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ABSTRACT

THE DEVELOPMENT AND IMPLEMENTATION OF A PILOT TRAINING COURSE IN PASTORAL DIAGNOSIS FOR SIX PASTORS IN THE LAKE REGION CONFERENCE

by

Richard D. B. Sylvester

Adviser: H. Peter Swanson

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

Seventh-day Adventist Theological Seminary

Title: THE DEVELOPMENT AND IMPLEMENTATION OF A PILOT TRAININGCOURSE IN PASTORAL DIAGNOSIS FOR SIX PASTORS IN THE LAKE REGION CONFERENCE

Name of researcher: Richard D. B. Sylvester

Name and degree of faculty adviser: H. Peter Swanson, Ph.D.

Date completed: April 2005

Problem

This study was an examination of the counseling style of six pastors and to determine if they have a clearly defined method of informing their interventions.

Method

The task of this dissertation was to design a curriculum to train a pilot group of six pastors in the Lake Region Conference to do spiritual diagnoses and assessments and to have a better psychological understanding of diagnosing in their pastoral ministry. They learned how to integrate spirituality and psychology into their counseling. They were also taught some *DSM-IV* concepts and how to use the Global Assessment of

Functioning (GAF) Scale.

I worked with the six pastors over a three-month period. A pre-training questionnaire was administered before the training program and a post-training questionnaire was administered afterwards. Due to the small size of the sample, the results of the two questionnaires are not intended to be applied to pastors in general. Some general observations were made from the findings. My intention was test the psychological knowledge of the six pastors and to assess their biblically based approach to counseling.

Results

I expected that pastors would have knowledge of psychological terms because they typically use them in counseling. The survey data revealed that they did not have adequate knowledge to do psychological counseling even though they were attempting just that. It was anticipated that the pastors would be able to make a clear differentiation between psychologically based counseling and scripturally based counseling. However, the results in the survey showed that they could not. While they claimed that they did both, the discussions during the workshops revealed some confusion as to how they applied the two disciplines independently of each other. It was believed that pastors would be able to identify pastoral diagnosis, but the survey showed a general lack in their ability to do so.

Pastoral counseling and diagnosis are a significant part of parish ministry. Yet many Seventh-day Adventist pastors are entering parish work with inadequate training in this area. Many Christians facing emotional and spiritual turmoil turn to their pastors

first because of easy access and because they are typically not charged for pastoral counseling. Often-times, pastors who provide counseling do so more from a psychological approach than from a biblical perspective. Pastors must be able to recognize mental disorders as described in the *DSM-IV* and other clinical literature, but their primary responsibility is to diagnose spiritual problems that are described in Scripture. This endeavor is designed to help pastors who are already in the field to improve their skills through conference-sponsored training. This training program is designed to help create within the church a safe place for hurting people who through appropriate spiritual diagnosis can be led towards wholeness and reconciliation to God.

Andrews University

Seventh-day Adventist Theological Seminary

THE DEVELOPMENT AND IMPLEMENTATION OF A PILOT TRAINING COURSE IN PASTORAL DIAGNOSIS FOR SIX PASTORS IN THE LAKE REGION CONFERENCE

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

by

Richard D. B. Sylvester

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APPROVAL BY THE COMMITTEE:

Adviser: H. Peter Swanson, Ph.D.

Skip Bell: Director of D.Min. Program

James J. North, D.Min.
Professor of Pastoral Care and Chaplaincy

Dean, SDA Theological Seminary
John McVay

Walter B. T. Douglas, Ph.D.
Professor of Church History Emeritus

April 21, 2005
Date approved

In memory
of my grandmother, Irene Small, affectionately known as "Dada,"
who raised me as an altar boy to always know
I was called to be a servant of the Lord.

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Last and greatest of all, thanks to God for preserving my life from birth in Grenada, through Hurricane Janet, and other near-fatal experiences. He has granted me the privilege of being in His presence since childhood as an altar boy and now pastoring.

He has also permitted me the rare opportunity to complete this pastoral diagnosis pilot study in the hope of helping other ministers become more proficient in pastoral diagnosis. Where I go from here is unknown, but the journey has been beyond my wildest dream. With confidence and gratitude I say, "All the way my Savior leads me; what have I to ask beside? Can I doubt His tender mercy, who through life has been my guide?" To God be the glory, He is still answering a grandmother's prayer.

CHAPTER I

INTRODUCTION

Statement of the Problem

Seventh-day Adventist pastors are encountering an ever-increasing number of members from dysfunctional homes and backgrounds. As the population grows and people travel away from home and family to seek employment, the destabilization of the family will continue. The emergence of blended families is adding stress to the family system and needs new relational paradigms. As women increasingly assume their legitimate place in the world of work, they are likely to encounter more abuse by their male counterparts. As society continues to be more open about discussing, mental health issues, and issues of the physically challenged, the church must also address these issues in order to remain relevant.

The Task

The task of this dissertation was to design a curriculum to train a pilot group of six pastors in the Lake Region Conference to do spiritual diagnosis and to have a better psychological understanding of diagnosing in their pastoral ministry. They would also learn how to integrate spirituality and psychology into their counseling. They would also be introduced to some *Diagnostic and Statistical Manual of Mental Disorders* Fourth

Edition (*DSM-IV*) concepts and how to use the *Global Assessment of Functioning Scale* (*GAF Scale*). Pastors must be able to recognize mental disorders as described in the *DSM-IV* and other clinical literature but their primary function within their pastoral role is to diagnose spiritual problems which are described in Scripture.

Justification

Because of the growing awareness of emotional and behavioral problems among members of the Seventh-day Adventist church, pastors need to be more adequately prepared to provide relevant ministries.

Societal problems are increasingly reflected among the members of Seventh-day Adventist congregations. In addressing this growing problem, Seventh-day Adventist pastors need to be aware of their own issues and inner needs and deal with them in ways that will avoid harm to themselves and the people they pastor.

Seventh-day Adventist congregations need to be, among other things, places where hurting, broken, abused, and dysfunctional people can be helped. Seventh-day Adventist pastors, either as general practitioners or as specialists, must be trained to use an eclectic approach in providing biblically based counseling to their congregations. To provide adequate counseling, the pastors need to understand the diagnostic process. Diagnosis is a tool professionals use to determine the nature of the problem and the appropriate intervention. Pastors are generally not adequately trained to do psychological and spiritual diagnoses in working with their parishioners. They are essentially doing counseling with a psychological mind-set for which they have little or no formal training.

In such an environment there are ample possibilities of misdiagnosing. This in turn can create opportunity for poor, wrong, or mistimed intervention. While they are trained academically in the disciplines of theology and philosophy, the ability to apply timely biblically based counseling to life's challenges is in itself a discipline, and one I feel that most pastors have not taken the time to get and develop. Pastoral diagnosis is an essential tool for the pastor working with members of the congregation in a counseling setting.

The Seventh-day Adventist pastors of the twenty-first century must be trained to integrate psychological as well as spiritual diagnoses into their ministry.

Expectations

This project will enable me to improve my understanding of psychological and spiritual diagnoses in pastoral counseling. It will help me be more effective in my role and function as a pastoral counselor.

Pastoral counseling is a significant part of parish ministry. Yet many Seventh-day Adventist pastors are entering parish work with an inadequate training in this area. Many who engage in counseling are doing so more from a psychological approach than from a biblical approach. It is my hope that with what I have learned, I will be able to equip other pastors already in parish ministry to be more effective in the counseling component of their ministries. I hope to do this through a training program with my colleagues at Workers Meetings beginning in my home conference.

I hope by God's grace this endeavor will prove fruitful and helpful to those

already in the field and that other conferences will employ this training to help equip their pastors. It is my prayer that this will eventually become a tool for the worldwide Seventh-day Adventist Church in making the gospel relevant to the needs of the people they are called to serve. This training program can help create within the church a safe place for hurting people. They can be properly spiritually diagnosed in regard to their life challenges and in their relationship to God and find wholeness and peace.

Definition of Terms

The following terms are defined as used in this study: Many of the definitions for the five theories were borrowed from Gerald Corey, see citation in footnote.

Assessment: The process by which someone seeking help is considered for appropriate treatment and care.

Biblical Counseling: A cooperative relationship between a Christian counselor/pastor and parishioner through which the person is helped to be restored into a reconciled relationship with Jesus Christ. "Wherever wise Christians have sought to encourage and admonish one another, biblical counseling has occurred."[1]

Behavior Theory: A scientific view of human behavior that is systematic and structured in its counseling application. The person is the producer and the product of his or her environment. When people overcome destructive behaviors that restrict their

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[1]John F. MacArthur, Jr., Wayne A. Mack, and the Master's College Faculty, *Introduction to Biblical Counseling: A Basic Guide to the Principles and Practice of Counseling* (Nashville, TN: W Publishing Group, 1994), 49.

choices, they are more able to select from possibilities that were not available before.[1]

Cognitive Theory: It is based on the assumption that human beings are born with a potential for both rational, or straight, thinking and irrational, or crooked, thinking. Humans have inborn tendencies toward growth. However, we often sabotage our growth as a result of the inborn tendency toward crooked thinking and the self-defeating patterns learned. After becoming disillusioned with psychoanalysis, Albert Ellis experimented with other therapeutic forms. He combined humanistic, philosophical, and behavioral therapies to form rational-emotive therapy also known as *Rational Emotive Behavioral Therapy* (*REBT*).[2]

Conference/Field: A conference or field is a united body of organized churches and companies in a state, province, region or territory.

Conference Workers: Employees of a local conference.

Counseling: A cooperative relationship between a counselor and client through which the client is helped to take active responsibility for his/her emotional healing.

Counter-transference: The feelings and/or behaviors towards someone either from the counselor's past or current life that he/she projects onto the person under his/her care. The parishioner may remind the pastor of someone towards whom he/she has strong negative or positive emotions.

Diagnosis: A process by which a professionally trained person determines the

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[1]Ibid., 280-311.

[2]Ibid., 316-358.

problem for the purpose of providing the cure.

***Diagnostic and Statistical Manual*, Fourth Edition for Mental Health Disorders** (*DSM-IV*): A diagnostic tool that has been designed by the American Psychiatric Association for the purpose of guiding clinicians, researchers, and other professionals in the diagnosis and treatment of mental disorders.

Dual Diagnosis: Diagnosing in two separate disciplines using each discipline's unique teaching to inform the process.

Ethics: A set of standards by which professionals govern themselves in relationships to the people they work with so as not to do or be perceived as doing harm to the persons they serve. It includes not using their position of power or influence to gain unfair advantages.

Family System Theory: The belief that individuals are best understood through assessing the interactions within an entire family. Behaviors are often seen as an expression of a dysfunction within a family; these dysfunctional patterns are believed to have passed across several generations. Central to all family therapy practitioners is the belief that the client is connected to living systems and that change in one part of the unit reverberates throughout other parts.[1]

Lake Region Conference of Seventh-day Adventists: The legal name for the united body of organized Seventh-day Adventists churches and companies primarily of African/American descent. The churches and companies are located in the states of:

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[1]Ibid., 365-387.

Michigan, Indiana, Illinois, Wisconsin, and Minnesota.

Pastoral Diagnosis: A process by which a person who is theologically trained uses the scriptural narratives to determine what is spiritually wrong with a person and determine the appropriate intervention by which the parishioner can be reconciled to God.

Person-centered Theory: People are essentially trustworthy. They have a vast capacity to both understand themselves and resolve their own problems without direct intervention by the therapist. People are capable of self-directed growth if they are involved in a therapeutic relationship where the therapist creates an environment of trust, congruency, acceptance and caring, and the ability to deeply grasp the subjective world of the person in counseling.[1]

Psychoanalytic Theory: According to this theory, human behavior is determined by irrational forces, unconscious motivations, and biological and instinctual drives. Humans develop through psychosexual stages of development which are driven by internal forces, drives, and motivations. Therefore, the aim of psychoanalysis is to make the unconscious conscious in order to facilitate the individual's ability to choose. Freud is the originator of the psychoanalytical theory of personality. He developed his theory from information he learned from his patients and from years of self-analysis. Freud also believed that the unconscious state of mind is a storehouse of all the memories,

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[1]Ibid., 196-217.

experiences, repressed information, needs, and motivations.[1]

Psychotherapy: The treatment of mental health illnesses by a trained mental health professional.

Therapy: Therapy is the treatment provided by the pastor or Christian counselor in a clinical setting to a parishioner whose faith and/or emotional well-being is shaken by a crisis. The term is used in other areas of service for the purpose of providing care/healing.

Transference: The feelings and behaviors towards someone, generally, from the client's past that he/she projects onto the counselor. In some psychological theories this will be welcome as part of the healing process for the client to deal with negative feelings towards others. There are other theories where transference is discouraged.

Workers Meeting: The assembling of the pastors, school teachers, Bible workers, Departmental directors, and occasionally office personnel by the conference administrators for the purpose of training, updating on conference matters and proving resource for effective ministry in the field.

Delimitations

Six pastors were chosen as the focus group and tutored for three months. A pre-training questionnaire was administered before the training program and a post-training questionnaire was administered afterwards. Due to the small size of the sample, the

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[1]Gerald Corey, *Theory and Practice of Counseling and Psychotherapy*, 5th ed. (Pacific Grove, CA: Brooks/Cole, 1996).

results of the two questionnaires are not intended to be generalized to the general population of pastors. The surveys are intended only to test the pre- and post-psychological knowledge of the six pastors as well as their biblically based approach to counseling.

The criteria used to select the pastors were: gender, race, geographic location within the Lake Region Conference field, willingness to work with me for the duration of the research, and having a graduate degree from the Seventh-day Adventist Theological Seminary.

Due to the time constraints of the pastors, three of whom work in multi-church districts, the program was taken to them.

I selected six pastors and explained what was being asked of them. They indicated their understanding and their willingness to commit the necessary time to this training and to applying what they learn to their current counseling relationships.

I spent two hours a month for three months with each of the six pastors. The time was spent in training, fielding questions, and dealing with difficulties and feelings the pastors may have encountered in the process. I did not act as the pastors' therapist but prayerfully directed the pastor to the appropriate resources. The pastors were not required to have Clinical Pastoral Education (CPE) as a prerequisite in order to be in this program.

Overview

This dissertation is made up of ten chapters. Following the introduction in chapter 1, chapter 2 is a literature review of authors and their contribution to the field of

pastoral counseling in general and pastoral diagnosis in particular. Chapter 3 takes a brief historical look at the role of pastoral care in its context and the shift towards pastoral counseling and pastoral psychotherapy in our contemporary society.

In chapter 4 a biblically based concept for counseling and therapy is examined. The therapeutic process of counseling is also discussed in this chapter. Finally, biblically based counseling is briefly compared and contrasted with psychological counseling. Chapter 5 discusses the theological foundation for pastoral diagnosis. The shepherd motif for pastoral diagnosis is discussed from the perspectives of the Old and New Testaments. The chapter closes with a series of extrapolations of diagnostic language from the writings of Ellen G. White. Chapter 6 deals with the moral and spiritual qualifications the pastor needs for doing pastoral diagnosis as well as some ethical concerns. It takes a historical view at pastoral diagnosis. Chapter 7 gives a profile of pastoral diagnosis and takes a brief look at what pastoral diagnosis is and is not. What is the setting for and use of pastoral diagnosis? How can the pastor use the theological language in pastoral diagnosis? It concludes with a brief discussion on religious and spiritual problems in the *Diagnostic and Statistical Manual of Mental Health Disorders* Fourth Edition (*DSM-IV*).

Chapter 8 presents the development of the questionnaires (pre-test), as well as the implementation and evaluation. It also looks at the program presented in the workshop and things I did not know before the study and what I have learned. An exit questionnaire (post-test) is evaluated with its findings and compared to the first test. My relationship with the six pastors during the three-month field-testing program is also

discussed.

Chapter 9 is a reflection on the outcome of the training program. The pre-test and post-test are evaluated and conclusions are drawn. What I have learned and how my preconceptions have been affected are also discussed. My relationship with the pastors as a model for counseling is considered.

Chapter 10 presents a summary of the dissertation and draws some conclusions. I also make recommendations. The dissertation concludes with appendixes and a bibliography.

