the sick. It is important that they have the skill to be sensitive to the implications of not only the physical changes of the sick but also the spiritual as well.

Due to the complexity of the demands of this ministry, caregivers will train in following clear lines of care that are like a medical model of calling the doctor. Clear and effective options of contacting the church will be delineated for the congregation. In an emergency--when someone dies or suffers a fatal event--CCMs must notify the pastor(s). Once documentation is made, two actions—documentation of the visit and a suggested plan for follow-up care—must be noted.

CCMs will learn how to create a hospital kit, which will consist of a Bible, anointing oil, business cards, and a small supply of appropriate gifts. Ending a hospital visit is as essential as the preparation for the visit. CCMs will be trained on how to prayerfully end their visits. Caregivers must establish, deepen, and end pastoral relationships with sensitivity, openness, and respect. Lampe’s *The Caring Congregation* will be a useful resource here as well, since it offers detailed steps on caring for the sick in the hospital. The book, however, fails to include how spiritual distress is ascertained. For this reason, Fitchett and Nolan’s *Spiritual Care in Practice: Case Studies in Healthcare*
Chaplaincy will offer guidelines on spiritual assessment of patients. Both CSI-MEMO and FICA models will help team members in their development of a spiritual plan. The effort to recognize and address the spiritual needs and differences of patients through spiritual/pastoral care because of injury or disease will emphasize the ethic of care.

The seventh area of training is Care for the Elderly. The ethic of care for the elderly is deeply rooted in Judeo-Christian tradition and stems from the commandment to honor father and mother (Exodus 34:28; Deuteronomy 4:13). However, the ethos of caring for the elderly is a somewhat modern concept. Research has identified two main groups of the elderly. According to Albert L. Meiburg, the elderly can be classified as the young old (fifty-five through seventy-four years of age) and the old (over seventy-five). Hence, pastoral care and counseling of the elderly in the church will be carried out by paying attention to evolving dynamics of the elderly.\(^{21}\)

The purpose for CCMs in this type of pastoral care is to help the elderly discern their unique growth possibilities and sustain and encourage them to use resources of their faith. This implies that pastoral care and counseling of the elderly is not just what is done for those who are unable to take responsibility and initiative; instead, it is an evolving ministry among people seeking dynamic relationships. The church’s pastoral care of the elderly will include providing a place for ministry whereby the elderly can use their talents and invest their time. This may include volunteer service in the church or community. However, it should be emphasized that the ethic of personal, family, and pastoral relationships are more

important than the mere provision of activity. Religious rituals are also important to the elderly. Religious rituals represent continuity and the steadfast presence of God in the midst of loss or change. CCM trainees will learn to assist the ordained clergy in administering the sacraments, traditions, music, and liturgy that have meaning and significance to the elderly.

For the elderly who are disabled and home-bound, CCMs will make regular pastoral visits because they are important reminders of both the caring community and the grace of God. Generally, the primary concerns of the elderly include lack of vocation and finitude. Vocation has given most of the elderly their sense of meaningful participation, so the loss of work can result in a felt loss of significance and identity. CCM trainees will learn to offer a new reality of self apart from work. In other words, the elderly will be guided to accept themselves and others for who they are rather than for what they do or did. CCM trainees also will learn how to guide the elderly to achieve faith and values that enable them to transcend their immediate limitations or crisis.

CCMs also will learn how to serve as a symbolic presence and reminder of the protection and guidance of God. Theological conversations with the elderly are a means whereby they may invoke their faith as a way of managing their physical, emotional, and spiritual worries. CCM trainees will benefit from reading Lampe’s *The Caring Congregation* and its training manual and resource guide; both provide tools on how to care for the aging. Robert N. Butler’s article in *Psychiatry*, “The Life Review: An Interpretation of Reminiscence in the Aged,” will teach the trainees and the clergy how to

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22 Ibid.

offer and conduct a life review. Life review can help the elderly affirm a sense of personal significance and meaning and contribute to the evolution of the quality and intimacy of lifelong relationships.24

Expected Interventions and Outcomes

A clearly defined intervention helps to lead to a desired outcome. Proper assessment of prevailing health and spiritual crisis is a means of acknowledging people and helping them journey from where they are to where they desire to be. Benner explains that caring for souls is caring for people in ways that not only acknowledge them as persons but also engage and address them in the deepest and most profoundly human aspects of their lives. This is the reason for the priority of the spiritual and emotional aspects of the person’s inner world in soul care intervention. These aspects of life mark us most distinctively as human. However, genuine soul care does not focus exclusively on any one aspect of a person’s being to the exclusion of others. If care is to be worthy of being called soul care, it must not only focus on problems but focus on the nurture and growth of the whole person.25

Reviewing the history of Christian soul care, William A. Clebsc and Charles R. Jaekle in their book, *Pastoral Care in Historical Perspective*, note that such care has involved four primary interventions: healing, sustaining, reconciling, and guiding. Healing involves efforts to help people overcome their illness and move toward health and wholeness.


These healing efforts can involve physical as well as spiritual healing, but the focus is always the whole person. Sustaining refers to acts of caring designed to help a hurting person endure and transcend a circumstance in which recovery is either difficult or doubtful. Reconciling refers to efforts to rebuild broken relationships with God and neighbor. The presence of this component of care demonstrates the collective nature of Christian soul care. Finally, guiding refers to helping a person make wise choices and thereby grow in spiritual maturity.26

All of these and many more interventions have been carried out in soul care and in what John T. McNeil describes as “the presentation of all people perfect in Christ to God.”27 Christian soul care has been overshadowed by cure, as clergy and laity alike have been displaced by counselors and others as the preferred providers. However, Christian soul care is far too important to be relegated to the curative activities associated with the modern medical model. Caregivers at SSUMC will be trained in five forms of soul care interventions with resultant outcomes including ‘Christian Friendship,’ “Spiritual Direction,” Pastoral Ministry,” “Pastoral Care,” and “Pastoral Counseling.”

Intervention/Outcome #1: Christian Friendship

Christian friendship is a basic intervention offered by one Christian to another. Friends do not think of themselves as offering soul care when they call one another to offer moral presence or support or just to maintain contact. They are simply caring for those they love. However, friends who understand the high ideals of Christian companionship offer one of the most important forms of Christian soul care. If


congregants could be cared for regularly by friends and family in their totality with particular attention to the inner self, the need for formal and specialized expressions of soul care would be greatly reduced. Christian friendship is both important and possible, because it has its source in God. The Christian doctrine of the Trinity places friendship at the very heart of the nature of God. The eternal exchange of companionship that binds Father, Son, and Holy Spirit to one another extends to those Jesus calls to be his followers and friends. It is friendship that Jesus asks us to show to one another (1 John 4:7). At its best, the care offered by family and friends has the unique potential for deeper growth and healing. Unfortunately, families can fail to live up to the ideals of soul friendship. For example, parents may content themselves with discipline and instruction, failing to offer themselves also in a gift of friendship. Tragically, of course, couples easily and regularly do the same. Too often those who are active in caring for others outside the home offer little genuine soul friendship to those within their own family.

Consequently, the foundation of the soul care provided by the CCMs involve helping families become networks of genuine soul friendship. They encourage and support friendships between non-family members that do not resemble mere generic fellowship but reflect nothing less than the ideals of mutual soul care.

**Intervention/Outcome #2: Spiritual Direction**

Benner explains that spiritual direction is “a prayer process in which a person seeking help in cultivating a deeper personal relationship with God meets with another for prayer and conversation that is focused on increasing awareness of God in the midst
of life experiences and facilitating surrender to God’s will.” Spiritual direction is not limited to a specialized few. It is highly relevant for every Christian to take the spiritual journey seriously. CCMs will be trained to bathe this intervention in spiritual friendship focused on one’s relationship with God. In this context the “director” acknowledges the Spirit as the true spiritual director and seeks to help the other discern and submit to the leading of the Spirit.

Of primary importance in spiritual direction is the relationship between the one seeking spiritual direction and the Lord, and the overall goal is helping the directee attend to the leading and the presence of the Spirit in his or her life and surrender to God’s love and will. John J. Shea suggests that while both pastoral counseling and spiritual direction share a focus on faith development, they differ in their approach. Pastoral counseling by CCMs at SSUMC seeks to help people reach mature faith, while they help those with mature faith deepen such faith by living it out in the midst of life. CCMs will follow Israel Galindo’s approach to spiritual direction by focusing parishioners on the promptings of the Holy Spirit and how to respond in prayer and action.

**Intervention/Outcome #3: Counseling**

CCMs will be trained to foster spiritual wholeness at the heart of any counseling activity. They will be equipped to set counseling apart from other pastoral contacts by

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means of specific appointments that are held in a consistent and appropriate setting, because not all parishioner concerns fit the definition of pastoral counseling. If pastoral counseling is to be appropriately set apart from other responsibilities of pastoral care, boundaries are essential. CCMs will be trained to be attentive to how the presence and leading of the Spirit anchors pastoral counseling in emotional and spiritual care. They will learn how the role of silence is relevant to the pastoral counseling process. They will be equipped on how to use counseling to alleviate distress and promote growth, as they seek to understand people from a spiritual and a holistic perspective.31

Certain readings and resources will be part of the CCMs’ preparation.32 Edward P. Wimberly’s *Prayer in Pastoral Counseling: Suffering, Healing, and Discernment* will offer an excellent discussion of the ways in which prayer can be used in counseling and not merely be seen as a technique but rather as the very heart of the process. Howard W. Stone’s *Strategies for Brief Pastoral Counseling* will provide an overview of eleven contemporary approaches to brief pastoral counseling and prove useful because it shares a distinctive pastoral and parish emphasis.33 Finally, Howard Clinebell and Bridget Clare McKeever’s *Basic Steps of Pastoral Care and Counseling* will give CCMs a general overview of all aspects of pastoral counseling and clearly set forth its uniqueness.34

31 Benner, *Strategic Pastoral Counseling*, 28-44.


34 Howard Clinebell and Bridget Clare McKeever, *Basic Steps of Pastoral Care and Counseling* (Nashville: Abingdon, 1984).
Intervention/Outcome #4: Pastoral Care

Pastoral care is commonly used to describe a wide range of help offered by pastors, elders, deacons, and other members of a congregation to those they seek to serve.\(^{35}\) Since it is a ministry of compassion centered on the love of God, CCMs will be trained in how to simply reach out with help, encouragement, or to support another at a time of need.

