The
Pastoral Associates Program

at
Mission Peak Unitarian Universalist Congregation
Fremont, California

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ACKNOWLEDGMENTS AND SOURCES

The information in this document has been compiled from a number of sources. Foremost among these are:

- The structure, organization and training materials from the Pastoral Associates program at the First Unitarian Church of Oakland, after which this program has been patterned. These materials are not published.
- Information from Rev. Ken Reeves from training of the Mission Peak Unitarian Universalist Congregation pastoral care committee. These materials are not published.
- Information in a reference book from the United Church of Christ, Office for Church Life and Leadership entitled, *Called to Care – a notebook for lay caregivers*, 1991. This is an excellent reference for providing pastoral care for 52 different situations that might come up in a congregation. For each situation, it includes:
    - Information about the situation
    - Suggestions for the caregiver when working with someone in the situation
    - Suggestions of scriptures and prayer addressing the situation
    - Suggestions for the congregation to care for someone in the situation
    - Resources: books, organizations, videos
    - Organizations: who specialize in working with people in the situation

  This excellent resource can be obtained from the United Church of Christ Resources by calling: 800-325-7061 or 800-537-3394. It costs about $95.

Other sources for the training and exercises are:

- Egan, Gerald, *Exercises in Helping Skills*, Brooks/Cole Publishing Co, 1994.
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- Kubler-Ross, Elisabeth, *On Death and Dying – What the dying have to teach doctors, nurses, clergy and their own families*, Macmillan, 1969.
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- Ragins, Mark, "*The Road to Recovery*, "available on-line at http://www.village-isa.org/Ragin's%20Papers/Road%20to%20Recovery.htm. ,
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Pastoral Associates Program

I. DESCRIPTION OF PASTORAL ASSOCIATES PROGRAM [1]

Purposes of the Pastoral Associates Program: To extend the care of the church, through one-to-one caring and helping activities by lay members of the congregation to those who are in special need. This is pastoral care – a ministry of presence and support, not pastoral counseling – which requires counseling certification.

Size and Characteristics of the Pastoral Associates Program: A group of 6-8 pastoral associates plus a coordinator and minister is what we will strive to maintain. Ideally, the group should reflect the diversity of the congregation. Additionally, it is advantageous if the group is diverse in terms of areas of pastoral interest and strength, i.e. a pastoral associate who is especially knowledgeable and effective in situations involving loss and grief, another which specialized in health problems, and so forth. Although assignments to church members in special need would not be made on that basis, diversity in expertise would allow group members to consult with one another on practical problems.

Responsibilities of Pastoral Associates:
1. Attends pastoral associate committee meetings, and any special training meetings that may be planned
2. Following request by a pastoral associate coordinator, initiates contact with person or family in a timely fashion.
3. Uses the resources of the Caring Circle as needed.
4. Keeps pastoral associates coordinator informed about special needs of church members.
5. Acts as a resource and provides support for fellow pastoral associates

Organizational Structure:
The Pastoral Associates Committee is a committee of the Mission Peak Unitarian Universalist Congregation. It meets monthly with the minister. A member of the church board is assigned as liaison between the board and the committee. The Caring Circle has a separate coordinator who is not a Pastoral Associate, but who coordinates requests for services by Pastoral Associates.

Operations:
1. Referral of church member in need to a pastoral associate comes from the pastoral associate coordinator
2. The pastoral associate coordinator schedules meetings, notifies members of meetings, prepares agendas, provides leadership at meetings, and maintains communication link with the minister.
3. Regular training and care for the caregivers is built into the meeting and training structure of the Pastoral Associates meetings.

[1] This program purposes and structure are adapted from the Pastoral Associate materials of the First Unitarian Church of Oakland.

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CONSIDERATIONS FOR A SUCCESSFUL PROGRAM

Identifying a Leader
The Leader should be someone other than the minister, and should have the following characteristics:

- A strong commitment to pastoral care and to the church
- Strong organizational and follow-up skills
- This should be the primary activity that this person is doing for the church so that their time will be less likely to become fragmented in other activities.
- A single focus for the committee is important. We don't recommend that this role be handled by more than one person.
- If possible, a Pastoral Associates Coordinator should have experience being a Pastoral Associate.

Identifying Pastoral Associates
Desired characteristics of pastoral associates include:

- Compassionate, has empathy for others
- Able to reach out and focus on needs of others
- Good listener
- Comfortable with feelings of loss, pain, anxiety in others
- Non-judgmental, does not have preconceived notion as to how others should feel or respond
- Personal integrity and ability to keep confidences

Allowing people to volunteer as Pastoral Associates is **not recommended** as the sole criteria for becoming an associate. One of the following two methods is recommended:

1. Minister and coordinator identify potential candidates, who are approached and invited to consider becoming Pastoral Associates.
2. Offer a class to the entire congregation in relational skills, and identify potential Pastoral Associate candidates from the members of the class.

A church may consider making **Background Checks** of Pastoral Associates so as to limit their exposure to being found negligent. We haven't yet done this, but I am told by those who have done it that the procedure for getting Background Checks is the following:

- Contact the California Department of Justice in Sacramento and tell them what you want Background Checks for.
- They will send a form to submit to give the church authorization to conduct Background Checks. The person at the church who will receive the Background Checks must themselves have a Background Check.
- The California Department of Justice will send Background Check forms to use.
- The people to be checked can get a live scan fingerprinting at a sheriffs office for about $20. Within 24 hours, the church will receive the results of the Check

Size of Pastoral Associates Group
We have a group of 6 Pastoral Associates plus the Pastoral Associates Coordinator to serve a congregation of about 90 members. This has resulted in having each person care for one or maybe two people at the same time.

Care of Pastoral Associates
Providing pastoral care can be stressful. For the success of the program, it is important that Pastoral Associates practice self care. We do this by:

- Limiting the length of the commitment to be a Pastoral Associate to 1 year, allowing people to renew as desired.
- Set aside time at each meeting for meditation and a self-care check-in.
- If a Pastoral Associate is having a difficult situation in his or her life so that doing adequate pastoral care is compromised, they may take a leave of absence until the situation is resolved.

Ministerial Involvement
The minister attends the monthly meetings.
The minister attends at least some of the training. The training topics where our minister has been most helpful have been in practicing listening skills and role playing situations. Using a video camera to record a role-playing situation was very useful in his critiquing our skills.

The Congregation
The congregation as a whole needs to be educated about the Pastoral Associates program and how they might either use the services of the program or provide assistance as part of it. To do this, we suggest the following:

- Create a brochure describing the program, what it is and is not used for, and how to request assistance. Put this in a prominent place in the church for members and newcomers to find.
- Make the Pastoral Associates Program the focus of a church worship service. The Order of Service we used for such a service is included in this document.
- Let them know how they can participate in the Caring Circle to provide short term assistance to people in a number of ways. A form for eliciting Caring Circle volunteers is included in the worship service materials in this document.
- Offer the congregation classes or groups that pertain to the program or to care situations. For example:
    - Workshops on relational skills. As mentioned above, this workshop can be used to identify future Pastoral Associates
    - Adult RE series on dealing with aging family members
    - Depression Support Group

Handling Chronically Needy People
Some people have so many needs that the Pastoral Associates can end up being overwhelmed. We have come to recognize that you need to deal with these situations as soon as you recognize that they are happening. If you don't, Pastoral Associates may quit, or people may stop helping.

In this kind of situation, we say something like: "Our Pastoral Associates program is set up to help people who either have a short term need of high intensity, or people who have a longer term need of low intensity. What we aren't able to do is provide long term needs of high intensity. What you need to do is to look to other sources of support besides the church to help you through these serious long term needs, since we cannot do it all for you."

Depending on the case, we might offer to help them come up with a list of other possible sources of support, but not be the ones to call up and make arrangements. This they must do themselves.

In the end, we really aren't helping them by enabling their overly dependent behavior. If they can see that they can develop their own support network, this might be a start at self-empowerment.

The Larger Community

Thus far in our program, we have not limited our care to church members. People have called our church requesting pastoral care and have been referred to our committee. Several members have joined our church after using our pastoral services. If this outside help were to become burdensome, we might rethink this policy.

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MONTHLY MEETING FORMAT

Chalice Lighting

With the Kindling of this Flame
I reaffirm my commitment to accept my gifts with grace and gratitude
And to use them to bless the world
In the Spirit of Love [2]

Opening Meditation

Pastoral Associates Self-Care Check In

Reviewing Situations of People we are Caring For

Committee Business

Training

Closing

Attendees:
Pastoral Associates Coordinator
Pastoral Associates
Parish Minister

Meeting length: 1.5 – 2 hours

[2] This is the chalice lighting from Starr King School for the Ministry. We use this to remind ourselves that we are doing a form of ministry in the world.

II. TRAINING FOR PASTORAL ASSCOCIATES

These topics are covered in a one-day training session, using a video camera for role playing and feedback. Having a minister with counseling skills coach us on listening skills and role playing is a very helpful part of this training.

- What is Lay Pastoral Care
- What Gifts we bring and Concerns We Have
- Guidelines for Contact and Follow-up
- Ethical and Legal Issues. Code of Ethics.
- Active Listening
- Responding

Other topics in this document are covered in monthly pastoral associates meetings.

Future topics not yet in this document:

Abortion
AIDS
Child Abuse
Incarceration
Rape and Sexual Abuse

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LAY PASTORAL CARE [3]

Purposes of the Pastoral Associates Program: To extend the care of the church, through one-to-one caring and helping activities by lay members of the congregation to those who are in special need. Special needs include:

- Major life changes, such as birth, adoption , loss of job, divorce, retirement
- Death of a family member or friend
- Health problems, illness or hospitalization
- Isolation because of age, mobility problems, disability or other factors
- Follow-up and maintenance after crisis intervention and counseling by minister or other trained professional

Special needs or situations that are outside the scope of the Pastoral Associates Program:

- Major crises such as suicide threat or psychological problems requiring professional intervention, such as marital problems, drug and alcohol problems, family violence or child abuse.
- Conflict between members of the congregation
- Disagreement or dissatisfactions on the part of the church member toward the church, ministers, programs, and so forth.

Important Distinction: This is a program of ***pastoral care*** – a ministry of presence and support – not pastoral ***counseling*** – working with someone to make a change in their life Pastoral counseling which requires a ministerial degree or certification as a counselor.

Responsibilities of Pastoral Associates:

1. Attends pastoral associate committee meetings, and any special training meetings that may be planned
2. Following request by a pastoral associate coordinator, initiates contact with person or family in a timely fashion. Demonstrates caring by any one or several of the following examples: (list is not all inclusive)
   - Being present with the person
   - Offering the opportunity for the person to talk about concerns
   - Active listening and acknowledging the person's concerns and feelings
   - Maintaining confidentiality or discussion where appropriate
   - Making appropriate referral for problems that are outside the scope of the program
   - Providing instrumental acts of kindness as feasible and appropriate, i.e. food, transportation, etc. This can be done using the resources of the Caring Circle.
3. Following committee practices, keeps a confidential record of contacts/visits with church members in need
4. Keeps pastoral associates coordinator informed about special needs of church members.

[3] This program purposes and structure are adapted from the Pastoral Associate materials of the First Unitarian Church of Oakland.

5. Acts as a resource and provides support for fellow pastoral associates

Operations:

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GIFTS WE BRING AND CONCERNS WE HAVE [4]

- **Gifts We Bring**

We need to recognize our personal skills and abilities that we bring to being an associate. Examples of components of giftedness for ministry are: interests, skills, talents, motivations, stories, hopes, intuition, energy, creativity, belief systems, emotions, relationships, spiritual resources. Each person is the one living with their "gift package", and must learn how to spend it / develop it.

Exercises:

1. Ask each person to take a few minutes to write what gifts that they bring to being a Pastoral Associate. Go around the room and have each person read what they have written.
2. Ask each person to describe what they would do to prepare themselves to visit a person who they will care for. And also describe what they would do after the visit.

- **Concerns We Have about Being Associates**

Each of us may have brought concerns that we have about being pastoral associates - things that we think may be a particular challenge for us to live up to the role of an associate. Examples might be: feeling one has to "fix" another's problems; guilt if a problem isn't resolved; becoming emotionally involved; what to do if it just isn't working out.

Exercise:

Ask each person to take a few minutes to write their personal concerns about being a pastoral associate. Go around the room and have each person read what they have written. Give feedback as necessary to understand and give helpful suggestions for dealing with these concerns.

[4] This exercise is adapted from Howard W. Stone's book, *The Caring Church – A Guide for Lay Pastoral Care*, Fortress Press, 1991.

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GUIDELINES FOR INITIAL CONTACT AND FOLLOW-UP WITH CHURCH MEMBERS [5]

1. After receiving the name of a church member in need, make contact by phone or letter:
   - If immediate problem, contact by phone within 24 hours
   - If not immediate problem, may contact by phone or letter within one week; continue attempting contact over reasonable time frame; refer back to the coordinator if unable to reach person within 2 weeks.
2. During initial contact, introduce self as Pastoral Associate and give purpose of contact; provide church member with a broad opener; indicate what you can offer and make future plans as necessary:
   a. Purpose: indicate here the particular problem or need you are responding to. (i.e. "I understand you are going to have surgery next week" or "I heard that your mother died yesterday" or "I know that it is difficult for you to get out and wanted to know how you are managing at home")
   b. Broad opener: give church member an opportunity to talk about the current problem, i.e. "How are you doing?"
   c. Indicate what you can offer as a Pastoral Associate:
      - Possibility of meeting with the church member in home or other meeting place
      - An opportunity for further talk
      - On-going emotional support
      - Food, transportation or other acts of kindness you feel you can provide during the crisis
      - Referral to other sources for help
   d. Make future plans as necessary:
      - Send follow-up letter reaffirming what you have to offer if you feel it is necessary
      - If desired by the church member, make specific arrangement with church member to get together
   e. Follow-up meeting with the church member:
      - Be yourself
      - Restate purpose of the visit
      - Provide the church member with a broad opener
      - Actively listen
      - Acknowledge or attempt to clarify what the church member is trying to convey i.e. "I hear you saying that you are lonely" or "Are you saying that you're angry with your mother?" or "It sounds like you are feeling down."
      - Don't feel you have to "fix" things; just to listen and convey understanding is often enough

[5] These guidelines are adapted from the Pastoral Associate materials of the First Unitarian Church of Oakland.

- Don’t give advice, but if the person asks for referrals, provide a range of possible choices to aid them in making their own decision.
- Ask what the church member would like from you
- Agree on what follow-up the church member would like from you. I.e. “Would you like another phone call next week to see how you are doing?” or “Would you like regular visits, say every month or six weeks?”

f. Ending Pastoral Associate care:
   - When you feel that the church members needs have been met and your care may no longer be needed, verify it with the church member i.e. “Are you feeling that you‘re ready to cope on your own?”
   - Leave the possibility of re-initiating the care from a Pastoral Associate when the church member feels a need.

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CODE OF ETHICS FOR LAY PASTORAL CARE

Preamble

Our work as Pastoral Associates is an expression of the call to care for others in this world, and a living out of the Principles and Purposes of our Unitarian Universalist faith.

- We accept the call as a sacred obligation and faithfully will perform all tasks to the best of our ability.
- We will follow this Code of Ethics as our standards of appropriate conduct

Handling Information

- Confidentiality
    - The client must be told that the information about his or her situation will be shared with all the people in the Pastoral Associates Group.
    - The Pastoral Associate will keep written or spoken information about the client confidential within the Pastoral Associate group.
    - Confidentiality restrictions apply even if you are no longer a Pastoral Associate.
    - Do not discuss confidential information with family or friends.
    - Do not inadvertently publicly discuss or identify confidential information, including at coffee hour. Meet in private if possible
- If records of Pastoral Associate visits are kept, they must be kept in a confidential manner, under lock and key.
- Pastoral Associates should avoid listening or contributing to gossip, or allow untrue or harmful charges to circulate.
- Pastoral Associates should avoid criticizing others in public.
- Pastoral Associates should be careful about the extent to which they get involved in someone's life. Referrals should be made if others would be of better service.
- Pastoral Associates should avoid publishing information about someone in a newsletter without that person's permission.
- Pastoral Associates must be taught their responsibility with regard to abuse and neglect. Inform the minister if you observe or suspect any of the following:
    - Child abuse or neglect
    - Elder abuse
    - Violence threatened against someone else

Handling Relationships

- The congregation as a whole should be educated about pastoral care and the Pastoral Associates program, and what issues are and are not dealt with.
- Pastoral Associates should observe appropriate Boundaries to protect the space that must exist between caregiver and client. Signs of Boundary problems:
    - Becoming emotionally involved in another person's problems.
    - Wanting approval of the person being helped, or they want your approval.
    - Becoming aware that you have had a part in the person's problem
- Dual Relationships must be managed

    - The Pastoral Associate must be sensitive to Dual Relationships with the client: friend as well as someone being helped. Can you live with them?
    - The Pastoral Associate and the client both need to agree that they can work together. Either can say "No".
    - The Pastoral Associate should recognize that they will have a dual relationship with the minister: supervisory as well as pastoral. They must be willing to worship and work with this situation.
- Pastoral Associates should not be misrepresented as being licensed counselors if they are not licensed.
- The Pastoral Associate should insure that there is no conflict of interest in his or her assignment.
- The Pastoral Associate should not have a sexual relationship with his or her client, and should monitor themselves for signs of sexual attraction. They shouldn't declare or act on these feelings. If necessary, they should ask to be reassigned from that client.
- The Pastoral Associate should not exert undue influence over clients by taking advantage of another person's weakness, infirmity, distress or vulnerability.
- The Pastoral Associate should not intentionally inflict emotional distress on the client. Such behavior is such that a reasonable person would be shocked
- Pastoral Associates must have undergone training and be supervised.
- Pastoral Associates will practice self-care.

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LEGAL ISSUES IN LAY PASTORAL CARE [6]

Handling Information

- ***Privileged Communication*** – Communication that is protected by law from forced disclosure. Limited to spouse, doctor, attorney and priest. Communications with Pastoral Associates are <u>not</u> covered under privileged communication.

- ***Confidentiality*** – A promise to not divulge information given by a client. This is an ethical, not a legal concept. But, you can be sued for breach of confidentiality. Pastoral Associates keep confidentiality within the group of Pastoral Associates. The client must be told this.

- ***Invasion of Privacy*** – Unjustified exploitation or intrusion into one's personal activity.

- ***Defamation*** – Communication that injures the reputation of another without just cause. Defamation can be spoken, Slander, or written, Libel.

- ***Abuse and Neglect Reporting*** – There is mandatory reporting of situations in which:
  - A child is being abused or neglected
  - An elderly person or dependent adult is being abused
  - Violence is being threatened to someone else

Handling Relationships

- ***Fraud*** – Knowing misrepresentation of the truth, or concealment of a matter of fact to induce another to act to his/her detriment. Examples: misrepresenting qualifications, improper use of titles, not going through training, committing to do some significant work when you know you are moving soon.

- ***Breach of Fiduciary Duty*** – A relationship of special trust and confidence is broken.

- ***Undue Influence*** – Taking advantage of another person's weakness, infirmity, distress or vulnerability. This would include the use of one's authority for the Pastoral Associate's best interest, not the best interest of the client.

- ***Intentional Infliction of Emotional Distress*** – Intentionally causing another person severe emotional distress. The behavior is such that a reasonable person would be shocked.

- ***Sexual Misconduct and Sexual Harassment*** –
  - ***Sexual Harassment*** – unwelcome sexual advances that affect one's prospects for employment or advancement, or interfere with one's performance.
  - ***Sexual Misconduct*** - Handled by 4 areas of law:
    - Sexual misconduct with children
    - Sexual misconduct with adults
    - Sexual harassment in the workplace
    - Liability of the church for actions of an agent

- ***Negligence*** – Failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation.

[6] Adapted from: *Legal Issues in Theological Field Education,* edited by Susan E. Fox and Judith Trott Guy, published by the Association for Theological Field Education in 2002.

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TRAINING IN ETHICS and LEGAL ISSUES
Case Study Exercises:

1. A Pastoral Associate talks to a parishioner about her problems getting child support and also discloses a substance abuse problem for which she is getting regular therapeutic support. This is discussed in the Pastoral Associates group. Some months later there is a trial for child custody and the Pastoral Associates are subpoenaed. How do privileged communication and confidentiality apply here?

2. A Pastoral Associate wants to be helpful to a woman who is having financial problems and asks to see all of her financial records. The Person later claims her privacy was invaded. What are the legal and ethical implications of this situation?

3. A Pastoral Associate hears through the grape vine that her assignee has been promiscuous. The Pastoral Associate asks the person about this and the person is shocked wants to know where this information came from. What are the legal and ethical issues here?

4. During a visit to a home bound elderly woman, a Pastoral Associate strongly suspects that she has been abused by her husband. He asks her about it and she says that there is no need to say anything to anybody about this because her husband is the only one who cares for her. Does this incident comply with mandatory reporting?

5. A Pastoral Associate falsely claims to have had special training in counseling during graduate school. As a result, she is assigned one of the more difficult pastoral cases. The situation with the assigned case seriously deteriorates and the family threatens to sue the church for the bad counseling. What are the legal and ethical issues here?

6. A Pastoral Associate is given some money by a church member to be used by the church at its discretion. The Pastoral Associate is a little behind in his bills and decides to use the money to tide him over, intending to pay back the church. However, he forgets to pay back the church and the church member discovers that the money was never accredited to her account, and is asking for an explanation. Did the Pastoral Associate commit a breach of fiduciary duty?

7. A Pastoral Associate takes it upon himself to strongly urge a person to give more money to the church, when the person is living on very limited means. What are the legal and ethical implications?

8. A Pastoral Associate believes that she knows how to cure a church member of her grief, by making constant, graphic references to death, and to stern comments about how she just needs to forget about it and get on with her life. The church member becomes more devastated and enters therapy. Later, she confronts the church minister and complains about the Pastoral Associate's behavior. What are the legal and ethical considerations here?