CHAPTER 2

LITERATURE REVIEW

Introduction

In this chapter, a brief review of several authors is given. The authors are selected for discussion based on their contribution to this thesis. In my search for materials relevant to my study I found only three books that were solely devoted to pastoral diagnosis. Other authors are mentioned because they had a chapter on pastoral diagnosis in one of their books. Gerald Corey is mentioned because in my pre-questionnaire and post-questionnaire, I asked questions of the test subjects regarding their psychological orientation in counseling and their knowledge of the *Diagnostic and Statistical Manual of Mental Health Disorders,* Fourth Edition *(DSM-IV)* as part of developing the training program. Corey's book, *Theory and Practice of Counseling and Psychotherapy,* was the primary book used for that portion of the exercise and training.

Don S. Browning

Don Browning has interests in the relation of religious thought to the social sciences, specifically in the way theological ethics may employ sociology, psychology, and the social scientific study of religion. A student of psychology, he has special interests in psychoanalysis, self-psychology, object-relations theory, and evolutionary

psychology, and has written on the cultural, theological, and ethical analysis of the modern psychologies. He is an ordained minister of the Christian Church (Disciples of Christ). He has authored nine books. His book *Religious Ethics and Pastoral Care*[1] has a chapter on diagnosis and decision. In it he provides a framework for pastors in their role of providing care. He gave five levels of practical reasons for arriving at a diagnosis, which he describes as both normative and descriptive. Those levels may help in providing boundaries in which the pastors can guide their thinking and behavior in the exercise of their duties. The book is in over 930 libraries around the world.

Howard Clinebell

In the section describing motivation, diagnosis, and intervention, Clinebell gives a brief mention of "pastoral diagnosis" and quickly refers to Pruyser's book *The Minister* As Diagnostician. Clinebell, like many others, sees diagnosis as taking place early in the counseling process; a view not shared by some in the field of pastoral diagnosis, and is informed through a series of questions and observations during the pastoral conversation. For him and others, diagnosis helps the pastor to determine if he/she has the time and expertise to help the person in need. In the book, *Basic Types of Pastor Care & Counseling*,[2] Dr. Clinebell probes the effects brought about by the emergence of lay caring groups, environmental concerns, liberation theology, the feminist movement,

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[1]Don S. Browning, *Religious Ethics and Pastoral Care* (Philadelphia, PA: Fortress, 1983).

[2]Howard Clinebell, *Basic Types of Pastoral Care & Counseling* (Nashville, TN: Abingdon, 1991).

transactional analysis, reality therapy, and crisis intervention. The book does not go far enough in addressing and developing the role, method, and effectiveness of pastoral diagnosis to the caring ministry.

Gerald Corey

Gerald Corey is professor emeritus of Human Services and Counseling at California State University at Fullerton and a licensed psychologist. He teaches both undergraduate and graduate courses and was coordinator of the Human Services department at CSU Fullerton for nine years. He is a Diplomat in Counseling Psychology, American Board of Professional Psychology, a National Certified Counselor, a Fellow of the American Psychological Association (Counseling Psychology), and a Fellow of the Association for Specialists in Group Work.

Corey surveys ten major concepts and practices of the contemporary therapeutic systems, and addresses some ethical and professional issues in counseling practice. His book, *Theory and Practice of Counseling and Psychology*,[1] covers contemporary theories (psychoanalytic, Adlerian, existential, person-centered, Gestalt, reality, behaviors, cognitive-behavioral, family systems), and theory that can be applied to a single case. Corey's fifth edition covers the major concepts of counseling theories, shows students how to apply those theories in practice, and helps them learn to integrate the theories into an individualized counseling style, incorporating the thinking, feeling, and behaving

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[1]Gerald Corey, *Theory and Practice of Counseling and Psychology*, 5th ed. (Pacific Grove, CA: Brooks/Cole, 1996)

dimensions of human experience. It is currently being used in 478 libraries worldwide.

George Fitchett

George Fitchett is chaplain and associate professor in the Department of Religion, Health and Human Values at Rush-Presbyterian-St Luke's Medical Center of Chicago. His book, *Assessing Spiritual Needs: A Guide for Caregivers,*[1] is the third book I found dealing primarily with pastoral diagnosis—in this case, pastoral assessment. Fitchett uses the terms "assessment" and "pastoral diagnosis" interchangeably.[2] I like the book because the models and constructs help my learning style. After reading Pruyser with his thematic guidelines that suggest Reformed Protestant categories of analysis (such as "providence," "grace," "repentance," and "vocation"), Fitchett's 7 x 7 model offers a more comprehensive approach for the pastor to do diagnosis. It also deals with issues around the disadvantaged and often disenfranchised in our society as well. Such issues are very sensitive and meaningful to me.

Fitchett's 7 x 7 model has two major subdivisions with seven dimensions in each. In the first subdivision, Fitchett writes about the spiritual analysis a pastor would make while looking at six other dimensions in the parishioner's life: medical, psychological, psychosocial, family systems, ethnic and cultural, and societal. While this portion of the diagnosis assumes a facility with other disciplinary approaches that, for the most part,

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[1]George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Minneapolis, MN: Augsburg Fortress, 1993).

[2]Ibid., 16.

pastors lack, it also, like William Kirwan's work on *Biblical Concepts for Christian Counseling: A Case for Integration of Psychology and Theology*,[1] affirms the integration of mind, body, and spirit. It has a personal as well as a cultural context and urges pastors to work collaboratively with physicians, social workers, and other professionals when applicable in determining spiritual diagnosis. The idea of multidisciplinary approach in pastoral diagnosis is discussed more fully in chapter 7.

The second subdivision of Fitchett's 7x7 model explicitly focuses on spiritual dimensions which are crucial when doing pastoral diagnosis. It speaks about beliefs and meaning, vocation and consequences, experience and emotion, courage and growth, ritual and practice, community, authority, and guidance. I find this work building on and enhancing Pruyser's work. A pastor already in parish ministry would find in this subdivision a rich vein of probing language that helps inform his/her pastoral conversation. As part of the intake, this language on a questionnaire can help the pastor in his/her assessment of the parishioner. The language can be interpreted both objectively and subjectively. Finally, I like the book because of the three chapters devoted solely to case applications. The people are real people with real struggles, failings, and sufferings. Equally real was the method in which Dr. Fitchett went about offering pastoral care and his own pathos in the process.

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[1]William T. Kirwan, *Biblical Concepts for Christian Counseling: A Case for Integrating Psychology and Theology* (Grand Rapids, MI: Baker Book, 1984).

William T. Kirwan

William T. Kirwan in his book, B*iblical Concepts for Christian Counseling: A Case for Integrating Psychology and Theology*[1] looks at the relationship between the disciplines of theology and psychology. He convincingly shows how Scriptures cannot be the only application for understanding and dealing with psychological pathologies. Unlike Jay Adams, Kirwan does not advocate that all pathologies can be referenced from the person's sin and therefore treated through his/her confession and acceptance of God.

His contribution to my dissertation is that he helps me look at the past as a way of understanding the present problem for the person in counseling. He recognized and correlates the person's developmental experience as a matrix for their present emotional disruptions. The chapter on diagnosis, unfortunately, does not go far enough in dealing with diagnosis as a process to discover and name the problem for the purpose of cure. His diagnostic approach is Freudian in nature. His approach suggests a psychoanalytical method of doing pastoral diagnosis. He then suggests that the method does not delve into the person's past as deeply as the Freudian theory would suggest, but that the diagnostician should take a look into the person's past in helping to provide relief and care in their acceptance of God's grace of regenerating the heart. It does, however, show that diagnosis must take into consideration a person's past developmental relationships to the significant people in his/her life as affecting their present problem. A child who does not experience love or significance from his/her parents in the early developmental stages

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[1]Ibid.

would develop certain emotional difficulties that will create obstacles to his/her ability to experience God's restorative work in his/her heart. Early negative relationships will create anxieties, low self-esteem, hostility, feelings of rejection, and other emotional maladjustments in the recipient's adult life.

In an attempt to be truly or purely theological in their diagnostic approach, none of the other writers whom I researched have looked at a person's past experience as a window to his/her present predicament. Kirwan states, "The reason for exploring the past is not to place blame but to produce understanding. . . . The ultimate reason for exploring the past, then, is to produce love, which is the goal of all Christian counseling. We need not fear that the client's interpersonal functioning will be hindered by this process, for nothing will surface which is not already there."[1] Care must be exercise to guard against false memory syndrome.

Paul W. Pruyser (1916-1987)

Dr. Paul W. Pruyser was a clinical psychologist who served as Director of the Interdisciplinary Studies Program and Emeritus Henry March Pfeiffer Professor of Research and Education in Psychiatry at the Menninger Foundation. He was President of the Society for the Scientific Study of Religion (1974-1975). He wrote five books: his most celebrated book is The Minister as Diagnostician: Personal Problems in Pastoral

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[1]Ibid., 168.

Perspective.[1] This pioneering work is the first in that it gave a more developed detail on pastoral diagnosis and how it can be done.

I first read *Minister as Diagnostician* in 1996 and found its admonitions and instructions to be helpful. I was ten years into parish ministry then and facing an ever-increasing demand from my congregation for counseling. I was not grounded into any particular counseling orientation. I had a curiosity and love for psychology and struggled to make theological sense of my members' presenting problems. In such a state it is easy to gravitate towards psychological language in an attempt to understand human suffering in a spiritual environment. The identity problems of the minister are never more acute than when dealing with those whom Paul Pruyser calls "problem-laden people." For my members facing life crises and emotional distress, how was I going to adequately address their suffering? I had a series of reflective questions that lacked coherence, but nevertheless begged for answers. In my quest I enrolled in Clinical Pastoral Education (CPE) and continued in the residency program.

Those classes coupled with this book and other materials helped me to begin feeling more comfortable with my theological discipline in pastoral counseling. In frustration during my earlier ministry, I asked myself, "Why were they coming to me?" Pruyser believes "that problem-laden persons who seek help from a pastor do so for very deep reasons—from the desire to look at themselves in a theological perspective."[2]

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[1]Paul W. Pruyser, *The Minister as Diagnostician: Personal Problems in Pastoral Perspective* (Philadelphia, PA: Westminster Press, 1976).

[2]Ibid., 43.

Pruyser urges ministers to reassert their own identity, their own important role in the crowded field of helping professionals. For pastors have "the pastoral right of initiative and access" that is uniquely theirs and is envied by other helping professionals such as psychologists and psychiatrists. Pastors have a prior relationship with the people they serve both in the home and in the congregation. Another part of the book that was helpful to me was the chapter on "The Diagnostic Partnership." I was able to articulate what I was experiencing in my helping relationship with my parishioners. They oftentimes told me what was wrong with them. I did not, however, have the ability to accept what they were saying about themselves and journey with them towards wholeness in Christ. That brings me to the next helpful piece of information in the book, that is, "The Guideline for Pastoral Diagnosis" (see more in chapter 7). Pastors can use this guideline to help those in their care appraise their problems in theological perspective, with their insights on what is holy to them, being a part of God's grand design, engaging life in faith, and living a life of gratitude; understanding repentance, experiencing and expressing love, and having a sense of calling in their lives

Nancy J. Ramsey

Nancy J. Ramsey holds a Ph.D. from Vanderbilt University and is the Anderson Professor of Pastoral Ministry at Louisville Presbyterian Theological Seminary and past chair of the Society for Pastoral Theology.

Ramsey's book, *Pastoral Diagnosis: A Resource for Ministries and Counseling,*[1] unlike the works of Pruyser and Fitchett, looks at the anthropological and hermeneutical nature of pastoral diagnosis. Pastoral diagnosis is hermeneutical because pastors bring a theological identity that reflects their internal and external orientation to their faith tradition and perspectives. What they believe and practice according to their faith is used as a compass to navigate the sufferer's troubled waters. Those traditions influence and help define pastors in their role and function. Therefore pastoral diagnosis is both objective and subjective. Pastors must not only know what their theological orientation teaches about the human condition but what they themselves have come to believe about the human condition. There could be a dichotomy between the pastors' beliefs and their theological orientation; therefore, which self is being brought to the counseling session is a question the pastor must constantly ask and answer.

Ramsey states that pastoral diagnosis relies on three assumptions. They are: an anthropological assumption, a specific world view commonly shared by the pastor and parishioner, and a mutually understood dynamics of authority in the helping relationship. Pastors, according to Ramsey, need to develop the skills to voice their theological assumption in the foundation of other disciplines. She said, "Pastoral diagnosis underscores our need to be multilingual conversationalists, for such conversation may include theological disciplines, ethics, philosophy, cultural anthropology, and theories of

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[1]Nancy J. Ramsey, *Pastoral Diagnosis: A Resource for Ministries of Care and Counseling* (Minneapolis, MN: Fortress, 1998).

personality and therapy."[1] Like Kirwan, Ramsey does not believe pastors can do effective pastoral care guided only by the discipline of theology. The pastor must be aware and become adapted to being part of other disciplines. Pastoral diagnosis is a rubric for developing and understanding a theological world view which Ramsey calls the "ecclesial paradigm." [2]

Ramsey seeks to (1) retrieve the theological and ethical foundations of the Judeo-Christian tradition for pastoral care; (2) develop lines of communication between pastoral theology and the other disciplines of theology; (3) create an ecumenical dialogue on pastoral care; and (4) move beyond the current preoccupation with secular psychotherapy and the other social sciences. I find her book to be too heavy on the theoretical and too light on the practical. This book will not aid a pastor, already in parish ministry, to build a better "mouse trap." It is not a practical tool to help the in-ministry pastor become more adept at doing pastoral diagnosis.

Robert J. Wicks and Richard D. Parsons

Robert J. Wicks, Psy.D, is professor in the graduate programs in pastoral counseling at Loyola College in Maryland. Richard D. Parsons holds a Ph.D in school psychology from Temple University, Philadelphia, PA. He is professor of counseling at West Chester University, West Chester, PA. He is also the author/editor of numerous books and articles.

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[1]Ibid., 14.

[2]Ramsey, 33.

In volume 2 of the *Clinical Handbooks of Pastoral Counseling*,[1] published in 1993, the editors make a strong case for the need of pastoral diagnosis to be *Re-Visioned.* They believe that pastors have, for too long, approached pastoral diagnosis either as something to avoid altogether or from the discipline of psychiatry or psychology. For the first group, caring for the person is inherent in the word "pastoral" and is in contrast to "diagnosing," which implies treatment of the disease. The second group of pastors believes that the theory and practice of diagnosis is beneficial to good clinical care of their parishioners. Within this second group are those who advocate that diagnosing is informed by a secular frame of reference, namely that of the American Psychiatric Association's *DSM- IV*, while their colleagues believe that pastoral diagnosis is a theological diagnosis. Faith, theology, and spirituality are operational in that they help interpret clinical data through, and in relation to theological symbols and the stories of Scripture.

Wicks and Parsons believe that diagnosis must be *Re-Visioned.* They see diagnosis not as a procedure that is initiated and completed at the beginning of care, as determined by set criteria and commitments. They postulate that diagnosis takes place in an expanded context as an ongoing procedure of "knowing apart." The diagnostician must identify the current state of the client's self and of his/her suffering by looking at the sufferer and suffering outside the context of the whole. It is in part a comparative analysis. How can the sufferer's experience be understood apart from and in the context

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[1]Robert J. Wicks and Richard D. Parsons, eds., *Clinical Handbook of Pastoral Counseling*, Expanded ed., Integration Books., vol. 2 (New York, NY: Paulist, 1993).

of their overall presentation? "Knowing is intimately contextualizing and organizing. As we contrast and compare, we are fitting the data into a context which pre-exists that data's appearance. As a natural and inevitable comparative procedure, diagnosis is an ongoing activity. We are seeking to know apart at any and every moment."[1] There is causality in "knowing apart." A person is injured and receives medical attention. The person's injury causes him/her to believe a particular way about himself/herself. The belief the person now holds onto as a result of the injury affects the healing process negatively or positively. The task of diagnosis now is to label this person's beliefs apart from and in context of his/her overall presentation and outlook.

Diagnosis involves assessment, goal setting, and treatment plans. Diagnosis also involves a set of treatment variables—systems of classification that answer a certain question, facilitate a clinical attitude, and express root-metaphors. How the client is viewed by the counselor and the private conversation he/she holds during the dialogue helps determine the direction and outcome of the counseling. For Wicks and Parsons, the pastor is trained to function as a psychologist, a theologian, and an ethicist. They also determined that the laity works out of those three disciplines. Wicks and Parsons see the clients as lay psychologists, lay theologians, and lay ethicists, because the clients use each of the aforementioned categories to inform their behavior, beliefs, and pursuits. They also believe that pastoral diagnosis is an interdisciplinary act. I agree and would add that pastors, as general practitioners, must do dual diagnoses as much as possible.