They will be trained in how to mediate the gracious presence of God to another who desires to live life in the reality of that divine presence.\(^{36}\) They also will learn how to visit the sick by obtaining their location as well as seek permission from the individual or family before the visit; attend to the dying by being a comforting presence; comfort the bereaved by actively listening to silences, to words, and to pain, offering words of comfort and support; and encourage reconciliation for those estranged. Visitation in general is a sacred moment for individuals, families and the medical community; during the visit caregivers will be with those who are experiencing existential crisis and must be bathed in prayer and compassion. Caregivers must seek consent from individuals and/or family members before initiating visitations. However, in the event of unexpected hospitalization or surgery or imminent death, the pastor(s) must visit within twenty-four hours. Death takes precedence; care to the dying and family could be ongoing; caregivers can help people experience moments of redemption. When relationships are estranged,

\(^{35}\) Benner, *Strategic Pastoral Counseling*, 19.

\(^{36}\) Ibid., 20.
caregivers could offer hope in Christ. Ultimately, they will learn how to pray specifically and with compassion.  

**Interviewing and Selecting Volunteers**

Not everyone who volunteers might be suitable for providing spiritual care. A sound evaluation must be made of the volunteers’ abilities to ensure that they will be capable of providing appropriate care. Volunteers who meet the following minimum requirements of one year membership, regular church attendance, active participation in Christian discipleship through a small group, financial giving to the ministry of the church, and certification in safe sanctuary policy of the UMC longevity will be scheduled for interviews. Volunteers will be required to answer the following questions: “Why do you want to be a Congregational Care Minister?” “What does it mean to be a deeply committed Christian (or perhaps disciple)?” and “Do you practice any spiritual disciplines? If so what are they?” They also will be asked to write a one-page spiritual (or faith) autobiography. Small group leaders will be encouraged to identify members who appear to be imbued with the desire and ability for congregational care. They will identify volunteers by their regular service to God and the church, active membership in a small group, Christian discipleship in a major teaching or leadership event in the congregation, and certification in safe sanctuary policy.

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37 Holger Eschmann, “Toward a Pastoral Care in a Trinitarian Perspective,” *Journal of Pastoral Care* 54, no. 4 (December 1, 2000): 419-27.


39 See Appendix A.
A ministry fair also will be launched twice a year, in the spring and fall, to recruit additional volunteers. Four weeks prior to the ministry fair, a promo will be created by the director of lay and connectional ministries and be placed in the three primary outlets of church communication: eZine, newsletter, and emails to small group leaders. Slides for announcements in all three services will be created and placed in the church bulletins as well. On missionary fair Sunday, stations for the various caring ministries will be setup for interested parishioners to sign-up. The list of volunteers from the fair and small group leaders will be screened by the associate pastor and contacted by the administrative assistant to set up the interviews. Both the senior and associate pastor will conduct the interviews.

Safe Sanctuary Policy

Throughout the Gospels, Jesus provides teachings on providing a peaceable kingdom for all of God’s people. The peaceable kingdom begins with sanctuary. Psalms 20:1-2 and 27:4-5 provide examples of how sanctuary is to be a community of protective nurture and harmony. As disciples of Christ, volunteers are called to create a safe sanctuary at SSUMC. This must be a holy, safe, and protective community for all of God’s children—regardless of age, race, gender, and ability. This policy is not the result of lack of trust; rather, it is intended to protect children, youth, vulnerable adults, volunteers, staff, and the entire congregation. SSUMC is committed to providing protective care to all parishioners who participate in church-sponsored activities. The purpose of this safe sanctuary policy is to address the safety of the church family at all SSUMC-sponsored events, by striving to eliminate opportunities for the occurrence and/or
the appearance of abuse of any person in the congregation and by protecting paid and
unpaid leaders from false accusations or suspicions.

This policy applies to all persons, whether lay or clergy, who have any direct or
indirect contact with persons in the church family who participate in any activities or
events sponsored by SSUMC. Persons wishing to volunteer to work with children, youth,
vulnerable adults, or in caring ministries must complete the appropriate Volunteer
Application. Persons applying or being considered for paid employment must complete
the Application for Employment. All volunteers and paid staff are required to complete
the Consent to Perform a Background Check Form before being approved as workers
with children, youth, vulnerable adults, or in caring ministries. All completed forms will
be submitted to the lead person of that ministry who in turn delivers them to the director
of Connectional Ministries; the director then requests the background check and issues
the clearance for the commencement of work. Any red flags will be discussed with the
pastor(s), and appropriate action will be taken.

It is the intent of this policy and procedure that any actions will err on the side of
protecting children, youth, vulnerable adults, and those in the custody of caregivers. The
selection and approval of volunteers for ministry at SSUMC shall be at the sole discretion
of the church and its leadership. Once volunteers and staff are selected, they must
complete and sign the Participation Covenant Statement. Incident report forms will be
completed for all infractions and adjudicated by the pastor(s) and the task force on safe
sanctuary. The main tenets of the policy will include training on facility rules, first
aid/CPR, documentation for volunteers, campus security, supervision rules, youth
individual counseling, overnight accommodations, response to incidents of abuse, and detailed guidelines for pastor(s).

**Leadership Structure and Resources Needed by the New Ministry**

As the CCMs are being trained in their cultural shift from simply performing and doing to being incarnational and relational, they will receive strong and pragmatic support from active and ongoing pastoral leadership. This will help to keep the CCM teams from old habits that tend to promote information over transformation. For a successful congregational care ministry, it will be important for pastors, lay leaders, and volunteers to understand holistic care-giving for the whole person.

**Role of Pastors**

Pastoral ministry is broader than simply pastoral care. Pastoral ministry also forms part of the broader context of pastoral counseling. Hence, any attempt to reduce all of pastoral ministry to pastoral care or pastoral counseling is to fail to recognize the breadth and distinctive nature of pastoral ministry. Pastors who are concerned about the welfare of the parishioners are those who place emotional and spiritual care at the heart of their ministry.

Within the new ministry endeavor of SSUMC’s Congregational Care Ministry, the senior pastor will exercise a broad overarching role that includes overseeing sanctification and fellowship, reconciliation and conversion, and blessing and healing.\(^{40}\)

The senior pastor will continue his more specific tasks of preaching, teaching, leading

\(^{40}\) Eschmann, “Toward a Pastoral Care in a Trinitarian Perspective,” 419-27.
worship, administration, community involvement, nurturing, guidance, and celebration of the sacraments. However, he will take part in the selection of CCM trainees, commissioning them for ministry, and monthly oversight of pastoral care and counseling as well as leadership development. Larry J. Michael defines pastoral leadership as “the empowering of laypersons to accomplish the mission of Christ through the local church.”

Leaders’ ability to develop those around them automatically will determine the outcome of their leadership. Benner explains that since the spheres of these responsibilities are sometimes unclear it is important to fit these diverse activities together as a whole. In this ministry project at SSUMC, there is, however, a division of pastoral ministry responsibilities whereby the associate pastor is chiefly responsible for pastoral care and counseling and the specific hands-on training of CCMs.

In particular, the associate pastor’s role includes recruiting and training CCMs to engage in pastoral care and counseling activities. Such acts of spiritual and emotional care include visiting the sick, attending to the dying, comforting the bereaved, encouraging the reconciliation of the estranged, supporting those who are struggling or facing difficulties of any kind, nurturing and protecting the faith of those within the congregation, preaching, teaching, intercessory prayer, and administering the sacraments. The associate pastor will facilitate the formal training of the CCMs in how to do both spiritual history and assessment, to take pastoral care notes, to conduct pastoral counseling on a limited basis with emphasis on active listening, and when to initiate a

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referral. Anointing gives the opportunity for spiritual and emotional healing, so CCMs will be trained on how to anoint the sick.

Although pastoral/congregational care at SSUMC has expanded to include the laity, pastors still maintain an important role because they are perceived to bring both a Christian perspective and unique Christian healing resources to their work as “Pastoral Counselors,” “Spiritual Directors,” “Pastoral Caregivers,” and “Pastoral Leaders.” They incarnate what they have in order to teach others. Members will follow their pastors who follow the example of Christ in personal evangelism, caring for the sick, making hospital visits, attending the dying, visiting prisoners, feeding the hungry, and helping the poor. Volunteers and lay leaders will be trained to become adept in the ministry of pastoral care and pastoral counseling, and pastors will equip them to serve the Body of Christ.

Role of Congregational Care Ministers

CCMs will engage in congregational care according to their unique gifts and calling. This will include strategic pastoral counseling, which involves fewer sessions and is frequently concluded in as few as one or two sessions. They will be trained in how to conduct a pastoral diagnosis, set proper boundaries, explore central concerns and relevant history, achieve a mutually agreeable focus for counseling; also how to identify the resources for coping or change; and finally, how to evaluate progress and assess remaining concerns, and arrange for any needed referrals.

CCMs will be expected to conduct their ministry with respect, authenticity, and empathy to relate in a beneficial way to parishioners. Prayer, Scripture, and sacraments will be their ministry tools. Remaining sensitive to the Holy Spirit’s guidance, CCMs will
avail themselves to be used as instruments in bringing a parishioner more closely in touch with the God, who is the source of all life, growth, and healing.\footnote{Ibid., 73-103.}

Another role that CCMs will have is to reach out in Christian friendship. Christian friendship has its source in the triune God. Hence, caregivers need to center their internal compass on God, so that he might work through them and they can manifest the presence of his love, peace, and comfort in all their circumstances.