9. A Pastoral Associate is too busy to attend the training, but the church really needs the help and assigns the Pastoral Associate to work with someone in the church. The Associate makes a number of ethical blunders, such as telling the church member how to solve his problems, and becoming romantically involved. Has the church been guilty of Negligence?

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GUIDELINES FOR ACTIVE LISTENING [7]

Attend, look, be present, and focus on the other person. They are giving a gift of vulnerability. Stand in awe of the other's courage as he or she lets you in.

Use a broad opening statement; initiating the discussion by allowing the person to determine what will be discussed.

Listen without judgment to what the person is trying to convey; Listen for words, feelings, and nonverbal communication, especially when there is a contradiction between body language and words.

Respond in a way that communicates you understand the message

- Acknowledging the person's feelings; Restating or paraphrasing – "You feel you can't go on…"
- Reflecting – "I hear your saying that you feel scared."
- Validating – "Yes, it's confusing with so many different opinions you have received."
- Undoing and refocusing – "I think I cut you off earlier when you were talking about your worries about your operation… Did you have more you wanted to say about that."
- Encourage the story
    - Ask for details: "What happened then?"
    - What was your father like?
- Selective reflecting – Directing back to the person what you believe to be the main idea the person has conveyed
- Allow your natural responses
    - "I am so sorry."
    - "How do you feel?"
    - "How are you handling this?"
    - Your own tears
    - Hand holding; hugs
    - Passing the Kleenex

Pitfalls to avoid

- Personal self-disclosure; that diverts attention to you
- Talking too much, filling the silence
- Keeping silent when a response is indicated; failing to acknowledge
- Changing the subject (especially when you are uncomfortable)
    - False reassurance; using reassuring clichés – "You'll do just fine!"

[7] These guidelines are from Rev. Ken Reeves, Unitarian Universalist minister and Pastoral Counselor in a workshop at Mission Peak Unitarian Universalist Congregation.

- Making assumptions (without checking them out), i.e. assuming that a person wants to be alone without asking the person directly
- Yes/no questions; they can lead to one word answers
- "Why?" questions; they can feel like an interrogation. Instead, ask, "What motivated you…"
- Belittling the person's feelings; equating the person's feelings with your own and other people's

Confidentiality – check to see if the information they share is to be kept confidential

Exercises:

- Naming feelings: The leader asks the class to name all the feeling words they can think of, writing them on a chart as they are suggested. For example: happy, sad, embarrassed, overwhelmed... The goal is to get people focused on what feelings are and how wide a spectrum they cover.[8]

- Mirroring: The leader suggests a number of potential situations with a client and asks the class to write a response to the client that mirrors the feeling that the client is expressing. The responses are shared with the class and discussed.[9]

1. A 27-year-old man is distressed because he yelled at his mother when she nagged him. "She kept nagging at me and I finally began screaming at her. I don't know what happened."
2. A 64-year-old man has been told he has terminal cancer and says, "Why me?"
3. A 30-year-old woman says, "My best friend has turned her back on me and I don't know why."
4. A 54-year-old man says, "They're asking me to do things at work that aren't right. If I complain I could be fired."
5. An 18-year-old girl is in a reformatory and won't answer any questions and finally says, "I don't know what I'm doing here."
6. A 39-year-old bachelor says, "I've finally met a woman who is very genuine and lets me be myself. I care about her and she cares about me. I never thought this would happen."
7. A 42-year-old woman says, "Why does my husband keep blaming me for his trouble with the kids?"
8. A 45-year-old man with a daughter, who has just been hit by a car, wrings his hands and says, "I should never have allowed my daughter to go to the movies alone."
9. A 72-year-old man says, "My 45-year-old son has never been able to get his act together. I don't know what will happen to him when I'm gone."
10. A 56-year-old man who is a lifelong smoker has just learned that his cancerous left lung will have to be removed. "I'll never be able to be as active as I used to be. What a fool I was."
11. A first-year engineering graduate student has been having a difficult time at school. "I just don't have much enthusiasm. I know I could do better if I wanted to, but I don't seem to care."
12. A client who you have been working with says "After much effort, I'm finally being able to make some progress on the job front."
13. The wife of a hospitalized man says, "This has been so hard on the whole family. I just hope everything can go back to how it used to be."

[8] This exercise is from Rev. Ken Reeves, Unitarian Universalist minister and Pastoral Counselor in a workshop at Mission Peak Unitarian Universalist Congregation.
[9] These exercises are adapted from Gerald Egan's workbook *Exercises in Helping Skills*, Brooks/Cole Publishing Co., 1994.

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GUIDELINES FOR RESPONDING [10]

Helpful Responses

- Clarify what you have heard –
  - "Sounds like you're dealing with …"
  - "Are you saying that it's difficult to talk with you partner?"
  - When hearing a vague generalization, ask for an example: "When was the last time…?"
- It is OK to go deeper with emotions,
  - "What is the most/worst aspect of this?"
  - "What else do you feel?"
  - "What are the losses you face?"
- Be specific. Vague responses like "You are too aggressive." Are hard for the person to use.
- Describe rather than evaluate – It is more desirable to describe how you feel about something the person has said than to put a label on it.
- Respond with immediacy. It is important to give frequent feedback at the appropriate time rather than to save it all up for a long summarization.
- Be brief. Try to keep most responses down to a sentence or two if possible.
- Ask "What has been helpful in the past?"
- Recognize that it is OK not to control the other's emotions
- Sharing to the person your observations or perceptions
  - "I imagine you are in great pain."
  - "You seem to be struggling with …"
- "What can I do for you?" Explain what a Pastoral Associates can provide:
    - On-going emotional support
    - Temporary help from the Caring Circle: meals, shopping, house/yard care, pet care, transportation, visits from church members

Pitfalls to avoid

- Giving advice or wanting to fix the problem – "If I were you, I would…" If asked, "What should I do?" inquire "What do you want to do" or "What do you see as your options right now?"
- Reassurance – "I'm sure everything will come out fine." It is inauthentic and inappropriate to promise what is impossible to predict.
- Platitudes – Well-meaning but ineffectual statements like "God helps those who help themselves." "You made your bed now you have to lie in it." It is better to say something specific, clear and meaningful to the situation.
- Arguing with the person. Respect their right to hold views different from yours.

[10] These guidelines are adapted from the Pastoral Associate materials of the First Unitarian Church of Oakland.

- Interpretations: “That’s because you…”, or “That’s because he’s a …”
- Giving approval, disapproval, or value judgments – “I don’t think that’s a good idea.”
- Looking for a sliver lining; the other can find one, when they are ready.
- Judgements that seem to wrap things up; they can stop the flow of talk

Exercises:

- **Responding:** The leader suggests a number of potential situations and asks the class to write a response that expresses empathy and probes for clarity with the client. [11]
  Ex: "You feel ____ because ___ . Tell me more about ___. "

1. A young man has been abandoned by his wife. “We’ve been married for a year and she left just like that. I don’t know what I can do to get her back.”
2. A woman’s migraine headaches have been getting worse. “Nothing has helped me reduce their number. I won’t go to a doctor. They’ve never helped.”
3. A man talks about having to work 2 jobs to support his family. “I guess I’m fortunate to have both jobs, but I’ve got no time for myself. My family doesn’t seem to notice my absence.”
4. A 38-year-old mother says, “I don’t know what to do about my daughter. Her grades are terrible.”
5. A 35-year-old man says, “I’m going to the hospital tomorrow for some tests. The doctor suspects an ulcer. I’ve heard rumors about what these tests are like, but I don’t really know."
6. A graduate student says, “I have two term papers due tomorrow. I’m giving a report in class this afternoon. My wife is down with the flu. And now I find out that a special committee wants to talk with me about my progress in the program.”
7. A high school counselor says, “Sometime I think I’m living a lie. I don’t have any interest in high school kids anymore. Most of them and their problems bore me.”
8. A high school girl says, “I think I may be pregnant. I’m afraid to tell my parents.”
9. A 43-year-old woman says, “I was raped but I don’t want to call the police. I just want to forget it and not keep reliving it over and over again.”
10. A 45-year-old man whose home burned down 2 months ago says, “We lost everything that we had worked for years to put together. I don’t know what to do.”
11. A 23-year-old woman has been bleeding internally. She has been told that she needs to undergo tests and is very frightened. She doesn’t want to go to the hospital.
12. A 74-year-old woman has suffered a stroke that has left her partially paralyzed on her left side. She is about to be transferred to a rehabilitation unit and has a long road ahead of her. She is depressed.
13. A couple has just learned that their 3-year-old son has been diagnosed as autistic. “We’re devastated. Maybe it is something we did wrong in bringing him up.”

- **Role-playing**: Situations are acted out. One of the leaders will play the part of the client and the part of the caregiver will be played by a succession of class members. Learning to handling of some of the pitfalls will be part of the exercise. The situations: [12]

1. Ask if someone in the group has a real situation in his or her life that they would be comfortable in using for role-playing. Often, these are the most meaningful exercises for the group and the person involved.
2.A 48-year-old wife who was married for 20 years has just been left by her husband.
3. A 50-year-old man has just lost his job. He has a wife and 2 children, one of whom is just about to go to college, and an expensive home.

[11] These exercises are adapted from Gerald Egan’s workbook *Exercises in Helping Skills*, Brooks/Cole Publishing Co., 1994.
[12] Role playing exercises were suggested by Rev. Chris Schriner, minister of the Mission Peak Unitarian Universalist Congregation.

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FEELINGS, NEEDS and EMPATHY*

It is important that pastoral associates know how to understand expressions of feelings and needs, and that they know how to show empathy.

* Primary Source: *Compassionate Communication, A Workbook for Cultivating the Tools and Consciousness of Nonviolent Communication* by LaShelle Lowe-Chardé

FEELINGS

Delighted
Joyful
Happy
Amused
Adventurous
Blissful
Elated

Thankful
Appreciative
Moved
Touched
Tender
Expansive
Grateful

Excited
Enthusiastic
Overjoyed
Fervent
Giddy
Eager
Ecstatic
Thrilled

Satisfied
Fulfilled
Gratified

Interested
Curious
Absorbed

Healthy
Empowered
Alive
Robust

Relaxed
Relieved
Rested
Mellow
At ease
Light

Content
Cheerful
Glad
Comfortable
Pleased

Friendly
Affectionate
Loving
Passionate

Energetic
Exhilarated
Exuberant
Vigorous

Alert
Focused
Awake
Clearheaded

Peaceful
Tranquil
Serene
Calm

Confident
Secure
Safe
Hopeful

FEELINGS

Scared
Apprehensive
Dread
Worried
Panicky
Frightened

Nervous
Jittery
Anxious
Restless

Tense
Cranky
Stiff
Stressed
Overwhelmed
Agitated
Aggravated

Hurt
Pain
Agony
Anguish
Heartbroken
Lonely

Depressed
Disconnected
Detached
Despondent
Dejected
Bored

Tired
Burnt Out
Exhausted
Lethargic

Angry
Furious
Rage
Irate
Resentful
Irritated

Frustrated
Disappointed
Discouraged
Disheartened
Impatient

Shocked
Disturbed
Stunned
Alarmed
Appalled
Concerned
Horrified

Sad
Grief
Despair
Gloomy
Sullen
Downhearted

Torn
Ambivalent
Confused
Puzzled

Jealous
Envious
Bitter

Embarrassed
Ashamed
Contrite

NEEDS

Intimacy
Empathy
Connection
Affection
Warmth
Love
Understanding
Acceptance
Caring
Bonding
Compassion
Communion
Spirituality
Sexuality

Autonomy
Choice
Freedom
Spontaneity
Independence
Respect
Honor

Security
Predictability
Consistency
Stability
Trust
Reassurance

Partnership
Mutuality
Friendship
Companionship
Support
Collaboration
Belonging
Community
Consideration
Seen/heard

Purpose
Competence
Contribution
Efficiency
Growth
Learning
Challenge
Discovery

Order
Structure
Clarity
Focus
Information

Celebration
Mourning
Aliveness
Humor
Beauty
Play
Creativity
Joy

Honesty
Integrity
Authenticity
Wholeness
Fairness

Peace
Groundedness
Hope
Healing
Harmony

Nurturing
Food/Water
Rest/Sleep
Safety

Expressing feelings and needs with empathy:
"When I (see, hear, notice) _____, I feel _____ because I need _____. Would you be willing to _____?"

EMPATHY: Ways We Stay Connected to Feelings and Needs

Empathy is giving your full attention to another by either silently or verbally guessing their feelings and needs.

Empathy requires a willingness to set yourself aside for the moment and completely enter the other's world with acceptance and respect. It also requires a willingness to be with someone who is in pain of difficulty without trying to get them out of it.

NOT EMPATHY: Ways We Disconnect with Feelings and Needs

- **SYMPATHY:** Bring attention back to yourself. *"Oh, I am so sorry. I feel terrible for you."*
- **ADVICE:** You assume the person needs information. *"Well, what you could do is..."*
- **EXPLAIN/ANALYZE:** You believe that if you tell someone why they feel the way they do, they will feel better. *"You just feel bad because..."*
- **CORRECT:** You try to point out someone's mistake in interpreting. *"He didn't do that to hurt you, he was just in a hurry."*
- **CONSOLE:** *"It will be okay. You're okay, everything will work out."*
- **TELL A STORY:** *"The same thing happened to me. This one time..."*
- **PUSH AWAY FEELINGS:** You might be uncomfortable so you tell others not to feel what they feel. *"Come on smile, don't be sad." "Just calm down and take a deep breath."*
- **INVESTIGATE / INTERROGATE:** *"Why did you do that? What made you feel that way?"*
- **EVALUATE:** You decide if another's emotional response is appropriate or not. *"You are over reacting. This is no big deal."*
- **EDUCATE:** *"What I see about the situation is... The reason you feel like that is..."*
- **ONE-UP:** *"That's awful, but something even worse happened to me and I was devastated."*
- **DIAGNOSE:** *"Sounds like you had a panic attack. I know some good herbs for anxiety."*
- **DEMAND:** *"If you don't get control of your emotions, I'm leaving!"*
- **DENIAL OF CHOICE:** *"It's a hard thing, but we all have to do it."*
- **NOD & SMILE:** You feel uncomfortable and just want to get out of the situation.
- **COLLUSION:** You join in criticizing another. *"You're right, he really is a jerk!"*
- **INCESSANT TALKING:** Filling every moment with words.

Exercises:

- Think of a situation when you have experienced great empathy from another person. Describe how it felt to you.
- Think of a situation when you have experience communication that has not been empathetic. Describe how this felt to you. What might have been done differently?
- Think of a situation when you have spoken to someone else with empathy. How did this feel?
- Think of a situation when you have spoken to someone else without empathy. How did this feel? What might you have done differently?

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MEETING SPIRITUAL NEEDS [13]

It is important that a person's emotional and spiritual needs be acknowledged. After all, we are *pastoral* associates. One way to do this is pray with the person. Another way is to connect them with what is happening in church in their absence.

Assessing the perceived spiritual needs
Determine person's theological background. One resource is to talk to the minister because he has discussed this with many people in the congregation.

Determine what the best approach to addressing spiritual needs would be for this person. Ex: prayer, meditation, or ritual of some sort… Ask the person if he or she would like for you to say a prayer. Be prepared to respond to the answer, whether it is yes or no.

Prayer
If the person wants to pray, consult the Pastoral Associates training page on prayer for ideas on how to conduct the discussion around prayer. If the person does not want to pray, listen to the reasons. Maybe the person doesn't feel worthy, or wants to pray in private. The decision of whether or not to pray belongs with the person, not you.

Inspirational Readings
Sometimes a person would like to hear an inspirational reading of some sort. These can exist in several forms: scripture, poetry, prose. The back of the UU Hymnal *Singing the Living Tradition* has numerous readings from several traditions that can be used. You can ask the person if he or she has a favorite poem or reading.

Ritual
Ask if they would like to use some form of ritual:

- Talk to the minister about anything that might be done, such as having a chalice lighting and prayer.
- If they haven't been able to attend church, bring an order of service and talk about the ceremony.
- Have them use the church's caring hands quilt
- Have the church children draw something for them.

[13] This exercise has been adapted from *Called to Care – A Notebook for Lay Caregivers*, a publication of the United Church of Christ.

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PRAYER [14]

Kinds of Prayer

- ***Prayers of Adoration and Praise*** – Giving honor and praise to that which we call Holy
- ***Prayers of Petition*** – Asking for something
- ***Prayers of Confession*** – Acknowledging some personal or corporate wrongdoing and asking for forgiveness
- ***Prayers of Thanksgiving*** – Giving thanks for something that we are grateful for

Styles of Prayer

- **Extemporaneous Prayer** – A prayer created on the spot for the particular occasion

  Format for a Prayer of Petition: [15]

  1. Address someone: ex: "Dear God"
  2. State the situation: ex: "We are standing here in Joe Smith's hospital room before he is about to go into surgery for …"
  3. Ask for something: ex: "We ask that the surgery go well", or "Be with us in this hour."
  4. Closing: "We ask this in the name of all that we hold holy. Amen" or "Amen."

  For prayers of Confession, Thanksgiving, or Praise, Step 3 of this general format can be altered, appropriately.

- **Meditation or Breathing Prayer –** Silent prayer or guided meditation
  - For silent meditation, give a short invocation, followed by silence of 2-5 minutes, and ended by "Amen"
  - For a guided meditation, ask Barbara Meyers or Chris Schriner for guided meditations that you may be able to use.

Praying

- Listen to the person's requests. Do not assume you know what they are. Ask, "What concerns would you like to pray about?" and invite the person to join you in prayer.
- Keep prayers short and in a conversational tone rather than a formal style.
- Be honest in prayer. Express real feelings thus far expressed to you: anger, sadness, bitterness, and fear.
- Be realistic. Pray for strength as the person faces his or her future, whatever the outcome of the problem may be.

[14] Much of this material comes from *Called to Care – A Notebook for Lay Caregivers*, a publication of the United Church of Christ.

[15] This prayer format is from Rev. Ken Reeves, Unitarian Universalist minister and Pastoral Counselor in a workshop at Mission Peak Unitarian Universalist Congregation.

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HOSPITAL OR SHUT-IN VISITING [16]

Call first. Patients love visitors, but if they've had a difficult treatment session, a restless night or an exhausting day, they may ask you to visit tomorrow. Find out when visiting hours are and observe them if possible.

Don't stay too long – Make the period very short if the person is in critical condition or appears very tired. Frequently 5-10 minutes is enough for someone who is acutely ill. Don't stay at all if the patient has family present and they appear to be involved in private conversation.

Talk to the patient. The most important part of a hospital visit is just being there to make a connection. Sit in a place where you can be easily seen.

Listen to the patient. Patients have a good deal on their minds and need to let some of it out. Listen and ask questions about the parts you don't understand, but try and not give advice. Be aware that patients will sometimes act in aberrant ways not only because of shock or the effects of illness, but because of medications they are taking.

Use physical gestures to express your caring: touching, holding hands, hugging, etc.

Encourage, but don't give false assurances. Don't force a cheerfulness you don't feel. It is better to adjust to the patient's mood than for him or her to adjust to yours.

Have a sense of humor. Find ways to encourage a little bit of laughter. It can help patients reduce stress and deal with illness, emotional setbacks and everyday upsets in a positive way.

Bring patients news of your life. Share stories; discuss upcoming plans and family events, the news of the day sports or a favorite television show.

Ask first before ordering flowers. Flowers are a beautiful way to brighten up a room, but some patients, due to certain illnesses or treatments, may not be allowed flowers. A card or photo of friends and family is always welcome.

There is nothing like a child's artwork to brighten a hospital room. Bring a card or drawing from a young relative or friend.

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[16] These tips are adapted from Voglezang, Nick, Tips for Better Hospital Visits, *American Institute for Cancer Research Newsletter*, Fall 1998, No. 61.

Bring favorite music. Tapes or CDs and a portable payer can be a welcome refuge from the usual buzz of hospital activity. Try books on tape or even relaxation or meditation recordings.

Rent a comedy. Depending on the facility, visitors may bring in VCR's and videos. Call ahead to be sure equipment can be connected in the patient's room.

Ask about snacks. Some patients may have a good appetite and be longing for their favorite slice of pizza or brand of biscuits, but others may not be allowed to eat certain foods or foods not prepared in the hospital.

Offer to run errands, either yourself or through the Caring Circle. Prepare a list of errands you could do for the patient – pet care, house care, watering plants/garden, house sitting, etc. Use Caring Circle resources to handle as many as you can.

Celebrate special days. Holidays, birthdays, weddings, graduations and other special occasions are important to share with patients. Request a special room or order a cake to celebrate in the hospital, or bring pictures or a videotape of an event the patient could not attend in person.

Make use of chaplains. They can make visits when you can't, alert you to problems that exist, and obtain information about a patient or resident that you might otherwise be unable to learn.

Other gifts that patients may be welcome: [17]

- Face, lip and body moisturizers
- A newspaper or magazine
- A book that you think the person will enjoy
- A good small reading lamp
- A notebook or journal to write in

Role playing Exercise:

Visit a church member who is in the hospital for a serious operation.

Visit a church member who is in a nursing home.

[17] These suggestions adapted from Karen Duffy's book *Model Patient – My Life as an Incurable Wise-Ass*, Harper Perennial, 2001.

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SERIOUS ILLNESS [18]

Having a serious illness, or a diagnosis of one, can give rise to a whole range of strong emotions - shock, fear, anger, bitterness, uncertainty, confusion and depression. All too easily, people with a serious illness can feel vulnerable and isolated. Sometimes there are issues of faith that arise; for example, a person might wonder about the meaning of suffering, or have anger at God.