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[1]Ibid., 55.

CHAPTER 3

A HISTORICAL OVERVIEW OF PASTORAL CARE IN THE NINETEENTH AND TWENTIETH CENTURY

This chapter looks at the traditional definition of "pastoral care" as lived out in the life of the pastor and at its more contemporary definition.

The Pastor and Pastoral Care

The traditional definition of pastoral care has changed significantly since the 1920s, and most rapidly after the Second World War. While the term "pastoral care" has come to mean different things to a diverse group of people and organizations, I am using the term solely to describe the spiritual functions of the clergy that are rooted in the Judeo-Christian tradition.

The term "pastoral care" evokes the image of a shepherd tending his flock. In Ezek 34 the metaphor for pastors as the spiritual guides of Israel is that of a shepherd. The pastor is the leader of a congregation, the "shepherd of a flock." In speaking of the leadership of the pastor, Alastair Campbell writes:

> The shepherd is undoubtedly a leader–a strong and courageous figure at the head of the flock. But this leadership has a very special quality. Concern is entirely focused on those entrusted for care, even to the point of life's surrender. Thus leadership is expressed in great compassion, sensitivity to need, and a knowledge of what is life-sustaining and wholesome. It is an image linked to the feel of strong arms, to the taste of cool refreshing water, and to the sensation of receiving truly strengthening nourishment. It is a leadership of real physical involvement, basic and simple,

leadership even when one's own blood is spilled and one's own body broken.[1]

Pastoral care as shepherding is woven into the fabric of Scripture. In the Old Testament the pastor as shepherd is vividly portrayed in all of his gentleness and manliness. As a caring shepherd he leads the flock to green pastures, to still, cool waters, and when necessary carries the young in his arms. At times he disciplines the unruly, seeks those that wander astray, and retrieves those fallen prey to predators. Portraying Himself as a shepherd God says, "I will feed My flock and I will lead them to rest. I will seek the lost, bring back the scattered, bind up the broken, and strengthen the sick" (Ezek 34:15-16).[2]

The most tender and intimate pastoral image of the Old Testament is found in Ps 23. King David, himself a former shepherd, describes God, the True Shepherd, as always being with His flock. He is there through the changing of the seasons, through the long dark night, through the annual migration to the alpines and back again to the low-lands. By the refreshing springs, through the valley of the shadows of death, even in the presence of enemies the flock is at peace because the shepherd is both present and attentive.

This is the work of pastoral care. It is both tiring and costly. It places a heavy demand on the life of the pastor. It demands courage, commitment, and compassion.

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[1]Alastair V. Campbell, *Rediscovering Pastoral Care* (Philadelphia, PA: Westminster, 1981), 39-40.

[2] Unless otherwise indicated all Bible references are to the New American Standard Bible (NASB).

The pastor must have the courage to stand against societal wrongs and those who practice them in the congregation; he is armed with the knowledge that his position is morally, ethically, and scripturally just. The pastor must have the courage to discipline when necessary.

The pastor must have the commitment to the call and work of shepherding the body of Christ. To do so, the pastor must adhere to the integrity of Scriptures as a way to care for the flock of God and not abandon the rich traditions of theology. The heart of pastoral care is using the theological dialogue to inform, nurture, admonish, exhort, and journey with individuals and groups in the congregation, homes, institutions, and community settings.

The pastor must also possess the compassion to journey with someone through their darkness and pain. Campbell says, "Those who have entered into the darkness of another's pain, loss, or bewilderment and who have done so without the defenses of a detached professionalism will know the feelings of wanting to escape, of wishing they had not become involved."[1] Yet that tension is precisely what needs to take place for the pastor "shepherd" to be truly authentic. That was the tension Jesus the "Good Shepherd" experienced in the "Garden Gethsemane." Jesus cried to the Father, asking if there was another way whereby humanity, the flock of God could be saved

Centuries before, the prophet Zechariah spoke about the messianic shepherd who would be killed for the saving and well-being of the sheep. "They will look on me whom

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[1] Campbell, 36.

they have pierced; and they will mourn for Him, as one mourns for an only son." (Zech 12:10). Jesus knew that to be truly caring and compassionate, to love unconditionally, and to fix what was broken in mankind would cost Him His life, and separate Him from His Father. That awareness drove Him to cry out in deep anguish "remove this cup from me; yet not My will, but Thine be done" (Luke 23:42). So too must be the pastor's determination in pastoral care work. He or she must want to escape because the journey through the valley of another's pain is too painful and emotionally taxing. Yet the pastor must be so committed to the image of God being restored in the broken one that he or she says, nevertheless, not what I want, but Your will be done, O Lord.

Hulme defines pastoral care as "a supportive ministry to people and those close to them who are experiencing the familiar trials that characterize life in their world, such as illness, surgery, incapacitation, death, and bereavement."[1] According to Pattison, pastoral care is "that activity, undertaken especially by representative Christian persons, directed towards the elimination and relief of sin and sorrow and the presentation of all people perfect in Christ."[2]

Pastoral care is more than a clerical person doing good works for hurting people. It includes a clerical person recognizing, acknowledging, and embracing his/her own humanity. He/she must also believe in and accept the redemptive acts of God, and share those acts with people who are broken, hurting, and estranged. It is also ministering to

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[1]William Edward Hulme, *Pastoral Care & Counseling: Using the Unique Resources of the Christian Tradition* (Minneapolis: Augsburg Pub. House, 1981), 9.

[2]Stephen Pattison, *A Critique of Pastoral Care* (London: SCM Press, 1988), 13.

members in the congregation and community through the Christian faith and traditions. Understanding one's own need of and identity in God enables that person to succor another like him. Donald Browning says that there are three types of pastoral practices, and of the three, pastoral care is the most inclusive. To him pastoral care is the

> more or less unstructured general work with youth, couples, adults and other such groups in various types of informal and formal conversations, dialogues, and other communicative interactions. Pastoral care in this sense occurs on the street corner, at the end of a committee meeting, in the hospital room, in and around the funeral, and in many other more or less marginal situations. Pastoral care must hold together religious, ethical, and psychological perspectives. It brings the full witness of the Christian community—even the moral perspectives—to each interpersonal exchange.[1]

There is a common theoretical and practical presupposition that many immediately formulate when they hear the words "pastoral care." That mental exercise not only serves as a guide but also as a bias—the former because it helps prepare them for the encounter; the latter because it creates premature boundaries that serves to either heighten or diminish expectations. Therefore, pastoral care needs to be flexible, user-friendly, and responsive to varied levels of human needs. Jesus, in His post-resurrection dialogue with Peter before ascending to heaven, framed His charge to Peter to "feed" His "sheep" in the context of love for Christ. "Simon, son of John, do you love Me? Feed My sheep" (John 21:16). The call to ministry is based on love for God and a commitment to feeding His sheep. James Griffiss refers to the commitment as the "Pastoral imperative, not only to the Apostles but all who come to have a part in pastoral

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[1]Robert J. Wicks, Richard D. Parsons, and Donald Capps, eds., *Clinical Handbook of Pastoral Counseling*, expanded ed., vol. 1 (New York, NY: Paulist, 1993), 5.

care."[1]

In Ezek 34, God pronounces judgment against the Shepherds of Israel for lack of attention to the safety and health of the Children of God (My sheep). The shepherds were accused of feeding themselves at the expense of the security and well-being of the sheep. The care due the sheep was not being given. The judgment implies that while the whole flock needed to be tended and guarded, the work of caring must be done on an individual basis. Jesus when describing Himself as the Good Shepherd said, "If anyone enters through Me, he shall be saved, and shall go in and out and find pasture" (John 10:9). Since the "anyone" is singular, the concept that the individual as well as the faith community as the focus of pastoral care and ministry is scripturally supported. True pastoral care has been the fostering of intimate relationships between the pastor and the individual. Individuals have sought pastoral advice and comfort in times of crisis.

Carr sees pastoral care as having its roots in the Hebrew word "shalom," meaning peace. For Carr the word lends itself to the thought of wholeness of being and relationship. Thus the prayers of Jesus, "Peace I leave you, my peace I give unto you," is more of an inner state of being than the absence of external conflicts. Listed below are three citations by Carr for the word "shalom"

1) God gives shalom: It is always something greater than human beings can conceive or achieve.
2) It weaves the individual and the community inseparably together: individual sin and social injustice can both destroy it.

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[1]James E. Griffiss, *Anglican Theology and Pastoral Care* (Wilton, CT: Morehouse-Barlow, 1985), 7.

3) Shalom is mainly discovered through relationships.[1]

The Changing Face of Pastoral Care

Pastoral care in contemporary theology and practice is inseparable from pastoral counseling. To use the term pastoral care is to infer pastoral counseling and pastoral psychotherapy. This is due in no small measure to the dominant role of the American Association of Clinical Pastoral Education (AACPE). At the very least, basic CPE is part of many mainstream dominations' seminary training. This movement was started in the mid-1920s by Anton Boisen.[2] Boisen used the verbatim records of the pastoral conversations with the one seeking help in a supervised setting to train the pastors. Thus a shift from traditional pastoral care in the spiritual, social, and judicial context to contemporary/clinical pastoral counseling was born.

Pastoral care prior to the emergence of the AACPE dealt primarily with spiritual, social, and judicial issues as they affected the individual and society. The pastor in times of loss and crisis helped the sufferer experience God through the sacraments, the reciting of scriptures, worship and the traditions of his faith. One only has to look at the American South in the 1950s and 1960s to see the role of the clergy in addressing social and political injustices. The pastors would organize their churches to feed the hungry, clothe the naked, visit the imprisoned, and defend the helpless and disenfranchised.

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[1] Wesley Carr, *Handbook of Pastoral Studies: Learning and Practicing Christian Ministry*, New Library of Pastoral Care (London: SPCK, 1997), 10.

[2] Pattison, 19.

Pastoral care in the Reformed tradition placed a heavy emphasis on teaching both in the home and in the pulpit. Pastoral care relationships were developed as much in the home as in the church. Pastoral care was calling the unconverted into a relationship with Jesus Christ, giving advice to those who sought it, building up the congregation as the body of Christ, being with people in times of need, and exercising discipline when necessary. The focus was on reconciling the individual self to God as part of the larger community.

Even so, Campbell sees a shift away from this perception of the pastoral role as early as the nineteenth century. "Already by the nineteenth century the directive emphasis in the approach (teaching as part of pastoral care) was clearly yielding to the 'acids of modernity'."[1] The teaching role of the pastor is giving way to the clinical role.

In the Anglican tradition, pastoral care is the primary responsibility of the parish priest. Throughout its evolution, the Anglican Church has maintained that pastoral care, among other things, is the celebration of the holy Eucharist, preaching, the use of the Book of Common Prayer, the reading of scriptures, conveying the message of sin and grace, and visitation in the congregants' homes. However, according to Griffiss, by the end of the late seventeenth century, Jeremy Taylor's prolific pastoral writings on how one should live, *moralism* became the primary focus of the church. Pastoral care in the Anglican Church was metamorphosing. Citing Taylor's writing on holy living, Griffiss writes:

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[1] Campbell, 15.

> A man does certainly belong to God who believes and is baptized into all the articles of the Christian faith, and studies to improve his knowledge in the matter of God, so as may best make him to live a holy life; he that, in obedience to Christ, worships God diligently, frequently, and constantly, with natural religion, that is prayer, praises and thanksgiving; he that takes all opportunities to remember Christ's death by a frequent sacrament, as it can be had, or else by inward acts of understanding, will and memory (which is spiritual communion) supplies the want of the external rite; he that lives chastely; and is merciful; and despises the world, using it as a man, but never suffering it to rifle a duty; and is just in his dealing, and is diligent in his calling; he that is humble in spirit; and obedient to government; and is content in his fortune and employment; he that does his duty because he loves God; and especially if after all this he be afflicted, and patient, or prepared to suffer affliction for the cause of God: the man that has these twelve signs of grace does as certainly belong to God, and His son as surely, as he is His creature. . . .These are the marks of the Lord Jesus, and the characters of a Christian: this is a good religion; and these things God's grace hath put into our powers, and God's laws have made to be our duty, and the nature of man, and the needs of commonwealths, has made to be necessary.[1]

What happened to pastoral care at the turn of the twentieth century? Gerkin states that

> the most significant developments in pastoral care at the beginning of the twentieth century were in continuity with the turn towards the self that emerged from the rapid developing privatization of religion in the nineteenth-century West. Religion had become closely associated with self-development. This was the case whether one found affinity with mainline liberal theology, an evangelical theology of salvation by acceptance of Christ as personal Savior, or the moral honing of the self by means of pietistic holiness practices.[2]

Now a more clinical setting has emerged. In this new pastoral care model, issues that psychologically interrupt one's growth, one's sense of being and wholeness are addressed using both the psychological and theological disciplines as a foundation for

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[1] Griffiss, 21.

[2] Charles V. Gerkin, *An Introduction to Pastoral Care* (Nashville, TN: Abingdon, 1997), 53.

renewal and reconciliation.

This shift has been attributed in part to such theologians as Bultmann and Tillich. Their writings were from more of a humanistic and existentialist point of view. Their emphasis was mainly on "the centrality of human experience, the experience of the transcendent in the present, and the importance of persons and personal experience."[1] Tillich's writings in the early 1960s looked at the relationship between theology and psychology and helped foster the role of psychology in pastoral care. This gave pastoral care a more clinical face with the focus on helping the individual but less from a purely spiritual context. Pastoral care was now more about methods and theories of helping the individual in an office setting for a set number of visits and the counseling hour and less about home visits and experiencing God at the point of need or during the worship service.

Individualism in the American Culture

Individualism is part of the American cultural fabric. The cliché "You can share in the American dream if you are willing to work hard and play by the rules" is a case in point. Oftentimes when one hears of a rag-to-riches story the old cliché "He pulled himself up by his own boot strings" is part of the tale of success. As it was in the old Greco-Roman culture, the individual is prized almost exclusively over the corporation, organization, institution, and/or family. According to Pattison there are seven powerful factors that make pastoral care-giving individualistic and psychological. They are:

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[1] Pattison, 21.

1. The theory and practice of psycho-dynamic psychology, psychotherapy, and counseling

2. The influence of individualism in religion and theology

3. Individualism in Western society

4. Secularism

5. The discrediting of political solutions to human problems

6. The adoption of professional role models by pastors

7. The influence of the pastoral care tradition.[1]

This shift in approach to pastoral care means more person-to-person attention in a clinical setting and less concern for people as a corporate body. It also means less concern for social and political issues. The individual's needs are no longer the reflection of societal needs. The person is given attention in isolation of the community. Little or no attention is given to social groups, for this will infringe on the rights, freedom, and privacy of the individual. Thus, while claiming to be a religious nation, religion continues to be less influential in mainstream American society. Pastors and the churches they serve are following the same trend in becoming less prominent and influential in this secular society. All this has left the pastor searching for role significance and possibly finding it from the grateful individuals who come to the office and say, "Pastor I have a problem."

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[1] Ibid., 84-87.

A Search for Relevance

As cited earlier, the pastor in the Judeo-Christian culture has been the champion of the underdog, the downcast, the disenfranchised, the hurting, and the spiritually misguided in society. The results have been a sense of significance for the pastor as a care-giver. However, political and social problems have become complex in their applications and implications, and the pastors have lost their ability to radically influence change.

In my view, the voices of the revivalists and reformists of the eighteenth and early nineteenth century have long been silenced, giving way to a plethora of clerical voices desiring to be heard but largely ignored by an ever-growing secular society. The god of this society has been formed and fashioned by the affluence of the wealthy and the politically well connected. Moral and ethical concerns are given lip service at best by the powerful in a society that promotes entertainment, smoking, drinking, and other types of self-destructive behaviors.