Additionally, CCMs will learn how to treat congregants with respect and establish ethical boundaries. In other words, caregivers should help congregants to share their stories in a safe and sacred space without fear or judgment. Congregants will learn to become informed that God heals through grace and not judgment so that they can share without fear. It is important that caregivers be ready to actively listen. Skilled listeners know how to ask leading questions and make reflective statements that will help the other person open-up. Allowing people to feel what they are feeling is important—\textit{that is} the art of listening to heal. Through listening and presence, healing can begin to take place. The key is ensuring that the person feels heard.\footnote{Lampe, \textit{The Caring Congregation}, 26-32.} Essentially, this is another key role that CCMs will fulfill as they are trained to attend to the congregation like Peter, who was charged by Jesus to feed his sheep (John 21:15-17).

Finally, CCMs will be trained to anoint the sick. In the UMC, anointing with oil offers an opportunity for spiritual healing as affirmed by Scripture in James 5:13-15. \textit{The United Methodist Book of Worship} explains that “anointing the forehead with oil is a sign
act invoking the healing love of God. The oil points beyond itself and those doing the anointing to the action of the Holy Spirit and the presence of the Healing Christ, who is God’s Anointed One.” Chapter 5 will discuss all of this information further, in its focus on implementation of the CCM strategy.

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CHAPTER 5
IMPLEMENTATION PROCESS

This chapter describes the implementation plan of the doctoral project. It lays out how the pastoral staff will interview and select volunteers who not only are suited for congregational care but are culturally competent and intelligent. This interview-and-selection process is important, since not every well-intentioned congregant is gifted to offer congregational care. This chapter also discusses how training will be completed, so that the initial team of leaders/volunteers can begin to conduct the ministry of care. They will be divided into teams of three to five members. Each team will have its leader monitor the activities of each team member to ensure accountability and compliance. Team leaders will mentor and provide individual training for their leaders/volunteers. The project will be assessed by each leader at the group’s first meeting and at the conclusion.

The chapter then discusses how each leader and participant will be tracked. It is important to track the provision of congregational care in order to discern and make adjustments, so the ministry can thrive in its effectiveness and efficiency. The hope is for this project to become a template for establishing congregational care teams in the Albuquerque District and the New Mexico Annual Conference of the UMC, respectively.
Timeline

The overall timeline for this project takes place over the course of three to four years. The time frame began during the summer of 2017 and will continue through December 2020. This is because it is very important to achieve full leadership buy-in, properly train congregational caregivers, and ensure that they are supported well as they are launched into ministry.

Prior to implementation was the pre-stage step, which occurred from July 2017 to December 2017. During a one-on-one regular meeting with the senior pastor in July 2017, there was a discussion about pastoral care. A suggestion for creating a pastoral care department to offer spiritual care for the needs of the parishioners was presented as a viable ministry project. The senior pastor liked the idea of creating a pastoral care department. This concept resonated with my recent experience as a Board Certified Staff Chaplain with the largest healthcare organization in Albuquerque. Subsequent meetings happened in order to flesh out the outline of a more structured and formalized spiritual and emotional care ministry at SSUMC, the existing care ministry notwithstanding. It was agreed upon that the existing care ministry which consisted primarily of Christian friendship be structured and formalized by training volunteers and leaders in pastoral care and counseling. This helped to launch the thesis for my doctoral project: creating congregational care teams to minister to the emotional and spiritual needs of the parishioners at SSUMC. The details of the project were formulated, and the final proposal was submitted for review and approval on December 7, 2017. The final proposal was approved in February 2018, and so the project started. The approved proposal was shared with the senior pastor, who formally approved the initiation of the ministry project.
From April 2018 to December 2018, there was an interim period of strengthening or “buttressing” the existing Care Team. In this interim period, I met with an informal care team consisting of a dozen lay people, who were already involved in offering some level of pastoral care. Together we sought to determine the future direction of pastoral care and counseling. This group met in April 2018. They were furnished with copies of the approved proposal of the ministry project and encouraged to spend time reviewing the tenets of the project. They were invited to offer feedback and suggestions during the next meeting in July 2018. After review and discussion of the proposal, it was adopted by the group. Under my direction, this group was given guidelines on how to offer Christian friendship, the least specialized form of congregational care. However, it is this friendship that Jesus asks us to show one another (1 John 4:7). They began intentionally visiting the sick and homebound; delivering meals, prayer shawls, and pillows; helping with funeral receptions; and sending cards to bereaved families and offering intercessory prayer. Formal training was scheduled to begin in November 2019 and to continue into February 2020.

The recruitment period for those who would be selected to participate in the formal training happened between January and May 2019. With the help of the director of connectional ministries, small group leaders received emails asking them to prayerfully identify and recommend members in their individual groups whom they felt were gifted with compassion and the capacity to offer regular service to God and the congregation with their time and talent. Other volunteers not affiliated with a small group but who expressed an interest in joining the pastoral care team were approached by me and other members. Moreover, congregants who have served and/or are currently serving
as police chaplains, social workers, and counselors also were approached. These volunteers were invited to attend ongoing quarterly care team meetings.

Between June and October 2019, the list of those who would participate in the formal training was solidified. Planning for the training began, and the CCM trainees were informed of the expected time commitment and responsibility to participate in CCM training. The second quarterly meeting was held on July 6. Thirteen volunteers attended. On July 30, a core group of six volunteers who agreed to be on the implementation committee met to review the details of the ministry fair on September 15. With the director of connectional ministries and me, they began helping to screen the list of volunteers, called them, and scheduled interviews during the first two weeks of October. The senior pastor, director of connectional ministries, two certified lay ministers, and I constituted the interview panel.

Formal training of leaders and volunteers began in November 2019 and will extend through February 2020, with a brief holiday break during the last two weeks of December. Training sessions currently are taking place on Saturdays for two hours for a period of twelve weeks. During this time, CCM trainees have been scheduled to complete their personal assessments. Teams will be formed based on how the CCMs are called to and are suitable for specific aspects of the care ministry.

Afterwards, the commissioning and releasing of the congregational care team will occur. In March 2020, the congregation will be informed of the graduation of CCM trainees and the imminent commissioning service to take place in all three services on

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1 Further details regarding this phase of implementation are discussed later in this same chapter.
Communion Sunday in April. The eZine, weekly newsletter, bulletins, and church website will be used to disseminate this information. The commissioning service will recognize and consecrate a commitment to the service of Christ in both the world and Church. Essentially, this is a reaffirmation of the Baptismal Covenant as a commitment to Christian service. As CCMs are released for congregational care ministry, they will embark on offering the full spectrum of congregational care as a result of the training, with close ongoing pastoral support, especially through December 2020.

**Recruitment of Leaders and Volunteers**

The recruitment of leaders and volunteers actually began in January 2019. Letters to small group leaders were jointly drafted by the director of connectional ministries, and the final draft was emailed to the thirty-five leaders of the thirty-five small groups. Other members were contacted when they expressed a desire to offer pastoral/congregational care. Still others were approached as result of the promptings of the Holy Spirit.

All three approaches launched in January resulted in ten new recruits. They were subsequently screened via a recruitment questionnaire. Each recruit had to answer four questions on why they felt called to and gifted for the ministry. The selected recruits were invited to the April quarterly care team meeting, where they were exposed to the overall mission of the ministry project. They were furnished with copies of the approved proposal and informed about the impending interview process that would be happening in October, followed by the commencement of formal training in pastoral care and pastoral counseling in November.

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2 See Appendix B.
Part of the formal recruitment process involved instruction on how to offer Christian friendship. Recruits learned that present lay pastoral care at SSUMC consists primarily of volunteers attending to prayer concerns from the weekend; visiting parishioners at home; and delivering meals, plants or flowers, cards and prayer shawls. Many already were engaging in these activities as an expression of their gifts. Others began making phone calls, compiling care notes, and creating a spreadsheet to document pastoral contacts. On occasion, housecleaning was offered by the volunteers when feasible or organized through a maid service. Hospital and other healthcare visits continued to be made by me and the senior pastor.

Present volunteers and recruits learned that the foci of New Testament theology is the notion that each baptized member is gifted for leadership and ministry. They came to recognize that one of the key responsibilities of pastors is to assist members of the congregation to recognize their gifts and calling, so all can be empowered to use their gift in God’s grace. Within the UMC context, supervision of lay leaders and volunteers is usually provided in the context of committee meetings or leadership training events.

A key aspect of recruitment involved a screening process. For example, volunteers were required to be active members of SSUMC for at least a year and actively fulfilling the four expectations of membership: attending worship each weekend, except when sick or out of town; consistently pursuing growth in the Christian life through participation in a small group or in some other form of Christian discipleship; serving God with their time in the ministry of SSUMC; and practicing generosity of time, talent, and treasure. Leaders and volunteers had to agree to and sign the Volunteer Leader Covenant. They were informed of the expectation to commit three hours per week to this ministry. In addition,
they were required to respond to questions on when they felt called and committed to congregational care and Christian discipleship, and to write a one-page spiritual (or faith) autobiography.\(^3\) This bio helped to screen volunteers for the care ministry.

Following the application process, interviews were scheduled by the director of connectional ministries/small groups. The pastors interviewed potential leaders and volunteers to ascertain their capacity for grace and compassion prerequisites for an effective care ministry. Volunteers who were gifted for a care ministry were selected for the necessary training. Others were redirected to ministry areas in the church where their gifts and grace could best be used.\(^4\) In total, ten volunteers were selected to participate in the formal training for SSUMC’s Congregational Care Ministry.

**Training Leaders and Volunteers**

The most important ability of a pastoral caregiver is the capacity to offer an honest, caring relationship. The relationship itself provides a personal and direct connection to the parishioners. The relationship is the context within which the resources necessary to help people deal with their emotional and spiritual needs can be mobilized. The caregiver offers such a relationship to the care recipient.

Consequently, the congregational caregivers at SSUMC need to demonstrate the ability to be honest and disciplined in their care ministry. Care ministry is disciplined when caregivers make sure to have their own needs met in other relationships. Care ministry is honest when the caregiver demonstrates what it is to be human. Essentially, it

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\(^3\) Lampe, *The Caring Congregation* 84-85. See also Appendix A.