Here are some suggestions for working with people who are living with a serious illness:

- Learn about the illness and its treatments, as much as you can.
- See if you can find someone else who has had the same illness and arrange for the two of them to talk.
- Visit them, even if visits must be very short
- Talking about fears can help to reduce anxiety. To a person with a serious illness, it's often not what you say but how you listen that matters most. You can help by encouraging the person to talk and by acknowledging the unpleasantness of some of their feelings. Getting a conversation going may sometimes be difficult, but you might find the following tips useful:
  - Get on the same level as the person you're talking to and don't sit too far away
  - If you're not sure whether the person wants to talk, ask them
  - Don't be offended if they don't want to talk

  Once the conversation is under way, help the other person say what's on their mind by:
  1. Encouraging the expression of emotion and grief caused by the illness.
  2. Ask if they are scared
  3. Encourage talking about any issues of faith that arise because of the illness
  4. Showing you're listening by picking up on things they've said
  5. Allowing silences and not filling them with words for the sake of it
  6. Not changing the subject, even if you find some of the things being said difficult
  7. Not interrupting or blocking their flow by saying things such as "You'll be all right" or "Don't worry"
  8. Not forcing your advice on the other person - try presenting your suggestions as questions, such as "Have you ever thought about...?" "What have you tried?"
9. If you believe the person has become seriously depressed, encourage them to get a professional mental health assessment

In addition to talking with and listening, practical assistance can be provided. Here are some examples

- Find ways of being supportive: arrange for rides to the doctor or hospital, childcare, special foods, or shopping, using Caring Circle resources.
- Encourage participation in church activities as much as strength allows. Give them church letters, orders of service, etc. and talk to them about church if they can't attend.
- Send cards

[18] Primary Sources: BBC Health website, *Supporting Someone with Cancer,* and United Church of Christ, *Called to Care*

- Provide respite for family caregivers
- Provide realistic hope
- Pray with them and their families
- Find out if there are any support lines or websites for people with this illness
- Find out if there are any local support groups for people with this illness

Exercises:

- Talk about an experience you have had with a person who had a serious illness. What helped, what didn't help.
- Role-play a visit to a person who is seriously ill.

Resources:

- The American Psychological Association, *Coping with Serious Illness*
- Margaret R. Cooke and Elizabeth Putnam. *Ways You Can Help: Creative, Practical Suggestions for Family and Friends of Patients and Caregivers*.
- Joanne Lynn, Joan K. Harrold, *Handbook for Mortals: Guidance for People Facing Serious Illness*.
- National Cancer Institute, *Taking Time: Support for People with Cancer*
- Niel A. Fiore, *The Road Back to Health: Coping with the emotional Aspects of Cancer*

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HEART ATTACK [19]

Heart attack is the leading cause of death in the United States. A heart attack happens when blood vessels that supply blood to the heart are blocked, preventing enough oxygen from getting to the heart. The heart muscle dies or becomes permanently damaged. This is called a myocardial infarction. In atherosclerosis, plaque builds up in the walls of your coronary arteries. This plaque is made up of cholesterol and other cells. A heart attack can occur as a result of the blockage it causes.

An Emergency: A heart attack is a medical emergency and immediate medical help is required. Do not delay, because the greatest risk of sudden cardiac death is in the early hours of a heart attack.

Symptoms: Severe or mild chest pain is a major symptom of heart attack. It can feel like: a tight band around the chest, indigestion, squeezing or heavy pressure. The pain usually lasts longer than 20 minutes. Women may feel nausea, pain in the left arm and cold sweats. They may come and go. After am a suspected attack, take aspirin quickly under the tongue. Call 911 and don't drive yourself to the hospital.

Risk Factors: Risk factors for heart attack and coronary artery disease include: increasing age (over age 65), male, diabetes, family history of coronary artery disease, high blood pressure, smoking, too much fat in your diet, unhealthy cholesterol levels, women in menopause and kidney disease.

Treatment: Treatment may involve surgery. Angioplasty is a procedure to open narrowed or blocked blood vessels that supply blood to the heart. A coronary artery stent is a small, metal mesh tube that opens up (expands) inside a coronary artery to help prevent the artery from closing up again. A coronary artery bypass, in which the surgeon takes either a vein or artery from another location in the body and uses it to bypass the blocked coronary artery, may be required to circumvent the blocked artery altogether. Surgery is followed by a period of rehabilitation at home or a nursing center. Most will be able to return to work or other daily activities.

Emotions Affect Recovery

A person's emotions can affect their recovery and risk of future cardiac events, so it's important to understand feelings, recognize problems and get help if needed. Sharing emotions with a pastoral care giver is one way to address them. The following table gives suggestions for common emotions.

Emotions	Tips for Addressing Emotions
Fear	Get correct and complete information about the illness
Anxiety	Share worries and feelings with someone else
Anger	Ask about anger or stress management programs in your community
Loneliness	Reach out to others
Depression	If it lasts over 2 weeks, seek treatment for depression

[19] Primary Sources:
Heart Attack Care Card, United Church of Christ, *Called to Care*
PubMed, website sponsored by the National Institutes of Health.

Suggestions for the care giver

- Visit, especially those whose recovery takes a long time.
- Actively listen to the feelings expressed
- Support necessary lifestyle changes such as diet, exercise, and stress reduction.
- Share hobbies and interests appropriate to the activity level of the individual
- If a long inactive convalescence is required, people may begin to question their self-worth. Affirm the worth of the person beyond his or her job and the roles performed in the past
- Communicate through cards, telephone calls and other ways of sharing concern and care
- Most people are depressed after heart surgery or a heart attack. If the person is seriously depressed, suggest they get help from a mental health professional.
- Listen to the family members, especially children. They may be fearful, guilty, or over protective. Let them express their feelings of anxiety, fear, and anger, and listen to them.

Congregational Support

This illness often results in isolation, as the restriction of daily activities interrupts the usual interactions with neighbors, coworkers, and the community of faith. Members of the church community can be a powerful resource for healing in this situation. An important spiritual dimension to healing is the ability to both give and receive. This can be shared through the interaction among the caregiver, local congregation and the person receiving care. The community of faith can help communicate unconditional love and hope. Some suggestions for doing this:

- Organize visitation during the home recovery period within guidelines set by the family.
- Organize to provide transportation for errands, groceries, childcare, and household chores for two to four weeks after hospitalization.
- Support the person's need to adjust his or her role in the congregation and other activities.
- Arrange for them to talk to someone who has had a heart attack.
- Find out if the hospital has a support group for people with heart attacks.

Exercises

- Ask if anyone has had experience with a heart attack in themselves or another person. Ask what helped? What didn't help?
- Role-play a visit to a person who is has had a heart attack.

More Information and Resources

- The American Heart Association www.amhrt.org -Information and latest research about heart attacks. Heart attack prevention and lifestyle following a heart attack. Care giver assistance. Advocacy. Sponsors support groups.
- Centers for Disease Control and Prevention – www.cdc.gov/heartdisease Information about heart disease, recommendations and guidelines, educational materials
- The National Institutes of Health www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001246/ information about heart attacks, treatments, prognosis, prevention.
- *The Cardiac Recovery Handbook: The Complete Guide to Life After Heart Attack or Heart Surgery*, by Paul Kligfield, Michelle D. Seaaton and Frederick Flach, Hatherleigh Press, 2004.
- *Heartmates: A Guide for the Spouse and Family of the Heart Patient* by Rachael Freed, Fairview Press, 2002

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CHRONIC ILLNESS [20]

A chronic illness is a disease for which there is no known cure. It lasts indefinitely. Chronic illnesses can appear at any age, even at birth. Examples of chronic illnesses are diabetes, lupus, arthritis, chronic kidney disease, cystic fibrosis, hemophilia, AIDS, fibromyalgia and chronic pain. Chronic illnesses must be continually managed by the person and their family or care givers.

Having a chronic illness can give rise to a whole range of strong emotions – denial, fear, anger, confusion, bitterness, grief, guilt, and depression. All too easily, people with a chronic illness can feel vulnerable and isolated, uneasy at how to handle reactions from others. Sometimes there are issues of faith that arise; for example, a person might have anger at God, wonder about the meaning of suffering, or wonder if God is punishing them for some reason.

Although each illness is unique, chronic illnesses have the following general phases:

- Acute Phase. This is the emergency phase of the disease. The illness may be managed in a hospital or health-care facility
- Comeback Phase. The person will work, usually at home, on rebuilding physical and psychological strength.
- Stability Phase. The illness is in a stable condition and the person and family caregivers work at maintaining this phase. However, this stable condition can deteriorate.

How to Cope with a Chronic Illness

- Acceptance. It is important that the person come to the realization that they have a chronic illness and accept this as a fact of their life.
- Taking Control. A person with a chronic illness will always have some things about their lives that they cannot control. It is important for them to learn how to have as much control over their lives as possible given that they have accepted that they have a chronic illness. There are several ways of taking control:
    - Control through knowledge – learning as much as possible about their illness
    - Control through planning – planning for one's medical needs and desires, estate, what kind of care one desires, power of attorney, advance health directives …
    - Control through problem solving – learn how to overcome problems associated with the illness.
- Benefit from contact with others. This includes cooperating with the medical team, seeking out support from others with the same illness, contact with and deepening relationships with friends.

Here are some suggestions for working with people who are living with a serious illness:

- Learn about the illness and its treatments, as much as you can.
- See if you can find someone else who has had the same illness and arrange for the two of them to talk.

[20] Primary Sources: National Institutes of Health, *Coping with Chronic Illness*, United Church of Christ, *Called to Care*

- Visit them, even if visits must be very short
- Talking about fears can help to reduce anxiety. To a person with a chronic illness, it's often not what you say but how you listen that matters most. You can help by encouraging the person to talk and by acknowledging the unpleasantness of some of their feelings.

When you speak with the person, help them to say what's on their mind by:

10. Encouraging the expression of feelings and emotions caused by the illness.
11. Encourage talking about any issues of faith that arise because of the illness
12. Showing you're listening by picking up on things they've said
13. Ask what they have tried so far in coping with their illness
14. Allowing silences and not filling them with words for the sake of it
15. Not changing the subject, even if you find some of the things being said difficult
16. Not interrupting or blocking their flow by saying things such as "You'll be all right" or "Don't worry"
17. Not forcing your advice on the other person - try presenting your suggestions as questions, such as "Have you ever thought about...?"
18. Encourage creative expression – painting, weaving, sculpture, …
19. If you believe the person has become seriously depressed, encourage them to get a professional mental health assessment

In addition to talking with and listening, practical assistance can be provided. Here are some examples

- Find ways of being supportive: arrange for rides to the doctor or hospital, childcare, special foods, or shopping, using Caring Circle resources.
- Encourage participation in church activities as much as strength allows. Give them church letters, orders of service, etc. and talk to them about church if they can't attend.
- Find out what things that give them pleasure and encourage them to do these things.
- Send cards
- Provide respite for family caregivers
- Encourage and provide realistic hope
- Pray with them and their families
- Find out if there are any support lines or websites for people with this illness
- Find out if there are any local support groups for people with this illness

Exercises:

- Talk about an experience you have had with a person who had a chronic illness. What helped, what didn't help.
- Role-play a visit to a person who has a chronic illness.

Resources:

- Robert Shuman. *The Psychology of Chronic Illness: The Healing Work of Patients, Therapists, and Families*. Hobart, Ind.: Basic Books, 1996.
- Friends' Health Connection (FHC) http://www.48friend.com. This is an organization that connects people coping with an illness with others facing similar challenges.
- Consult *The Encyclopedia of Associations, Vol. 1: National Organizations of the U.S.; Vol. 2: Geographic and Executive Index* (look in your local library) to find organizations related to the specific illness or condition.

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CARE IN SITUATIONS OF HIV/AIDS [21]

What Is HIV?

The human immune system can't get rid of the Human Immunodeficiency Virus (HIV) as it can with other viruses. HIV can hide for long periods of time in the cells of your body and it attacks a key part of your immune system – your T-cells or CD4 cells. Your body has to have these cells to fight infections and disease, but HIV invades them, uses them to make more copies of itself, and then destroys them. Over time, HIV can destroy so many of your CD4 cells that your body can't fight infections and diseases anymore. When that happens, HIV infection can lead to AIDS.

What is AIDS?

Acquired Immunodeficiency Syndrome (AIDS) is the final stage of HIV infection. People at this stage of HIV disease have badly damaged immune systems, which put them at risk for opportunistic infections. A person is diagnosed with AIDS if there are one or more specific OIs, certain cancers, or a very low number of CD4 cells. If you have AIDS, you will need medical intervention and treatment to prevent death.

How is HIV Spread?

HIV is spread primarily by: unprotected sex with a person who has HIV; sharing needles, syringes or other equipment used for injection of drugs; being born to an infected mother; receiving blood transfusions or organ transplants contaminated with HIV.
HIV cannot reproduce outside the human body. It is not spread by: air, water, insects, saliva, tears, sweat, casual contact, closed-mouth or "social" kissing.

Pastoral Care with Someone with HIV/AIDS

1. **The First Question to Ask is Not, "How did You Get Infected?"** When someone tells us their HIV status, they are usually dealing with the present and future more than the past. There may be lifestyle issues that need to be discussed at a future time, but our initial reaction needs to be compassion-- not questioning.
2. **Avoid the "Blame Game."** The "blame game" prevents us from giving beneficial pastoral care to those who need it.
3. **Compassion is the Key**. Compassion is coming to the side of one who is hurting. We suspend judgment and focus on the needs of others. Compassion is shown in gentleness, kindness, acceptance, and love.
4. **Confront Your Own Fears**. We must confront our fears with facts, put judgmental and prejudice behind us.
5. **Focus on Life, Not Death**. We all will die; none of us knows when death will arrive. Therefore, our focus needs to be on how we will live the rest of our life. Focusing on life declares that the person has a lot of living yet to do.
6. **Let the Individual Set the Agenda**..
7. **Confidentiality is a Must.** Pastoral visitors are not free to tell others secrets entrusted to us. We do not tell spouses, church committees, pastors, or friends. If we break confidentiality, we may hurt the one who trusted us so much that he/she never reaches out for help again.
8. **Act Like There is Hope.** HIV is not a situation completely devoid of hope. New medications are extending the lives of persons infected with HIV. Most importantly, we all have much living left to do.

[21] This section is adapted from Information on HIV/AIDS from the Centers for Disease Control and *Guidelines for the Giving of Pastoral Care to Those Persons Who are Infected/Affected by HIV/AIDS* by Don Nations.

9. **Affirm the Worth of the Person.** All people inherently have great dignity and worth.
10. **Feel Free to Show Emotion.** Be emotionally present. Feel free to appropriately cry, laugh, or express other emotions when visiting with a person who has HIV.
11. **Remember to Touch**. One of the tragedies of HIV is that many people are reluctant to touch someone who is HIV positive. Whatever the reason, refusing to touch someone who wants to be touched sends the message that we are not emotionally present for the person or that we do not accept the person. Our willingness to touch shows our willingness to care.
12. **Look for the Stages of Grief.** People who are infected/affected by HIV wrestle with the stages of grief. They deal with shock, denial, anger, bargaining, depression, and acceptance. People go through these stages in differing periods of time and may bounce back and forth between stages. Our job is not necessarily to move people through these stages but to help them deal with their present stage.
13. **Be Aware of the Psychosocial Issues Surrounding HIV/AIDS**. Those infected/affected with HIV deal with a variety of issues such as social isolation, rejection by friends and family, prolonged periods of illness, fear of what tomorrow will bring, the sometimes negative reactions of the religious community, reproductive decisions, guilt, and grieving. As givers of pastoral care, we need to recognize these issues and help people as they work their way through them.
14. **Expressions of Spirituality and the Experience of Spiritual Life Varies from Person to Person.** Since religious expressions differ, we must not require everyone to experience faith the way that we do. We must be present as pastoral guides who help people to find their own way on their spiritual journey.
15. **Avoid Saying, "I Know How You Feel**." Even if we had similar situations, we cannot completely understand how anyone else is experiencing a particular situation. More helpful responses include, "I hear your pain"; "I am sorry"; "I am here for you"; "I understand this is a difficult time for you"; "What can I do to help?"; and "How do you feel?" Sometimes a quiet hug is appropriate and needed.
16. **Get Educated**. To give helpful, consistent pastoral care, educate yourself about HIV. Learn the basic facts about modes of transmission, progression of the infection, common illnesses and medications, and the psychosocial issues that surround HIV/AIDS.
17. **Pastoral Care with a Person Infected/Affected by HIV/AIDS is Usually a Long Process**. Our role is to come along side of people and support them, to be present with them. It is not to answer every question and give the solution to every problem. We must be patient as people work through the stages of grief and the myriad of issues that surround HIV.
18. **Know Your Limits.** HIV brings us into contact with issues such as counseling, bio-ethics, living wills, medical treatment, grief, guilt, stress reduction, and nutrition. None of us can adequately deal with all of these issues. We must realize when we have reached our limits and be willing to refer the client to another person.

Exercises:

- Do you know anyone who has HIV / AIDS? Tell about the situation and your reaction to it.
- Do you have fears of working with someone with HIV / AIDS?
- Role play a visit to a person with AIDS.

Resources:

- *Johns Hopkins HIV Guide* by Joel E. Gallanat, Johns Hopkins Press, 2012.
- *HIV Essentials 2011* by Paul E. Sax, Calvin J. Cohen and Daniel R. Kuritzkes, Jones and Barnett, 2010.
- *The AmFAR AIDS Handbook: The Complete Guide to Understanding HIV and AIDS*, Darrell Ward and Mathilde Krim, W.W. Norton, 1999.
- *The Guide to Living with HIV Infection: Developed at the Johns Hopkins AIDS Clinic* by Dr. John G. Bartlett MD and Ms. Ann K. Finkbeiner, A Johns Hopkins Press, 2001.

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ELDER CARE [22]

Aging individuals who become unable to care for themselves need help managing routine activities of day-to-day living. Many times this care is provided by family members – spouses, children, siblings. This can range from 24-hour home care to occasionally looking in on someone.

Family members may experience physical or emotional stresses in doing this work for their loved one. They may become isolated due to the demands of caring, and unable to engage in outside activities or relationships. As stressful as it is, many caregivers also find the experience rewarding. Family caregivers are more effective when they do not neglect their own needs.

Here are some suggestions for ministering to the family caregivers:

Communication:.
Treat the aging person and their family with dignity and respect. If possible, directly engage the person cared for as well as the family caregiver.

1. Encouraging the expression of feelings and emotions
2. Encourage talking about any issues of faith that arise because of their caregiving
3. Try reminiscing about old friends or past events
4. Ask caregivers what they have tried so far in coping with caring for their aging relative
5. Allowing silences and not filling them with words for the sake of it
6. Not changing the subject, even if you find some of the things being said difficult
7. Not interrupting or blocking their flow by saying things such as "You'll be all right" or "Don't worry"
8. Not forcing your advice on the other person - try presenting your suggestions as questions, such as "Have you ever thought about...?"
9. Concentrate on ability rather than disability

Practical Assistance:
In addition to talking with and listening, practical assistance can be provided. Here are some examples

- Find out their needs and determine ways of being supportive: arrange for rides, special foods, or shopping, using Caring Circle resources.
- Connection with faith
  - Encourage participation in church activities as much as possible.
  - Pray with them and their families
- Support from others
  - Provide respite for family caregivers, having others come in for a while
  - Find support lines or websites for people with elder care (see resources)
  - See if you can find someone else who has gone through stages of elder caregiving and arrange for the two of them to talk.
- Encourage self care for the caregiver:
  - self improvement

[22] Primary Source: National Institutes of Health, *Eldercare – caregiving for aging relatives*, United Church of Christ, *Called to Care*

    - hobbies
    - time with friends
    - other things that give them pleasure
    - stress management - many communities have stress management classes
    - support groups - see if there are any support groups for caregivers or for aging people and recommend them. For example, the Alzheimer's Association.
    - If you believe the caregiver or person they care for has become seriously depressed or over stressed, encourage them to get a professional mental health assessment. Find out if there are family counseling services in the community
- Help them to learn about things that may become important as their relative continues to age:
    - If there is a point when they can no longer provide adequate care, what are the alternatives? What about assisted living or hospice care? Think this through with them.
    - Are important documents such as wills, access to needed money, insurance, and durable power of attorney for health decisions, in place and do you know where they are?
    - Is medical care adequate? Or, do some changes need to be made?
    - Will their elder need to move into another home or facility to be cared for?
    - Preparing for emergencies in health, safety and otherwise
    - Managing medications
    - Transportation and mobility
    - Quality of life. Have they talked with their family member about their end of life care wishes?
- Watch for signs of elder abuse. Report all threats or acts of physical harm immediately to your minister

Exercises:

- Talk about an experience you have had with a caretaker of an elder. What helped, what didn't help.
- Role-play a visit to a caregiver.

Resources:

Books

- Joy Loverde, *The Complete Eldercare Planner, Second Edition: Where to Start, Which Questions to Ask, and How to Find Help*, Three Rivers Press 2009.
- John Portnov, MD with Martha Houtmann, RN. *Home Care for the Elderly: A Complete Guide*, New York: McGraw-Hill, 1987.
- Kerry Smith. *Caring for Your Aging Parents: A Sourcebook of Timesaving Techniques and Tips*. Lakewood, Colorado: American Source Books, 1992.

Organizations

- Aging Parents and Elder Care www.aging-parents-and-elder-care.com/
- American Association of Retired Persons (AARP) www.aarp.org
- Children of Aging Parents (CAPS) www.caps4caregivers.org/
- National Council on the Aging (NCOA) www.ncoa.org
- National Hospice and Palliative Care Organization (NHO) www.nhpco.org
- Organizations for the particular health problem or illness that the aging relative has. Ex:
    - Alzheimer's Association www.alz.org
    - American Heart Association www.heart.org
    - Hearing Loss Association of America www.hearingloss.org/
    - Mobility International, USA www.miusa.org
    - Multiple Sclerosis Society www.nationalmssociety.org/
    - Muscular Dystrophy Association www.mda.org

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ALZHEIMER'S DISEASE [23]

Alzheimer's disease is a brain disorder named for German physician Alois Alzheimer, who first described it in 1906. Scientists have learned a great deal about Alzheimer's disease in the century since Dr. Alzheimer first drew attention to it. Today we know that Alzheimer's:

- **A progressive and fatal brain disease.** Alzheimer's destroys brain cells, causing problems with memory, thinking and behavior severe enough to affect work, lifelong hobbies or social life. Alzheimer's gets worse over time, and it is fatal.