This loss of pastoral authority has caused pastors to seek meaning for their profession. "Pastoral care which concentrates on individuals, especially if it is informed by the insights of psychology and pastoral counseling, may be a way some pastors find meaning and a role in a world which does not seem to want them."[1]

An Urgent Need

The complexities of today's society make the call of traditional pastoral care

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[1] Ibid., 86.

needful and urgent. Secularism is part and parcel of post-modernism. This has created a need for a reemphasis of traditional Christian values. The global and cross-country migration in search of jobs and a better standard of living has changed the traditional role of the family. This in turn has contributed to the growing alienation between family members in the home and the breakdown of the family and Judeo-Christian values. The rise in illegal drug usage, the rise in sexually transmitted diseases, pornography, gambling and other forms of addictions and behaviors that are attacking the moral fabric of our society are all calls for the active role of the pastor in the homes and the life of the community. "The loneliness, isolation, and fragmentation produced in our society by our greater complexity have caused people to turn to many other places for the pastoral care which the church no longer seems able or willing to provide."[1]

A recent poll ranked the clergy seventh of ten professions rated by the American public for their honesty and ethical standard. Firefighters scored 90 percent; nurses, 84 percent, U.S. Military, 81 percent; police officers, 68 percent; pharmacists, 68 percent; and medical doctors at 66 percent. The clergy were ranked at 64 percent. Engineers were ranked at 60 percent, college instructors at 58 percent and dentists at 56 percent.[2]

These data help to confirm that the relevance of pastors and their ability to impact society has greatly diminished. This also shows that pastors in their traditional pastoral care role are still needed. In a nation where so many claim to attend places of worship

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[1] Griffiss, 2.

[2] Sam Ward, "Firefighters Receive Top Marks for Ethics, Honesty," *USA TODAY*, 12/05/ 2001, 1.

weekly, this lack of pastoral relevance seems incongruous.

The pastor as an agent of change is needed again. Historically, the pastor in his pastoral care role was an agent of change. However, the venue for that need must be remade and shaped. Pastoral counseling can only take place if pastoral care is held distinct from pastoral counseling and done compassionately. God's judgment against the shepherds, *pastors*, in Ezek 34 and Jesus' description of the false or (unfaithful) shepherd as thieves whom the sheep will not follow, in John 10, can be applied to the way much pastoral care is understood and carried out today.

There needs to be clearer distinctions made between pastoral care as the daily ministerial functions of ministry. Pastoral care in the context of Ezek 34 and John 10 means being the custodians and protectors of the people of God. Pastoral counseling takes place under the rubric of pastoral care. It is a very different discipline done with members of the congregation in times of spiritual, emotional and physical crisis and suffering.

If pastoral care is *the caring of souls or soul caring,* then one must asked, "How or when are souls cared for?" Souls are cared for at the point of need. The pastoral application of caring must therefore be tailored to meet the specific needs at specific times along the continuum of the person's spiritual and social development. Caring must begin from the time of the person's specific need and continue until the person no longer has or feels the need.

The pastor's work of leading worship, the communion service, exhortation, admonition, prayer, home visits, calling for repentance and reconciliation, and

performing baby dedications, weddings, funerals, and other rites specific to one's faith traditions is all pastoral care or soul caring. Leroy Aden and J. Harold Ellens write that pastoral care is to "relate the word to specific need, to embody it in a living relationship of loving service in a way that is appropriate to the situation. In this sense, it is a very human act, person ministering to person, even though it flows out of what God is and does for us rather than out of our own inner resources."[1]

The pastor is in a sense called by God to be a *parakletos* to another human being. *Parakletos* combines the preposition *para*, meaning "beside," and the adjective *kletos*, meaning "called," or "one called." The literal meaning then is "one called to the side of."[2] The verb form of the word *parakaleo* means to exhort. The word is found only in the NT writings of John. It is designated as a title of the Holy Spirit as promised to be sent by Jesus in His place. The word is translated in the NASB as "Comforter." The word is used not as a designation of title but of function.

The pastor comes "along side" the parishioners in different ways at different times for different reasons, but should always do so for the purpose of caring or soul caring, comforting the soul in relationship with God. Thus the pastors are indeed comforting others with the comfort which they received from "the God of all comfort, who comforts them so that they might be able to comfort those who are in any affliction with the

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[1]LeRoy Aden and J. Harold Ellens, eds., *The Church and Pastoral Care* (Grand Rapids, MI: Baker Book, 1988), 40.

[2]"The Comforter" [John 14:16], *The Seventh-day Adventist Bible Commentary*, ed. Francis D. Nichol (Washington, DC: Review and Herald Pub. Assoc., 1980), 5:1037.

comfort with which they are comforted by God" (2 Cor 1:3-4).

Pastoral Counseling as a Form of Psychotherapy

Psyche is used more than 900 times in the LXX and the Aprocrypha. It is most often used as the equivalent to the Hebrew *nepes*, "soul."[1]

The Soul

We as Seventh-day Adventists believe that the soul is a "unite of life uniquely different and separate, from other similar units. This quality of individuality in each living being, which constitutes it a unique entity, seems to be the idea emphasized by the Hebrew term *nephesh*. When used in this sense *nephesh* is not part of the person; it is the person . . . . The idea that a 'soul' can have sentient existence apart form the body, or that it possesses an immortal essence, is wholly foreign to the Bible."[2] Harder believes that

> The 'soul' reveals its life in movement and the most various expressions of the emotion, hence the phrase 'with all your soul' (Deut. 13:3). Within the soul dwells the desire for food (Deut. 12:20), the lust of the flesh (Jer. 2:24), and the thirst for murder and revenge (Ps. 27:12). The soul expresses its feelings: it weeps (Ps. 119:28), is poured out in tears (Job 30:16), is 'made long' in patient endurance (Job 6:11). . . . To such a degree is the soul the summing up of the whole personality, of the whole self of a person, that 'soul' can be equivalent in meaning to 'I myself' or 'Yourself.'[3]

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[1]G. Harder, "Soul," *The New International Dictionary of the New Testament*, ed. Colin Brown (Grand Rapids: Zondervan, 1978), 3:676-687

[2]SDA Bible Dictionary (1979), s.v. "Soul."

[3]Harder, 3:676-687.

In the New Testament, *psyche*, soul, is used 101 times.[1] It is thought of as the seat of life. It also conveys the meaning of life itself. Such was the message of Christ as recorded in the Synoptic Gospels. "Whoever wishes to save his life (*psyche*) shall lose it, but whoever loses his life (*psyche*) for my sake and the gospel's shall save it" (Matt 16:35; Mark 8:35; Luke 9:24). In the parable of the Good Shepherd, Jesus speaks of laying down His life, *psyche*, for the sheep (John 10:11). *Psyche* takes in the totality of the human person: the ego or personality, the beliefs, hopes, aspirations and moral values, the insights, will and dispositions. It is the essence of the Jewish Shema, "Hear, O Israel! The Lord is our God, the Lord is one! And you shall love the Lord your God with all your heart and with all your soul and with all your might" (Deut 6:4-5).

The lawyer in his discourse with Jesus about what is required to inherit eternal life cited the above statement from Deuteronomy and added "with all your mind and your neighbor as yourself" (Luke 10:27). The idea is that one's whole being must be engaged to fully live and experience life with all its joys and pains, victories and defeats, brokenness and healing. Citing Jas 1:21 and 5:20 (cf. 1 Pet 1:9 and 2:2-11), the salvation of a person's soul (*psyche*) could be eternally lost. Therefore, life and death decisions are made in the area of the soul (*psyche*).

The pastor in the caring of souls or soul tending becomes the Undershepherd, creating an environment, a safe place where souls, can be rescued and healed through the mystical union with and reconciliation to God, self and others. In this sense Wise is

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[1] Ibid.

correct in stating that "Pastoral psychotherapy is not doing something to another person; it is assisting another person to do and be something."[1]

The Pastor as Healer

The word therapy is rooted in the Greek word *therapeia* or *therapeuo* and is rendered "to heal." It occurs forty-three times in the New Testament. It is found forty times in the Synoptic Gospels and the book of Acts. With two exceptions found in Luke 4:23 and 8:43, *therapeuo* describes miraculous healing on the part of Jesus and His disciples.[2] In the life of Jesus, *therapeuo* (healing) usually accompanied His teaching. (Matt 4:23; 9:35; and Luke 6:18), In His commission to the Twelve and the Seventy, Jesus told them among other things to "heal the sick" (*therapeua*) (Matt 10:8).

In John 14:12-13 Jesus said, "Truly, truly I say to you, he who believes in Me, the work that I do shall he do also; and greater works than these shall he do; because I go to the Father and whatever you ask in My name that I will do, that the Father may be glorified in the Son." Taken in this theological context, the pastor who is called by God to preach, teach, and heal, is working as a psychotherapist with those in need of healing because of bereavement, estrangement, family crisis, pathological religious ideation, and otherwise normal behaviors taken to extremes, and is in the historical and theological tradition as practiced by Christ. This level of clinical involvement requires much more

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[1] Carroll A. Wise, *Pastoral Psychotherapy: Theory and Practice* (New York, NY: Jason Aronson, 1980), 5.

[2] F. Graber, D. Muller, "Healing," *The New International Dictionary of New Testament Theology*, ed. Colin Brown (Grand Rapids: Zondervan, 1976), 2:164-165

psychological training by the pastor to deal adequately with pathologies. The average parish minister does not possess that level of clinical and psychological training.

Healing of the sick, and tending to the wounded as part of soul caring is the commissioned work of the pastor.

> From Biblical days, the priest and the pastor have been concerned with and ministered to persons suffering from emotional conflict. But they have been called other names, such as sinner, the penitent, the deviant, the depressed (dark night of the soul), the rebel, the over scrupulous, the grandiose, the over controlled and the under controlled, the sensuous and the extreme puritan, the person with rigid conscience and the person who lacked conscience. Emotional disturbances and spiritual disturbances have had something of a common meaning. It has long been recognized that in the midst of profound emotional disturbances there may be a creative religious or spiritual process emerging.[1]

Christ as the Wounded Healer

When one thinks of healing the wounded, images of blood and exposed flesh emerge. Even in this image Christ is both an example and a forerunner. Isa 53 portrays Him as the Suffering Servant. He was grief stricken, sorrow bearing, smitten, and afflicted by God. He was chastened for our well-being, and by His scourging we are healed. In this paradoxical image, the healer is in need of healing. The One who will stop the bleeding of humanity and bind up their wounds is Himself bleeding and wounded.

Jesus is not only damaged physically, He is wounded psychologically. He experiences the loss of equality with God. In His humanity, Jesus experienced the loss of

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[1] Wise, 5-6.

Self-existence, of never having to be in need. As a man of sorrows, Jesus needs food, water, sleep, rest, shelter, companionship, and belonging. In the Garden of Gethsemane on the night of His betrayal, Christ asked three of His disciples to be present with Him in His time of greatest distress (Matt 26:37-38). In His acquaintance with grief, He becomes acquainted with humanity's grief.

In the truest sense Jesus is in the words of Henri Nouwen the "wounded healer." Though sorely distressed even to the point of death, Jesus does not recoil from the terrible darkness He faces. He does not hide from His fear. In the company of other human beings He openly makes Himself vulnerable. Though forsaken by friends, He is alone with the Father and taking the cup of sorrow He drinks. He surrenders Himself to the inhumane ordeal that is soon to come. Undaunted, Christ faces His own terrible destiny, knowing that the outcome is death. Christ by His life and death showed that for healing to be truly authentic, the healer must first know by experience what it is to be wounded. "Of all human experiences, the experience of loss is the most pervasive and potentially the most crippling."[1]

> The wounded healer heals, because of ability to convey, as much by presence as by the words used, both an awareness and a transcendence of lost....Wounded healers heal because they, to some degree at least, have entered the depths of their own experiences of loss and in those depths have found hope again....The healer has learned (a little at least) from the Son of Man, who had nowhere to lay His head (Luke 9:58), and has understood the wisdom of Job's words: 'Naked I came from my mother's womb, naked I shall return' (Job 1:21).[2]

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[1] Campbell, 51.

[2] Ibid.

Christ as the Suffering Servant leaves an example for His undershepherds. Those who offer healing to others must first become very acquainted with their own grief and brokenness. They must by experience know pain, suffering, and loss. They like Christ must know the aloneness with the Father when they must drink from their own cups of sorrow and face the fear of their own destiny. Healers who have experienced pain and suffering themselves and dealt with it appropriately, have a unique understanding of the pain and suffering of others. Yet truly caring individuals can work effectively with people who are suffering without having suffered in similar ways.

All suffering is unique to the sufferer and therefore can never be fully understood by another. The healers who have not constructively dealt with pain and loss will avoid those who are having the experiences of pain and loss or attempt to have the sufferer avoid or escape the ordeal. Yet pain and loss are an inherent part of life as we know it.

What is it to be a human being? It is to live knowing that some day you will die (Eccl 9:5). Life is transitory. The Psalmist writes, "As for the days of our life, they contain seventy years, or if due to strength, eighty years, yet their pride is but labor and sorrow; for soon it is gone and we fly away" (Ps 90:10). To have been born is to march inevitably from the vigor of childhood and youthfulness to the declining years towards geriatric care.

Each stage of life has its own complications, challenges, pains, and losses. Each comes with its own set of rules, rituals, rewards, and punishments. A tender of souls who manages to go through the various stages of life unscathed by human suffering does not know how to be authentic with one in pain. In a cosmological sense, such a person has

no humanity. Such a person has no true sense of God and His redemptive act in the person of Christ.

One must hope for what is unseen, not what is seen. Those who have no need have never journeyed outside of themselves. Having never had a Gethsemane experience they have never invited another to "watch" with them. Because they never needed one to watch with them, they do not know how to watch with another. It is reciprocal. After the Gerasene man with the legion of demons was liberated, he asked to follow Jesus, his liberator. Jesus denied him his request, beseeching him instead to go to his people and "report to them what great things the Lord has done for you, and how He had mercy on You" (Mark 5:19). It is a person in relationship with God at a point of deepest need that can later be the connection to God with others during their periods of deepest need.

> The Wounded healer gains his power by acknowledging his weakness and by finding God's healing force at the moment of deepest despair. There is no short cut to such healing, no hope without fear, no resurrection without the tomb's deep darkness. We must now see how, by acknowledging our wounds and facing our finitude, we too, in a small way, can be healers of others.[1]

Christ by His death and resurrection assured the restoration of the total person. Therefore for true reconciliation to occur the pastor, as healer or psychotherapist, must deal with the person being counseled as an organic unity that is broken and is in need of healing.

Converted Care-Givers

Before that healing can take place, the pastor must be in an ongoing state of conversions. Pastors need to become aware of the areas in their lives that they have not

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[1]Ibid., 50.

gotten victory over and surrender them to the Lord. Jesus said to Peter "when you are converted strengthen your brethren" (Luke 22:32 NKJ). Wicks, Parsons, and Capps believe that pastoral counselors need to go through a thorough conversion. They also believe that the counselors must be free from addictions and maintain a healthy self-respect and self-love. Only then can they model healthy love and respect for others.[1] Jesus said to Peter "When you are converted, strengthen your brethrens" (Matt.

Above all things the pastors must not do any harm. For pastors to do no harm to themselves and the people they serve, they must know themselves at their deepest emotional need. Before the pastors can be true agents of change, they must have themselves experienced change by the agency of the Holy Spirit. As humans we are all in the ongoing process of becoming.[2]

The pastor as brings his/her lifelong learning and experiences (baggage) into the counseling relationship. From what has been learned and experienced, patterns of behavior are formed. These in turn impact the personality. If the pastoral counselor has a dysfunctional personality, he/she will bring a distorted view of life and expectations into the counseling relationship. This will result in an unhealthy alliance with the client, and open the door for abuse in the therapeutic relationship.

Paramount to pastoral psychotherapy is the relationship between the pastors and the people they counsel. "The relationship between pastor and person is the necessary

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[1]Wicks, Parsons, and Capps, eds., 59-60.

[2]Jay E. Adams, *Competent to Counsel* (Phillipsburg, NJ: Presbyterian and Reform Publishing Company, 1970), 74.

ingredient in all pastoral ministry, and crucial in pastoral therapy. It is the basis for the process, the interaction and movement, and the manner in which dynamics and contents are used." Richard Dayringer writes:

> Relationship is the essence of counseling being done by clergy. To be sure, such counseling may incorporate a wide variety of methods and techniques, but the essential component that brings about the resolution of difficulties is the therapeutic relationship between the minister and the counselee. . . . Relationship is considered to have this importance in all psychotherapy and the clergy's vocation centers in interpersonal relationships both human and divine.[1]

Listed below are some questions Dayringer suggests that the counselors ask themselves during the therapeutic dialogue:

1. Can I be perceived by the other person as trustworthy, as dependable consistent in some deep sense?

2. Can I express enough as a person that what I am will be communicated unambiguously?

3. Can I let myself experience positive attitudes towards this other person?

4. Can I be strong enough as a person to be separated from the other?

5. Am I secure enough within myself to permit this separateness?

6. Can I let myself enter fully into the world of the client's feelings and personal meanings and see these as he or she does?