\(^4\) Ibid., 24-31.
is a kind of pastoral relationship that creates a safe space for the people to move toward
telling their heartfelt stories. Competency of the caregivers is expressed through their
skill in hearing and accurately understanding the story as it is presented. As collectors of
stories, caregivers need to begin to reinterpret the stories in terms that present the care
recipient as one with significant responsibility for the events of his or her life. Both
dimensions of the process are equally important. Caregivers need to be able to function
on highly relational levels, where they are properly interpreting what they are seeing and
hearing from the care recipient. Ultimately, training CCM participants to function in
highly relational ways with cultural competence and compassion, while also meeting
their own very real need for pastoral care in a healthy manner, is the primary objective of
the training component of this ministry strategy.

Training topics include the following: “Praying Out Loud,” “Boundaries,” “Pastoral
Care through Crisis,” “United Methodist Polity and Doctrine,” “Preparation of Sacred
Spaces,” “Funerals and Weddings,” “Hospital Visitations,” and “Care for the Elderly.” In
addition to the training modules, which will be discussed below, ongoing monthly meetings
will provide CCMs with training in “Listening,” “Self-Care,” “Pastoral Response,” and
“Healing Objective.” Each session happens on Saturdays and lasts about two hours. They
begin with a 15-minute icebreaker in the form of introductions and getting acquainted and
then follow with a 15-minute video presentation, 20 minutes of content presentation, 20
minutes of group practice and discussion, and then 10 minutes for a brief break.
Afterwards, there is time for a 10-minute debriefing, 15 minutes for engaging in the
practice of praying aloud, and 15 minutes for a time of general questions and answers.
Class #1: Praying Out Loud

Prayer is communicating with God to draw others as well as the one praying into a deeper relationship with the divine. Our deepest longings are brought into the presence of God through prayer yet speaking to God is a spiritual discipline that takes practice. Learning to pray aloud, and to be comfortable doing so, requires practice and discipline. As the creator of this strategy and as part of my role as associate pastor in charge of pastoral care, I lead this class and all those that follow—unless another facilitator is raised up within the congregation to take on any portion of this role. Regardless of who serves as facilitator, the flow of training will stay the same.

At the beginning of the class, the facilitator will introduce himself and open the session with prayer. Participants then introduce themselves by name, state their length of time at the church, and briefly explain the reason why they feel called to the ministry of care. A video on activities to help learn how to pray aloud also is presented. These activities primarily include writing extemporaneous prayers, finding inspiration and language for written prayers, and praying Scripture. Lampe suggests that writing prayers down on paper is one of the best ways to begin to learn how to pray aloud. Participants will learn how writing prayers can help clarify and organize their thoughts and help them grow spiritually. After the video presentation, 20 minutes is spent on writing prayers. The class reviews a format of the facilitator’s written prayer, which will include an introductory praise, a confession, and a request for forgiveness and to be kept from temptation and acts of evil. The written prayer then will present requests, thank God in advance for granting

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them, and magnify and exalt God. The Lord’s Prayer and Psalm 91 will serve as inspiration and language for the written prayer. The facilitator then prays it aloud. Afterwards, participants divide into pairs and practice praying out loud their own written prayers. The group will come back together to share their experiences followed by any questions or concerns they may be experiencing. The class will end with a prayer, just as it started.

Class #2: Boundaries

On this day of training, the facilitator will open the session with prayer. Participants then will be asked to introduce each other and reflect on what they have learned about one another thus far. Participants will reflect on Galatians 6:2 and what it means to “carry each other’s burdens and so you will fulfill the law of Christ.” Boundaries are the limits or borders people place on relationships, which allow them to balance closeness and freedom. Boundaries safeguard and delineate what is acceptable and unacceptable behavior. Participants will be instructed to respect the boundaries of the parishioner in their care but also set boundaries for their relationship with parishioners.

Content on setting appropriate boundaries will include being aware of and managing personal emotions and maintaining caution in sharing personal information, as doing so could cause people to confuse the role of the caregiver who might be seen as just a friend instead of a spiritual caregiver. Trainees will learn the importance of being aware of their actions during the pastoral contact, especially with regard to touch and tone of voice. Additional basic rules may include never allowing themselves to be in an unsafe or compromising situation, setting a “date” for a meal or coffee or travel with a person of the
opposite sex for whom they are caring, going alone to a home visit if it may put them in a
dangerous situation, or sharing a person’s personal and/or health information.

The facilitator will role-play with a participant on how to set appropriate
boundaries and then encourage the trainees to work in trios to role-play setting
boundaries. One person will be the caregiver, another will function as the care recipient,
and the third person will serve as observer. Under the guidelines for boundaries that will
be provided to trainees, the observer will report on the setting, the emotions, the tone of
voices, the use of touch, the effect on the caregiver, the risk to the caregiver, and the
reaction of the care recipient. The rest of the participants will share how they felt when
the boundaries were breached or pushed and how to manage a strong emotional
atmosphere. The class then will break for ten minutes for refreshments and other needs.
Upon returning, participants will debrief on how their perspective has been impacted by
the presentations on boundaries followed by clarification of any concerns presented by
the class.\footnote{Ibid., 34-36.} The session will conclude with prayer.

Class #3: Pastoral Care through Crisis

On this day of training, the facilitator will greet the class and open the session with
prayer. Participants should know one another by name at this juncture. However, getting
to intimately know one other is essential for team cohesiveness, so trainees will be led in
how to engage in emotional transparency by breaking into pairs and sharing something
personal. Learning how to draw close to others is important for understanding how to offer
compassionate pastoral care, particularly during a health crisis or emergency. Following
this experience, the facilitator will instruct trainees on how to minister during a crisis and how to maintain clear channels of communication for the congregation to access care.

In an emergency, the pastor(s) is notified so an immediate visit can be made. If the pastor(s) cannot go, a trained volunteer/leader (CCM) will be sent. This procedure will be set for the weekday routine. Over the weekend, the associate pastor and two CCMs will take turns being on call. Once the initial visit is made, the following details will be noted: documentation of the visit, including information gathered about the illness, those who were present, and the care that was offered as well as a suggested plan for follow-up care. This information will be given to the triage person who can create the follow-up care plan. The pastor(s) should always be informed of important changes. Special considerations should be assessed in each situation, but the following are factors: age, severity of the illness, intensive care situation, possibility of imminent death, prolonged illness, family situation, and involvement of other churches. The following guidelines will be followed in a medical crisis: if the patient is a child, daily contact will be made by a volunteer; the pastor(s) will set a personal standard of visiting at least twice a week; if the patient is in intensive care or it is critical, the pastor(s) or CCM(s) will visit every day; if there is imminent death, the pastor will visit and assess the situation; if the parishioner is dying or has died, this is of utmost concern and urgency. When death occurs, the pastor(s) is to be notified as soon as possible so as to attend to the family immediately.

In the class, the facilitator will role-play with a participant to demonstrate this type of care, after which participants working in pairs will practice the basic rules and guidelines in the ministry to the other in an emergency or critical circumstance. The group then will break for ten minutes for refreshments and other needs. Upon
reconvening, they will debrief on how their perspective has been impacted by the presentation on pastoral care through crisis, and any concerns or questions will be addressed. The session will conclude with prayer.

Class #4: United Methodist Polity and Doctrine

The facilitator will greet the class and open the session with prayer. Participants will review the salient points of the three previous presentations and specify any areas of concern. The purpose of this is to deeply connect and root the ministry of caregiving into United Methodist Polity and Doctrine. One of the guiding principles of the UMC in its Book of Discipline is a caring congregation. Integral to the Methodist concept of care is the doctrine of grace for everyone. According to Wesley, every human being has a measure of the grace of God, because all are created in the image and likeness of God. Consequently, we have the cultural and moral mandate to nurture and care for one another. Lampe further stresses the importance of a caring congregation by suggesting that “life is messy and painful and no one can avoid the grief and loss that happens in all of our lives at some point.” UMC believes that sick or grieving people matter to God and warrant our compassion and support. Consequently, leaders and volunteers will be trained to carry out their SSUMC caregiving mission by living lovingly and justly as

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7 UMC, Book of Discipline, 159 -161.
8 Ibid.
servants of Christ by healing the sick, feeding the hungry, caring for the stranger, freeing the oppressed, and becoming a compassionate and caring presence.  

The facilitator will role-play with participants on how to uphold the gospel understanding that all persons are important, because they are created by God and loved through and by Jesus Christ and not because they have merited significance. The UMC Book of Discipline will be offered to ground participants in UMC doctrinal standards, theological task, and social principles. These tenets will guide participants in offering congregational care. The class then will break for ten minutes for refreshments and other needs. Upon return they will debrief on how their perspective has been impacted by the presentations on Church doctrine and polity. This will be followed by addressing any concerns and concluding the session with a final time of prayer.

Class #5: Preparation of Sacred Places

On this day of training, the leader will greet the class and open the session with prayer. Working in pairs, participants will continue to reflect on past session topics—praying aloud, boundaries, UMC doctrine and polity—and brainstorm what they think God is calling them to do in a congregational caring ministry. They will share what they collectively create with the whole class.

People experiencing some crisis will first call on their pastor hoping to have a safe and confidential place to process a challenging situation. As pastors and volunteers take on congregational care, it will be helpful to offer some guidelines and tools for engagement and creating sacred places. These include praying before each encounter, having the parishioner

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10 UMC, Book of Discipline, 159 and 94-96.
complete and sign the appropriate paperwork (if needed), and helping parishioners be ready to share. These steps help prepare a sacred space for the pastoral contact.

The facilitator will role-play with a participant to demonstrate how to transform the space by invoking and welcoming the Holy Spirit into their midst. First, the caregivers will learn how to center themselves on the triune God to be totally before the Spirit, so the light of Christ might overcome any insipid darkness by shining through them. Second, caregivers will ask the congregant to complete and sign the appropriate paperwork, which helps parishioners realize how much their situation is respected and kept confidential unless it needs to be shared with another pastor or CCM or psychological counselor. In such cases, a parishioner’s consent will be sought per prevailing state laws that govern the dissemination of such information. However, in cases of child abuse, caregivers are required to report. Caregivers will disclose their ethical boundaries to help the parishioner share without fear or judgment through active listening. After the guided role play, trainees will work in teams of three. One participant will act as the caregiver, another will function as the seeker of care, and a third person will observe and report when the class later convenes. The class then will break for ten minutes for refreshments and other needs. Upon returning, they will debrief on how their perspective has been impacted by the presentations on preparing sacred places, and any concerns will be clarified. The session will conclude with prayer.