- **The most common form of dementia**, a general term for the loss of memory and other intellectual abilities serious enough to interfere with daily life. Vascular dementia, another common type of dementia, is caused by reduced blood flow to parts of the brain.

- **Has no current cure.** But treatments for symptoms, combined with the right services and support, can make life better. There is an effort under way to find better ways to treat the disease, delay its onset, or prevent it from developing.

- **Prevalence:** As many as 5.3 million Americans have Alzheimer's. 1/8 persons over age 64, ½ over 85. Millions of baby boomers are nearing the age of greatest risk

- **Stages** that Alzheimer's patients go through
  - *No impairment / Very Mild Decline- memory loss*
  - *Mild Decline- more problems with learning and memory of recent events, clumsy*
  - *Early Stage / Mid Stage- lose independence, conversation difficult, memory worse, anger*
  - *Severe / Very severe- dependent, lose speech, passive, can't feed themselves, death*

10 Signs of Alzheimer's

1. Memory Loss.

Someone with Alzheimer's memory loss	***Someone with normal age-related memory loss***
▪ Forgets entire experiences	▪ Forgets part of an experience
▪ Rarely remembers later	▪ Often remembers later
▪ Unable to follow written/spoken directions	▪ Is usually able to follow directions
▪ Is gradually unable to use notes as reminders	▪ Is usually able to use notes as reminders
▪ Is gradually unable to care for self	▪ Is usually able to care for self

2. Difficulty performing familiar tasks. ex: how to use telephone, how to cook favorite meal
3. Problems with language. Forgetting simple words
4. Disorientation to time and place. Wandering. Becoming lost.
5. Poor or decreased judgment. Dress inappropriately. Giving away money to strangers.
6. Problems with abstract thinking. ex: What are numbers for?
7. Misplacing things.
8. Changes in mood or behavior. Mood swings with no apparent reason.
9. Changes in personality. Becoming confused, suspicious, dependent
10. Loss of initiative. Becoming very passive.

Suggestions for the Caregiver

[23] This is adapted from the web site of the Alzheimer's Association www.alz.org,.

- **Encourage early diagnosis** if you recognize the signs of Alzheimer's. Early diagnosis helps the person maintain a better quality of life by opening up opportunities to:
  - Plan for the best life experiences in the remaining years
  - Choose and receive treatments
  - Prepare legal documents concerning care during the more advanced stages of the disease
  - Advocate for public-policy change or enrolling in research programs
  - Share experiences in Alzheimer support groups

- **How to Communicate:** Treat the person with dignity and respect. Directly engage the person. Talking only to the family can leave the person feeling left out and isolated.
  - Create a soothing environment
    - Approach the person from the front and avoid sudden movements
    - Speak slowly and reassuringly and maintain good eye contact
    - Identify yourself and your place of worship, even if the person is a long-time member
  - Keep communication simple
    - Ask only one question or present one idea at a time
    - Use short sentences with familiar words
    - Ask questions that require a "yes-or-no" answer
    - Try reminiscing about old friends or past events
  - Go beyond words
    - Use gestures, music and symbols of your faith
    - Show your affection with smiles, hugs and hand-holding, when appropriate
    - Don't be uncomfortable with silence – your presence says a great deal

- **Spirituality and Alzheimer's**
  - Be attuned and flexible to the way the person talks about his or her spirituality
  - Foster an atmosphere of joy, trust and comfort
  - Make connections through music – traditional songs, favorite hymns
  - Encourage the person to take part in services and social events appropriate to his or her abilities

- **Support and empower the family**
  - Encourage the family to stay strong by taking care of themselves.
  - Recognize signs of care-give stress: tired, joyless, moodiness, withdrawal, anxiety
  - Encourage care-giver support groups and other services of the Alzheimer's Association
  - Spend time with the person so family members can take a break
  - Encourage continued involvement in worship and other congregational activities
  - Be a willing listener

Exercises

- Talk about someone you know who had Alzheimer's, and how that person's illness affected themselves, their care givers and their family.
- Role-play a visit to an Alzheimer's patient and his or her family.

Resources

- **Website**: Alzheimer's Association www.alz.org. Information and links to support groups
- **Movie:** *Complaints of a Dutiful Daughter* by Deborah Hoffmann.
- **Book:** Robinson, A.; Spencer, B.; White, L. *Understanding difficult behavior: some practical suggestions for coping with Alzheimer's disease and related illnesses.*
- **Book:** Nancy L. Mace, Peter V. Rabins, *The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer Disease, Related Dementing Illnesses, and Memory Loss in Later Life*

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CARE IN SITUATIONS OF DEATH AND DYING [24]

Care in situations of death and dying has two dimensions:

- Care for the person who is dying, and
- Care for the family and friends in their grief after death of a loved one.

First, we will look at the situation of care for a person who is dying. Following this, we will deal with care in situations of grief.

The psychiatrist Elisabeth Kubler-Ross is well known for her research and work with dying patients. She has identified five stages of dying that are listed below. The five stages of dying do not necessarily happen one after another. For example, one who comes through the experience of anger does not automatically go next to bargaining. But, the stages are to be regarded as five major elements of the typical process of adapting to the knowledge that one is dying. It is helpful when working with a dying person to know the stages and the kind of pastoral care that would be appropriate in each stage.

1. **Denial and Isolation -** Most people react at first to the news that they are dying with statements like: "No, not me, it cannot be true." Denial functions as a buffer after unexpected shocking news, allows the person to collect her/himself and, with time mobilize other, less radical defenses. It can also recur later from time to time. The fact that a person is in denial does not mean that later on the person will not be willing or even happy and relieved is he or she can sit and talk with someone about his or her impending death. This needs to happen when the person is ready to face it. And it needs to be stopped when the person can no longer face the facts and resumes denial.
2. **Anger** – When denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentment. The person often asks, "Why me?" This stage is often difficult to deal with for family and caregivers because the anger is often directed in many different directions: doctors, family, work, friends, etc. A person who is respected and understood, who is given attention and time will know that he or she is a valuable human being, cared for, and allowed to function at the highest possible level as long as he or she can.
3. **Bargaining** – A dying person may try to "bargain with God" for an extension of life, or at least for a few days without pain. It is really an attempt to postpone the inevitable. Often, a person will feel guilty for not living a better life. Pastoral care can be very helpful in these situations to understand the source for the guilt and help to relieve it.
4. **Depression** – When the terminally ill person cannot any longer deny his or her illness, he or she cannot keep up a hopeful appearance, and will be overcome with a sense of great loss. Loss of life may be accompanied with loss of a job and a way of life. This depression is preparatory grief the person has to undergo in order to prepare him or hers for final separation from the world. An understanding person can help to discover the cause for the depression and help alleviate some of the unrealistic guilt they may have. The person should not be encouraged to "look on the sunny side of things", because the depression is a tool to prepare for the impending loss of love objects, in order to facilitate the stage of acceptance. Care can often be done with a touch of a hand, a stroking of the hair or just silently sitting together.

[24] This is adapted from Elisabeth Kubler-Ross's book: *On Death and Dying – What the dying have to teach doctors, nurses, clergy and their own families*, Macmillan, 1969.

5. **Acceptance** – If a dying person has enough time, he or she can reach a stage with they are no longer angry or depressed about their impending death. This shouldn't e mistaken for a happy stage. It is almost void of feelings. Often a person will not want visitors and is not talkative. Silence may be the most meaningful communication. Your presence can confirm that they will be cared for until the end.

Suggestions for caregivers: [25]

- Let the dying person set the direction for the conversation by using a broad opening statement like: "I've been thinking about you."
- Offer to play or sing music that is meaningful to the person
- Sit silently with the person
- Do not take it personally if the person does not treat you as you expect
- Encourage the person and their families to share memories.

Exercises:

- Talk about an experience you have had with a dying person. What helped, what didn't help.
- Role-play a visit to a dying person in each of the five stages.

Resource Books:

Barbara A. Backer, et al, *Death and Dying: Understanding and Care. 2nd edition*, Delmar, 1994.

John E. Biegert, "My Loved One is Dying", Pilgrim Press, 1990. This is a United Church of Christ publication.

Maggie Callanan and Patricia Kelley, *Final Gifts – Understanding the Special Awareness, Needs, and Communications of the Dying*, Bantam Books, 1997.

Earl A. Grollman, *Explaining Death to Children*, Beacon Press, 1967.

Barbara Karnes, *Gone From My Sight – The Dying Experience*, privately published by Barbara Karnes, RN, P.O. Box 335, Stilwell, Kansas 66085, 1995.

Elisabeth Kubler-Ross, *On Death and Dying – What the dying have to teach doctors, nurses, clergy and their own families*, Collier Books, MacMillan Publishing Company, 1969.

M. Catherine Ray, *I'm Here to Help – A Hospice Worker's Guide to Communicating with Dying People and their Loved Ones*, Hospice Handouts, McRay Company, 1992. ISBN 0-963611-0-1

Paula White, compiler, *Home Care of the Hospice Patient – An Information/Instructional Booklet for Caregivers in the Home*, Purdue Frederick Company.

[25] These suggestions come from *Called to Care – A Notebook for Lay Caregivers*, a publication of the United Church of Christ

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END OF LIFE ISSUES [26]

Decisions to be made

- **Advance Directives** Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on. Types of advance directives worth considering include:
  - **A living will**, which is a formal legal document, authorized by State laws, that describes the kinds of medical treatments you want or do not want if you become incapacitated. It can be as specific or general as you wish.[27] There are many issues to address, including
    - The use of dialysis and breathing machines
    - If you want to be resuscitated if breathing or heartbeat stops
    - Tube feeding
    - Organ or tissue donation
  - **A durable power of attorney**, also known as a health care proxy, which is a document that lets you designate a person to make treatment decisions for you if you cannot make those decisions. You'll want to alert your proxy that you have given him or her this responsibility and talk about your wishes.
  - **A Do-Not-Resuscitate (DNR) order**, which is a document that directs what measures should or should not be taken on your behalf in events such as cardiac or respiratory arrest. Typically, a DNR order is directed to emergency medical services or other first responders.

- Hospice Care Some patients remain at home during this time, while others enter a hospital or other facility. Either way, services are available to help patients and their families with the medical, psychological, and spiritual issues surrounding dying. A hospice often provides such services.

Providing Emotional Comfort

Some emotions common to most dying patients include fear of abandonment and fear of being a burden. They also have concerns about loss of dignity and loss of control. Some ways caregivers can provide comfort are as follows:

- Keep the person company—talk, watch movies, read, or just be with the person.
- Allow the person to express fears and concerns about dying, such as leaving family and friends behind. Be prepared to listen.
- Be willing to reminisce about the person's life.
- Avoid withholding difficult information. Most patients prefer to be included in discussions about issues that concern them.
- Reassure the patient that you will honor advance directives, such as living wills.
- Ask if there is anything you can do.
- Respect the person's need for privacy.
- Ask if they would like to help plan their memorial service

[26] This is adapted from information in the Library of Health, National Institutes of Health, and "Offering Spiritual Support" by National Hospice and Palliative Care Organization.
[27] Some hospitals have social services workers that can get an attorney to come into the hospital to draw up a living will.

Be aware of spiritual pain and suffering.

There are many spiritual and religious issues people who have a serious illness may face:

- Meaning and Purpose: Many people who are very ill question what their life means. They may wonder if they have done anything positive or lasting with their life.
- Guilt and forgiveness: As people face illness, they may feel guilty about or blame others for things that have happened.
- Loss of faith: Living with a serious illness can cause people to question their spiritual beliefs or faith.

Spiritual Care: spiritual questions people with a serious illness may ask.

- What gives my life meaning?
- What am I thankful for?
- What is my relationship with God?
- Is there anything I want to change in my relationships?
- Are there ways I need to ask for forgiveness?
- What do I fear?
- Are there ways I feel alone or abandoned?
- What is my source of strength?
- How do I want my family and friends to support me spiritually?
- How do I want my clergy, chaplain or spiritual leader to support me?
- Are there sacraments or rituals that are meaningful for me?
- What books, music, prayers, readings, art are meaningful for me?

As a "spiritual companion," you can best support others by helping them explore these questions rather than providing the answers.

Offering spiritual support.

Offering thoughtful spiritual support as people struggle with spiritual issues can make a significant difference in someone's life.

- Be present. Realize that it is your presence that matters most.
- Ask open, supportive questions.
- People cope with illness in different ways at different times, so it is important to ask permission to have the conversation. You could begin by saying something like: "I was wondering if you might want to talk with me about how your illness is affecting you spiritually."
- Listen with an open heart, being open to the emotions that may come up.
- Avoid clichés. Listen for the thoughts and feelings in the questions and repeat the question in your own words. Listen for what lies at the heart of the question.
- Offer compassionate support.
- Use spiritual resources and rituals as appropriate. Based on your experience with the person, offer prayer, spiritual readings, music or sacred rituals as appropriate or requested. Remember to ask if the person has a favorite prayer, scripture, reading, hymn or sacred psalm. Be sure to ask the person's permission first before offering these resources.

More Information and Resources

- **Agency for Healthcare Research and Quality** *Advance Care Planning: Preferences for Care at the End of Life* http://www.ahrq.gov/research/endliferia/endria.htm
- **National Hospice and Palliative Care Organization** *Caring Connection* http://www.caringinfo.org/
- A**ARP** *Advance Directives: Planning for the Future* http://assets.aarp.org/external_sites/caregiving/multimedia/EG_AdvanceDirectives.html

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CARE IN SITUATIONS OF GRIEF [28]

Research in the process of grieving by several researchers shows that there are several stages that people go through after a loved one dies. Some researchers have identified different stages than others. The seven dynamics of grief listed below do not necessarily occur in a linear progression: thus, one who comes through the experience of catharsis does not automatically go next to depression. But, the dynamics are to be regarded as seven major elements of the typical process of adapting to a great loss and are listed according to the order in which they generally appear. It is helpful when working with a bereaved person to know the stages and the kind of pastoral care that would be appropriate in each stage.

Shock: In the first few hours and occasionally for the following two weeks or so after the death, the bereaved experiences periods of shock. The pain of separation is so intense that the mind is numbed until later, when the loss can be accepted better. A person may act as if nothing has happened or behave in a wooden manner while planning the funeral.
Catharsis (Release of Emotion): After shock wears off, the immensity of the loss begins to grip the bereaved, and as one emotion surfaces others follow in a flood.
Depression: After the funeral is over and acquaintances have gone back to "business as usual", the survivors face depression, despair, and even thoughts of suicide. Periods of depression are especially prevalent during the first six months, they seem to come and go with diminishing frequency and duration.
Guilt: Feeling guilty is very common after a loss by death. Questions such as "Could I have done more for Mom before she died?" regularly arise, and guilt over something said or done to the deceased is common.
Preoccupation with the Loss: Survivors can become obsessed with thoughts about the deceased. This isn't a constant condition, but it ebbs and flows. The preoccupation can manifest itself in guilt-laden ruminations, intense loneliness, sleeplessness, hallucinations about the loved one, or even taking on the behavior and mannerisms of the deceased. All are normal parts of grief; only when the preoccupation becomes an ongoing obsession is it mal-adaptive.
Anger: When anger is manifested it usually means that one is beginning to come out of depression and preoccupation and is being openly expressive again. Grieving people often focus their anger on various individuals and objects – doctors, the police, friends, relatives, churches, or even the deceased. Questions like "Why did God do this to me?" or "How could God let him die?" are often raised by an individual struggling with anger.
Adapting to Reality: The futility of withdrawal from reality dawns on the person, who now goes on to be a stronger, emotionally healthier person, better able to help others who face the same experience. Reaching this final stage doesn't mean the bereaved will no longer experience any of the previous dynamics – the individual will struggle with these feelings intermittently for years – but he or she is now open to new possibilities in the present and in the future.

Responding to the Bereaved
The appropriate kind of care in the first few hours and days is different from the care required months later.
What helps:

[28] This section is adapted from *Called to Care – A Notebook for Lay Caregivers*, a publication of the United Church of Christ

- Find out about immediate needs after the death. If the Caring Circle can be helpful, get them involved.
- Let the bereaved feel free to express their emotions in their own ways. Do not be frightened when strong feelings come out; it is a normal, healthy part of grief.
- Let them know that there is no right or wrong way to grieve.
- Talk about the person who has died with the family – laugh, cry, hold hands, hug
- The grieving person can talk to or write to the person who has died
- Listen to music
- Stop by in the days, weeks, and months after the funeral when others have stopped visiting; asking, "How are you doing now that Peter is gone?"
- Tell the bereaved "I still miss Loretta."
- Talking with someone who has been there – arrange for them to talk to another widow, or widower, child who has lost a parent, … Or find out about any grief groups in the area.
- Be on the lookout for problems in handling grief that seem to be seriously maladaptive, and discuss the possibility of professional counseling.
- Come to the funeral or memorial service. Encourage other church members to come to the funeral and sign a book of remembrance if there is one.
- If it was an accident that caused the death, talk to others who were in the accident.
- Maybe someone didn't like the person who died, so be ready to hear this.

What doesn't help:

- Telling the person how lucky they are
- Telling them you know just how they feel
- Telling them they shouldn't feel that way
- Telling the person to "Cheer up"
- Ignoring the bereaved or not talking about the person who died.
- Asking if you or someone else can have some of the deceased's property
- Feeling sorry or pity for the bereaved
- Not respecting that they may don't feel up to talking

Exercises:

- Talk about a grief experience you have had. What helped, what didn't help.
- View video about grief (check resources below).

Books:

After Suicide: A Ray of Hope by Eleanora Ross
Children and Grief by William Worden
Children and Grief: Big Issues for Little Hearts by Johnette Hartnett
The Class in Room 44—When a Classmate Dies by Lynn Bennett Blackburn
Death Etiquette for the '90s, What to Do/What to Say by Johnette Hartnett
Getting Back to Life When Grief Won't Heal, by Phyllis Kosminsky
Healing Grief, 2nd Edition, Medic Publishing Company. ISBN 0-934239-42-0
Helping Teens Work Through Grief by Mary Kelly Perschy
How to Recover From Grief by Richard Lewis
How Will I Get Through the Holidays by James E. Miller
It's Not Your Fault by Accord
Recovering From the Loss of a Parent by Katherine Fair Donnelly
The Undertaking by Thomas Lynch
Will We Do? Preparing a School Community to Cope With Crises by Robert G. Stevenson

Videos:

Expressions of Grief (teen grief) by National Funeral Directors Association
Grief in America by Bert Atkinson
How to Survive a Death in the Family (children & grief) by The Guidance Club
You Are Not Alone by Steve Gilman (death of a spouse)

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CARE IN SITUATIONS OF MISCARRIAGE AND STILLBIRTH [29]

A loss of a child is considered one of the deepest pains, regardless of a child's age. The pain of what *would have been* is often the most difficult to embrace and work through. When a miscarriage or stillbirth occurs, society's attitude is to not talk about it, in fear that it's too upsetting. However, not talking about it only makes it harder to move on.

A miscarriage or stillbirth leaves a woman in a state of physical and emotional readiness for a baby that will never be. Grief is a natural process which has no exact time frame and is experienced in unique ways by different individuals. (See section on Grief.)

How to Show Support

- Listen. A person who has experienced a miscarriage or stillbirth may need to tell her story repeatedly.
- Be prepared to talk about the baby by his or her name. Hearing others say the name helps a grieving person heal.
- Talk about the hopes and dreams they had for the family and the baby.
- Express your own feelings of sadness.
- Know when to be silent... sometimes it is best to say nothing at all. A grieving person may just want someone to listen. Sometimes the grieving person may want to be alone.
- Be aware that grief has physical reactions and emotional reactions on the body. Physical reactions might include: poor appetite, disturbed sleep patterns, restlessness, low energy, and other pains. Emotional reactions may include: panic, depression, fears, despair, nervousness and nightmares. Some people may feel anger, guilt, blame, or that they have lost goals in their life. Professional help may be necessary. Contact the minister if you think this may be the case.
- Painful questions with religious implications may be asked:
    - Why did this happen to my baby, my family, me?
    - Why didn't I know something was wrong? Was this all my fault?
    - Why did God allow this to happen?
- Encourage the grieving person to express pain and stress.
- Understand that grief is an individual process that is bound by no exact time frame. It involves finding ways of living with memories and the pain associated with the loss.
- Spouses often grieve in different ways, possibly misunderstanding each other's reactions or needs, including needs for intimacy. Encourage communication and couples therapy if you think this is a problem.
- Reassure the grieving person that their feelings and reactions are normal and necessary for healing.

[29] This section is adapted from www.americanpregnancy.org/pregnancyloss/mcsupportingothers.html and www.compassionatefriends.org/Other_Pages/Stillbirth,_Miscarriage,_and_Infant_Death.aspx

- Remember that specific dates or events such as the anniversary of the loss or the expected due date, may trigger an emotional response.
- Get the Caring Circle Involved as needed: help with housework, cooking, child care, etc.
- Recommend a local support group.

Some things one shouldn't say or do

After a miscarriage or stillbirth, others sometimes say or do hurtful things without meaning to. The following are some potential hurtful words and actions that you should avoid:

- Not acknowledging the loss can be hurtful because for many parents it is important to have their experience recognized.
- Asking about how one partner is doing and not the other can be hurtful. "How are you, and how is your partner?" shows you care about both of them and you acknowledge they are grieving in their own way.
- There are no competitions in grief, each person's loss must be respected for the sense of loss and sadness it has for them. Therefore, certain sayings can be hurtful such as: "It was only a miscarriage, you'll get over it," "You're young, you can have another one," etc.
- Don't try to rush the grief process. This only causes more pain and feelings of confusion, loneliness and inadequacy.
- Talking at length about your own story of loss. Some identification may be helpful, but keep it to a minimum.
- Not allowing the person to express emotions such as guilt, shame, and anger.