7. Can I receive the client as he or she is? Can I communicate this attitude?

8. Can I act with sufficient sensitivity in the relationship that my behavior will

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[1]Richard Dayringer, *The Heart of Pastoral Counseling: Healing through Relationship*, rev. ed. (Binghamton, NY.: Haworth Press, 1998), 5.

not be perceived as a threat?

9. Can I free the client from the threat of external evaluation?

10. Can I meet this other individual as a person who is in process of *becoming,* or will I be bound by his or her past and my own past?[1]

Addressing the role that relationship plays in successful therapy, Richard Sipe and Clarence Rowe stated:

> The client-therapist relationship should be the single most important factor in securing psychotherapeutic success. The patient-therapist relationship encompasses the unconscious, transference, and counter-transference elements that the analytic tradition has clarified. It also includes conscious positive and negative realistic aspects. All these factors combine to form the therapeutic transaction. Each person-patient and therapist contributes something to the therapeutic experience.[2]

Because the relationship is imperative in the emotional healing process, the need for the healer to have experienced his or her own inner healing is equally imperative. Speaking about pastoral qualification, Carroll Wise writes "The pastoral therapist needs to have gone through his own therapy with some positive results. Having had therapy does not of itself make a therapist. But being in close touch with feelings, attitudes and motives is very important to any pastoral work, particularly when one is dealing with loneliness, suffering, frustration and the like in others."[3] But healing is never static, nor does healing take place in a vacuum. Healing for the under-shepherd must be ongoing

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[1]Ibid., 38.

[2]A. W. Richard Spie and Clarence J. Rowe, *Psychiatry and Pastoral Counseling*, 2nd ed. (Collegeville, MN: Liturgical, 1984), 52.

[3]Wise, 13.

and takes place in an abiding relationship with Jesus Christ, the "Good Shepherd."

Shared Beliefs

Pastoral counselors and psychotherapists and those who seek their help must share commonly held beliefs and practices about God, the incarnation, the nature of humanity, sin, death, and the resurrection, and much more. Based on those commonly shared values, pastors have the intrinsic authority derived from and informed by their discipline to name the experience of the counselee and chart an appropriate course of action or method of intervention. Diagnosis is an ongoing process that comes out of the ongoing conversation between the pastor and the parishioner in the therapeutic setting. At the same time it is specific in language and definable in scope.

Ramsay believes that diagnosis is dependent on "three sets of assumptions" that are held by the practitioner:

1. The anthropological (the nature of human beings and all the possibilities for fulfillment)

2. A communally shared world view (How are things, and how should they be? And by whose standard should we ascribe value?)

3. The dynamics of authority (How does the practitioner use power and to whom is he accountable?).[1]

People most often come to pastors (most likely of their own religious orientation) in times of family, personal, community, and national crises for an informed

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[1]Ramsay, 14.

understanding of their faith and closely held sets of beliefs. Pastors can use their theological resources for their therapeutic assessment and appropriate intervention. Ramsay calls it "the ecclesial paradigm, the Christian theological world view that describes a distinctive way of being in and seeing the world."[1] Jesus said that we are to be in the world but not of the world. The psychotherapist must interpret the redemptive acts of God as seen in Christ and the power of His love to empower, nurture, protect, hold accountable, and sustain throughout the complete life cycle.

If the role of the clergy is to once again have national, moral, and ethical significance, it must be changed. Pastoral care needs to be put back into its traditional practice and significance. The pastoral care role is rooted in the rich historical and traditional dialogue of scripture that needs to be revisited and put back into the practicing ministry of the pastor. There also needs to be more clarity between pastoral care, pastoral counseling and, if Wise is correct, pastoral psychotherapy. Pastoral care is among other things home and institutional visitation, preaching, performing the liturgy, leading out in prayers and worship, providing comfort to families in times of bereavement and other life altering experiences. Pastoral care is ongoing. Pastoral counseling is narrower in scope but more intense in function. It involves the private meetings between the pastor and members of the congregation who are having experiencing difficulties for which they need help to put into theological perspectives. The pastor contracts with the parishioner to meet at a set time and place, most likely in the office, to assess and help clarify

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[1]Ibid., 34.

negative experiences in the sufferer's life. Pastoral psychotherapy is the work done by a clinically licensed pastoral therapist with individuals whose negative experience has become pathological. This level of counseling work is more intense than that of pastoral counseling. The services are provided for a fee and are performed contractually in an office by clinically trained pastors who are licensed by the state.

The pastors of the twenty-first century must be adequately trained to handle the varying demands of ministry. Pastors need to understand the rich theological heritage available to them and use it to inform their thinking and dialogue in ministry.

Pastors as undershepherds are healers of wounds. Therefore they must be aware of their own wounds and be committed to their own ongoing healing. Pastors must also be aware of the need to be in an ongoing state of conversion so not to become all things to all people and nothing to themselves.

Pastors in their roles as counselors or psychotherapists must become acquainted with the diagnostic tools available to them in their Christian traditions when counseling. They must also use these diagnostic tools to determine the best form of intervention.

Finally, pastors need to also be aware that the diagnostic process is ongoing throughout the counseling process; and that the therapeutic relationship is part of the alliance between them and the person or persons they are present with in therapy.

CHAPTER 4

BIBLICALLY BASED COUNSELING AND THERAPY

This chapter presents a basic knowledge about using Scriptures appropriately as an alternative to psychology in counseling. The Bible is not a diagnostic textbook in the sense that it deals with a psychological approach to human disorders. The Bible is a diagnostic textbook in that it deals with human estrangement from God and with His definition of our behavior. This chapter would normally be part of the training program in the appendix. However, it is presented here because it seems appropriate to the flow of the paper. I am regarding biblically based counseling from a Christocentric point of view. However, I believe that the Protestant pastor, with some training and sensitivity to the individual's particular faith and practice, can provide counseling to people of non-Christian backgrounds.

Key Proponent: Jesus Christ (John 5:39)

Jesus says, "You search the Scriptures because you think that in them you have eternal life; it is these that testify about me, and you are unwilling to come to me so that you may have life" (John 5:39-40). The Apostle Paul writes, "For as in Adam all die, so also in Christ all will be made alive" (1 Cor 15:22). The Ancient of Days was born into the human family and died a substitutionary death so that He might redeem lost humanity

back to God the Father. In Christ is the love of God for a perishing world revealed. "For God so loved the world, that He gave His only begotten son, so that whoever believes in Him shall not perish, but have everlasting life" (John 3:16). Biblical counseling, therefore, is about redirecting people towards God.

Key Concept: The Holiness of God

This section is not intended to be a study in Systematic Theology on the nature of God and that of man. It is the intent to give a basic understanding of God and His activities in human history. As part of the assessment the pastor should ascertain whether or not the parishioner understands about the holiness of God. Our knowledge of God, although limited, gives us an understanding of ourselves in terms of origin, disposition, and propensities. The prophet Jeremiah wrote, "The heart is more deceitful than all else and desperately sick; who can understand it?" (Jer 17:9). Fundamental to biblically based counseling are: (1) an understanding of the holiness of God (Lev 19:2; Rev 4:8); (2) an understanding of the creation story (Gen 1 & 2); (3) an understanding of the nature and fall of mankind (Gen 3; Rom 5:12-19); (4) an understanding of the presence and power of sin (Rom 7:14-25; Ps 51); (5) an understanding of God's redemptive acts in salvation history (John 3:16-17; Luke 19:10); and (6) an understanding of His abiding presence in the believer's life (Isa 43:1-2; Matt 28:18-20). Biblically based counseling concludes with a personal recommitment to God and an acceptance of His will (2 Cor 5:18-20; Prov 3:5-12). These are the essential Christian values as taught in the Scriptures and held in common among Christian churches.

Early in Israel's formation as the people of God, He exhorts them to be holy. God told Moses, "Speak to the congregation of the sons of Israel and say to them, 'You shall be holy, for I the Lord your God am holy'" (Lev 19:2). R. C. Sproul writes:

> This special call to Israel was really not new. It did not begin with Moses or even with father Abraham. The call to holiness was first given to Adam and Eve. This was the original assignment of the human race. We were created in the image of God. To be God's image meant, among other things, that we were made to mirror and reflect the character of God. We were created to shine forth to the world the holiness of God. This was the chief end of man, the very reason for his existence.[1]

This call to holiness on the part of God is not primarily a call to separation but to a distinctive righteousness. It is a tenet of Scriptures. In the New Testament, the believers are called *"Hagioi,"* saints. Being a saint is not an accomplishment on the part of the believer. It is what God by His grace calls or designates one. Both Old and New Testaments ascribe holiness in relationship with and proximity to God. Such was the case with Moses when he saw the back of God. His face shined with the glory of God, so much so that the people could not bear to look on his face resulting in him having to veil it. Like Moses it was the hope of every Jew to see the face of God (Exod 33:18-23; Num 6: 24-26). That hope is given eschatological consummation by the Apostle John. He writes, "Beloved, now we are the children of God, and it has not appeared as yet what we will be. We know when He appears, we will be like Him, because we will see Him just as He is" (1 John 3:2).

In order to respond to the command of God to be holy one must begin by looking upward. Isaiah, distraught over the death of the beloved king, Uzziah, and an imminent

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[1]R. C. Sproul, *The Holiness of God* (Wheaton, IL: Tyndale House, 1985), 202.

threat by Tiglath-pileser III, king of Assyria, went into the temple of the Lord for comfort and solace. Isaiah's account of that life-changing experience follows.

> In the year of King Uzziah's death I saw the Lord sitting on a throne, lofty and exalted, with the train of His robe filling the temple. Seraphim stood above Him, each having six wings: with two he covered his face, and with two he covered his feet, and with two he flew. And one called out to another and said, "Holy, Holy, Holy, is the LORD of hosts, the whole earth is full of His glory." And the foundations of the thresholds trembled at the voice of him who called out, while the temple was filling with smoke." (Isa 6:1-4)

Notice the repetition of the word *holy* on the part of the Seraphim. "Three times the word is sung in succession, giving the Church its most august anthem. The song is called the *trishagion*, which means simply the 'three times holy.'"[1] Very early in the therapeutic dialogue, the counselor must create an awareness of both the holiness and presence of God. Properly taught and understood, this awareness of the holy helps to foster change in both the pastor and parishioner and reduce the potentially devastating effects of transference and counter-transference as well as idolatry.

God's holiness must be viewed not as abstract and detached from who He is or from His creation. For God is at the same time immanent and transcendent. God who occupies the entire universe confines Himself to a tiny body as a baby. God who is beyond comprehension invites us to reason with Him. He makes Himself known to finite humanity and holds conversation with them. He even reverses His decision because of human intervention on behalf of others. Isaiah did not see the face of God, for no one in mortal form can see His face and live. He saw the glory of God and the manifestation of

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[1]Ibid., 38.

that glory on the Seraphim and on the temple. It caused in Isaiah awful dread to recognize his uncleanness by contrast, and he cried out in fear of losing his life. God's glory is associated with His holiness. Like Isaiah, Moses centuries earlier had an encounter with the Excellent glory. When he asked to see God's face, Moses was permitted to see His glory (Exod 33:19-23). The Apostle Paul invites all believers to participate in the holiness of God. He writes, "Therefore I urge you, brethren, by the mercies of God, to present your bodies a living and holy sacrifice, acceptable to God, which is your spiritual service of worship. And do not be conformed to this world, but be transformed by the renewing of your mind, so that you may prove what the will of God is, that which is good and acceptable and perfect" (Rom 12:1-2). The primary role of the counselor is to help the client discover and surrender to the will of God for his/her life.

Knowing God and being a member of the family of God necessitates a change at the very core of one's being, the personhood. The Apostle Peter wrote: "But you are a chosen race, a royal priesthood, a holy nation, a people for God's own possession, so that you may proclaim the excellencies of Him who has called you out of darkness into His marvelous light; for once you were not a people, but now you are the people of God; you had not received mercy, but now you have received mercy" (1 Pet 1:9-10). Such a transformation is only possible through the acceptance of and surrendering to the will of God in the life. Holiness in the Old Testament was through the sanctuary services and the continual blood sacrifices as an efficacy for sin which pointed to the divine human sacrifice in the person of Jesus Christ. In the New Testament the imperative to holiness or holy living is through an acceptance of and a union with Christ. MacArthur and Mack

write:

> Counselors must emphasize the doctrine of union with Christ because it incorporates two key issues essential to understanding change and struggle. First, union with Christ is an all-encompassing doctrine. 'It embraces the wide span of salvation from its ultimate source in the eternal election of God to its final fruition in the glorification of the elect.' Second, it is the one doctrine that embraces the factors of what Christ has accomplished (the indicative) and what believers are commanded to do (the imperative). Moule says that the gospel begins 'in the indicative statement of what God has done,' and before it goes on to the imperative 'to struggle' it confronts us with the imperative 'to attach oneself (be baptized! Be incorporated).' Configured between what God has accomplished in Christ and what we are to do in obedience, and possessed with a scope that extends from eternity past to eternity future, union with Christ is an indispensable doctrine in understanding change and struggle in people's lives.[1]

Key Concept: God's Act in Creation

What is the parishioner's understanding of the creative acts of God? The Bible says, "In the beginning God created the heavens and the earth." "By the word of the Lord the heavens were made, and by the breath of His mouth all their host. . . . For He spoke and it was done; He commanded and it stood fast" (Gen 1:1; Ps 33:6, 9; cf. Ps 19:1-6; John 1:1-4; and Rom 1:20).

Paul, in his letter to the church in Colosse, puts Christ at the center of the creation story. He writes, "He [Jesus] is the image of the invisible God, the first born of all creation. For by Him all things were created, both in heaven and on earth, visible and invisible, whether thrones of dominions or rulers or authority—all things have been created through Him and for Him. He is before all things, and in Him all things hold together" (Col 1:15-17).

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[1]MacArthur, Mack, and Faculty, 120.

In the work of creation God called into existence that which did not exist before, *ex nihilo* (out of nothing) through His creative force. Three times in chap.1 of Genesis is the word *bara* (created) used. "In the beginning God created the heavens and the earth" (Gen 1:1). It is also used in vs. 21 for the creation of sea creatures and winged birds. Again *bara* is used in vs. 27, this time for the existence of mankind, the zenith of God's creation. *Bara* is used exclusively in connection with God. It is the sole act of divinity. It is never used as an act of man or mankind. The creation narratives (Gen 1and 2) give the believer a sense of origin, community, and identity, "for in Him we live and move and exist . . . 'for we are His children'" (Acts 17:28). The unambiguous nature of the accounts helps believers to know who they are in relationship to the Creator, the cosmos, and its inhabitants. Neither of the two creation accounts attempt to explain the existence of God. He is there before the beginning. He ushers in the beginning in a dramatic and decisive way. He commanded creation into being by the authority of His sovereign will (Ps 33:6-9).

Key Concept: God's Act in Salvation History

Fundamental Belief #7 of the Seventh-day Adventists church states:

> Man and woman were made in the image of God with individuality, the power and freedom to think and to do. Though created free beings, each is an indivisible unity of body, mind, and spirit, dependent upon God for life and breath and all else. When our first parents disobeyed God, they denied their dependence upon Him and fell from their high position under God. The image of God in them was marred and they became subject to death. Their descendants share this fallen nature and its consequences. They are born with weaknesses and tendencies to evil. But God in Christ reconciled the world to Himself and by His Spirit restores in penitent mortals the image of their Maker. Created for the glory of God, they are called to love Him

and one another, and to care for their environment.[1]

Key Concept: Human Nature before the Fall

Mankind was created by God on the sixth day of creation week as His crowning act. The Bible stated, "Then God said 'Let Us make man in Our image, according to Our likeness'. . . . God created man in His own image, in the image of God He created him; male and female He created them" (Gen 1:26-27). "God made man perfectly holy and happy. . . . Man was originally endowed with noble powers and a well-balanced mind. He was perfect in his being, and in harmony with God. His thoughts were pure, his aims holy. . . . In his sinless state, man held joyful communion with Him 'in whom are hid all the treasures of wisdom and knowledge' (Col 2:3)."[2] According to the Genesis account Adam was made from the dust of the ground and the breath (*ruah)* of life was breathed into his nostrils and he became a living being (*nephesh chayyah)* or a living soul (Gen 2:7). While Adam was made from the dirt, God performed the first genetic cloning with a twist. Putting Adam into a deep sleep, God extracted a rib from his side and fashioned Adam's life partner, Eve, from it (Gen 2:21-22).