Class #6: Funerals Planning

On this day of training, the leader will greet the class and open the session with prayer. Participants then will be asked to reflect on funerals that they have personally
experienced and the one thing they would have modified if they had been in charge. This exercise will help CCMs to reflect and set aside their own presuppositions about funerals and guide them into remaining receptive to new ideas. Planning a funeral is one of the most important elements of care that a pastor can offer a family. Although funeral planning is usually reserved for the pastor, there are also many opportunities for volunteers and leaders to help care for the family. For example, CCMs can deliver meals to the family, babysit children and family pets, run errands and offer a ministry of presence—essentially, just being present with the family.

The facilitator, acting as the caregiver, will role-play with three participants functioning as family of the deceased. Trainees will learn how caregivers introduce themselves; express the appropriate condolence to each family member by name, if at all possible; humbly express the honor and privilege of being able to be present in this sacred family moment; gently ask if it is appropriate to offer a prayer, and then invite them to share stories about the deceased. Participants will learn how this style of care can help break the ice with the family and help them relax. Working in groups of three, participants will role-play the demonstration. The class then will break for ten minutes for refreshments and other needs. Upon returning, they will debrief on how their perspective has been impacted by the presentations on funerals and weddings, with the facilitator responding to any concerns that surface.\textsuperscript{11} The session will conclude with prayer.

\textsuperscript{11} Ibid., 60-70.
Class #7: Hospital Visitation

The facilitator will begin with prayer and open the floor to participants who have done hospital visits to share their reflections on those experiences. Hospital visitation is one of the most important elements of care that can be offered through the church. As clergy and volunteers in the care ministry attempt to do this type of ministry with skilled eyes and intuitive hearts, they need to understand how physical and emotional distress affect the spirit and vice versa. Also, when one person is hurting, that person’s family and friends also may need care. For this reason, trainees will learn how important it is to be sensitive to changes in physical pain or spiritual perspectives. Much of the success of this ministry depends on clear means of communication.

The congregation may submit requests for care in four ways: a call to the office, a prayer request card that is usually received through the offering plate and the prayer box, online requests, and email requests. All these requests upon receipt will be jointly triaged by a CCM. The facilitator will teach participants how to triage a call or request by finding out the name of hospital, date of hospitalization, time, and place of surgery as well as the congregant’s relationship to the church. This is done along with ascertaining contact information, reason for admission, and whether the patient wants this divulged. This information will be entered electronically and only remain available to clergy, CCMs, and the pastoral team.

The facilitator will role-play with a participant on the basics of a successful visit. Trainees will learn how to first obtain permission to visit, since there are times when the patient or family does not want any visitors except immediate family members. Then they will observe how to pray before entering the room to ensure the presence of God’s
comfort, hope and love. Caregivers should have in their possession a “hospital kit” consisting of a Bible with special verses marked, devotional books, anointing oil, business cards, prayer shawls, lap quilts, and comfort pillows. Finally, trainees will learn how to “prepare the table” for communion in a hospital as well as how to anoint the sick with oil. Working in teams of three—the CCM, the parishioner, and an observer who reports on the work of the team when the class reconvenes—participants will practice among themselves. The class then will break for ten minutes for refreshments and other needs. Upon returning, they will debrief on how their perspective has been impacted by the presentations on hospital visitation. This will be followed by a question-and-answer segment to clarify any concerns that may have surfaced. The session will conclude with prayer.

Class #8: Care for the Elderly

On this day of training, the leader will greet the class and open the session with prayer. Participants then will be asked to reflect on any experiences they have had on offering care to the elderly. The facilitator will present an overview of this ministry by reviewing how in developmental terms, human beings move in infancy from the intense dependency upon their primary caregiver for nourishment and nurture to an ability to nourish and nurture themselves. Donald W. Winnicott describes the process of attachment and separation as a lifelong challenge, which is enhanced by discovery and use of transitional objects, such as the “blankie,” teddy bear, the arts, and religion—all of which help to soothe and distract people from pain and fear in the transitional
experience. Issues of attachment and separation surface multiple times in life and can be particularly troublesome during times of emotional or spiritual distress. Gregory Fricchione suggests that in healthcare, the physician and other caregivers in effect become transitional objects, a symbolic parental presence of protection and guidance.\textsuperscript{13}

The facilitator will role-play with two participants as to how congregational caregivers can function as transitional objects for the elderly and their families in the crisis of illness, whether a family is religious or not. If the family is religious, then the CCMs also may serve as a symbolic presence and reminder of the protection and guidance of God. This can be achieved only after the relationship has deepened and trust has developed. Trainees will learn how these conversations of ecstatic expression of faith dominate the interactions. The elderly tend to primarily reiterate their absolute faith in God’s sovereignty and loving care. Working in teams of three, CCMs will role-play on how to comfort the elderly and family by helping them affirm their worldview that God is in control; therefore, whatever happens will be the right thing. Theological conversations with the elderly is a means whereby they armor themselves with their faith as a way of managing their physical, emotional, and spiritual stresses. Sometimes unmet spiritual needs are buried underneath familiar comfortable religious language and imagery. CCMs will learn to help the elderly articulate those needs during their interactions, at the pace


and depth and choosing of the elderly. CCMs will practice respecting the elderly, which is deeply rooted in the Judeo-Christian ethos of honoring father and mother.

The spiritual task is to achieve faith and values that enable one to transcend the immediate limits of the self. The objective is to challenge the elderly to discover their unique growth possibilities and sustain and encourage them to use their faith resources. CCMs will practice how to help older persons find a place for ministry as part of offering congregational care. This may include volunteer service in the church or community. Overall, personal and pastoral relationships are more important than the mere provision of activity.

Another important aspect is helping adult children respect the importance of having confidence in the decisions their parents make. Religious rituals are also important to the elderly. CCMs will help facilitate the sacraments and the lifelong memories associated with these practices. Religious rituals represent continuity and the steadfast presence of God in the midst of loss and change. For the disabled and homebound, home communion and regular pastoral visits are important reminders of both the caring community and the grace of God. After concluding this topic, the class will break for ten minutes for refreshments and other needs. Upon returning, participants will debrief on how their perspective has been impacted by the presentations on caring for the elderly and raise any concerns to be addressed by the facilitator. The session will conclude with prayer.

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14 Meiburg, “Pastoral Care with the Aged,” 95.
Class #9: Listening

On this day of training, the facilitator will greet the class and open the session with prayer. Participants will be asked to visualize someone who is a good listener and identify characteristics that make that person a good listener. The facilitator will provide an overview of active listening and role-play the guidelines of listening with participants, after which trainees will role-play in groups of three. The most important task of the CCMs is to listen. As they listen, the Spirit may help them direct the conversation.

A chief skill in pastoral caregiving is that of listening to the silences, the words, and the pain and suffering. This skill may come naturally to some, but others can be trained to acquire such a vital skill. Some situations may warrant words of guidance, exhortation, or discipline. However, typically care recipients are not cognitively able to absorb very much in their circumstances. This is true in moments of shock and sadness and even celebrations of joy.\(^\text{15}\) Through listening and being incarnationally present with someone in the midst of their pain, healing can begin to occur. It is important that parishioners feel heard. They must experience this through the caregiver’s tone of voice and body posture as well as their full attention.

For this reason, the facilitator will articulate the different types of listening for different situations. This will include Miller’s assertions that different life situations call for different forms of listening. In other words, one style of listening may not be conducive for all of our encounters and engagements. He points out that there is a time to listen casually and a time to listen for comprehension; a time to listen critically and a time

\(^{15}\) Stevenson-Moessner, *A Primer of Pastoral Care*, 87.
to listen appreciatively; a time to listen therapeutically and a time to engage in healing listening. In pastoral care, Miller contends that healing listening differs from all the others, because it focuses more on being than doing. We listen not to help someone but simply to be with someone offering a shoulder for them to lean on and precipitate wholeness. Healing listening affirms and upholds the story of the other and frees them to feel complete or more validated. Listening in a healing way involves unconditional regard and empathic understanding for the other.

The facilitator will role-play the guidelines for listening. This may seem like an easy task, but authentic listening takes skill and patience. A prayer will be offered to set the stage for the conversation; the parishioner will be assured that it is safe to share without fear and that God heals through grace and not judgment. The facilitator will demonstrate how to seek the Spirit’s guidance and prepare to hear, pay attention and be empathetic. Skilled listeners know how to ask leading questions and make reflective statements that can help the person receiving care to open up. Working in smaller groups of three, CCMs will role-play a listening session. One person will seek care, another will be the caregiver, and the third will evaluate. A listening session may consist of a 5-minute conversation and 2-minute feedback, with trainees switching roles for another 5-minute conversation and 2-minute feedback, all followed by evaluation. As always, a

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17 Ibid., 13.
quick session break and time for debriefing with the facilitator as a large group will follow. The session will conclude with prayer.

Class #10: Self-Care

On this day of training, the facilitator will greet the class and open the session with prayer. Participants will be asked to reflect on what self-care means to them and to visualize what truly caring for themselves really is. The didactic will look at the importance of caring for self. Although ministry is fulfilling and gives life purpose, it also can be draining without proper balance. Consequently, trainees will learn how important it is to carve out time to replenish themselves spiritually, emotionally, and physically.

Cameron Lee and Kurt Fredrickson posit that the actual experience of pastoral ministry is both a joy and a burden.\textsuperscript{19} God alone gives the humility and courage needed to serve him and the Church. Without him, one’s calling constitutes cruel and unusual self-punishment.\textsuperscript{20} It is impossible to offer quality and consistent care, if caregivers do not care for themselves. Stevenson-Moessner explains that taking care of one’s own body, mind, and spirit is an essential part of responsible pastoral intervention. Pastoral caregivers need to see themselves in the way that God sees and loves them. This awareness then frees them to appreciate themselves and to love themselves in the same way that God does,\textsuperscript{21} which in turn empowers them to love others. Stevenson-Moessner holds that love of self is a commandment that Jesus has emphasized in Luke 10:27.