Siblings reactions

It is important to explain to children on their level about the miscarriage or stillbirth in honest, appropriate, terms they can understand. Children process grief differently than adults and may ask questions, express fears, and act out in various ways to get attention. Young children may be more clingy, easily upset and distressed. Older children may be aggressive, disruptive or unusually quiet. Ways to help include children:

- Encourage children to ask questions, and express their emotions.
- Give children who are old enough, the option of being involved in the grieving process. For example, saying good-bye, drawing a picture, planting a tree, etc.
- Remain patient.

Exercises:

- Talk about your experience or that of someone you know, who had a miscarriage or stillbirth. What helped, what didn't help?
- Role-play a visit to a person who has had a miscarriage or stillbirth.

Resources:

- **Books:** *Stuck For Words*, by Doris Zagdanski. *Good Grief*, by Granger E. Westburg. *Coping with Grief*, by Mal McKissock, *How can I help?: Suggestions for People Who Care About Someone Whose Baby Died Before Birth*, by Martha Wegner-Hay
- Organization: The Compassionate Friends: **www.compassionatefriends.org**

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CARE IN SITUATIONS OF CONGREGATIONAL GRIEF WHEN A MINISTER LEAVES [30]

Research in the process of grieving by several researchers shows that there are several stages that people go through in grief. They have been adapted here for the situation when a minister leaves.

Anticipatory Grief: In the first few days or weeks or so after the announcement of the departure, the congregation members experience periods of anticipatory grief. They may be sad, disappointed, abandoned, relieved, angry, etc. Sometimes it's all in the same person. Those who never liked the minister, or are disappointed with his ministry, will feel relief and joy, and might not feel able to say that.

Actual Grief:
Some of the members of the congregation may react in these stages:
Shock: When the minister actually leaves, the bereaved may experience periods shock.
Catharsis (Release of Emotion): After shock wears off, the immensity of the loss begins to grip the bereaved, and as one emotion surfaces others follow in a flood.
Depression: When all have gone back to "business as usual" some may experience depression or despair.
Guilt: Feeling guilty over something said or done to the departed is very common after a loss.
Preoccupation with the Loss: People can become obsessed with thoughts about the departed. This isn't a constant condition, but it ebbs and flows.
Anger: When anger is manifested it usually means that one is beginning to come out of depression and preoccupation. Grieving people often focus their anger on various individuals and objects – friends, relatives, churches, or even the departed.
Adapting to Reality: The futility of withdrawal from reality dawns on the person, who now goes on to be a stronger, emotionally healthier person.

Responding to the Bereaved

For anticipatory grief: Companion congregants on the journey
For actual grief: Try and recognize what stage a person is in. The appropriate kind of care in the first few days and weeks after a minister departs is different from the care required months later.

What helps:

- Have a formal leave taking and ask all to take part
- Identify people likely to have pastoral care needs. Plan how you will handle each situation individually.
- Work with the interim minister to handle pastoral care
- Let the bereaved feel free to express their emotions in their own ways. Do not be frightened when strong feelings come out; it is a normal, healthy part of grief.
- Talk about the departed – laugh, cry, hold hands, hug
- Tell the bereaved "I still miss Chris."

[30] This section is adapted by Barbara Meyers from *Called to Care – A Notebook for Lay Caregivers*, a publication of the United Church of Christ. It is specially adapted for the situation when a minister leaves.

Situations and How to Handle Them

Situations / Emotions that come up in a congregation	How to handle
Anxiety/uncertainty about the future when retirement is announced	Give people information about what comes next Explain the process: ex: - DE does a transition interview with the Board and an exit interview with Chris. - The DE talks with the Board at that time about transition stuff--about the interim process, etc. The UUA also sends the Board president info on the process, including a video on interim ministry stuff.
Members of the congregation may have grief reactions, and they will be all over the block: sad, disappointed, abandoned, relieved, angry, etc. Sometimes it's all in the same person. Those who never liked Chris, or are disappointed with his ministry, will feel relief and joy, and might not feel able to say that.	**Now:** Anticipatory grief Companion congregants on the journey **In the fall:** Loss sinks in Interim's job is to work with the congregation to reclaim the good, let go of the yuck, and figure out how they want to move into the future. Pastoral care team deals with grief issues.
The Leave Taking	Minister should aim for the best leave taking possible. - Say the truth, even the hard things. - Be gracious to people. - Truly say good-bye The congregation needs to celebrate minister's ministry. - There should be a farewell party that includes a gift to the minister - Often people contribute pages to a memory book. Or make a quilt for that person.
People with acute pastoral care needs	Identify those families and individuals likely to be impacted by a change in pastoral care when the minister leaves. Determine how each situation will be handled. One way to solve it: The previous minister could offer to serve their needs until the new minister (interim or settled) is able to get on board, at which time previous minister would offer to take the new minister to meet the family, introduce the minister, and after the visit sit and talk and see how both ministers feel about how this care will be shared or transitioned.
Possible conflict between retired and new ministers	Have a covenant that is agreed to by both ministers and witnessed by the lay leadership of the congregation, so that they own it too.

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CARE IN SITUATIONS OF GRIEF AFTER SUICIDE [31]

How grief from suicide is different from grief from other causes
A recent study [32] concluded that suicide bereavement is distinct from bereavement for other causes in three significant ways: the grief often focuses around shame, guilt and anger, the way that society treats the survivor, and the impact suicide has on the family. The study concluded that for grief following suicide, there is a need for support groups, educational services, and family and social network interventions.

How to Comfort Survivors
A UU minister who herself experienced suicide in her family says, "There is no resource you need other than the willingness to tell the truth about what happened and to acknowledge it to the grieving loved ones, who need not to be pariahs. People have a hard time speaking to the grieving in general, but they really grow tongue-tied after a suicide. If you can help them be open about the truth and keep reinforcing that nobody is responsible for another person committing suicide, you will be doing very valuable ministry.[33]" Help them to understand that the whole life of the person who died must not be defined by the final act. Help them to focus on the positive aspects of the deceased loved one.

Help Survivors Deal with Their Guilt and Anger
"Sometimes family members and friends of people who have died by suicide have feelings of guilt. We think maybe there is something I could have done differently. If only I had ... Why did I . . . ? Why didn't I . . . ?" [34] Rehearsing or rehashing these questions is a nearly universal experience, but at some point it serves no useful purpose and we must move on.

Many times family members and friends of people who have died by suicide have feelings of anger. "These feelings may take several forms: anger at others, anger at themselves, and/or anger at the deceased. Surviving family and friends should be assured that feeling or expressing their anger is often part of the normal grieving process. Even when their anger is directed toward the deceased, it does not mean they cared for their loved one any less." [35]

Other Congregational Members
A suicide is very disturbing and sometimes can remind other members of the congregation about suicides or suicide attempts in their own family. Try to identify such people and reach out to them, listening to their feelings and concerns. If you think therapy would be helpful, suggest it.

How congregations can help
A death by suicide often leaves surviving family and friends with excruciating emotional pain, which may persist for an extended time. There is comfort in being able to mourn a loss with a faith community and help the survivors overcome any shame they may be feeling by:

- "Supporting them with the same gestures of kindness that are extended to others who have deaths in the family (taking in meals, etc.).

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[31] Primary Resource: *After a Suicide – Recommendations for Religious Services & Other Public Memorial Observances*, Suicide Prevention Resource Center, edited by David Litts.
[32] Jordan, J. R. Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31, 2001,* pp 91-102.
[33] Rev. Barbara Child, personal communication, 2006. Used by permission.
[34] *After Suicide*, p 8.
[35] *After Suicide*, p 8.

- Reaching out to draw survivors into the fabric of the community's normal activities.
- Talking with the survivors about the deceased in the same sensitive way they would about any other person who had recently died.
- Encouraging them to seek support in their grieving process, either through support groups for survivors of suicide or by seeking professional grief counseling with a therapist experienced with suicide survivors."[36] You can help them to find a therapist or group.

"Suggest that surviving friends honor the deceased by living their lives in concert with community values, such as compassion, generosity, service, honor, and improving quality of life for all community members. Activity-focused memorials might include organizing a day of community service, sponsoring mental health awareness programs, supporting peer counseling programs, or fund-raising for some of the many worthwhile suicide prevention nonprofit organizations. Purchasing library books that address related topics, such as how young people can cope with loss or how to deal with depression and other emotional problems, is another life-affirming way to remember the deceased.[37]"

When a young person has died by suicide [38]

"Young people are most prone to imitate or model the suicide event. The death of their peer may make them feel numb or intensely unsettled." If the young person was active in your youth group, talk to the minister about having a special meeting with the group to talk about suicide. Help them to identify specific adults - ministers, teachers, counselors, and coaches - who they can reach out to if they are "feeling down or depressed or having thoughts of death or suicide. In the course of this discussion, point out the value of seeking professional help for emotional problems in the same way one would seek professional help for physical problems."

Exercise:

- Ask if anyone has had an experience of someone they care about dying by suicide. What happened afterwards? Was it spoken of? What was most helpful? How did the religious community respond? Is there anything you would do differently if it happened again?
- What special self-care should the care giver be sure to do in cases of suicide?

Resources:

- *After a Suicide – Recommendations for Religious Services & Other Public Memorial Observances,* Suicide Prevention Resource Center, edited by David Litts. www.sprc.org/library/aftersuicide.pdf.
- American Association for Suicidology, www.suicidology.org Helps to locate support groups.
- American Foundation for Suicide Prevention www.afsp.org
- The Compassionate Friends, Inc. www.compassionatefriends.org for bereaved parents.
- The Link's National Resource Center for Suicide Prevention and Aftercare www.thelink.org/national_resource_center.htm
- The National Alliance on Mental Illness, www.nami.org
- *Fierce Goodbye - Living in the Shadow of Suicide*, Harrisburg, VA: Mennonite Media Productions. A TV special that can be ordered on DVD at http://fiercegoodbye.com/
- *My Son … My Son … - A Guide to Healing After Death, Loss, or Suicide,* by Iris Bolton with Curtis Mitchell, Roswell, GA: Bolton Press Atlanta, 1983.
- *Night Falls Fast - Understanding Suicide*, by Jamison, Kay Redfield, New York: Knopf, 1999.
- *No Time to Say Goodbye – Surviving the Suicide of a Loved One*, by Carla Fine, NY: Broadway Books, 1997.
- *Sanity & Grace – A Journey of Suicide, Survival and Strength*, by Judy Collins, NY: Penguin, 2003.
- *Silent Grief – Living in the Wake of Suicide – A survivor and a psychologist tell what it's like to be left behind – and offer help for moving on*, by Christopher Lukas and Henry M. Seiden, NY: Charles Scribner's Sons, 1987.

[36] Jordan, J. R. (2001). *Is suicide bereavement different? A reassessment of the literature. Suicide and Life-Threatening Behavior*, 31(1), 91–102. Quoted in *AfterSuicide*, p 6.
[37] *After a Suicide*, p 10.
[38] *After a Suicide*, p 9-10.

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ASSESSING SUICIDE RISK [39]

Pastoral Associates normally don't get involved with helping people who are suicidal, but in the course of their activities, they may hear something that sounds potentially dangerous. This is a brief guide to assessing suicide risk.

How to Tell if Someone is Feeling Suicidal
Some warning signs of suicide:

- Threatening to hurt of kill himself or herself
- Looking for ways to kill himself or herself: seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- No reason for living, no sense of purpose in life.
- Making final arrangements and giving away special possessions
- Sudden loss of interest in something that was once quite important
- Deep depression
- A recently experienced loss

People can show one or many of these signs, and some may show signs not on this list

What to do if you suspect someone is suicidal
It is important to ask directly about suicidal thoughts. Don't avoid using the word "suicide." It is important to ask the question without expressing a negative judgment. Here are some things you can say:

- Are you thinking about killing yourself?
- Are you having thoughts of suicide?

Speaking to people who are suicidal
Express empathy for them, and tell them that thoughts of suicide are often associated with a treatable mental disorder. Let them know that such thoughts are common and don't have to be acted on.

Tell them that you will be talking to the minister about the problem so that they can get the kind of pastoral care they need. Pastoral Associates don't handle situations where a person is suicidal, but this doesn't mean that you don't care about them and have hope for their situation.

Determining seriousness of intent

[39] The major resource for this section is: *Mental Health First Aid USA*, by Betty Kitchener, Anthony Jorm, and Claire Kelly, Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health and National Council for Community Behavioral Healthcare, 2009, pp 106-108.

- Does the person have the means to die by suicide? Has preparation been made? Is the method highly lethal?
- Is the plan a near term plan? Is intervention possible?
- Has the person made a suicide attempt in the past?

If a person has actually made a near-term serious plan for committing suicide, he or she needs to be in a hospital. Call 911or take the person to the hospital emergency room for immediate treatment. Call the minister and let them know what has happened.

If you are unsure what to do, call the minister and have him or her take over the pastoral care of this person.

Impulsive acts

While it is true that a person who really wants to die by suicide can do it, it is also true that many times suicides are impulsive, and can be triggered by anniversaries of traumatic events, or by places with special association with suicide, ex: the Golden Gate Bridge.

How can the person be kept safe?

- A person who is actively suicidal should not be left alone. If you can't stay, you need to arrange for someone else to do so.
- Give the person the suicide help line 1-800-SUICIDE
- Ask the person what has helped in the past.
- Do not use guilt or threats to prevent suicide.
- Don't promise not to tell anyone else. Involve him or her in decisions regarding who else will be told.

When a young person is suicidal

Adolescence can be a difficult time moving from childhood to adulthood, and some teenagers have such a difficult time that they consider or attempt suicide. Factors that increase suicide risk for teens are: depression, alcohol, drug use, hopelessness, a previous attempt, abuse, and lack of a support network. Teens can be more impulsive than other age groups.

Lesbian, gay, bisexual, transgender and questioning youth are up to four times more likely to attempt suicide than their heterosexual peers. Being rejected by their families, being bullied and harassed at school, feeling isolated and lonely play a part in these statistics. Encourage the person to share their feelings with the minister and one of the free LGBT-focused hotlines: 1-866-4-U-TREVOR and 1-800-THE-GLNH .

Tell the minister about the situation if you encounter a youth who is suicidal.

Exercise:

- Ask if anyone has had an experience of being with someone who is suicidal? What happened? Is there anything you would do differently if it happened again?

Resources:

- American Association for Suicidology, www.suicidology.org Helps to locate support groups.
- American Foundation for Suicide Prevention www.afsp.org
- The Link's National Resource Center for Suicide Prevention and Aftercare www.thelink.org/national_resource_center.htm
- The National Alliance on Mental Illness, www.nami.org
- *Night Falls Fast - Understanding Suicide*, by Jamison, Kay Redfield, New York: Knopf, 1999.

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PASTORAL CARE IN TIMES OF DISASTER [40]

Preparing to meet with Victims – Things to Remember

- When people go through a disaster or trauma, their whole life is impacted. They will never be the same, but they can be stronger and better as they learn from their experience.

- People may confront critical questions about good and evil and God's role in the disaster and in their lives.

- Major trauma is frequently followed by one or more emotional reactions: depression, memory impairment, moodiness, survival guilt, bereavement and anxiety which may need professional care.

- Common physical reactions to trauma are: restlessness, nausea, digestive problems, headaches, insomnia, tremors, and sexual problems.

- As they recover from the disaster or trauma, they need effective support and help as they work to find a "new normal" – a new way of living that will eventually feel right for them.

- Healing and forgiveness are processes, not events. They take time.

- Victims can and do make choices as they recover. They can be an active participant in their recovery and not just let things happen to them.

- Forgiveness cannot be forced or demanded. It is a choice each makes, as they are ready.

- In a disaster, the poor and less powerful are often ignored. The religious community must seek out marginalized communities and find trusted people within these communities who can be advocates and who can communicate effectively to their constituents.

- Management of post-incident stress can be helped with physical exercise, proper rest, proper diet, some kind of "normal" activities, and open discussion. Encourage these.

- Take care of your self as a care giver, as well.

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[40] Sources:

- *Emotional and Spiritual Care, an introduction on basic concepts***,** a working document from the Emotional and Spiritual Care Committee of the National Voluntary Organizations Active in Disaster, 24 May 2004.
- "How Faith Communities Can Respond in Crisis and Disasters," Carol L. Hacker, PhD, CTS
- Two very helpful documents from Church World Service available at www.cwserp.org/training/:
  - *Operating The Faith-Based Disaster Recovery Organization – A Capacity Building Guidebook for Boards of Directors and Program Managers*
  - *Prepare to Care: Guide to Disaster Ministry in Your Congregation.*

Responding to Victims/Survivors about Spiritual Issues

1. Use reflective listening and active listening techniques when working with victims/survivors.

2. Avoid "fixing" things. You can only assist them. Presence is the key. ex: You cannot promise that their child will be found alive, but you can stay with them while they wait for news.

3. Be honest, with compassion, and do not assume you know what they will say or believe.

4. Do not argue with their beliefs or try to persuade them to believe as you do.

5. Do not respond with platitudes or clichés to victims/survivors. "It will be okay." "It is God's will." "They are in a better place."

6. Let them tell you what their religious/spiritual beliefs are. Do not assume anything.

7. Stay theologically neutral. Survivors may try to explain things in ways that contradict your theology. Resist the urge to preach at this time. Rather, help them use their spiritual/religious beliefs to cope.

8. They may need reassurance that it is "normal" to ask questions about God and/or their religious beliefs. However, some faiths do tell their members not to question God.

9. Allow expressions of anger toward God or others – in healthy, non-destructive ways. If they ask "Why did God do this?", complex theological answers may confuse them right now. Instead, say "I don't know. But what I do know is that God is with us now."

10. Try and shift anger constructively to the management of the consequences ("How can we do the work required?") so that their anger will be used productively.

11. Questions about sin and evil do not go away. It is appropriate for people of faith to struggle with these questions. In responding to victims, the goal is not so much to answer them as to feel the struggle and pain of the survivors.

12. Do affirm their search for spiritual/faith-based answers. Do not impose your thoughts or beliefs on them.

13. Do affirm the wrongness, evil, and/or injustice of what has happened, especially if the trauma was caused by humans.

14. Give them the materials that can help them in their search for meaning or their search for spiritual answers: Bibles, prayer books, daily readings.

15. Emphasize that everyone has to find their own answers and way of understanding in traumatic events.

16. Pray for them.

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PASTORAL CARE IN TIME OF WAR[41]

In times of war, it's not unusual for people to have feelings of uncertainty. No one knows how long a war will last or how it will affect our lives. We may feel uncertain about the future and anxious about events that are out of our control. We do not all respond the same way to war. Someone with previous experience in war or other types of conflict may unexpectedly recall distressing thoughts and feelings from that previous experience. It is normal that you are concerned about people you are providing pastoral care for.

Building resilience -- the ability to adapt well to unexpected changes and events -- can help us manage stress and feelings of anxiety and uncertainty related to war. We all can develop resilience. It involves behaviors, thoughts and actions that can be learned over time. Following are steps to building resilience that can help you and those you are helping adapt to unexpected events and stressful situations in a time of war. In addition, if you or the person you are helping are feeling overwhelmed you may want to consider talking to a mental health professional.

10 Steps for Resilience in a Time of War

1. **Make connections:** Keep in touch with family, friends and others. Some find comfort in connecting with a higher power, whether through organized religion or privately.
2. **Help yourself by helping others**: Volunteer at a community organization or helping families of active reservists or military personnel serving in the war can help you as well as others.
3. **Maintain a daily routine:** Keep up with your daily routine of work, errands, household chores and hobbies.
4. **Take care of yourself:** Make time to eat properly, exercise, rest and do things you enjoy such as hobbies and social activities.
5. **Give yourself a "news" break:** Control the amount of time you and your family spend watching and reading war-related news coverage.
6. **Have a plan:** Establish a clear plan for how you, your family and friends will respond and connect in the event of a crisis.
7. **Prepare a Security kit:** Create an emergency kit, including those things that give you comfort and security such as a favorite book, a journal or pictures of loved ones and their phone numbers.
8. **Nurture a positive view of yourself:** Recall the ways you have successfully handled hardships in the past, drawing on these skills to meet current challenges.
9. **Keep things in perspective:** Try to consider the stressful situation in a broader context and keep a long-term perspective. Remember that wars end.
10. **Maintain a hopeful outlook:** An optimistic and positive outlook enables you to see the good things in your life and can keep you going even in the hardest times.

[41] Source: American Psychological Association at: **http://helping.apa.org/resilience/war.html**

RESILIENCE IN A TIME OF WAR: FOR YOUNG PEOPLE

These are tips for young people to help them develop resilience.

It may seem like the war has nothing to do with you. On the other hand, the news can seem overwhelming. You keep hearing about being prepared for war - is there something you can do to prepare mentally? The good news is that you can learn the skills of resilience - the ability to adapt well in the face of hard times; disasters like hurricanes, earthquakes or fires; tragedy; threats; or even high stress. The following are tips for developing resilience. As you use these tips, keep in mind that each person's journey along the road to resilience will be different - what works for you may not work for your friends

10 TIPS IN A TIME OF WAR

1. **Talk about It**: Talk with your friends and, yes, even with your parents. Understand that your parents may have more experience with war than you do, and they may be afraid as well. Get connected to your community, whether it's as part of a church group or a high school group.

2. **Turn It Off**: Try to limit the amount of news you take in, whether it's from television, newspapers or magazines, or the Internet

3. **Cut Yourself Some Slack:** The stresses of war may heighten daily stresses. Be prepared for this and go a little easy on yourself, and on your friends.

4. **Create A No-War Zone:** Make your room or apartment a "no war zone" -- home should be a haven free from the stress and anxieties associated with war.

5. **Stick To The Program:** Map out a routine and stick to it. You'll be doing all kinds of new things, but don't forget the routines that give you comfort.

6. **Take Care of Yourself:** Be sure to take of yourself - physically, mentally and spiritually. And get sleep. If you don't, you may be more grouchy and nervous at a time when you have to stay sharp.