The antitype after whom Adam and Eve were made gives us a clue as to their noble status in the creation plan of God. All other living creatures bore the image of their

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[1]Ministerial Association Seventh-day Adventists: General Conference, *Seventh-Day Adventists Believe. . . A Biblical Exposition of 27 Fundamental Doctrines* (Hagerstown, MD: Review and Herald, 1988), 78.

[2]Ellen Gould Harmon White, *Steps to Christ* (Mountain View, CA: Pacific Press, 1908), 9, 17.

kind—an image other than the divine. But the human pair was made to bear and reproduce in the image of the Creator. Charles Hodge writes:

> The essential attributes of a spirit are reason, conscience, and will. A spirit is a rational, moral, and therefore also a free agent. In making man after his own image, therefore, God endowed him with those attributes which belong to his own nature as a spirit. Man is therefore distinguished from all other inhabitants of this world, and raised immeasurably above then. He belongs to the same order of beings as God Himself, and is therefore capable of communicating with his Maker. This conformity of nature between man and God is not only the distinguishing prerogative of humanity, so far as earthly creatures are concerned, but it is also the necessary condition of our capacity to know God, and therefore the foundation of our religious nature. If we were not like God, we could not know Him.[1]

Although the Bible is replete with accounts of God appearing in human form—He is spirit, He is incorporeal. Therefore Adam and Eve in human flesh did not bear this likeness of God. Eph 4:24 supports the belief that what Adam and Eve lost at, Christ gave us back at the re-creation. It reads, "and put on the new self which in the likeness of God has been *created* in righteousness and holiness of the truth" (italic added). They could not exist in the unveiled glory of God in any less an estate. The prophet Habakkuk writes, "Your eyes are too pure to approve [look at] evil and you can not look on wickedness with favor" (Hab 1:13). "In their innocence and holiness they had joyfully welcomed the approach of their Creator; but now they fled in terror, and sought to hide in the deepest recesses of the garden."[2] According to William Shedd:

> Holiness is more than innocence. It is not sufficient to say that man was created

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[1]Charles Hodge, *Systematic Theology* (Grand Rapids, MI: W. B. Eerdmans, 1946), 97.

[2]Ellen G. White, *Patriarchs and Prophets* (Mountain View, CA: Pacific Press, 1958), 57.

> in a state of innocence. This would be true, if he had been destitute of a moral disposition either right or wrong. Man was made not only negatively innocent, but positively holy. Man's regenerate condition is a restoration of his primitive state; and his righteousness as regenerated is described as *kata theon*, Eph. 4:21; and as 'true holiness,' Eph 4:24. This is positive character, and not mere innocence.[1]

Key Concept: Human Nature after the Fall

Paul standing in the Areopagus at Athens addressed the philosophers and gathered assembly and said, "And He [God] made of one man every nation of mankind to live on all the face of the earth" (Acts 17:26). To the church in Rome he wrote, "Through one man sin entered into the world, and death through sin, and so death spread to all men, because all have sinned" (Rom 5:12; cf. 1 Cor 15:22). After the original sin of Adam, his descendents inherited a sinful nature. For Adam and his progeny, propensity for corruption or to sin became natural. "Indeed, there is not a righteous man on earth who continuously does good and who never sins" (Eccl 7:20). Paul asserts that "there is none righteous, not even one. . . . All have turned aside, together they have become useless; there is none who does good, there is not even one" (Rom 3:10, 12).

> Man was originally endowed with noble powers and a well-balanced mind. He was perfect in his being, and in harmony with God. His thoughts were pure, his aims holy. But through disobedience, his powers were perverted, and selfishness took the place of love. His nature became so weakened through transgression that it was impossible for him, in his own strength, to resist the power of evil. He was made captive by Satan, and would have remained so forever had not God specially interposed. It was the tempter's purpose to thwart the divine plan in man's creation, and fill the earth with woe and desolation.[2]

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[1]William Greenough Thayer Shedd, *Dogmatic Theology* (Edinburgh: T. & T. Clark, 1889), 96.

[2]White, *Steps to Christ*, 17.

Mankind's natural bent toward that which is not pleasing to God causes guilt, fear, shame, and anxiety at the emotional and psychological level. This in turn often manifests itself in ways that can be neurotic, psychotic, and physically injurious to the person or persons involved. The soteriological act of God was a means whereby the estrangement between Him and His creation can be removed. Jesus was the promised Seed to Adam and Eve (Gen 3:15). The Apostle Paul sees that promise being fulfilled through the lineage of Isaac, the seed of Abraham (Rom 4:13-21; cf. Gal 4:16-17, 29). Jesus was God's Lamb who would rid the world of sin according to John the Baptist (John 1:29). After their act of disobedience, Adam and Eve, out of shame, sewed garments of leaves to cover their nakedness (Gen 3:7). Upon hearing the voice of God in their garden home they hid themselves out of fear (Gen 3:10). The first homicide was the result of anger and jealousy (Gen 4:6-8).

Biblical Counseling

Jeffrey Watson defines biblical counseling as:

1. A call to respect scriptural process
2. A call for principled intervention
2. A call for compassion with integrity
3. A summons to excellent communication
4. A commitment to regard each person as an independent whole
5. A call to privacy with permeable boundaries
6. A coaching session for resilient coping

7. A private version of public speech
8. A way to shepherd souls
9. A practice in relational accountability.[1]

Time and space will not permit me to address all nine of Watson's definitions of biblical counseling. I will, however, address the first three from a slightly different perspective.

The **process** of biblical counseling is having the counselee encounter God through the unfolding of the Scriptures. This is not a quick fix but rather an opportunity to gain insight through revelation and inspiration of how God is "a very present help in time of trouble" (Ps 46:1). Biblical counseling should not always be about bringing direct or immediate change in behavior. These changes may be the result of guilt on the part of the client or the inappropriate use of Scriptures by the pastor and are then temporary at best. It should be about having the person experience God. The subsequent change will be long-lasting because it is supported by an ongoing relationship with Christ. The person will either change their perception of the problem or of God or both. The people in Jesus' hometown of Nazareth did not experience any miracles because of their perception of Jesus (Matt 13:53-58). "And He did not do many miracles because of their unbelief" (13:58). In Martha's dialogue with Jesus over the death of her brother Lazarus, she changed her perception of the problem. She said, "Lord if You had been here, my brother would not have died. Even now I know that whatever You ask of God,

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[1]Jeffrey Watson, *Biblical Counseling for Today: A Handbook for Those Who Counsel from Scripture* (Nashville, TN: Word, 2000), 47.

God will give You" (John 11:21-22). With the Lord now present hope sprung alive "*even now*." She moved from despair to hope. Although she should have been in a position to know, the discourse between Martha and Jesus provided an opportunity for Him to correct her theological understanding of the resurrection. Yes, it is at the end of the world, but it is also centered in Christ (11:23-27). Thus, Martha also had to change her perception of the role and function of the Messiah.

Biblical counseling is also **principled intervention**. But intervention can take many forms. Intervention must be based on the pastor's level of competence. Perhaps the most appropriate form of intervention is to refer to a trusted professional more qualified or who has the time for the amount of counseling needed by the parishioner. While not a counseling setting, the account of Jesus' disciples and the father with the demoniac boy warrants attention. In utter desperation following the disciples' failure, the man relates the story to Jesus and pleads for help. After Jesus cured the boy, His disciples queried as to why they could not do the same. Jesus told them it was because they lacked a level of faith. Their unbelief was their undoing (Matt 17:14-20). Miller and Jackson say that there are five practical questions the pastor who counsels must ask; they are: (1) Should I intervene? (2) What is the problem? (3) When should I intervene? (4) What should I do? (5) Should I refer?[1]

Intervention is more than speaking the truth in love. One can do that and still do harm because of the misuse of Scripture. For example, Rom 8:28 states that "all things

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[1]William R. Miller and Kathleen A. Jackson, *Practical Psychology for Pastors*, 2nd ed. (Englewood Cliffs, NJ: Prentice Hall, 1995), 5-6.

work for the good to those who love God, to those who are called according to His purpose." While this is true and can be spoken in love and sincerity, it can be ill-timed and cause more pain in the counselees and hostility towards God if they are not at that place of acceptance. The Apostle John gives an account of Jesus healing the man who was born blind in John 9. It sheds light on a commonly held belief among the Jews in the time of Christ. The Disciples of Christ queried if it was the sin of the unfortunate man or that of his parents that caused his blindness. Jesus said it was neither, "but that the works of God may be displayed in him" (9:3). One can only imagine the lifetime of emotional pain this person endured in a culture that believed and probably conveyed as truth that mishaps and misfortunes come from God or are caused by God as a punishment for sin.

Another aspect of biblical counseling is to counsel with compassion and integrity. Compassion is the ability to show love to those who have not done loving or even kind things. Integrity is being consistently truthful or transparent. Counseling is very emotionally intense. Having someone share very personal and hurtful things with another person draws both into a circle of intimacy. The pastor's responsibility is to act responsibly, speak truthfully, and show compassion, all the while maintaining healthy boundaries with the parishioner.

Therapeutic Process

Therapeutic Goals

In my view, the therapeutic goals of pastoral counseling are: (1) to remove any distortions about God, self, and others; (2) to heal spiritual brokenness; (3) to help the

individual use the resources of Scripture and other appropriate non-canonical materials for aid, growth, and comfort; (4) to talk about sin and salvation as it addresses one's spiritual functioning; (5) to address the issues of guilt and shame when present; (6) to experience the gift of grace; and (7) to experience reconciliation to God through the working of Scripture and the rites of the church according to one's faith.

Therapist's (Pastor's) Function

In biblical counseling the pastor functions: (1) as a companion (Eccl 4:9-10); (2) as a comforter (2 Cor 1:3-4); (3) as a moral guide (1 Tim 3:1-7); (4) as a servant (Matt 20:25-28); (5) as a biblical teacher (Matt 28:20; Acts 5:42); (6) as a diagnostician (Matt 9:1-6; cf. Luke 5:17-24; John 3:1-8; 4:7-18); and (7) as a reconciler (2 Cor 5:18-20).

Client's Experience

Among other things, the expectations of biblical counseling are that the parishioner: (1) will experience God's grace in the midst of crisis (Ps 46:1-3; 2 Cor 12:9); (2) will develop a relationship with God based on faith (Hab 2:4; cf. Heb 11:1, 6); (3) will develop new coping skills and an increased ability to trust in the promises of God (Prov 3:5-6); (4) will come to believe that our victory is in Christ (Rom 8:26-39); (5) will celebrate the assurance and maintenance of salvation in Christ (Gal 2:20; Eph 2); and (6) will experience reconciliation to God (2 Cor 5:18-21).

Therapeutic Relationship between the Pastor and Client

Christ has an unbroken relationship with His followers on earth, represented in

figure 1 by the solid lines (**a**), between Christ and the pastor, and Christ and the parishioner. The pastor's relationship with Christ, represented by the solid line (**b**), must also be unbroken. Maintaining a healthy, spiritually vibrant relationship with Christ is crucial to the pastor's effectiveness in ministry.

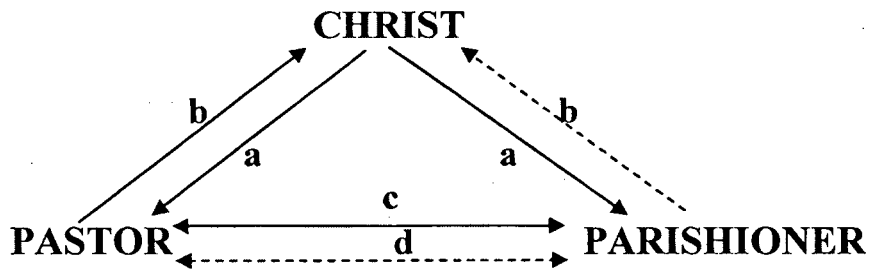

Figure1. The relationship triangle; the relationship between Christ and His followers.

Allen Groff suggests that: "Relationship is one of the most used words in counseling. So much, if not everything, hinges on relationships. To relate to others at an optimum level, the Christian counselor must maintain a personal, vibrant relationship with God. This is the central relationship that affects all others. This being true, the only way to stay free of a gnawing free-floating anxiety regarding one's own up-to-date relationship with God is to maintain an adequate devotional life."[1] Christians cannot build healthy horizontal relationships independent of a healthy vertical relationship.

Pastors must have an ongoing relationship with God through prayer, meditation, reading of Scriptures, and other resources that foster their dependence upon Christ. They

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[1]Marvin G. Gilbert and Raymond T. Brock, eds., *The Holy Spirit & Counseling: Theology and Theory* (Peabody, MA: Hendrickson Pub., 1985), 60.

must have experienced the healing grace of God and the forgiveness of sin. They must have both an understanding (heart work) and a knowledge (head work) of sin and of the redemptive acts of God through Christ.

A two-fold relationship exists when a pastor begins to counsel members of the congregation. There are two lines depicting this two-fold relationship (Figure 1, line **c** and **d**). The solid line (**c**) represents the existing relationship between the pastor as a shepherd and the parishioner as a sheep, a member of the congregation, the flock. The therapeutic relationship (counselor and client) shown as the broken line (**d**) is in the early stage of developing. This relationship must be developed into a solid working relationship represented (see Figure 2) by the solid line (**d**) before meaningful therapy can take place. It is developed through the pastor's ability to be: (1) genuine; (2) congruent; (3) compassionate; (4) empathetic; (5) a good listener; (6) a person of integrity; and (7) a person who can maintain confidentiality.

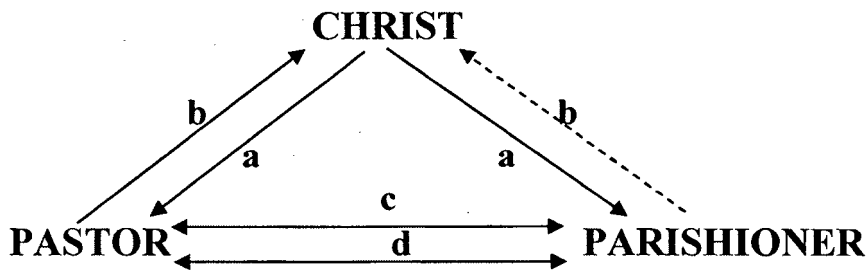

Figure 2. The relationship triangle; twofold relationship in counseling.

A level of trust between the pastor and the parishioner is necessary for effective positive change and is reflected by the solid line (Figure 2, **d**). Only after the pastor, in

the role as counselor, is able to genuinely connect on a therapeutic level with the parishioner can the work of reconnecting him/her to Christ begin. Pastors, however, have an advantage in that they already share a pastoral relationship that is rooted in Scripture and shored up by the beliefs of their faith (Figure 2, **c**).

Relationship between the Parishioner and Christ

Notice also in figure 2 that there is a broken line (**b**) between the parishioner and Christ. That line depicts interruption in the person's relationship with God. The A-B-C Theory of Personality approach[1] (see Training Manual in appendix F, page 342) is helpful to show the clients' present relationship with God or at least the distortion in their theological beliefs in the midst of a crisis. They have a negative experience, for example, a recent loss (activating event). This has caused their assumptions (beliefs) about God and/or His promises to be challenged. This in turn creates an emotional or behavioral crisis (consequence or reaction) in their theology. Such a case could be made for the believers in Thessalonica (1Thess 4:13-18). Believing that they would see the Coming of the Lord in their day, many of them became alarmed about the eternal salvation of their loved ones, who were dying (activating event). In the face of death, their misunderstanding about the resurrection caused them to rethink what they believed (beliefs) about the Second Coming. In turn, they began to act and feel different (consequence or reaction). Paul, with his *disputing intervention,* challenged their

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[1]Gerald Corey, *Case Approach to Counseling and Psychotherapy* (Albany, NY: Books/Cole Pub. Co., 1996), 322.

thinking as being "uninformed" (1Thess 4:13-17). He then assured them that their loved ones will see and live with Christ (new and effective rational philosophy). He concludes by telling them to "comfort one another with these words" (4:18). Paul, in essence, was saying "comfort one another" by helping each other to think differently about the Resurrection and Second Coming of Jesus Christ.

The Pastor's Relationship with Client as a Model for Reconciliation

To help the counselees/parishioners reexamine their understanding of the will of God during their present trouble, the pastor must model a trusting relationship with Christ (figure 3, line **b**). The pastor's life and actions must say "be imitators of me, just as I also am of Christ" (1 Cor 11:11). "In counseling as in any other relationship, we must remember that our impact and influence in people's lives is usually related to their perception of us. That is why involvement is so important to the counseling process. Usually, the counseling process is truly effective only when an acceptable level of involvement has been established."[1] Therefore, pastors' lives must, among other things, be congruent. There must be integration between what is said and how the life is lived. Pastors must be respectful of the counseling process and the shared journey. They must know the difference between sympathy and empathy and the appropriateness of those feelings. Both are needed in counseling, but when and under what circumstances are important to the integrity of the therapeutic experience.