\textsuperscript{20} Ibid., 7.
\textsuperscript{21} Stevenson-Moessner, \textit{A Primer of Pastoral Care}, 53.
The facilitator will partner with one or two other participants to discuss how each carries out (or not) the following practices: spiritual practices such as praying, Scripture reading, worshiping, and a spiritual retreat; physical practices such as eating healthy food, exercising, getting enough sleep, and being able to recognize signs of stress; and emotional practices, which include taking breaks when needed or not, family time, and doing things they enjoy as well as working with a specific team to share the ministry load, debrief, and counsel with friends and colleagues. To encourage healthy ministry, this list will be used by trainees for personal periodic evaluation, once they are released formally to serve in the Congregational Care Ministry. Working in smaller groups of three, participants will process this information and start to formulate strategies for self-care. A quick session break and time for debriefing with the facilitator as a large group will follow. The session will conclude with prayer.

Class #11: Pastoral Response

Like previous sessions, this final class will begin and end with prayer. After the facilitator greets the class, participants will be asked to reflect on what a pastoral response means to them. This didactic will review the guidelines CCMs will need to respond pastorally. Lampe points out that a pastoral response is not judgmental or psychological. After actively listening to a suffering person’s story, CCMs will need to know how to deploy compassionate care in diverse situations. For this reason, in this session participants will learn how to allow time to reflect briefly on what they have heard.

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CCMs will be instructed on how to offer a moral presence and supportive validation, because in many situations they may be hard pressed to find adequate and appropriate words to respond to people’s personal stories. In these cases, it will be acceptable for caregivers to learn to respond by saying something like this: “Your story is so sad, and frankly it is hard to find words of comfort.” In moments of stress, anger, doubt, unbelief, and countless others, caregivers should know that it is good to offer a non-anxious and pastoral response, companionship, prayers, and the capacity to listen in a healing way. The key in all pastoral encounters is that people feel heard in the encounter.23

To model this response process, the facilitator will role-play with a participant to demonstrate a pastoral response by conveying through tone and body posture how to help parishioners feel heard. The facilitator also will model how to offer the Word of God as comfort, compassion, or wise guidance. Scenarios may include a 65-year-old man whose wife has died, hospital visits, or other moments of intense sadness or stress. Working in pairs, participants then will role-play a pastoral response session by processing theological questions that may arise by providing biblical references to their responses. Suggestions about grief, marriage, sexual abuse, addictions, and the like also may be provided as additional help.24

Commissioning and Introduction of Care Team to the Congregation

After new CCMs are trained, it is important that the congregation be given a chance to embrace their leadership. This will be accomplished by the senior pastor introducing them

23 Ibid., 30.
24 Ibid., 30-31.
and actually having a short commissioning element during Sunday worship. CCMs will be commissioned in March 2020 during a special service in front of the congregation. This will authenticate their pastoral authority and their ministry of care. CCMs will be given certificates and will be required to sign the Volunteer Leader Covenant before embarking on their ministry. Commissioning Scripture will be taken from Matthew 28:19-20:

Go therefore and make disciples of all the nations [help the people to learn of Me, believe in Me, and obey My words], baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe everything that I have commanded you; and lo, I am with you always [remaining with you perpetually—regardless of circumstance, and on every occasion], even to the end of the age.

This Scripture is chosen for the commissioning service to remind the CCMs that they have been called by and imbued by God and chosen by the people of God for leadership in the church. This ministry is both a blessing and a serious responsibility. It recognizes the CCMs special gifts and calls them to minister among the parishioners by offering their best to them, to witness in the world and to the Lord. This will remind CCMs as well as the parishioners of their baptismal covenant to live a life in Christ and make him known in their witness as faithful disciples of Jesus Christ.

An order of commissioning service will be part of all three Sunday morning services, because different CCMs attend different services so most and/or all of the congregations can be a part of the commission services this way. CCMs will be invited to the front of the church. Initially facing the pastor(s) and as their names are called, they will be asked to turn and face the congregation. Members of the leadership council will be invited to stand behind them and lay hands on them, as the rest of the congregants stretch their right hands toward CCMs in agreement with the UMC’s official “Order for
Commissioning Christian Service.” The mission of the UMC is to love God, love others, and serve the world. The commissioning service will celebrate the CCMs’ graduation from the training and their devotion to the tasks ahead of them, as they join with clergy to minister to the emotional and spiritual needs of the congregation at SSUMC. These leaders and volunteers who have chosen to serve God by serving their neighbor with their heads, hearts, and hands are deeply devoted to Christ and seek to partner with him in offering comfort, compassion, and healing.

**Dividing the Care Team into Sub-teams and Assigning Responsibilities**

Together the participants in the CCM training modules will form the pilot care team. The responsibilities of the pilot care team will include hospital visitation, hospitality, funerals, and caring for the elderly. Sub-teams will be created based on the skills and acumen demonstrated by volunteers and indicated on the self-assessment surveys by trained volunteers. Special attention will be taken to staff each committee with volunteers equipped to facilitate the tasks and responsibilities of their ministry areas. There will be four sub-teams staffed by a minimum of three members each. Whenever multiple tasks arise, a team will divide into teams to accommodate the imminent tasks. Additionally, new sub-teams will be created as congregational needs surface and are identified. The needs of parishioners will determine our path.

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25 See Appendix C for more information.
Hospital Visitation

Hospital visitation is one of the most important elements of care that the church offers its parishioners. Due to a pastor’s demands and responsibilities, visitation can be done by the pastor(s) or trained CCMs or together as a collaboration. This requires more than showing up, although a simple visitation may prove to be a useful intervention. Pastors, through their years of training, usually are able to discern the spiritual distress of the patient. Equally important is understanding the interconnectedness of the mind, body, and spirit so that what affects the body also affects the mind and spirit.

In the pastor’s absence, the leader of the Hospital Visitation Team will be called upon to facilitate the visitation after assessing the needs of the patient and to help to triage where multiple parishioners need to be seen at different locations. CCMs may visit in pairs following Jesus’ model. CCMs will learn to seek permission before doing hospital visits. If the request is for an unexpected admission, CCMs will visit within twenty-four hours of receiving the information. In an emergency or trauma care, the pastor will be notified so that visitation can happen immediately. If the pastor is unavailable, key CCMs will be dispatched depending on their proximity to the hospital. CCMs will wear their name tags so they will be easily identified by both the medical team and the patient in the event they have never met. CCMs will make sure they bring their “tool kit” consisting of prayer shawls, lap quilts, Bible with verses marked, small devotional book, and business cards. CCMs will document all clinical contacts, including the patient’s condition and the care/intervention given and how the patient responded during and at the end of the visit. Most interventions usually include anointing with oil,
Scripture reading, and prayer. This important element of care is bathing in prayer, before going to the hospital and entering the patient’s room.

Hospitality Team

The Hospitality Team will begin their ministry in March or April 2020, after the official commissioning service. The Hospitality Team will oversee greeting people and welcoming them to the church. They will help escort people to the designated areas in the sanctuary and seat them; they will help with the distribution of bulletins. They also will escort the immediate family members to a designated room and seat them. They will serve the water, tea, or coffee that awaits the family in the designated room and will stay with the family until handing them over to the pastor when he or she arrives. CCMs will attend to the needs of the pastor before exiting the room, ready to be called when needed. The Hospitality Team will be mobilized for special events and perhaps even Sunday services.

Many of Jesus’ most important lessons were taught while he was a guest at banquets. Friendly hospitality and fellowship made Christian gatherings more loving in biblical times and in the Roman Empire. It was faith in Jesus and his resurrection that gave birth to Christian fellowship. Perhaps the most effective tool with which to create a new and better world is simple hospitality—offering to God and people fellowship in our homes and the warmth of our personal interest in gatherings. This team will have the repast ready after the service and will escort the family and later all who came to the fellowship hall, where they will have a meal prepared with input from the family. The
team will ensure that everyone present has been served well. They will ensure safety and have the hall cleaned after the family and other people have left.

Funeral Planning Team

The Funeral Planning/Reception Team will begin their ministry in March or April 2020, after the official commissioning service. Although funeral planning is reserved for the pastor, there are many opportunities for CCMs to help care for the family. This team can provide meals, transportation, care of children, care of pets, setting up a memorial table at the visitation, and a host of other tasks.

In the absence of the pastor, a key CCM will be notified by the church office, where the initial notification is received, to mobilize the team to honor and meet the family at their point of need. The team leader will make the first contact and assess what the family needs. This will determine how many members of the team will be invited to offer care. Generally, CCMs will be of immense help if they respond graciously to the needs of the family to help people dispel their petty grievances. They also can help ameliorate familial dysfunctions. By providing prayers, Scriptures and words of comfort, CCMs can create a sacred space as well as moments for families to affirm their hope in Jesus. Christ’s resurrection makes these moments of redemption and community possible. CCMs also may help in drafting a bulletin for the celebration of life. Part of the Funeral Team’s responsibility will be to design a follow-up plan to support bereaved families.  

CCMs will be present for the family during the first three months after the burial as well

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as contact the family intermittently throughout the year. Grief books with notes will be
sent every four months after the date of death. Families will be invited to attend services
of remembrance such as All Saints Day.27

Caring for the Elderly Team

The Caring for the Elderly Team will begin their ministry in March or April 2020,
after the official commissioning service. Since elderly care involves personal visits much
in the same way as hospital visitation, and the two ministries may overlap, CCMs on this
team will function in a similar manner as the hospital ministry team. CCMs will visit in
pairs following Jesus’ model. CCMs will seek permission before doing visits. The team
leader will be informed of all requests for visitation and facilitate the deployment of
CCMs based on the needs of parishioners.