7. **Take Control**: Make sure you are included in any emergency planning at home, school or work.

8. **Express Yourself:** War can bring up a bunch of conflicting emotions, but sometimes, it's just too hard to talk to someone about what you're feeling. If talking isn't working, do something else to capture your emotions like start a journal, or create art.

9. **Help Somebody:** Try volunteering in your community or at your school, cleaning-up around the house or apartment, or helping a friend with his or her homework.

10. **Put Things In A Positive Perspective:** War may be all anyone is talking about now. But eventually, wars end. If you're worried about whether you've got what it takes to get through this, think back on a time when you faced up to your fears, whether it was asking someone on a date or applying for a job. Learn some relaxation techniques, whether it's thinking of a particular song in times of stress, or just taking a deep breath to calm down. When you talk about bad times, make sure you talk about good times as well.

PLACES TO LOOK FOR HELP

- To locate the psychological referral system in your local area call **1-800-964-2000**.
- Investigate local self-help and support groups
- Read books and other publications by people who have survived a war.

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THE CARE OF DIFFICULT PEOPLE [42]

Introduction

- Care of
  - Care of – rather than the manipulation or isolation of – the difficult person.
  - Care of caregivers
  - Care of the church
- Shared responsibility:
  - No one is to blame but everybody is responsible to fix
  - Person not to be treated as a scapegoat
  - We don't "play God" in others' lives
  - Remember respect for the individual
- Mental illness and disruptive behavior
  - Some people may need professional mental health care to change behavior
  - Not all people with difficult behavior are mentally ill; sometimes mentally ill people are treated badly by other difficult people who aren't mentally ill.
- Not covered here
  - Intentionally illegal, malicious, or destructive actions
  - Sexual misconduct

[42] Primary source: Wayne E. Oates. *The Care of Troublesome People*, New York: Alban Institute, 1994.

Discernment is Required When Walking the Line …

Between …	And …
Respect for the inherent worth and dignity of each individual as a precious human being.	Allowing individual behavior that is disruptive to the workings of the congregation as a whole.
The use of the democratic process within the church institution.	Rule by a majority which doesn't understand the culture of a minority and doesn't address its rights, needs or dignity. Minorities include: o Racial or cultural minorities o People with physical or mental disabilities o People of different sexual orientation o Someone who is odd or eccentric o Someone of a different economic class
Speaking the truth to power.	Wanting to co-opt power for one's own narrow personal ends.
A visionary who sees a direction that the community should be moving in, dealing with people who are resistant to change. Ex: o Women in Religion o Welcoming Congregation	Someone who is disruptive in a non-productive and destructive way, not leading to change for the common good.
People who are drawn to a religion which comes from a heretical stance and encourages work for change in society.	People whose actions toward creating societal change are abrasive, ineffective, and counter-productive.
People of a religion which encourages its believers to search for their own truth and meaning.	People who have no sense of what activities are ethical or non-ethical and no inner or outer guide to determine one from another, leading to arbitrary, inconsistent decisions.
People in opposition to a culture which often teaches that people are either "good" or "evil" based on narrow religious principles.	People who don't think any delineation of actions as "good" or "evil" in society should be made. Thus, anything goes.

A Guide to Discernment

- By its nature, this discernment is subjective
- Aspire to use your power wisely, not arbitrarily, dealing with others in a spirit of gentleness and humility
- Aim to confront individual behavior that is disruptive to the workings of the congregation as a whole
- Try to understand the motivation of the disruptive behavior, treating each person with respect
- Be sensitive to the needs of the minorities
- Be open to hearing the visionary voice
- Seek productive efforts towards societal change
- Work towards developing ethical positions on important issues
- Ask for help from the minister or others if needed
- Mistakes in discernment will be made. Learn to apologize and forgive yourself.

The Care of Difficult People

Some Advice from Jesus: The Three-Step Model

This model is described in Matthew 18: 15-17 (NRSV)

[15] If another member of the church sins against you, go and point out the fault when the two of you are alone. If the member listens to you, you have regained that one.

[16] But if you are not listened to, take one or two others along with you, so that every word may be confirmed by the evidence of two or three witnesses.

[17] If the member refuses to listen to them, tell it to the church; and if the offender refuses to listen even to the church, let such a one be to you as a Gentile and a tax collector.

Notes:

- In Judaism, to "sin" often means to "miss the mark"
- Jesus loved Gentiles and tax collectors, too.

Using this Model in our Churches:

Focus on behavior that is disruptive and not productive.

1. Talk face-to-face with the offender.
   - This may nip the problem in the bud.
   - Give the person the benefit of the doubt:
     "This is what I feel when you …. Is this what you intended?" Or
     "I don't know whether this is accurate or not, but is it true that you said or did this?"
     Try not to put them on the defensive.
     Use "I" statements

2. Ask one or two people to join you and meet with the offender.
   - Check your views with the wisdom of others
   - Get offender to "pay attention," not "get attention."

3. Ask the offender to come before the congregation (or sub-committee)
   - Involve the minister, if not already involved
   - If problem is harmful to the congregation, and the person refuses to change, ask person to take a leave of absence, or otherwise remove him/her self from the congregation. Cordiality outside of church is still appropriate.
   - The goal is restoration; determine what steps need to be taken for this
   - Recommend therapy, if appropriate
   - Restore person to community in a spirit of gentleness
   - Learn when to let go if restoration is not possible

Some Kinds of Difficult People and Their Care

Back-Biting Person

- Doesn't deal face-to-face with someone with whom they have a grievance; rather spreads storied behind that person's back, starting rumors and gossip.
- How to handle: Deal face-to-face with the originator of the story.
  - Encounter done in a spirit of gentleness and humility, not with anger
  - If the back-biter is telling the truth, understand the situation and take action to address it. If serious, alert the minister.
  - Try to understand person's motivation, fears, etc that led to action; it may be linked to a larger set of difficulties that need to be addressed, maybe using mental health care

Authoritarian, Power-Ridden Person

- Relies on intimidation to get his or her way.
  - Probably needs an audience to make power moves.
  - May have a "palace guard" who depend upon him / her for leadership.
  - May use money as power.
  - May hold all signs of weakness with contempt
- One-on-one encounter is the best way to start: no audience, no embarrassment
- Objective: have him/her hear you out. If there has been a legitimate mistake, admit it. Look for opportunities for reconciliation while "saving face" for authoritarian

Competitive Divider of the Congregation

- Divides congregation into competitive camps
  - Examples: social class, cliques, contending families, staff conflicts
  - Inappropriate use of model of competitive conflict from business world
- Need to set limits beyond which a competitor may not go in terms of divisive behaviors. ex: job descriptions, covenant of right relationships
- When staff members start demeaning each other, nip it in the bud, by pointing it out and restore harmony in a spirit of gentleness and self-examination.
- Be sensitive to people who are disappointed about some action, affirming their gifts

Dependent Clinging Vine

- Dependent on constant attention. Cannot do many things independently. Not sensitive to the effects of his or her behavior.
- May be conscience stricken and need someone to hear him / her out – for a limited number of encounters
- Encourage independent actions
- May need referral to professional counseling - Get minister involved

The Star Performer

- Wants to grab or share the spotlight as much as they can
- Often fickle, sort-tempered, superficial, oblivious to needs of others, undependable, lack integrity, and act against the common good of the church as a whole.
- May criticize the minister who is "in the spotlight" every Sunday morning
- Star performer may need:
  - Friendship that is steadfast and durable
  - A richer spiritual life
  - To find a purpose or calling to their life, maybe studying drama
  - Professional mental health care

Discussion / Role-Play Case Studies

Use these, or suggest your own

1. A man frequently disrupts a committee meeting and keeps work from getting done.

2. A top donor threatens to reduce his contribution if the church plans aren't changed to his liking.

3. A person in a committee takes an action not sanctioned by the committee and represents it as the committee's decision. The person believes they took the right action.

4. The chair of a committee, a person of long-standing power in the congregation, has a very authoritarian style. He has cultivated a "palace guard" on the committee. Open conflict results when there is any disagreement, and ideas are co-opted when the chair likes them.

5. A woman spreads a story about the treasurer's handling of church money.

6. A woman is unhappy about not being selected to a key committee, and seeks to undermine the committee's work.

7. A person expects/demands daily interactions with lay pastoral care staff without an understandable reason

8. A man disrupts worship on a regular basis with loud entrances and exits.

9. A poorly-dressed man is laughed at when entering church and later tries to disrupt a sermon talk-back session.

10. A person has been warned before about disruptive behavior and has continued to do it because the church didn't take any action on past warnings.

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PASTORAL CARE FOR MENTAL HEALTH PROBLEMS

Mental Health and Mental Disorders[43]

Mental Health

The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity

Mental Disorder

A psychological behavioral syndrome occurring in a person that results in clinically significant impairment or distress, not an expectable response to a particular event and not a manifestation of cultural norms

Every phrase of this definition is significant:

- ***psychological behavioral*:** A diagnosis of a mental disorder occurs where the psychological or behavioral symptoms are the most prominent symptoms
- ***syndrome*:** A pattern or cluster of symptoms that tend to occur together
- ***occurring in a person*:** An individual, not societal problem
- ***clinically significant impairment or distress*:** There is a difference between unconventional behavior and a mental disorder. People shouldn't be diagnosed with a mental disorder just because they're 'different'. It is acknowledged that in some cases there is a blurred line between normality and abnormality, and that diagnosis has a subjective component. Care should be taken not to over-pathologize behavior.
- ***not an expectable response to a particular event and not a manifestation of cultural norms***

[43] Sources:

- U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*
- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*

Categories of Mental Disorders[44]

Category	Characteristics	Example Disorders
Mood Disorders	A disturbance of mood as the predominant characteristic.	Depression Bi-polar disorder
Anxiety Disorders	Characterized by an unpleasant feeling of apprehension usually accompanied by physical discomfort, such as palpitations, and shortness of breath.	Obsessive compulsive disord Post traumatic stress disorder Agoraphobia Generalized anxiety disorder Panic attack
Psychotic Disorders	Characterized by the presence delusions, hallucinations, disorganized speech or behavior	Schizophrenia, Schizoaffective disorder, Delusional disorder
Substance-Related Disorders	These disorders result from taking a *substance*: i.e. a drug of abuse (including alcohol), the side effects of a medication and toxin exposure.	Substance Dependence Substance Abuse Example substances: Alcohol Amphetamine Opium Cocaine LSD PCP Inhalants Nicotine
Disorders usually first seen in infancy, childhood, or adolescence	Although most people with these disorders usually are diagnosed when they are infants, children or adolescents, this isn't a diagnosis requirement, and some are not diagnosed until adulthood.	Retardation Autism Learning disorders Attention deficit disorders Feeding disorders Disruptive behavior
Cognitive Disorders	Dysfunctions of the brain caused by neurological problem and/or drug abuse.	Delirium Dementia
Personality Disorders	An enduring pattern of inner experience and behavior that deviates markedly from cultural expectations, is pervasive since adolescence, is inflexible and leads to distress or impairment.	**Paranoid:** distrust and suspiciousness **Antisocial**: disregard for, and violation of the rights of others **Borderline:** instability in interpersonal relationships and feelings of abandonment **Histrionic**: excessive emotionality and attention seeking **Narcissistic:** grandiosity, need for admiration **Avoidant:** excessive social inhibition, feelings inadequacy, hypersensitivity to negative evaluation **Schizotypal:** acute discomfort with close relationships, with cognitive distortions **Dependent:** overly dependent on others

Notes:

- Diagnosis of more than one mental disorder is possible.
- In general, a general medical condition is ruled out before making a diagnosis of a mental disorder
- Categories of DSM mental disorders **not** included in this chart: Eating, Sleep, Sexual and Gender Identity, Impulse Control, Factitious (intentional), Dissociative (identity)and Somatoform (physical symptoms)

[44] Source: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*

Pastoral Care for People with Mental Disorders and their Families

General

- ***Part of a team***: Your care augments that of mental health care specialists.
- ***Education:*** Learn about mental illnesses and how to recognize them. As much as possible, keep up to date with the latest findings in mental health. Encourage education of all parties.
- ***Presence:*** Be emotionally present, listen and recognize their unique gifts. Visit them if hospitalized.
- ***Encouragement***: Encourage them to stick to the treatment plan prescribed by the mental health professional they are seeing, including taking prescribed medications.
- ***Prayer:*** Pray with and for the mentally ill person and their family, when you think it will be helpful.
- ***Referrals***: Develop a referral list of therapists, psychiatrists and clinics and hospitals taking patients with mental disorders. Learn the low-cost alternatives in your community. Locate support groups in your community which specialize in a particular disorder and encourage client / family participation.
- ***When to refer to a psychiatrist*** Make a psychiatric referral when a person has a mood disorder, psychotic disorder, is suicidal, is abusing drugs, or is severely anxious.

Depression

- The depressed person needs to be reassured that help is possible.
- The family needs help in recognizing the illness and dealing with the afflicted person

Schizophrenia and Psychotic Disorders

- When talking to a person in acute crisis, simplify your communication style and write down suggestions so they can be referred to in your absence.
- Call the schizophrenic person periodically, because they may be isolated and lonely.
- When emotions in a family are dramatic and highly expressed, the schizophrenic person does poorly, so encourage the family to keep the emotional level subdued;

Suicidal People

- A mental health professional should be consulted immediately. If you think the situation is grave enough, you can take them to the hospital yourself

Anxiety Disorders

- A person may ask nothing more than your listening to them with understanding
- Give them encouragement to face their fears
- Make a proper referral to a therapist if you feel there is a mental disorder.

Personality Disorders

- You can't deal with every person the same way; learn how to tailor your style slightly to account for a particular personality type. For example: an obsessive-compulsive person works best with details; a histrionic person enjoys being in a crowd and performing

Dementia

- See if your congregation can offer respite to the family or caregivers on a dependable basis. But, don't over-promise.
- Encourage caregivers to go to support groups and find adult day-care centers.

Emotionally Disturbed Children

- Be a good listener to children who seem disturbed and to their parents. If you suspect sexual or physical abuse, find shelter for them.
- Give respite care to family caregivers of severely affected children.

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STAGES OF RECOVERY FROM MENTAL ILLNESS [45]

The psychiatrist Mark Ragins has observed that recovery from mental illness occurs in stages, similar in concept to the stages of dying proposed by Dr. Elizabeth Kubler-Ross. Like all models, it isn't perfect, but it can be very helpful in identifying where someone is and what would be helpful to a person at a particular point in recovery. His model for recovery from mental illness has the following four stages:

The first stage: HOPE
During times of despair, everyone needs a sense of hope, a sense that things can and will get better. Without hope, there is nothing to look forward to and no real possibility for positive action. Hope is a great motivator, but for hope to be truly motivating, it has to be more than just an ideal. It has to take form as an actual, reasonable vision of what things could look like if they were to improve. It's not so much that people with mental illness will attain precisely the vision they create, but that they need to have a clear image of the possibilities before they can make difficult changes and take positive steps.

The second stage: EMPOWERMENT
To move forward, people need to have a sense of their own capability and their own power. Their hope needs to be focused on things they can do for themselves rather than on new cures or fixes that someone else will discover or give them. To be empowered, they need access to information and the opportunity to make their own choices. They may need encouragement to start focusing on their strengths instead of their losses. Often people have to experience success before they believe they can be successful. Sometimes they need another person to believe in them before they're confident enough to believe in themselves.

The third stage: SELF-RESPONSIBILITY
As people with mental illness move toward recovery, they realize they have to take responsibility for their own lives. This means they have to take risks, try new things and learn from their mistakes and failures. It also means they need to let go of the feelings of blame, anger and disappointment associated with their illness. This is a particularly difficult stage for people with mental illness and their caregivers. Old patterns of dependency must be broken.

The fourth stage: A MEANINGFUL ROLE IN LIFE
Ultimately, in order to recover, people with mental illness must achieve some meaningful role in their lives that is separate from their illness. Being a victim is not a recovered role, and frankly, neither is being a survivor. Newly acquired traits like increased hopefulness, confidence and self-responsibility need to be applied to "normal" roles such as employee, son, mother and neighbor, apart from their mental illness. It is important for people to join the larger community and interact with people who are unrelated to their mental illness. Meaningful roles end isolation and help people with mental illness recover and "get a life".

Exercise

- Review people in your congregation with mental disorders, and try to identify if these stages are helpful in what would be most helpful for them at this point in their recovery.

[45] This section is adapted from *The Road to Recovery* by Mark Ragins, MD

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ALCOHOLISM [46]

"Craving...[is] the equivalent on a low level of the spiritual thirst of our being for wholeness..."
—Carl Jung in a letter to Bill Wilson, Co-founder of Alcoholics Anonymous

Alcoholism is a substance-related disorder. It can exist as alcohol dependence, or alcohol abuse. Here is how the DSM-4 defines dependence and abuse:

Alcohol Dependence
The person continues use alcohol despite significant substance-related problems.

1. ***Tolerance*:** need for ever increasing amounts of alcohol
2. ***Withdrawal:*** withdrawal symptoms when using alcohol is stopped.
3. ***Compulsive pattern of use***:
    a. taking in larger amounts and over longer period than intended
    b. time spent in activities necessary to obtain alcohol
    c. important activities given up
    d. continued use despite persistent problems related to use

Alcohol Abuse
A maladaptive pattern of alcohol use that causes harmful consequences, but that doesn't meet the criteria for dependence; tolerance, withdrawal and compulsive use are not present

1. Recurrent alcohol use resulting in a failure to fulfill major role obligations
2. Recurrent alcohol use in situations in which it is physically hazardous
3. Recurrent alcohol-related legal problems
4. Continued alcohol use despite having persistent problems related to alcohol

Co-Occurring Disorder: A diagnosis of a substance abuse and another psychiatric disorder.

Why people become alcoholics
Most people who drink alcohol never move beyond social or recreational use. For some individuals, however, their first experience initiates a progressively serious attachment to alcohol ultimately leading to abuse or dependence. About one third of these people will become alcohol dependent. Binge drinking by teenagers and college students can lead to alcoholism.

The pattern of the downward progression in thinking and behavior can be said to occur in stages: (Not everyone goes through these stages in this order, but it is a helpful model.)

1. Experimentation – try it out and it feels good
2. Occasional use, or social use – a pattern of where, when it is used. Create bond.
3. Loss of control – attachment to alcohol overpowers ability to control use. Guilt and shame. Preoccupied with how to get alcohol
4. To relieve withdrawal – Must drink or will have withdrawal symptoms

[46] Main Sources:
- Meacham, Denis. *The Addiction Ministry Handbook: A Guide for Faith Communities*. Skinner House, 2004.
- UUA Addictions Ministry web pages www.uua.org/leaders/leaderslibrary/addictionsministry/

Questions to determine alcohol problem One "yes" answer suggests an alcohol problem.

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

The UUA Addictions Ministry

The UUA's Addictions Ministry was formed to offer resources and information to congregations to support reflection and transparency, and to help those with addictions, their families, and their communities along the path to recovery. The web-pages of this ministry at www.uua.org/leaders/leaderslibrary/addictionsministry/ have many resources, both books and organizations that are helpful to a congregation.

Recovery from Alcoholism – the Spiritual Dimension

AA, the most successful recovery regime is avowedly a spiritual program. Sometimes, as with AA founder Bill W., recovery comes after a "spiritual experience" in which in the words of Carl Jung, "ideas, emotions and attitudes which were once the guiding forces of the lives of these people are suddenly cast to one side, and a completely new set of conceptions and motives begin to dominate them."

Suggestions for Pastoral Care

- Invite alcoholics to activities not associated with drinking
- Suggest Alcoholics Anonymous or other program. Some UUs are uncomfortable with AA's "higher power" and find that other programs such as the Buddhist Recovery Network or Save Ourselves work better for them.
- Suggest Al-Anon, Alateen or Adult Children of Alcoholics for family members
- Ensure that congregational teen groups get education on alcoholism
- Talk to recovering alcoholics to gain insights and to learn what works for them

Exercises

- Ask if anyone has had experience with alcoholism in themselves, their family, or friends. Tell about how it manifested itself and the current status.
- Role play talking to a member of your congregation who comes for help with a alcohol problem.
- Role play talking to someone who is in denial of an alcohol problem, or is an enabler.

Helpful Organizations

- Alcoholics Anonymous® is a fellowship of men and women who share their experiences and hope with each other that they may solve their common problem. Associated organizations for family members are Al-Anon and Alateen
- Save Ourselves uses a mutual-aid support group model toward sobriety without God and provide a secular alternative to the religious language of most 12-step programs.
- The Buddhist Recovery Network is open to people of all backgrounds. It promotes mindfulness and meditation, and is grounded in Buddhist principles.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) builds resilience and facilitates recovery for people with mental or substance use disorders.
- Adult Children of Alcoholics and acknowledge the common experiences of growing up in alcoholic or otherwise dysfunctional homes.

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CO-OCCURRING DISORDERS

Co-Occurring Disorders (COD) an individual having one or more substance abuse disorders and one or more psychiatric disorders at the same time. Recent studies:

- 50%+ diagnosed with *alcohol* abuse/dependence also had a mental disorder at some time.
- 60% of people with a history of *other drug* abuse/dependence also had a mental disorder.
- Mental health problems can predate or postdate substance abuse problems

Integrated Services: With integrated services, one clinician or treatment team provides services for both mental illness and substance use at the same time.

Assessment of Co-Occurring Disorders[47] There are 3 diagnostic possibilities:

1. The person may be self-medicating a psychiatric disorder with substance use.
2. The mental health problems may be symptoms of the addiction e.g., depression because of the crash after a cocaine binge
3. The person may have both a co-occurring mental and substance use disorder.

How clinicians tell what might be going on:

- Addiction came before the mental illness: first focus on the addiction and observe mental health.
- Mental Illness came before addiction: first focus on the mental health problem and observe what happens to the substance use. The person could be self-medicating a mental disorder.
- If both came together this could be a possible Substance-Induced Mental Disorder.
- Check for any drug-free periods in the person's life. If the psychiatric problems dissipated after some drug-free periods of weeks to months, then the mental health problems may be substance-induced.