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[1]MacArthur, 175.

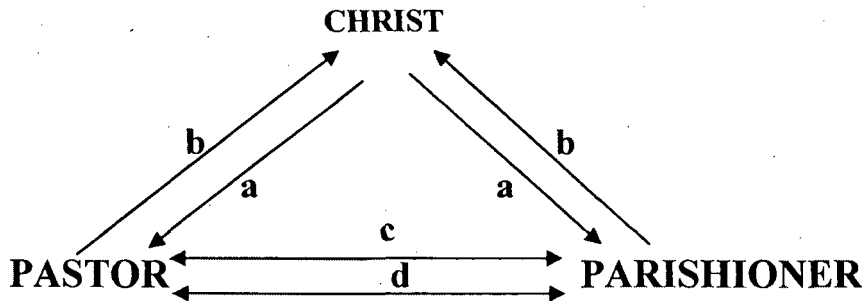

Figure 3. The relationship triangle; the relationship between the parishioner and Christ.

Line **b** in figure 3 shows the reconciliation and reaffirmation of theological beliefs about God and Christ on the part of the parishioner. Using Scriptures as a base for healing and learning, pastors challenge the assumptions of the members in therapy. The Apostle Paul instructs us in his letter to Timothy, ". . . that the sacred writings . . . are able to give you [us] the wisdom that leads to salvation through faith which is in Christ Jesus. All Scripture is inspired by God and is profitable for teaching, for reproof, for correction, for training in righteousness; so that the man [person] of God may be adequate, equipped for every good work" (2 Tim 3:15-17). One of the goals of counseling is the growth of the client's understanding of salvation. One of the two characteristics of the Scripture cited above is that it has the power to make one wise about salvation. The other is that it is profitable [useful] for teaching, reproof [conviction], correction, and training in righteousness.

The order of the four points of the Apostle's admonition is vital to counseling if one is to experience reconciliation with God. Jay Adams asserts that "attempting the disciplined training of a counselee before teaching him what he must do, or before he is

convicted that he should do it, or before he has corrected other erroneous and sinful ways, simply won't work. Moreover, there can be no conviction apart from teaching—one is convicted over against a standard. Similarly, correction is impossible for one who doesn't first know what is wrong."[1]

A Comparison of Biblical Counseling in Parish Ministry with Psychological Counseling

Similarities

The primary role of the therapist in psychological counseling is to help the person regain emotional wholeness or develop the necessary coping skills to function. In biblical counseling the primary role of the pastor is to help the parishioner achieve balance and spiritual wholeness and develop a trusting relationship with Christ. Some principles of psychological theories can be integrated into biblical counseling and vice versa. Both disciplines gather data on the person in counseling for the purpose of intervention. Both disciplines see the person as an individual. Both disciplines teach the counselee to abandon unhealthy behavior. Both disciplines believe that there is a causal effect for the counselee's unhealthy behavior or emotional disturbance.

Differences

Biblical counseling deals with the person as someone who is spiritually disconnected. The role of the pastor/counselor is to help the person connect or reconnect

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[1]Jay E. Adams, *How to Help People Change* (Grand Rapids, MI: Zondervan, 1986), 13-14.

with God, who is their only true source of help. Psychology deals with the person as someone who is emotionally incongruent. The role of the psychologist is to help the client gain or regain congruency between his/her inner and outer world. Pastors can and must at times initiate counseling. Psychologists do not and cannot initiate counseling. Pastoral counseling can take place in the home. Pruyser terms the traditional right of pastors to initiate contact and visit in the homes of the parishioners as "the pastoral right of initiative and access."[1] Psychological counseling always takes place in an office. Pastors in parish ministry do not charge a fee for their service. Psychologists charge a fee for their service. Biblical counseling sees the parishioner as integrated: body, soul, and spirit. Some secular psychologists do not advocate a divine origin, while others acknowledge the possibility of a divine origin. Biblical counseling advocates a divine origin (God). Secular psychology advocates an evolutionary origin. Biblical counseling advocates that the ability to change and heal comes from an ongoing relationship with Christ. Psychology advocates to a large degree that the client's ability to change and heal comes from within him/herself.

Using the Five Theories and Biblical Counseling to Do an Assessment

I will make a brief assessment of Jeanine's presenting problem using the five theories and the biblical counseling model presented in the training program. (See training program in appendix F and vignette in appendix G.) This will not be exhaustive but a brief summation from each approach.

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[1]Pruyser, 25.

In the **psychoanalytical model** Jeanine's defense mechanism is addressed. The therapist will look at how her unconscious messages are helping her in coping and functioning. The psychologist would also pay attention to how her id, ego, and super-ego are working. Transference would be encouraged as a method of having her deal with her feelings towards her husband.

In the **cognitive model** Jeanine will be encouraged to accept herself and not dwell on negative thinking. Jeanine would be told that she has the ability for self-talking, self-evaluating, and self-sustaining, and that blaming is at the core of our negative thinking. Rational emotive behavior therapy (REBT) would be employed to help Jeanine tap into her potential for rational or straight thinking.

In the **behavioral model** Jeanine will be encouraged to act rather than reflect passively and introspect at length on her problem. She will be helped to take specific actions to change her life. She will be shown how stimulus events are mediated by cognitive processes and private or subjective meanings. The emphasis will be placed on her taking responsibility for her behavior.

The **person-centered** therapist would enter into a shared journey with Jeanine and help her to accept herself as trustworthy and resourceful. They both would reveal their humanness and participate in a growth experience where the therapist acts as guide. She will be encouraged to more fully encounter reality. Believing that Jeanine can do her own work in a safe, caring environment, the therapist would show genuineness, unconditional positive regard and accurate empathy towards her.

In the **family systems** approach Jeanine would be recognized as connected to a

living system and that change in one part of the unit will reverberate throughout the other parts of the system. The Bowenian approach would look at the family multi-generationally. The therapist would go back at least three generations. A genogram of the family would be developed looking at her family across the generations. The therapist would look at how Jeanine differentiates herself from the family. Also the therapist would look for any triangulation that may exist. If Jack, the husband, would come to therapy, they would be treated as a dyad.

In **biblical counseling** the pastor sees the parishioner as an individual who is valued and loved by God. The pastor enters into the counseling relationship as: (1) guide; (2) counselor; (3) teacher; (4) diagnostician, and (5) reconciler. The pastor helps the parishioner explore his/her understanding of God and His acts in salvation history. The pastor uses the Bible to: (1) teach; (2) reprove; (3) correct; and (4) train in righteousness. The pastor acts as a moral guide for the counselee. The pastor teaches dependence on God as the source of healing and restoration. The pastor must experience the grace of God and the forgiveness of sin. He/she must develop and maintain an unbroken relationship with Christ. Biblical counseling is a shared journey between the pastor and the parishioner. It is a dual relationship in which the pastor is shepherd and counselor.

Pastoral Diagnosis

Pastoral diagnosis is the ability of the pastor to define and determine what the spiritual needs of the person in counseling are. It is done to decide what would be the

most appropriate biblically based intervention. Pruyser describes diagnosis as "grasping things as they really are, so as to do the right thing,"[1] The heart of pastoral counseling is helping the person in counseling gain the necessary resources for coping through a trusting relationship with Christ. Thus pastors must use the biblical narratives and theological language in their assessment and description of the problem. Pruyser noted:

> Would he [the counselor] not like to know beforehand, prior to unleashing his therapeutic furor, something about the person's religious situation–his state of grace, his despair, his deep shaken loyalty, his tenets of disbeliefs [Sic], his grounds for hope, if any, his rebelliousness or his tendency to deny any responsibility for himself by the pious sheep talk of the Twenty-third Psalm?[2]

The pastoral counselor must diagnose, not for the purpose of labeling but for scriptural application. Pruyser warns against authoritarianism in pastoral diagnosis. "Granted that some theological diagnoses in the past have amounted to authoritarian dispositions over the very lives of men, this aberration does not invalidate the idea of making theological judgments in the pastoral assessment of anyone's condition."[3] The pastor should use the experiences of the Bible characters when applicable as an aid in understanding the needs and functioning of the parishioners in counseling.

Jesus used a diagnostic approach at times in His discourse with individuals. Nicodemus, a member of the Pharisees, came to Jesus and began his conversation by affirming Jesus' credentials as from God. Jesus diagnosed him as needing to be born

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[1]Ibid., 30.

[2]Ibid., 39.

[3]Ibid., 40.

again through the baptism of both water and spirit for entrance into the kingdom of God. According to the Bible, Jesus responds to Nicodemus before he could ask a question or complete his statement. Jesus' response does not come out of the dialogue. Usually diagnosis follows some sort of discourse between Jesus and the person. However, in the case of Nicodemus, Jesus seems to have interrupted his sentence. Jesus said, "Truly, Truly, I say to you, unless one is born again he cannot see the kingdom of God" (John 3:3 NASB). A possible conclusion is that Jesus' diagnosis of Nicodemus is the result of prior engagements and or encounters with him. There are times when the pastor, out of familiarity with and/or prior knowledge of his/her congregant, can determine a diagnosis early in the process. Other possible conclusions are (1) that the whole dialogue is not included, (2) that Jesus read Nicodemus through an innate supernatural insight, and (3) the Holy Spirit gave Jesus the insight on him.

On another occasion Jesus diagnosed the spiritual condition of the Samaritan woman at Jacob's well in the city of Sychar. He diagnosed the woman who came to draw water as in need of living water while telling her of her morally questionable life (John 4:1-26). Jesus, lamenting over the nation of Israel, diagnosed them as a stubborn and obstinate people whose house is left desolate (Matt 23:37). Stubborn and stiff-necked is commonly employed language by God in His description of Israel. Paul in his second letter to Timothy warned him of the difficult times to come and the types of people who will be present. According to Paul they will be

> lovers of self (narcissists), lovers of money (greedy), boastful, arrogant (pride and self-centeredness), revilers, disobedient to parents (rebellious), ungrateful, unholy, unloving, irreconcilable (recalcitrant), malicious gossips, without self-control

> (impulse driven), brutal (anti-social personality), haters of good, treacherous, reckless, conceited, loves of pleasure (hedonism) rather than lovers of God, holding a form of godliness, although they have denied its power. (2 Tim 3:1-5 NASB), (additions mine).

Using Jeanine's case as an example, see appendix F, a pastor can diagnose her presenting problem from a biblical standpoint. Some of the things the pastor may have to deal with are: adultery, anger, anxiety, childhood memories, cultural taboos, death, depression, divorce, fear, forgiveness, gossip, and separation. At some point the counseling session may be about her being on powerful anti-AIDS drugs and her body's response to the medication. If the doctors are not very hopeful and death becomes a high possibility, issues about salvation, the children's well-being, and planning for death must be looked at. Funeral arrangements may also be a topic of discussion. At some point in the therapy, Jeanine's anger may be directed towards God because He did not spare her this dreadful disease. Jeremiah's anguish towards God (Lam 3:1-18) would be a good starting point in helping validate her feelings as she works through them with the pastor. The pastor may have to initiate some of these topics in the form of a gentle question such as, "This is or may be extremely difficult for you to deal with and I would understand if you are not ready to talk about it but have you thought of . . .?" All the aforementioned topics can be discussed using the Bible as the therapeutic tool.

During the therapeutic sessions, the pastor should be doing self-examination (self-diagnosis) for the purpose of maintaining integrity and avoiding counter-transference. Pastors must be aware of any inner pulls and contradictions in the counseling process and define them scripturally. For example, during the counseling the counselor may discover

that his/her thoughts and feelings can come under a specific Scriptural admonition. While this list is not meant to be exhaustive, here are some of the names given to our behaviors: adultery, anger, fornication, gossip, greed, guilt, hatred, haughty eyes, idolatry, incest, lust, lying, malice, murder, pride, rape, shame, stubbornness, theft, unforgiveness, unrighteousness, and wickedness. The pastor's past may be mirrored in the presenting problem. He or she may have been a victim of the same offenses presented by the parishioner during the counseling. The pastor may have perpetrated some of the offenses the client is struggling with, in the past, or may be in bondage to them in the present. The pastor may have close ties with someone who has or is experiencing some of the same challenges facing the person in counseling. The pastor's unregenerate spirit could have him/her desiring or reaching out to the person in counseling to fill the desired need in the client or his/her unmet needs. If any of the above mentioned experiences is hindering the pastor's ability to do effective client-centered counseling, he/she is ethically bound to refer the person and seek counseling as quickly as possible.

Spiritual Assessment

Part of pastoral counseling is assessment. George Fitchett uses assessment and diagnosis interchangeably. He defines assessment as "a statement of a perception and a process of information gathering and interpreting."[1] Among mental health professionals the two terms are use separately. Assessment is the distinction given to the informational gathering and interpreting process phase of counseling. That then leads to the diagnostic

[1]Fitchett, 17.

phase. Diagnosis is the labeling or naming of the disease for the purpose of intervention. As part of pastoral counseling, pastors must be prepared to do a spiritual assessment on the person(s) needing help. A spiritual assessment must, therefore, look at the counselee's understanding of life as it pertains to the sacred. It looks at how people integrate their spiritual life and understanding into their psychosocial functions. The assessment can, but does not have to, be completed at the intake interview. More likely, the assessment should be a joint ongoing activity between the pastor and parishioner in counseling. Therefore, there is the early stage of assessment and the late stage. It does not represent the pastor's conclusive feelings about the person(s) coming for counseling. However, the pastor's perceptions and feelings of the client are part of the assessment. The assessment is a process undertaken to better understand the client by evaluating all the relevant factors in his/her life for the purpose of making a diagnosis and determining the appropriate treatment plan. What the person knows about himself/herself or the way he/she interprets life is part of the assessment. It is an interactive and shared experience between the pastor and the parishioner in counseling. Fitchett and his study group have come up with a model called "a functional, multidimensional model or (the 7 x 7 model)" for short.[1] It is so named because the model looks at seven holistic dimensions and seven spiritual dimensions of assessment (see table 1).

Each of these dimensions is a window through which the pastor catches a view of the inner-workings of the person's life and how it contributes to the person's problem(s)

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[1]Ibid., 39.

or supports his/her growth. Any discovery for service from the holistic side of the 7x7 model will likely be cause for referral. The pastor is more adequately trained to work with the person in need of help from discovery made on the spiritual dimension side of the model. However, all discoveries help to inform the pastor's thinking, diagnosis, and the appropriate intervention.

TABLE 1

THE 7x7 MODEL FOR SPIRITUAL ASSESSMENT

Holistic Dimensions	**The Spiritual Dimensions**
Medical Dimension	Beliefs and meaning
Psychological Dimension	Vocation and Consequences
Psychosocial Dimension	Experience and Emotion
Family System Dimension	Courage and growth
Ethnic and Cultural Dimension	Ritual and practice
Societal Issues Dimension	Community
Spiritual Dimension	Authority and Guidance

George Fitchett, *Assessing Spiritual Needs*: A Guide for Caregivers (Minneapolis, MN: Augsburg Fortress, 1993), 42.

Referral

All pastoral counseling in parish ministry should be brief. The busy schedule of the pastor demands that he/she be prepared to refer the people who come for counseling after three to five sessions. There are times when the engagement between the pastor and parishioner would be brief. The person may just want someone to listen, be supportive, and give some advice and/or encouragement. That can be accomplished in probably

three or fewer sessions. Referral is not to be viewed as an admission of failure on the part of the pastor. Rather, it allows the pastor to involve a greater number of helping professionals and other community-based organizations so as to become part of a helping/healing team. Referral is one of the most effective tools and loving acts a caring pastor can perform for his/her client. This is especially true when the pastor realizes that the client's needs are outside his/her expertise or availability of time. Referral is very much a part of pastoral counseling and at times can be the outcome of pastoral diagnosis. Clinebell believes that "pastors should begin to prepare themselves for an effective referral ministry soon after arriving in a new parish."[1] Clinebell identifies ten types of persons the pastors should refer—thus widening the support team:

> (1) Those who can be helped more effectively by someone else; (2) those with problems for which effective specialized agencies are available in the community; (3) those who do not begin to use pastoral help in four or five sessions; (4) those who needs obviously surpass the minister's time and/or training; (5) those with severe chronic financial needs. Public welfare agencies with trained social workers are appropriate referrals; (6) those who need medical care and/or institutionalization; (7) those who need intense psychotherapy; (8) those about the nature of whose problem one is in doubt; (9) those who are severely depressed and/or suicidal; (10) those to whom the minister has a strong negative reaction or intense sexual attraction.[2]

The pastoral role in contemporary society is an ever-demanding one. It is multifaceted. And based on the current trend of public funding cutbacks for social services, the demands for pastoral services in the area of counseling will increase. There will be fewer funds available to send individuals to mental health professionals. The

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[1]Clinebell, 314.