During an appointment with the elderly or homebound, CCMs will rely on their
specific training from the teaching model. They will respect the elderly in the Judeo-
Christian ethos of honoring father and mother. CCMs will help the elderly to reaffirm
their absolute faith in God’s sovereign care and comfort them in their
respective situations. CCMs will engage in theological conversations with the elderly, as
they seek to armor themselves with their faith as a way of managing their physical,
emotional, and spiritual stresses. Sometimes unmet spiritual needs are buried underneath
familiar comfortable religious language and imagery. CCMs will learn to help them
articulate those needs during their interactions, at the pace and depth of the choosing of
the elderly. CCMs will honor their spirituality and invite them to go even more deeply

27 Ibid., 42-44.
into these experiences to encounter the God of their understanding. CCMs will walk with them as a spiritual companion and fellow pilgrim in their own search for God. CCMs will demonstrate with their presence and behavior that this visit is a sacred encounter. They will be a sacramental presence of God’s love, compassion, and healing. They will set a table for communion to be served with the permission of the elderly and, as they leave, ask when another visit might be permitted.

**Next Steps for the Ministry Strategy**

It is vital to continue to envision and anticipate the needs of the congregation and how SSUMC can thrive. Scripture says that without a vision the people perish (Proverbs 29:18). Next steps will entail examining results, furnishing the results of the care ministry to the congregation, and modifying the care teams according to the needs of the church. As associate pastor, I will prepare quarterly surveys to be completed by care recipients.

This will provide insights into the key expectations of the parishioners. The responses also will be examined and actions will be taken to improve CCMs’ acumen and skills. Ongoing responses to questions on each intervention offered by CCMs and received by parishioners in these surveys can provide a valuable picture of the degree and range of commitment from CCMs. Sorting out the responses based on interventions and outcomes will further determine not only where investment in the ministry endeavor is needed but its effectiveness and efficiency. The CCMs will be required to write a report

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28 Fitchett, *Spiritual Care in Practice*, 257-261.

29 Ibid.
and submit it to me in my role as director of pastoral care. This process will help the
CCMs to self-identify specific barriers that need improvement.

Examining the Results

Continuous evaluation on the macro and micro levels are essential to the success of
this ministry. Six months after the CCMs have been functioning, the results of their efforts
will be examined. During the first year, ministry results will be evaluated on a monthly
basis. At the end of the first year, the project will be analyzed to ascertain what works well
and what aspects of the ministry endeavor will be pruned and/or created. On the macro
level, a key principle to keeping this ministry fresh and nimble is to constantly evaluate
the needs of the church, create a plan of action, and then review the results.\footnote{Lampe, \textit{The Caring Congregation: Training Manual}, 3.} Essentially, this will entail a ministry rhythm of action, reflection, and integration. On the micro level, CCMs will consistently evaluate the interventions received by parishioners in spiritual and emotional crisis.

On a micro level, CCMs will be required to constantly evaluate the interventions
they offer to parishioners in stressful situations. These evaluations will be analyzed and
used to deconstruct the overall focus of the project. This will be done in such a way as to
empower CCMs to use their gifts and help them collaborate with and support one another.

Furnishing Results to Congregation and Modification
of Care Teams

A written report pointing out the strengths and areas that need improvement will be
furnished to the leadership council and the senior pastor at our regular brainstorming
meeting. Together a plan will be developed to augment the ministry endeavor. High numbers of parishioners experiencing wholeness in their encounters with CCMs will be newsworthy, and this information will be communicated to the congregation through the announcements during worship services. The following Thursday a complete and full report will be shared with the whole congregation through the church newsletter, eZine, and email.

Reviewing the ministry project for further implementation and sustainability will be an ongoing building project. The findings of these reviews will be used to further analyze the congregational care teams. The needs of the congregation will determine our path. For example, the Funeral Team and Hospitality Teams may be combined to augment the services being offered to families, if the number of funerals increase.

Similarly, new teams may be created to meet unexpected needs. For example, if a few the parishioners suffer from joblessness, a team will be created to support their job search by designing an online job board. Guidance in résumé writing and financial counseling will be provided. A food bank would be set up to help struggling families in the church.\textsuperscript{31} Such innovation will be welcome from CCMs and others.

\textsuperscript{31} Ibid., 4.
CONCLUSION

The primary purpose of this project has been to set forth a plan to create congregational care teams to serve the emotional and spiritual needs of the parishioners at SSUMC in Albuquerque, New Mexico. Life is difficult and complicated, not to mention stressful and painful at times. As people of faith commit to healing and wholeness, sometimes just showing up and reaching out to one another can usher in a relevant intervention and be of much help. Other times, words of comfort or a listening ear can trigger a healing process. The ministry of Congregational Care at SSUMC is being carefully designed to connect parishioners with CCMs during their difficult times. CCMs along with the pastors will minister to the emotional and spiritual needs of the parishioners as an overflow of their gifts and graces in compassion, encouragement, and comfort.

The basic function of pastoral/congregational care is listening. Listening to the stories of others offers an outlet for healing. It provides the caregiver a chance to come alongside the care recipient to offer the kind of empathic and incarnational listening that is both subjective and objective. Robert Coles in *The Call of Stories* shares advice he received from his mentor, David Ludwig. Ludwig advised him to make the stories of his clients more of a priority than the diagnosis. Likewise, caregivers will do well to honor the stories of the people they engage in their pastoral contact, whether in churches or hospitals. Caregivers should not rush to identify emotional and spiritual distress of care recipients. In other words, as important as spiritual assessment is it should not be rushed.

The people who seek out pastoral or spiritual care bring the stories they hope to tell well enough, so caregivers understand the truth of their lives.

People need to know and feel that their stories have been heard. Ludwig also stresses that clinicians and for that matter caregivers should be good listeners by paying special attention to the nuances of people’s stories, including the manner of the presentation, the development of plot, character, and the addition of new dramatic sequences. Also, of importance is the emphasis accorded one character or another in the story and the degree of enthusiasm and coherence the care recipient gives to his or her story.

It is essential that the stories of parishioners are respected and honored by caregivers. Caregivers should see people as the subjects of their stories rather than the needs expressed by them. In this way, people are not viewed as problems but appreciated as actors in a narrative that is central to their lives.

By listening, caregivers may be able to help people locate their own stories in the larger story of what God has done in Jesus Christ. God demonstrates his love for us by listening to us when we pray. God commands us to love one another; so when caregivers listen to the other, they are demonstrating obedience to the love edict. Moreover, they are partnering with Christ in his healing ministry. By attending to the stories of others, congregational caregivers will create a bridge of understanding into the divine drama hidden in each person’s story that cries out to be heard. Trusting that Jesus Christ is

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2 Ibid., 7.

3 Ibid., 23.
already at work in the situation, caregivers will seek guidance from God. Since the gospel addresses fundamental human needs— for forgiveness and reconciliation, for love and hope, for justice and mercy, in short, for salvation—they listen to God as well as to the other.⁴

Listening in a healing way offers a care recipient a tool to start his or her healing process.⁵ Congregational caregivers, by listening in a healing way, empower people to abandon and renounce the stories that have shaped their lives in false or distorting ways.⁶ Hence, congregational care is an invitation that summons care recipients to switch stories and therefore change lives. In other words, congregational care invites people to give up and renounce the powers and principalities that hold them down and move into a new reality. People change their hearts and minds when they are given a new model, understanding, or interpretation of reality and can see how to fit their own stories into this new way of seeing reality.⁷ The Bible is already clashing with the presumed world of our culture.⁸

The congregational care project at SSUMC will help people confront the powers that have hold on their life. In the Wesleyan tradition, congregational care is much more than comforting people in their distress, although this is certainly part of a caring

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⁴ Ibid.


⁷ Ibid., 11.

congregation. It also includes discomforting people. In other words, this ministry project at SSUMC will not be content to reserve congregational care to only the accepted venues of life including funerals, weddings, and hospitals where people are apt to desire the presence of a CCM and/or clergy.\(^9\)

It is imperative that CCMs be equipped with the courage and practical guidance on how to offer Christ-like comfort and compassion during an encounter with parishioners in any stressful circumstance. The interplay of love of God, love of neighbor, and love of self will form the basis of every congregational care contact.\(^{10}\) This combination should mitigate the fear and anxiety that naturally accompany visits with people in their journeys through the valley of trials, hardships, sorrow, and suffering.

As congregational caregivers move forward to minister to SSUMC, they must maintain a robust view of compassionate and culturally relevant care. They must never allow it to become domesticated and assigned to certain life’s concerns. Rather, their ministry must be understood as care for the whole person and the whole congregation.\(^{11}\)

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\(^{10}\) Stevenson-Moessner, \textit{A Primer in Pastoral Care}, 47.

Applicant Contact and Membership Information

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Areas of involvement at St. Stephen’s United Methodist Church

**PRESENT INVOLVEMENTS:**

**PAST INVOLVEMENTS:**

Areas of involvement in a previous church, profession or volunteer capacity

**PREVIOUS CHURCH:**

**PROFESSION:**

**COMMUNITY VOLUNTEER:**

Please Respond to the Following:

1. **WHY DO YOU WANT TO BECOME A CONGREGATIONAL CARE MINISTER?**

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Our lay leaders, along with our staff, fulfill the biblical roles of elders and deacons, shepherds and teachers. Throughout the New Testament, leaders are called to be examples to the rest of the church. As leaders, they are held to higher standards than other members. Paul sets forth lists of attributes of elders and deacons in his letters to the early church. Leaders should be “above reproach” and “not be puffed up with conceit” among other things. Peter, likewise, challenges leaders to be “examples to the flock” and to exercise leadership with a willing heart. Because leaders are held to a higher standard, James says, “not many of you should become teachers, because you know that we who teach will be judged more strictly.”

As leaders, we set the tone and pace for the entire congregation. We model the Christian faith, the Christian life, and the attitude and heart of a Christian for our congregation. We shape the heart, character and life of this Christian community. For this reason, it is vital that we walk the Christian walk. Spiritually healthy leaders will produce a spiritually healthy church. Likewise, leaders who fail to walk with Christ will have devastating consequences.