Current State of the Practice for Co-Occurring Disorders [48]

Recent Innovations in treating COD

- Screening, Brief Intervention, Referral and Treatment
- Research-based Prevention strategies
- Many evidence-based practices
- Genetic testing
- For many agencies, co-occurring is now the expectation rather than the exception

Current Problems with treating COD

- High cost of care
- Lack of information given to clients/families
- Medications not widely used
- Few adequate treatment facilities
- Intervention often not adequate
- Education needed on outcome success
- Many need but don't receive treatment

Effective Approach: Based on Stages of Change

- Meet people where they are
- May be ready to deal with one issue, but in denial on the other. Need to adjust approach

Stage	Strategy
1. **Pre-contemplation** - Not yet ready to change behavior	• Establish rapport, trust • Express concerns ○ Perception of problem with substance and/or mental health

[47] Mee-Lee, D. *Tips and Topics*: http://www.changecompanies.net/blog/?p=1436
[48] Mee-Lee, D. *Tips and Topics*: http://www.changecompanies.net/blog/?p=1408

	○ Suggest trial abstinence followed by a psych evaluation ○ Give factual information on addiction / mental health • Explore person's perception of psych / addiction problem • Important to see the person again
2. **Contemplation**- Acknowledges concerns, considers change, ambivalent	• Normalize ambivalence • Help person decide: ○ Pros and cons of use and/ or psych symptoms ○ Discrepancies between personal values and actions ○ Consider trial abstinence and / or psychological evaluation ○ Free choice for each of co-occurring disorders
3. **Preparation**- Committed to change, but still considering what to do	• Acknowledge significance of seeking treatment • Affirm ability to seek treatment successfully for each of the co-occurring disorders • Give options for action for each disorder • Caution that road ahead is tough but important • Ask what has worked in the past
4. **Action**- Actively taking steps but hasn't reached a stable state	• Encouragement and support wherever they are • Realistic view of change – uncomfortable aspects to withdrawal and / or psychological problems • Reinforce importance of staying in recovery for both problems
5. **Maintenance**- Achieved initial goals, working to maintain gains	• Help find new pleasures, Support lifestyle changes; Go with them to new activities. • Recognize struggle with either or both problems • Maintain supportive contact • Review long-term goals • Help planning for relapse prevention
6. **Recurrence**- Recurrence of symptoms, coping with consequences and what to do next	• Help re-enter change cycle • Recurrence as learning opportunity for either substance use or mental disorder • Alternative coping strategies • Maintain supportive contact

Motivational Enhancement Approaches to Co-occurring Disorders [49]

Basic Mental Health Assessment Questions[50]

Use your own words, natural, not clinical conversation. Don't ask what they aren't ready to hear.

- Have you ever felt you needed help with an emotional problem? If so, have you gotten help?
- Have you ever heard voices that other people cannot hear, or seen things others don't see?
- Have you ever been depressed for a prolonged period of time? Have you felt suicidal?
- Have you had nightmares or flashbacks as a result of some terrible, traumatic event?
- Have you ever had strong fears – e.g. heights, animals, dirt, being in a crowd... ?
- Do you feel that people are against you without their saying so?
- Do you worry excessively about gaining weight, severely limit eating, or vomiting after a meal?
- Have you had a time of excessive energy, racing mind, little sleep, talking non-stop?
- Have you had spells when you suddenly felt very anxious, frightened, heart beating rapidly?
- Have you ever had a troubling, persistent impulse to do something over and over without reason?

Questions to determine substance abuse problem[51] One "yes" answer suggests a problem.

[49] *Substance Abuse Treatment for Persons with Co-Occurring Disorders*, SAMHSA TIP 42, p 117-118.

[50] Summarized from *Mental Health Screening Form –III* by J. Carroll and John McGinley, Project Return Foundation, 2000.

- Have you ever felt you should cut down on your drinking or use of other drugs?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or taken a drug first thing in the morning to steady your nerves?

Suggestions for Pastoral Care

- Invite people to activities not associated with drinking
- Suggest Alcoholics Anonymous, Narcotics Anonymous or other program. Some UUs are uncomfortable with AA's "higher power" and find that other programs such as the Buddhist Recovery Network or Save Ourselves work better for them.
- Suggest Al-Anon, Alateen or Adult Children of Alcoholics for family members
- Ensure that congregational teen groups get education on alcoholism, drug use and mental health
- Talk to recovering alcoholics and addicts to gain insights and to learn what works for them

Exercises

- Ask if anyone has had experience with addiction and mental disorder in themselves, their family, or friends. Tell about how it manifested itself and the current status.
- Role play doing a mental health and substance abuse assessment.
- Role play talking to someone who is in denial of a co-occurring disorder, or is an enabler.
- Role play talking to someone who admits to an addiction, but is in denial of a mental health problem

Resources for Co-Occurring Disorders

Books

1. Bucciarelli C. *Addicted and Mentally Ill. Stories of courage, hope, and empowerment*. Binghamton , Haworth Press. 2005.
2. Daley Dennis, *Coping with Dual Disorders: Addiction and Psychiatric Illness*, Center City , MN . Hazelden. 2003.
3. Daley DC & Spears J. *A family guide to coping with dual disorders*. Center City , MN : Hazelden. 2003
4. Ekleberry, SC. *Co-occurring Disorders: Personality Disorders and Addiction*, Routledge, 2008.
5. Miller, WR & Rollnick S. *Motivational Interviewing*, 2nd Edition. Guilford Press, New York, 2002.
6. Peters RH & Hills HA. *Intervention strategies for offenders with co-occurring disorders. What works?*. National GAINS Center , Delmar , NY . 1997.

On-Line Information

1. Co-occurring Center for Excellence (COCE): *Overview Papers*: SAMHSA, Rockville, MD. 2006-2007. coce.samhsa.gov/ .
2. Dual Recovery Anonymous. www.draonline.org
3. Mee-Lee, D. *Tips and Topics*: an on-going series on co-occurring disorders. www.changecompanies.net/
4. National Center for Trauma-Informed Care. mentalhealth.samhsa.gov/nctic
5. National Institute of Alcohol Abuse and Alcoholism. *Helping patients who drink too much: a clinician's guide*. NIAAA. 2005. www.niaaa.nih.gov/guide .
6. National Institute of Drug Abuse , *The science of addiction, drugs, brains, behavior*. www.drugabuse.gov . Rockville, MD, NIH Publication 07-5605, 2007.
7. Substance Abuse and Mental Health Services Administration. *Substance Abuse Treatment for Persons with Co-Occurring Disorders*, www.samhsa.gov.

[51] Adapted from the CAGE Questionnaire for alcohol abuse counsellingresource.com/quizzes/alcohol-cage/index.html

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EATING DISORDERS [52]

There are three types of eating disorders:

1. bulimia nervosa – episodic binge overeating followed by purging
2. anorexia nervosa – under-eating to the point of starvation
3. compulsive overeating – using food excessively to cope with the stresses of life

Eating disorders are a serious health problem and can cause serious, even life threatening, physical effects. They can cause malnutrition, dehydration, electrolyte imbalance, ruptured stomach, serious heart, kidney, and liver damage, tooth/gum erosion, tears of the esophagus, low self-esteem, shame and guilt. Anorexia nervosa has the highest death rate of any psychiatric illness: 6%, due to suicide or starvation.

It is estimated that one in every 250 American female teenagers and one in 10 of American female college students have eating disorders. Denial is a common and can persist despite overwhelming evidence of the problem. These disorders can be linked to other psychiatric disorders, like depression. Unlike anorexia and bulimia, compulsive overeating is common among males.

Theories of the causes for eating disorders are in 3 categories:

1. biological: chemical or hormonal imbalances, with possibly a genetic link
2. socio-cultural: cultural obsession with thinness and physical appearance
3. psychological: The following have been suggested as possible causes:

Anorexia: fear of growing up; inability to separate from the family; need to please or be liked; perfectionism; teasing about weight and body shape

B*ulimia:* difficulty regulating mood; - more impulsive - sometimes with shoplifting, substance abuse, etc.; - sexual abuse; family dysfunction

Overeating: eating in response to boredom, stress, guilt, fatigue, tension, depression, anger, anxiety or loneliness as a way to "fill the void."

In addition, families can become co-dependent in the disorder, covering up for and abetting the person's problem, much like a family of someone abusing substances.

Effective treatment usually involves a team effort by a nutritionist, a physician and a therapist. It may also include family counseling so that the family can understand the disorder and how to be patient and not co-dependent when their loved one is improving. There are residential treatment programs for people who need them.

Here are some suggestions for working with people who are living with an eating disorder:

- Listen to the person and don't underestimate the pain they may be in as a result of their disorder or what caused it.
- Learn about the eating disorders and its treatments, as much as you can.
- Learn about co-dependency and how family systems become involved in abuses of food
- Learn where you can refer people (see resources and web sites below) and encourage them to join a support group

[52] Primary Source: United Church of Christ, *Called to Care.* Other sources NAMI website information, ANAD website information, Overeaters Anonymous website information

- Encourage therapy, including family therapy
- See if you can find someone else who has had an eating disorder and is now better, and arrange for the two of them to talk.
- Be sensitive to social events that revolve around food

Exercises:

- Talk about an experience you have had themselves or with another person who had an eating disorder. What helped, what didn't help.
- Role-play a visit to a person who has an eating disorder

Resources

Books:

Costin, Carolyn. *The Eating Disorder Sourcebook: A Comprehensive Guide to the Causes, Treatments and Prevention of Eating Disorders,* Los Angeles: Lowell House, 1997.

Hall, Lindsey Hall and Ostroff, Monika, *Anorexia Nervosa: A guide to recovery*, Carlsbad, California: Gurze Books, 1998.

Hall, Lindsey and Cohn, Leigh, *Bulimia: A guide to recovery*, Carlsbad, California: Gurze Books, 1998.

Siegel, Michelle, Ph.D., Brisman, Judith Ph.D. and Weinshel, Margot, Ph.D., *Surviving an Eating Disorder: Perspectives and strategies for family and friends*, New York: Perennial Currents, 1997

Organizations and Websites:

- National Association for Anorexia Nervosa and Associated Eating Disorders (ANAD): www.anad.org The oldest eating disorder organization in the nation. Has support groups and hotlines, education and public advocacy.

- National Eating Disorders Association (NADA): www.nationaleatingdisorders.org Education, resources and support

- Overeaters Anonymous (OA) www.oa.org Overeaters Anonymous offers a 12-step program of recovery from compulsive eating.

- National Alliance on Mental Illness information on eating disorders: www.nami.org. From the home page, search on eating disorder to get information.

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DEATH OF A BELOVED PET[53]

Anyone who considers a pet a beloved friend, companion, or family member knows the intense pain that accompanies the loss of that friend. Following are some tips on coping with that grief, and with the difficult decisions one faces upon the loss of a pet.

1. Am I crazy to hurt so much?

Intense grief over the loss of a pet is normal and natural. Don't let anyone tell you that it's silly, crazy, or overly sentimental to grieve!
During the years you spent with your pet (even if they were few), it became a significant and constant part of your life. It was a source of comfort and companionship, of unconditional love and acceptance, of fun and joy. So don't be surprised if you feel devastated by the loss of such a relationship.
People who don't understand the pet/owner bond may not understand your pain. All that matters, however, is how you feel. Don't let others dictate your feelings: They are valid, and may be extremely painful. But remember, you are not alone: Thousands of pet owners have gone through the same feelings.

2. What Can I Expect to Feel?

Different people experience grief in different ways. Besides your sorrow and loss, you may also experience the following emotions:

- **Guilt** may occur if you feel responsible for your pet's death-the "if only I had been more careful" syndrome. It is pointless and often erroneous to burden yourself with guilt for the accident or illness that claimed your pet's life, and only makes it more difficult to resolve your grief.
- **Denial** makes it difficult to accept that your pet is really gone. It's hard to imagine that your pet won't greet you when you come home, or that it doesn't need its evening meal. Some pet owners carry this to extremes, and fear their pet is still alive and suffering somewhere. Others find it hard to get a new pet for fear of being "disloyal" to the old.
- **Anger** may be directed at the illness that killed your pet, the driver of the speeding car, the veterinarian who "failed" to save its life. Sometimes it is justified, but when carried to extremes, it distracts you from the important task of resolving your grief.
- **Depression** is a natural consequence of grief, but can leave you powerless to cope with your feelings. Extreme depression robs you of motivation and energy, causing you to dwell upon your sorrow.

3. What can I do about my feelings?

The most important step you can take is to be honest about your feelings. Don't deny your pain, or your feelings of anger and guilt. Only by examining and coming to terms with your feelings can you begin to work through them.
You have a right to feel pain and grief! Someone you loved has died, and you feel alone and bereaved. You have a right to feel anger and guilt, as well. Acknowledge your feelings first, then ask yourself whether the circumstances actually justify them.
Locking away grief doesn't make it go away. Express it. Cry, scream, pound the floor, talk it out. Do what helps you the most. Don't try to avoid grief by not thinking about your pet; instead, reminisce about the good times. This will help you understand what your pet's loss actually means to you.
Some find it helpful to express their feelings and memories in poems, stories, or letters to the pet. Other strategies including rearranging your schedule to fill in the times you would have spent with your pet; preparing a memorial such as a photo collage; and talking to others about your loss.

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[53] From *Coping with Sorrow on the Loss of Your Pe*t, by Moira Anderson Allen, M.Ed. 1987.

4. Who can I talk to?

If your family or friends love pets, they'll understand what you're going through. Don't hide your feelings in a misguided effort to appear strong and calm! Working through your feelings with another person is one of the best ways to put them in perspective and find ways to handle them. Find someone you can talk to about how much the pet meant to you and how much you miss it-someone you feel comfortable crying and grieving with.

If you don't have family or friends who understand, or if you need more help, ask your veterinarian or humane association to recommend a pet loss counselor or support group. Check with your church or hospital for grief counseling. Remember, your grief is genuine and deserving of support.

5. When is the right time to euthanize a pet?

Your veterinarian is the best judge of your pet's physical condition; however, you are the best judge of the quality of your pet's daily life. If a pet has a good appetite, responds to attention, seeks its owner's company, and participates in play or family life, many owners feel that this is not the time. However, if a pet is in constant pain, undergoing difficult and stressful treatments that aren't helping greatly, unresponsive to affection, unaware of its surroundings, and uninterested in life, a caring pet owner will probably choose to end the beloved companion's suffering.
Evaluate your pet's health honestly and unselfishly with your veterinarian. Prolonging a pet's suffering in order to prevent your own ultimately helps neither of you. Nothing can make this decision an easy or painless one, but it is truly the final act of love that you can make for your pet.

6. Should I get a new pet right away?

Generally, the answer is no. One needs time to work through grief and loss before attempting to build a relationship with a new pet. If your emotions are still in turmoil, you may resent a new pet for trying to "take the place" of the old-for what you really want is your old pet back. Children in particular may feel that loving a new pet is "disloyal" to the previous pet.
A new pet should be acquired because you are ready to move forward and build a new relationship-rather than looking backward and mourning your loss. When you are ready, select an animal with whom you can build another long, loving relationship-because this is what having a pet is all about!

Resources:

- The website of the Best Friends Animal Society www.bestfriends.org has pet memorials and other resources for grief over the loss of a pet.
- Other on-line resources can be found at: http://www.petloss.com/, http://www.chancesspot.org/ and http://www.rainbowbridgepets.com/
- *Goodbye Friend: Healing Wisdom for Anyone Who Has Ever Lost a Pet*, by UU minister Gary Kowalski.
- University of California, Davis toll-free Pet Loss Support Hotline: 1-800-565-1526.

Training Exercises:

- Ask if anyone has had a pet that died. What feelings did they experience? How did they handle them? What got them through?
- How do you handle feelings if a pet seems more valuable than a human?

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CARE IN SITUATIONS OF UNEMPLOYMENT [54]

The experience of unemployment can have a variety of effects on the individual and the family.

Individual:
For many there is a link between work and identity. A job gives not only money, but also identity – a role as a worker and therefore dignity in a society where one's worth is often measured by one's work. Therefore, the loss of work can lead to identity-related problems. These include:

- *Psychological*. A person's self-esteem can be adversely affected by unemployment due to a perceived loss of status and prestige. Self-blame, feelings of worthlessness, isolation, anxiety and depression can be present. Some may feel that they are lesser in God's eyes or that God has rejected them.
- *Financial / Material.* The wages they have depended on to live are no longer there. They may need to cut back on many purchases, and maybe even need to move.
- *Relational.* Loss of contact with others from the workplace may leave people to feel isolated, adrift and without friends.
- *Systemic.* The loss of a daily system and routine can be disorienting and frightening.
- *Physical*. Unemployment can increase stress and stress-related health problems. These may include headaches, insomnia, loss of appetite, weight loss, fatigue, and indigestion.

Family:

- *Money Conflicts.* The family may struggle with reduced income and a lowered standard of living. This may lead to conflicts within the family, possibly even abuse or neglect of family members. Children may have to change schools, which can be stressful for them.
- *Role Conflicts.* There may be role changes between husband and wife. The principle "bread winner" may change, and the other may feel a loss of status. It may change how the children regard the unemployed parent.

Grief associated with Job Loss

- Grief experienced with job loss is individual and may vary according to whether the loss was anticipated or sudden, the length of time in the company position, and the person's values and beliefs.
- As in other kinds of grief, people can feel like they are on an "emotional roller-coaster" and go through several emotions sometimes more than once. At first they may be in shock, confused, and disoriented. They may experience some of the other "stages of grief": depression, guilt, preoccupation with the loss, and anger. Sometimes people experience anger directed at various sources: family, self, employer, or God that may last for a few days or months. When moving out of grief, people learn how to adapt to the reality of not having the job that was lost. This may happen before or after a new job is found.
- The feelings of grief need to be acknowledged and addressed.

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[54] Primary sources:

- Smith, Jacoba Lourensa, "A Journey Through the 'Desert' of Unemployment: Pastoral Responses to People 'Between Jobs'", MT Thesis, University of South Africa, November 2006.
- *Called to Care*, United Church of Christ. Care Cards on Unemployment and Financial Crisis.

Suggestions:

- Find ways to show that you believe the person still has worth and dignity in your eyes.
- If you think the person could benefit from professional counseling because of their psychological state, you can suggest that they might consider this alternative.
- Suggest that this might be an opportunity to find out what the best vocation for them really is. Maybe a change in the kind of work they are doing can lead to a more meaningful life.
- Help the person to be less isolated. Phone or visit them. Suggest things they can do with others.
- Encourage physical and recreational activity and activities that don't require money.
- Do things that can give the person a sense of hope. Examples: tell stories of others who have lost and found jobs; introduce them to someone who has gone through an experience like this before successfully.
- Suggest resources that the family can turn to: consumer credit counseling services, job training.
- See if there are job transition support groups in the area.

Exercises:

- Talk about an experience you have had with unemployment. What helped, what didn't help.
- Role-play a visit to a person who has been unemployed.

Resources:

- Richard N. Bolles. *What Color is Your Parachute?: A Practical Manual for Job Hunters and Career Changers,* Berkeley: Ten Speed Press.
- Richard Lathrop. *Who's Hiring Who*, Berkeley: Ten Speed Press, 1989.
- Paul Lewis, Thom Black and Judith Briles. *30 Days to a Smart Family: Moneysense Getting Control of Your Family Finances,* Grand Rapids: Zondervan Publishing House, 1997.

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CARE IN SITUATIONS OF DIVORCE [55]

Divorce is the end of a marriage - certainly not what the couple envisioned when they married. Even though close to half of all marriages end in divorce, it can create a difficult time in the lives of everyone involved – the spouses, the children, friends, and the church.

Emotionally, either or both partners may:
- Feel a sense of failure
- Go through grief
- Need counseling for emotional crisis
- Find that handling financial independence frightening
- Worry about the effect on their children

Legally, divorce can involve:
- attorney consultations and fees
- legal hearings and court appearances
- disposition of marital property
- custody and visitation of children
- alimony payments to a dependent spouse
- enforcement of agreements

Divorce mediation is an alternative to attorneys and the court process. Instead of court, parties who decide to use mediation work with a neutral third party mediator to negotiate issues concerning child custody and support, spousal support, and division of assets and debts.

Religious Issues: Sometimes there are religious issues involved
- One person may keep the church and the other may lose it, leading to social isolation
- May feel that they have failed God and need forgiveness

Needs of the Children:
The effect of divorce on children can vary depending on their age and their relationship with their parents.
- Preschoolers may become depressed and subdued. However, they may adjust faster than children of other ages
- School-aged children may think they are to blame for the divorce and thus feel guilty. They may experience conflicts of loyalty toward their parents and take sides.
- Adolescents may be the hardest hit because of removal of a parental role model. It may affect their ability to form healthy relationships.
- Adult children are also affected. They may have demands placed on them by parents who may expected them to be an "adult" and support them through the divorce. They may also be drawn into their parents' arguments in ways that younger children might not be.

[55] Primary source:
- *Called to Care*, United Church of Christ. Care Cards on Divorce, Children and Divorce.

Changes in the life of the children may happen: they may have to adjust to changes where they live, reduced money available in the family, school, friends, and activities available to them. Fortunately, parents who handle their divorce with care and maintain close relationships with their children can mitigate many of these problems.

What a Pastoral Associate can do

- Recognize that the hurt will not heal immediately. Be there. Listen without judgment.
- If you think that they may need professional counseling, consult our referral list. Get the minister involved if you think it would help.
- Identify community resources such as support groups and Parents Without Partners and urge people to take advantage of them.
- Provide assistance in finding a new congregation for a spouse who feels he or she needs to leave the congregation
- Include divorced and divorcing people in community life – potlucks, events, etc.
- If there are a number of divorcing couples in the congregation, talk to the minister about possibly starting a peer support group.
- Recognize needs of children:
    - Listen to them
    - Write them a note or bring them a small treat
    - Avoid taking sides
    - Talk to the parent about keeping the child involved in religious education and other church activities.
    - Suggest a Big Brother or Big Sister if you think it is appropriate
    - If you think there are significant problems, recommend counseling for the child You may want to get the minister involved, as well.