With this in mind, the following covenant was developed to guide our life together as leaders. We use these standards to hold ourselves accountable to pursuing the Christian life. And in so doing,

Please Respond to the Following:

2. WHAT DOES IT MEAN TO BE A DEEPLY COMMITTED CHRISTIAN (OR DISCIPLE)?

3. DO YOU PRACTICE ANY SPIRITUAL DISCIPLINES? IF SO, WHAT ARE THEY?

4. EXPLAIN YOUR UNDERSTANDING OF GRACE.

Please Respond to the Following Questions:

5. WRITE A ONE-PAGE SPIRITUAL (OR FAITH) AUTOBIOGRAPHY

VOLUNTEER LEADER COVENANT

Our lay leaders, along with our staff, fulfill the biblical roles of elders and deacons, shepherds and teachers. Throughout the New Testament, leaders are called to be examples to the rest of the church. As leaders, they are held to higher standards than other members. Paul sets forth lists of attributes of elders and deacons in his letters to the early church. Leaders should be “above reproach” and “not be puffed up with conceit” among other things. Peter, likewise, challenges leaders to be “examples to the flock” and to exercise leadership with a willing heart. Because leaders are held to a higher standard, James says, “not many of you should become teachers, because you know that we who teach will be judged more strictly.”

As leaders, we set the tone and pace for the entire congregation. We model the Christian faith, the Christian life, and the attitude and heart of a Christian for our congregation. We shape the heart, character and life of this Christian community. For this reason, it is vital that we walk the Christian walk. Spiritually healthy leaders will produce a spiritually healthy church. Likewise, leaders who fail to walk with Christ will have devastating consequences.

With this in mind, the following covenant was developed to guide our life together as leaders. We use these standards to hold ourselves accountable to pursuing the Christian life. And in so doing,
we recognize that it is God’s grace which calls forth our faithful response, and it is God’s grace which brings such transformation in our lives.

I. THE GOAL OF THE CHRISTIAN LIFE: SANCTIFICATION

Jesus summarized the goal of the Christian life with two commandments: love the Lord our God with all your heart, soul, mind and strength; and love your neighbor as yourselves. John Wesley spoke of this goal as sanctification, Christian perfection, or holiness. In our Methodist tradition, three General Rules were designed to help Christians pursue this goal. As leaders we pursue these “rules” as we grow in faith and service together.

A. Avoid those things which are inconsistent with the life of faith, separate us from God, and bring harm to others, such as:
   1. Self-destructive behavior (addictive behavior, poor self-care)
   2. Moral compromise (sexual misconduct, greed, dishonesty)
   3. Self-centeredness and pride
   4. Malice (harboring resentment, acting in anger, backbiting)
   5. Wasting of resources (the church’s, or personal resources of time, talent, finance)

B. Do good of every possible sort, such as:
   1. Live a life of love
   2. Share our faith inside and outside of Resurrection
   3. Care for our families
   4. Build others up
   5. Be engaged with those in need, both inside the church and out

C. Pursue growth in our spiritual lives, such as:
   1. Attend worship each weekend, except when sick or out of town
   2. Engage in close Christian friendships for spiritual growth and accountability in a small group
   3. Serve God with our time and talents
   4. Give in proportion to our income, with the tithe being the goal
   5. Spend time in prayer and the personal study of scripture

II. THE HEART AND ATTITUDE OF A LEADER AT RESURRECTION

A. What is the heart and attitude of a Resurrection leader?
   1. Humble (servanthood)
   2. Positive
   3. Joyful
   4. Committed to Christ
   5. Devoted to the purpose and vision of the Church of the Resurrection

B. How will Resurrection leaders live toward one another?
   1. Demonstrating respect and grace
   2. Accepting differences
   3. Maintaining appropriate confidentiality
   4. Publicly supporting other volunteer leaders, pastors and staff members
   5. Going directly to the individual whenever a problem arises

III. THE FAITH AND CHARACTER OF A UNITED METHODIST

The Church of the Resurrection is a United Methodist Church. We expect our leaders to honor our denominational heritage and to pursue ministry in keeping with our tradition.
United Methodists are people who seek to love and serve God with our head, our heart and our hands. They are orthodox in faith, liberal in spirit, passionate and deeply devoted to Christ, and desire to be wholly surrendered to God. They bring together both the evangelical and social gospel-inviting people to a life-transforming relationship with Jesus Christ, and then equipping and challenging them to live their faith in the public sphere, being engaged in the issues of our time and seeking to shape a world that looks more like the Kingdom of God. Methodists have been known as "reasonable enthusiasts"-valuing both a personal, passionate faith and one that is intellectually informed. Methodists are constantly looking to connect our faith to the world in meaningful, relevant ways. Methodists value spiritual disciplines and a "methodical" approach to growing in the faith. They strive for both personal holiness and social holiness.

United Methodists are not afraid to ask difficult questions, to take on tough subjects, and to admit that they do not always understand the answers. They are "people of the Book" - holding the Bible to be the inspired Word from God and encouraging people to read, study and live by its words. "While we acknowledge the primacy of Scripture in theological reflection, our attempts to grasp its meaning always involve experience, tradition and reason. Like Scripture, these become creative vehicles of the Holy Spirit as they function within the church."¹ Methodists also believe the Bible came to us through people who heard God’s Word in the light of their own cultural and historical circumstances. And hence, they study the scriptures carefully, making use of scholarship and asking critical questions. And, as Methodists encounter theological differences amongst Christians, they bear in mind John Wesley’s approach, “in essentials, unity; in nonessentials, liberty; in all things, charity.”²

Methodists are people who love God with all their heart, soul, mind and strength, and love their neighbors. They pursue acts of piety toward God and acts of mercy toward others. They value passionate worship, relevant preaching, small groups to hold Christians accountable to one another, the need to address the social issues of our time, and the need to be people whose faith is firmly rooted in and built upon the scriptures. Methodists value the full participation of women and men, people of all races, classes and backgrounds in all facets of fellowship and leadership within the church and society.

This is our heritage, and it continues to shape the Church of the Resurrection in every area of our ministry.

COVENANT:
I have read the above and am committed to living my life and pursuing ministry in a way that is consistent with these expectations, and desire to do so at the United Methodist Church of the Resurrection.

____________________________________________________  ______________________________
Name                                                      Date

¹ 2012 Book of Discipline of the United Methodist Church, ¶ 105. ² ¶ 103.
APPENDIX B

SELF-ASSESSMENT QUESTIONNAIRE

Please fill in or circle the answer that most reflects your personal experience.

Why do you feel called to the ministry of pastoral care?
________________________________________________________________________________

What spiritual gifts do you bring to the ministry of care?
________________________________________________________________________________

How important is self-care to you?  (Circle one)
Very Important/Important/No opinion/Unimportant/Very unimportant

How comfortable do you feel about debriefing with a counselor or clergy?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

How comfortable do you feel about praying out loud or one-on-one?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

How comfortable are you in caring for the elderly?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

How comfortable are you in offering care through crisis?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

Do you know how to set appropriate and proper boundaries with others?  
Yes  No

Tell us how much you know about United Methodist Safe Sanctuary policy.
___________________________________________________________________________

How would you prepare a sacred space?
________________________________________________________________________________

How comfortable are you with hospital visitation?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

How comfortable are you attending to a grieving family and with funeral planning?  (Circle one)
Very comfortable/Comfortable/No opinion/Uncomfortable/Quite uncomfortable

Whom do you consider a good listener? ___________________________________________

Is there a difference between healing and cure? ________________________________

Do you know what type of behaviors must be reported to the authorities? __________

Do you know what steps to take to make a report? ______________________________

What is spiritual assessment and how would you initiate one? _______________________

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APPENDIX C

AN ORDER FOR COMMISSIONING TO CHRISTIAN SERVICE

This order is intended to recognize and consecrate a commitment to the service of Christ in the world, either in general terms or in connection with a particular responsibility in the world or in the Church. It is designed to be used within a service of worship. When used separately, it should follow appropriate praise and prayer, scripture lessons, and sermon.

Individual reaffirmation of the Baptismal Covenant, using appropriate parts of the service, may be used as an alternative to this form, since baptism is the Christian’s basic consecration to ministry and its reaffirmation is appropriate to celebrate any form of commitment to Christian service.

As a Response to the Word or at some other appropriate place within a public worship service, the pastor invites the person(s) undertaking some special responsibility to come forward and then says to the congregation:

Dear friends, today we recognize the ministry of Name(s) and commission him (her, each of them) to a special task in the service of Jesus Christ.

The pastor or the person being commissioned briefly describes the form of service to which each person is being commissioned.

The pastor turns the person to face the door leading out of the sanctuary. From behind, the pastor lays hands on the shoulders of the person being commissioned and invites the congregation to stretch their hands in prayer toward the person being commissioned.

Name, in the name of this congregation I commission you to this work and pledge to you our prayers, encouragement, and support.

May the Holy Spirit guide and strengthen you, that in this and in all things you may do God’s will in the service of Jesus Christ.

After the commissioning(s) the pastor concludes with extemporaneous prayer or with the following:

Almighty God, look with favor upon Name (these persons) who today (re)affirm(s) commitment to follow Christ and to serve in his name.

Give him (her, each of them) courage, patience, and vision;

and strengthen us all in our Christian vocation of witness to the world and of service to others;

through Jesus Christ our Lord. Amen.

A hymn may be sung and a blessing given. Jesus, We Are Here (Hymn 187) and the following hymns in UMH are suggested:

425 –50 Social Holiness
567 –93 Called to God’s Mission
939 Hymns listed under Commitment
413 A Charge to Keep I Have
251 Go, Tell It on the Mountain

548 In Christ There Is No East or West
383 This Is a Day of New Beginnings
344 Tu Has Venido a la Orilla (Lord, You Have Come to the Lakeshore)

Copyright: Original version: “An Order for Commitment to Christian Service,” alt. from The Book of Common Prayer (The Episcopal Church, 1979). Further altered 2013 by the General Board of Discipleship to align with language and rubrics used in Services for the Ordering of Ministry in The United Methodist Church, 2008 and 2012. For a more recent and interactive version of this service, see “Pentecost Commissioning of Laypersons for Ministry in Christ’s Name.”


Branson, Mark Lau and Juan F. Martinez, Churches, Cultures & Leadership: A Practical Theology of Congregations and Ethnicities. Downers Grove, IL: IVP, 2011.


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*The United Methodist Book of Worship*. Nashville: The United Methodist Publishing Un