Exercises:

- Ask if anyone in the pastoral associates team has gone through a divorce. What helped, what didn't help.
- Role-play a visit to a person who has just been told that their spouse is divorcing them.
- Role-play a visit to a child of a divorcing couple

Resources

Parents without Partners www.parentswithoutpartners.org The problems are many in bringing up our children alone, contending with the emotional conflicts of divorce, never-married, separation or widowhood. PWP Inc. provides help in the way of discussions, professional speakers, study groups, publications and social activities for families and adults. Locally, they have chapters in Livermore and Hayward.

Big Brothers/Big Sisters www.bbbsa.org Big Brothers Big Sisters mentors children, ages 6 through 18, in communities across the country. They offer one-to-one youth services developing positive relationships that have a direct and lasting impact on the lives of young people.

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VICTIMS OF CRIME [56]

A victim of a crime has had his or her private world invaded and something of value has been taken. Some may experience an emotional disturbance as well. Victims often go through several stages:

- At first, they are taken by surprise and may experience shock, disbelief and even denial. They may appear detached from reality, or display helpless behavior.
- After the initial impact, and as reality sinks in, victims may feel anger, resignation, resentment or nightmares.

Some of the challenges that victims have when trying to resolve their situation:

- If people are seriously disturbed, and unable to regain a sense of control over their lives, they may be experiencing Post Traumatic Stress Disorder. Consider making a referral to a therapist who works with people with trauma or PTSD.
- If their experience leads to an experience with the police and/or legal system, they may feel re-victimized, frustrated, or angry. They need understanding, compassion, and assurance that they are valued members of a church community.

Advice for Caregivers:

- Adopt a non-judgmental attitude
- Help resolve a sense of normalcy if necessary. Ex: help clean up any mess, fix broken windows, put on new locks. If necessary, help find money to do these repairs.
- Help in getting assistance from governmental offices, walking through red tape (see below).
- Help them finding support groups, particularly for rape or abuse
- Help in finding out what they need to do: get legal advice, counseling, financial assistance.

Local Victim Assistance Services

Alameda County Victim and Witness Services[57] has trained *Victim Advocates* to work with victims, witnesses and their families throughout and beyond the criminal justice process. They serve as the liaison between the victims, prosecutor, law enforcement and other criminal justice agencies. Among the services provided in Alameda County are:

- ***Crisis Intervention and Emergency Assistance***- Assistance with an emotional crisis as a result of a crime. In certain cases, they provide emergency services such as food, shelter, clothing, medical care and transportation.

[56] Primary Source: *Called to Care*, Care Card on Victims of Crime.
[57] Alameda County Victim and Witness Services http://www.alcode.org/victim_witness

- ***Resource and Referral Assistance*** will help obtain appropriate services to meet the victims' special needs by connecting the victim with resources which offer financial aide, emergency assistance, counseling and psychiatric services, legal assistance and assistance with medical and rehabilitation programs.
- ***Orientation to the Criminal Justice System***
- ***Court Support and Escort***
- ***Property Return***
- ***Victim's Compensation Program***

The ***Victims' Bill of Rights*** in the California Constitution, Article i, Section 28(b) allows victims: to be treated with fairness and respect; to be protected from the defendant; to get reasonable notice of all public proceedings; to be heard at any proceeding; to be informed of the conviction, sentence, place and time of incarceration of the defendant; to restitution; to the prompt return of property when no longer needed as evidence; to be informed of all parole procedures; to have the safety of the victim, the victim's family, and the general public considered.

Support Groups
In many localities there are local support groups for victims of crime. Groups generally focus on one kind of victimization. Check to see if support groups for your particular situation are available. Commonly available groups cover the following situations:

- Rape and domestic violence
- Victims of murder
- Children and families coping with abuse and trauma
- Parents who have lost children
- Groups that focus on one particular ethnic group such as Latinos, African Americans, Asians, etc.

Exercises:
- If you have been a victim of crime, talk about this experience.
- If someone close to you has been a victim of crime, what was it like for them? For you?

Resources:
Books:

- *Transcending: Reflections Of Crime Victims* by Howard Zehr
- *After the Crime: The Power of Restorative Justice Dialogues between Victims and Violent Offenders* by Susan Miller.

Organizations:
Consult your local directory for crime emergency phone numbers and organizations related to crime victim assistance.

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HUMOR AND PASTORAL CARE [58]

Angels can fly because they take things lightly – Anonymous

Humor can be used effectively in pastoral care when used carefully and appropriately. As we know life is a mixture of glad and sad, mirth and misery, laughter and tears, joy and sorrow and when engaged in pastoral care the line between the two is sometimes very thin indeed.

Gelotology

The study of humor and laughter, and its effects on the human body is called *gelotology*. Research has shown that laughter and humor have positive effects on the heart, diabetes, blood flow, immune response, relaxation and sleep, physical fitness, anxiety and asthma.[59]

There are forms of therapy called "humor therapy", "clown therapy" and "laughter therapy." Many hospitals have incorporated formal or informal laugh therapy into their programs. For example, having a clown come and perform in a children's ward. There is even a form of yoga called "laughter yoga." Some businesses engage laughter therapists to do laughter workshops for their employees because it reduces stress and improves productivity.

Writer Norman Cousins wrote about his experience with laughter in helping him recover from a serious illness in 1979's *Anatomy of an Illness As Perceived by the Patient* [60]. Late in life Cousins was diagnosed with a very painful form of arthritis. Told that he had little chance of surviving, Cousins developed a recovery program incorporating mega-doses of Vitamin C, along with a positive attitude, love, faith, hope, and laughter induced by Marx Brothers films. "I made the joyous discovery that ten minutes of genuine belly laughter had an anesthetic effect and would give me at least two hours of pain-free sleep," he reported. "When the pain-killing effect of the laughter wore off, we would switch on the motion picture projector again and not infrequently, it would lead to another pain-free interval."

New Perspectives

Many people who receive pastoral care are dealing with a crisis in their life: it might involve an illness, accident, an ethical dilemma, religious conflicts, fear of death or looking to find meaning in their life. Sometimes, humor can serve an important function in challenging linear, rational thinking and lead to new solutions, and new perspectives which may assist in healing.

Humor more than an emotion is a quality that one has or does not have. It is the ability to perceive, express and enjoy that, which is amusing, comical, or entertaining. Humor can stand old ways of thinking on their heads. Plus humor can cut through layers of defenses and can touch others at deep levels through the process of identification, the sharing of common values and breaking down perceptions that keep unhealthy distance and impede healing.

The response to or lack of response to humor can help assess the person's mood and energy level, and their expressiveness.

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[58] Primary Source: *Humor and Pastoral Care*, by Rev. Dr. Susan Suchocki Brown, Convocation of the Greenfield Group, Spring 2004. Dr Suchocki is the head of the UU Trauma Response Ministry.
[59] www.en.wikipedia.org/wiki/Gelotology
[60] Cousins, Norman. *Anatomy of an Illness As Perceived by the Patient*, New York: W.W. Norton and Company, 1979.

Appropriate Use: Sparingly
Humor is about right timing. Any stand-up comic knows that. Using humor in many circumstances and especially in pastoral care situations is about timing. However humorous, some one-liners are not appropriate at some times. For example, in the first ten minutes of a first meeting with a guilt ridden person you would not say to them, "Ah guilt- the gift that keeps on giving."

Barry Sanders in his book, *Sudden Glory*[61] says: "Excessive laughter- even of the most gentle sort- can easily turn into derision and scorn. So use it sparingly; it's exotic stuff and doesn't come cheaply." He also writes of Socrates speaking about laughter like salt - a seasoning that can spice up food, or can hurt when rubbed onto open wounds.

Laughing at Ourselves
Laughter is part and parcel of being in relationship with others. If the pastoral care giver cannot laugh at themselves and at the circumstances that they find themselves in, they may loose the ability to be compassionate caregivers. For who knows, there may be truth in the statement, "but for the Grace of God there go I".

Reinhold Niebuhr in the article, *Humour and Faith*, had one of the most crucial statements about this quality when he wrote, "All of us ought to be ready to laugh at ourselves because all of us are a little funny in our foibles, conceits and pretensions. What is funny about us is precisely that we take ourselves too seriously."[62] He goes on to tell us that we are not the center of the universe and that laughing at and with ourselves helps to bring us humility and honesty, and contrition, all of which I think can lead us to a balanced and joyful nature.

Life is magnificent, powerful, beautiful, irresistible, and humorous and sometimes pain filled. But our existence would be so much worse if we did not reach out to those who need and seek our pastoral care with caring connections filled with laughter, joy and humor.

Exercises:
- Talk about an experience you have had when laughter helped you deal with a difficult situation.
- Talk about an experience you have had when laughter made things worse.
- What did you learn from the first two questions about using humor with others?
- Tell about a time when have you been able to laugh at yourself. How did it make you feel afterwards?

Resources:
- Discover Health (2004) www.helpguide.org/life/humor_laughter_health.htm. Has a good summary of the benefits of laughter; how to create opportunities to laugh; how not to offend; laugh and joke web sites.
- MacDonald, C., *"A Chuckle a Day Keeps the Doctor Away: Therapeutic Humor & Laughter"* Journal of Psychosocial Nursing and Mental Health Services(2004) V42, 3:18-25
- Klein, A. *The Healing Power of Humor: Techniques for Getting through Loss, Setbacks, Upsets, Disappointments, Difficulties, Trials, Tribulations, and All That Not-So-Funny Stuff.* Los Angeles, CA: Tarcher/Putnam, 1989.

[61] Sanders, Barry. *Sudden Glory: Laughter as Subversive History*. Boston: Beacon Press, 1995. 88
[62] Niebuhr, Reinhold. "Humour and Faith" in *The Essential Reinhold Niebuhr by Reinhold Niebuhr*, Robert McAfee Brown, Yale University Press, 1987.

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MAKING REFERRALS

Making Referrals:
Recognize that the need to refer does not mean that you are inadequate or unskilled.
A referral should be made when:

- You learn that there is a major crisis such as a suicide threat or psychological problems requiring professional intervention such as marital problems, drug and alcohol problems, family violence or child abuse…
- Conflict between members of the congregation
- Disagreement or dissatisfactions on the part of the church member toward the church, ministers, programs, and so forth.
- You do not have enough time to help the person yourself or with the Caring Circle
- You don't think your skills are sufficient to deal with the situation.
- You don't think you can remain emotionally neutral

When making a referral:

- Use the Pastoral Associates referral list, Big Blue Book, or talk to the minister to locate possible referral resources.
- Suggest several resources if possible
- The person being helped, not you, should make the calls to the referral.
- Don't assume that everyone will accept your suggestions for referral.

Exercise:
Review the referral list and the Big Blue Book.

Mission Peak Unitarian Universalist Congregation
Pastoral Associates Program

SELF CARE FOR PASTORAL ASSOCIATE CAREGIVERS [63]

Do Unto Self as You Tell Others to do Unto Themselves

Self Awareness and Self Care

1. Know your own "triggers" and vulnerable areas and learn to defuse them or avoid them.
2. Resolve your own personal issues and continue to monitor your own reactions to other's pain.
3. Be human and allow yourself to grieve when bad things happen to others.
4. Develop realistic expectations about the rewards as well as limitations of being a helper.
5. Set and follow appropriate limits and boundaries for yourself and tell them to others.

Ask For and Accept Help <u>from</u> Other Caregivers

1. Find opportunities to acknowledge, express, and work through your experience in a supportive environment.
2. Seek assistance from other colleagues and caregivers who have worked in the trauma field and have remained healthy and hopeful.
3. Delegate responsibilities and get help from others for routine work, when appropriate.
4. Develop a healthy support system to protect you from compassion fatigue and emotional exhaustion.
5. Remember that most victims of trauma do grow and learn from their experiences and so can their helpers.

Live a Healthy Balanced Life

1. Set and keep healthy boundaries for work. Ask yourself, "Will the world fall apart if I step away from my work for a day, or a week? Do I really have that much power?"
2. Think about the idea that if you never say "no," what is your "yes" worth?
3. Find professional activities that provide opportunities for growth and renewal.
4. Have a life beyond your professional work that nurtures you personally.
5. Eat nutritious food, exercise, meditate, and take care of your whole self.
6. Remember to laugh, enjoy life, have healthy personal relationships, and breathe deeply.

Take good care of yourself, so you will be a healthy caregiver
for those who need your help.

[63] Source: *Emotional and Spiritual Care, an introduction on basic concepts***,** a working document from the Emotional and Spiritual Care Committee of the National Voluntary Organizations Active in Disaster, 24 May 2004.

The following is a list of suggestions for taking care of yourself as a Pastoral Associate. Other suggestions are welcome.

- Take advantage of meditation and check-in time at each Pastoral Associates meeting.
- If you are having a difficult situation in your life so that doing adequate pastoral care is compromised, take a leave of absence until the situation is resolved.
- Request a Pastoral Associate if you think one would be helpful.
- Get regular exercise. Examples: walking, jogging, aerobics, swimming…
- Identify and tap into your own sources of spiritual renewal: God, meditation, other people.
- Eat a good solid balanced diet.
- Avoid getting over fatigued. Get plenty of rest.
- Avoid getting over-committed in time to any activity or activities, so that you feel overwhelmed. Learn how to say "No" and not feel guilty.
- Learn how to recognize your own personal warning signs of becoming overstressed such as changes in sleep patterns or anxiety levels. Take action to head it off or minimize it.
- Indulge in some creative activity. Ex: drawing, painting, crafts, creative writing, weaving…
- Allow yourself to be spiritually nurtured by the people you work with; let their courage inspire you
- Increase the time you spend with helpful people
- Have humor, laughing, play and fun in your life
- Spend time with music – listening to relaxing music, singing, playing, composing
- Spend time with your pets
- Spend more time in activities that you find joyful
- Go to places you find helpful to your mood, such as the beach, a park, a museum or taking a walk, or imagine yourself away.
- Learn how to love yourself as an individual, spiritually and creatively. There is no one else on Earth quite like you.

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Pastoral Associates Program

CARING CIRCLE PROCEDURES

The Caring Circle is a list of congregation members who have volunteered to provide services of various types (meals, transportation, child care, chores, shopping) to other members of the congregation who are in need. It is managed by a Caring Circle Coordinator, (or a pair of co-coordinators). This is the procedures for how services are requested.

1. Pastoral Associate Contacts the Caring Circle Coordinator
    - Pastoral Associate will be working on behalf of a parishioner in need
    - Pastoral Associate will find out from parishioner what the need is and will tell the Caring Circle Coordinator
        - If there is more than one coordinator, the coordinators will decide how to co-manage this situation. i.e. who gets called when. They will let the Pastoral Associate chair know. If the arrangement changes, they will let the PA chair know.
    - Current Pastoral Associates are:
        - (list of names goes here)
        -
        -
2. Caring Circle Coordinator Contacts Donor
    - If there is a question about what is needed, the Caring Circle Coordinator calls the parishioner in need to understand this further.
        - In providing meals, find out if they have things that they won't eat, such as spicy food or meat.
        - Find out for what date(s), time(s) they need the service.
    - Caring Circle Coordinator will contact someone on the contact list to provide the service
        - Try to make sure it isn't always the same person getting called for every need. That is, keep track of who has given before, as much as possible.
    - If it isn't possible to find anyone to fill the need, the Caring Circle Coordinator should let the Pastoral Associate know. The Pastoral Associate will tell the parishioner.
        - It is OK if this happens. We don't guarantee that we will provide a service to someone – just that we will try.
3. Donor provides service for the parishioner in need

Caring Circle Self Care and Ethics

Self Awareness and Self Care

- Take Care of Yourself
    - If you are over stressed or have some family situation come up, let the Pastoral Associate Chair know. It is OK to take a break for a while.
    - Eat nutritious food, exercise, meditate, and take care of your whole self.
    - Remember to laugh, enjoy life, have healthy personal relationships, and breathe deeply.

- Develop a Healthy Set of Boundaries
    - Signs of Boundary problems:
        - Becoming overly emotionally involved in another person's problems.
        - Wanting approval of the person being helped, or they want your approval.
        - Becoming aware that you have had a part in the person's problem

    - Avoiding Boundary Problems
        - Develop realistic expectations about the rewards as well as limitations of being a helper.
        - Monitor your own reactions to other's pain. Be human and allow yourself to grieve when bad things happen to others.
        - Do <u>not</u> think that you personally have to fill a need if you can't find anyone else to do it.
        - Do <u>not</u> feel that you have to engage in repetitive, lengthy phone conversations with people about their problems. This is what the Pastoral Associates and the minister are for.

    - If you think you have a boundary problem, discuss it with the Pastoral Associate chair or the minister.

Ethics

- Keep Confidentiality when Necessary
    - The parishioner may want to keep their situation confidential except for the people providing the service.
    - The Pastoral Associate will tell you if this is the case.
    - If so, don't discuss confidential information with family or friends.

- Avoid listening or contributing to gossip, or allow untrue or harmful charges to circulate.
- Avoid criticizing others in public.

Mission Peak Unitarian Universalist Congregation
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III. CEREMONY OF COMMITMENT

The following is a service given at Mission Peak Unitarian Universalist Congregation on January 28, 2001 to formally begin the Pastoral Associates program.

Order of Service:
Welcome and Announcements
Prelude
Call to Worship: #418 "Come Into the Circle of Love and Justice"
Unison Chalice Lighting
Opening Hymn: #347 "Gather the Spirit"
Story for all Ages: Now One Foot, Now the Other, by Tomie de Paola, 1991
Singing the Children to Class: #413 "Go Now in Peace"
Offering – See Insert Pastoral Associates Caring Circle
Hymn of Reflection: #391 "Voice Still and Small"
Prayer Silent and Spoken: #501 "Spirit of Community"
Sharing Joys and Concerns
Musical Interlude
Readings:

- From "Called to Care"
- Responsive reading: #609 "To Serve the People"
- The Most Caring Child

Hymn: #340 "Though Gathered Here to Celebrate"
Sermon: "The Pastoral Associates Program at Mission Peak" – Barbara Meyers
Statement of Support – Reverend Chris Schriner
Ceremony of Commitment for Pastoral Associates (See Insert)
Closing Hymn: #323 "Break Not The Circle"
Benediction

CEREMONY OF COMMITMENT
ORDER OF SERVICE INSERT

PASTORAL ASSOCIATES CARING CIRCLE RESOURCE SURVEY

Occasionally, the Pastoral Associates will become aware of church members who, because of an emergency such as unexpected hospitalization or death of a family member, need assistance on a one-time or temporary basis.

We would appreciate knowing who might be willing to help out in such emergencies. Please indicate those activities below that you might be able to provide by placing an "X" on the line next to your choices. Please fill out the survey and return it to the church. Your name and the list of things that you can do will remain with the Pastoral Associates. If someone needs support that you have indicated you may be able to provide, a Pastoral Associate will call you first to determine if you can help in this particular case.

Name _____

_____ Preparing and delivering a meal

_____ Shopping for groceries of other needed items

_____ House care, yard care, pet care (watering plants, bringing in mail, feeding/walking pets)

_____ Providing transportation

_____ Visiting someone who is in the hospital or home-bound

_____ Assistance at a memorial service (ushering or providing food/drinks, etc)

_____ Child Care

_____ Callers to call people to arrange for care

CEREMONY OF COMMITMENT
ORDER OF SERVICE INSERT

CEREMONY OF COMMITMENT FOR PASTORAL ASSOCIATES

Leader: All of us are called by the spirit of life and love to strengthen and deepen our community of faith.

Pastoral Associates: We give thanks for the opportunity to learn and serve.

Congregation: We give thanks that all of us are called to serve, according to our personal gifts.

Leader: May we bear witness to the goodness of creation, teach, and help others with a spirit of humbleness, sincerity, simplicity and awe.

Pastoral Associates: May all that is sacred and life-giving empower our individual abilities to care for others, and deepen our awareness that we are a team of caregivers who need one another to faithfully do this ministry.

Congregation: We congratulate you for your commitment to our community, and we deeply appreciate your willingness to serve.

Pastoral Associates: May we be given the grace to live out the call to care faithfully. We in turn call for the members of the congregation to share in service as our partners in the Caring Circle.

Congregation: May we be given the grace to live out the call to care faithfully.

All: We go forth, committed to make this congregation a more caring place. Amen.

CEREMONY OF COMMITMENT
READINGS:

Reading from *Called to Care: a handbook for lay caregivers,* United Church of Christ.

The historical relationship of healing and religion can be traced to the beginning of recorded history. The healing ministry of Jesus and the disciples is an integral part of the New Testament. In more modern times, healing was identified with science and disassociated from religion. Although we have learned much about healing from the scientific world, the complete understanding of healing is still a mystery.

We know that the body, mind and spirit cannot be separated. Therefore, our mind and spirit can greatly affect the physical healing process. In the New Testament, we read how faith, forgiveness of sins, and the act of touching often are involved in healing. Today, we can cite examples of people whose illness was expected to lead to death, but their faith and attitude seemed to bring about a change and healing occurred.

It is important to remember that God does not promise that we will be spared suffering, but God does promise to be with us in our suffering. A caregiver can encourage an individual to trust that promise to help her or him bear what seems to be unbearable.

Reading: "The Most Caring Child"

Author and lecturer Leo Buscaglia once talked about a contest he was asked to judge. The purpose of the contest was to find the most caring child. The winner was a four-year-old child whose next-door neighbor was an elderly gentleman who had recently lost his wife. Upon seeing the man cry, the little boy went into the old gentleman's yard, climbed onto his lap and just sat there. When his mother asked him what he had said to the neighbor, the little boy said, "Nothing, I just helped him cry."
Ellen Kreidman
Submitted by Donna Bernard to the book "A 3rd Serving of Chicken Soup for the Soul".