[2]Ibid., 312.

pastor, as a free counseling resource, will be in greater demand. Speaking to this societal demand, Miller and Jackson write:

> Members of the clergy are called upon to play many roles in modern society—to be priest and prophet, administrator and pastor. Within each of these are many specific and demanding areas of expertise. One pastoral role ever in demand is that of the counselor, the one to whom a person turns at life's moments of distress, despair, and decision.[1]

Pastors should pay careful attention to any medical history the person shares and psychological behavior that are bizarre or would be considered abnormal by the general population. If the person has not had a medical checkup recently, the counselor should encourage the person to get one before the next visit.

The pastor should develop some guidelines for effective referral counseling. Clinebell suggested nine. They are:

> (1) Create this expectation; (2) mention the possibility of referral early in counseling relationships where it is likely to occur, explain why specialized help may be needed; (3) start where persons are in their perceptions of their problems and the kind of help needed; (4) work to bring counselees' perceptions of their problem and their solutions close enough to the counselor's perceptions to permit referrals to take; (5) help counselees resolve their emotional resistance to the particular helping person or agency recommended; (6) interpret the general nature of the help that persons may expect to receive, relating it to their own sense of need; (7) establish strong enough rapport with persons to develop a bridge over which they may walk into another helping relationship; (8) encourage referred persons to really try a given therapist or agency, even if they are only mildly willing; and (9) let persons know that one's pastoral care and concern will continue after the referral.[2]

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[1]Miller and Jackson, 1.

[2]Clinebell, 316-319.

The Pastor as Part of a Multidisciplinary Team

Another guideline for referral that Clinebell did not mention but I believe is necessary is, whenever possible, for pastors to work concurrently and collaboratively with another agency or helping professional in providing concurrent care to the person. This is especially helpful when the client's needs are both medical and spiritual or psychological and spiritual. The pastoral counselor should be prepared to make some general diagnoses. For example, the pastor should inquire about the person's medical history and based on the response draw inferences about the person's medical condition which can be confirmed or corrected after a medical examination by a physician. There need to gender sensitivity and questions framed in a way as to not make a person feel invaded or violated. The same can be done for a psychological diagnosis that is confirmed or corrected by a mental health professional. The idea is for the pastor to rule out any medical or psychological factor or impairment that might be contributing to the person's presenting problem or present concerns. Once the matters of physical and psychological diagnoses are settled, the pastor can then make a spiritual diagnosis. This will be his/her primary area of focus in working with the client.

Competency

Competence in counseling is the pastor's ability to journey with the person in therapy through a difficult period in life by knowing and providing the appropriate resource for his/her healing and restored dependency on Christ. Pastors must not counsel beyond their level of training and expertise. They must not continue to provide

counseling when the parishioners' issues are mirroring current or unfinished problems in their lives. The pastor should, when possible, get the necessary training in the counseling art so as not to do harm. The pastor should, when possible, develop the skills to diagnose the problem so as to be able to provide the necessary intervention. Sometimes the right intervention is a referral to some person or agency whose expertise will be most helpful to the person in need. Above all, the best care for spiritual and emotional wholeness for the parishioner should be the guiding principle in the mind of the pastor.

What Is Being Asked of Me?

The pastor by vocation is called to provide guidance to the family (here referred to as a system) through religious teachings, worship, general pastoral care, and pastoral counseling. Therefore the pastor must be aware of his/her role and responsibility not only to the person in the other chair, but also to the larger system of which he/she is a part. Failure on the part of the pastor to have a clear understanding of what is being asked of him/her in counseling is to create an environment for much harm to the people in counseling and to the process itself. If the pastor cannot make an accurate diagnosis because he/she for whatever reason is unable to be actively engaged in the therapeutic process, the client can become frustrated. The client can experience setbacks in his/her progress towards wholesomeness and the counseling process in this particular case.

The system, however, should not be maintained at the expense of the individuals in pain within that system. For example, the pastor in the role of providing either pastoral care or counseling should not ignore the abusive behavior by a member of that family

system. The pastor should also not subtly or overtly use Scripture or his/her pastoral presence or influence to encourage a member of an abusive system to stay in it in while the abuse is ongoing. The pastor needs to understand both the socio-systems and the individuals who are being influenced by them. To do so, Browning developed what he calls "the four steps of practical theological action." They are: "(1) Experiencing and defining the problem; (2) attention, listening and understanding; (3) critical analysis and comparison; and (4) decision and strategy."[1]

These four stages in the pastoral counseling experience must take place by the third session. At step 3 above, during the pastoral dialogue with the parishioner, the pastor must process the information through what Browning calls "the five levels of practical moral thinking," especially when faced with a moral issue. These are:

> (1) The metaphorical level: What kind of world or universe constitutes the ultimate context of our action; (2) the obligational level: What are we obligated to do; (3) a tendency-need level: Which of all our human tendencies and needs are morally justified in satisfying; (4) a contextual-predictive level: What is the immediate context of our action and the various factors which condition it; (5) a role-rule level: What specific roles, rules, and processes of communication should we follow in order to accomplish our moral ends?[2]

There are two things the pastor must be aware of at the outset of counseling: (1) He/she is capable of doing harm; and (2) the pastor is a person with a history. The pastor brings his/her historical, cultural and family-of-origin self into the counseling experience. He or she is neither value-neutral nor unbiased. A person's life experiences are what help

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[1]Browning, 100.

[2]Ibid., 53-55.

shape his/her life. These life experiences can get in the way of effective therapy. The pastor must take all necessary steps to ensure that that does not happen.

Case/Client's History

I use the words *case history* and *client's history* interchangeably and make no distinction between the two. Intake differs from case history. Intake occurs at the initial session. It is data gathering from the client about him/herself. It could vary from a simple form that informs the counselor about the client with some basic history, to much more in-depth knowledge about the client. Case history is all the relevant information gathered on the person in counseling that helps the counselor get a better understanding of the counselee. It is a composite of the information gathered in the intake interview and assessment of the person. It takes into account, among other data, the person's age, gender, race, marital status, medical history, psychosocial history, mental health history (if applicable), religious affiliations, sexual orientation, family of origin, educational, and professional/vocational background. If a genogram is done on the person it also becomes part of the case/client's history. The case history helps to determine the strengths, weaknesses, and resources of the person. It looks at the coping and behavior patterns of the person in counseling.

Using the client's history, the pastor can clarify the presenting problem, and determine if there are other mitigating problems that warrant investigation and discussion. The case history helps the pastor recognize his/her legal, moral, and ethical obligations. It also helps pastors determine if they have the expertise and time to address

the client's needs. The client's history helps to determine the diagnosis and the necessary intervention strategies. The diagnosis will be made and intervention strategies will be determined between the first and third session. The pastor should always attempt to make dual diagnoses in counseling. The first should be to determine if the client has a need that is outside of his/her area of expertise. The pastor should be asking him/herself, Are there any medical or mental health issues that need to be addressed? The second diagnosis should be to determine how the person's presenting problem is affecting his/her relationship with God. Both diagnoses should be the result of a careful analysis of the client's history from the intake form and the pastor's assessment of the parishioner.

CHAPTER 5

A THEOLOGICAL FOUNDATION FOR PASTORAL DIAGNOSIS

In this chapter the shepherd language in parts of the Old and New Testaments is examined. In the Old Testament, God is referred to as the Shepherd of Israel (Ps 80:1). The kings were referred to as shepherds (Eze 34:23). The Nation of Israel as the people of God flourished under God-fearing leaders and was decimated under ungodly leaders (2 Chro 14 compared with 13). Christ used the title in the Gospel narratives in reference to Himself, and metaphorically in reference to the judgment and of the Jewish leaders (John 10:1-14). The Apostle Peter used the terms shepherd, Chief Shepherd, and undershepherd when writing to the leaders of the newly-founded fledgling church that was scattered abroad (1 Peter 5:4; 2:25). I will look at instances where both Jesus and Ellen White used a diagnostic approach in addressing both spiritual and physical concerns of individuals.

The Shepherd Motifs

In the Old Testament: Ps 23, the Shepherd Psalm

The Lord is my shepherd, I shall not want.
He makes me lie down in green pastures;
He leads me beside still waters. He restores my soul;

He guides me in paths of righteousness for His name sake.
Even though I walk through the valley of the shadow of death,
I fear no evil, for You are with me; Your rod and staff, they comfort me.
You prepare a table before me in the presence of my enemies;
You have anointed my head with oil; my cup overflows.
Surely goodness and lovingkindness will follow me all the days of my life,
And I shall dwell in the house of the Lord forever.

This metaphorical and sublime expression of the shepherd-king has inspired, awed, and comforted Christians throughout history. It is the most concise and graphic portrayal of the pastoral/shepherd life to be found anywhere in Scriptures. Its sublimity lies in the personal nature of the psalm. This psalm immediately becomes the personal pronouncement and internal reality of every reciter. Peter Craigie in his commentary on Ps 23 writes:

> The distinctiveness in the opening words of this psalm lies in the use of the pronoun, *my* shepherd; the shepherd theme, traditionally interpreted communally of the "flock" (or nation), is here given its most personal interpretation in the entire biblical tradition. (Even if the use of "I/my" was intended, or later interpreted, in a communal sense, the implications of a personal association with the shepherd remain.)[1]

Designating God as Shepherd is not novel to the cantor of Ps 23. More than nine hundred years earlier, Jacob (b. 2006 BC– d.1859 BC)[2] upon his death bed blessed his twelve sons and two grandsons. While pronouncing a blessing upon Joseph, Jacob referred to God as the "Shepherd," the "Stone of Israel" (Gen 49:24). Moses in his benediction on behalf of Israel likened them to sheep (Num 27:17); and prayed that the

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[1]Peter C. Craigie, *Psalms*, Word Biblical Commentary, vol. 19 (Dallas, TX: Word Books, 1998), 206.

[2]Kenneth Barker, ed., "Old Testament Chronology," plate 1, *Zondervan NASB Study Bible* (Grand Rapids, MI: Zondervan, 1999), n.p.

Lord will not let them be without a leader so that they "will not be like sheep without a shepherd" (Num 27:17).

The Patriarchs Abraham, Isaac, and Jacob were recognized leaders both by God and the nations around them, and they were also shepherds. Moses was a shepherd over the flock of Jethro, his father in-law, for forty years before being called by God to liberate the Children of Israel from Egypt's bondage and shepherd them in the wilderness on the way to Mount Sinai and onward to the boarders of Canaan. David was a shepherd over his father Jesse's flock. In response to Samuel's inquiry as to whether or not there were more children, Jesse said "There remains yet the youngest, and behold, he is tending the sheep" (1 Sam 16:11). In their lives as shepherds both Moses and David were being prepared by Jehovah to lead, and *shepherd,* the Children of Israel. They both learned invaluable lessons of patience and tender care. They honed their ability to study and discern character traits in people by sheep tending. They learned how to be watchful and protective of those in their care. But most of all they learn how to trust and depend on someone greater than themselves. Of Moses Ellen White writes:

> Moses was not prepared for his great work. He had yet to learn the same lesson of faith that Abraham and Jacob had been taught not to rely upon human strength or wisdom, but upon the power of God for the fulfillment of His promises. And there were other lessons that, amid the solitude of the mountains, Moses was to receive. In the school of self-denial and hardship he was to learn patience, to temper his passions. Before he could govern wisely, he must be trained to obey. His own heart must be fully in harmony with God before he could teach the knowledge of His will to Israel. By his own experience he must be prepared to exercise a fatherly care over all who needed his help. Man would have dispensed with that long period of toil and obscurity, deeming it a great loss of time. But Infinite Wisdom called him who was to become the leader of his people to spend forty years in the humble work of a shepherd. The habits of caretaking, of self-forgetfulness and tender solicitude for his flock, thus developed, would prepare him to become the compassionate,

longsuffering shepherd of Israel.[1]

Exod 32 and 33 record a dialogue between God and Moses regarding the fate of Israel after their making of and worshiping the golden calf. God told Moses He will keep His promise to Abraham, Isaac, and Jacob to cause their descendants to live in a land flowing with milk and honey, but He Himself "will not go up in your midst because you are an obstinate people, and I might destroy you on the way" (Exod 33:3). Moses' passionate plea for the people comes in vss. 12-16. His response to God is in brevity a recounting of his call to be the leader of the Exodus Movement, and to whom the descendants of Abraham, Isaac, and Jacob really belong. Moses implied that God had both a moral obligation and a covenant promise to uphold. He closed his discourse with God by posing a moral question. He asked, "For how then can it be known that I have found favor in your sight, I and Your people? Is it not by your going with us, so that we, I and Your people, may be distinguished from all the other people who are upon the face of the earth?" (Exod 33:16).

His advocacy for Israel mirrors that of Jesus' in John 17 for His disciples and those who will believe on Him after them. John 17 is known as the High Priestly prayer of Jesus. Both Moses and Christ reminded God (although it was not necessary, for God keeps His promises) that the people He put in their charge are to be protected and cared for by Him. They both informed God that they kept their charge as shepherd of His flock. They both asked for a cleansing of the people in their charge by God. Moses

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[1]White, *Patriarchs and Prophets*, 247-248.

wanted them to be forgiven and kept in God's favor. Jesus wanted them to be sanctified by the word of God which is truth and that they might be kept by God from the evil one. Moses identified with the people of Israel and was willing to suffer their fate. He also asked that God might stay in their midst, be one with His people. Jesus identifies Himself with His followers by His very name, "Immanuel, which means 'God with us'" (Matt 1:23). He suffered their fate, (see Isa 53). He asked that they share in His glory of oneness with the Father and be where the Father is. Both Moses and Christ spoke of the glory of God. Moses asked that he might see God's glory (Exod 33:18). Jesus requested that the Father might glorify the Son so that the Son may glorify the Father (John 17:1).

David in obedience to his father went to take food to his brothers who were fighting in King Saul's army against the Philistines. While there, Goliath of Gath, the Philistine's champion, challenged Israel to send a warrior to meet him on the field of battle. None among the Israelite soldiers answered the challenge. Upon entering the camp, David heard Goliath's insults hurled against his countrymen. After some inquiry as to the rewards for the one who fights the challenger, he accepted the challenge. His courage and desire were made known to King Saul. Saul out of concern for David asked how, he being a youth, hoped to engage a seasoned warrior. David's reply demonstrated his steadfast confidence in Jehovah, Israel's true Shepherd. He said, "The Lord who delivered me from the paw of the lion and from the paw of the bear, He will deliver me from the hand of this Philistine" (1 Sam 17:37). David's, Moses', and Jesus' words underscore their belief of the shepherd's responsibility, and that is to protect and preserve the flock and, in so doing, the name and honor of God. Through his encounters with the

predators of the wild, David had learned lessons that would prepare him for service as God's anointed shepherd, the king, over the people of God. Ellen White states that "God was teaching David lessons of trust. As Moses was trained for his work, so the Lord was fitting the son of Jesse to become the guide of His chosen people. In his watch-care for his flocks, he was gaining an appreciation of the care that the Great Shepherd has for the sheep of His pasture."[1]

The idea and imagery of Israel's leader as shepherd did not start with the ushering in of a monarchy by God when they desired a king like the nations around them. From the call of Abraham, in 2091 BC,[2] by God to leave Mesopotamia, today's Iraq, and go to Canaan, to the anointing of Saul in 1050 BC,[3] as Israel's first king, the people of God were under a theocratic rule. Yahweh was their King and Shepherd. Through all their desert wanderings and conflicts in the wilderness and with the nations around them, the patriarchs experienced God's great interventions. "The God of Israel stands apart from all the supposed gods of other nations in that He reveals Himself in human history by His deeds."[4] God was to them among His many other names, *El Elyon, El Shaddai, Jehovah-Jireh* and *Jehovah Rohi,* "God Most High," "God Almighty," the "One who provides," and "The Lord is my Shepherd." Jacob, then Israel, placed his hands on the

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[1]Ibid., 644.

[2] Barker, plate 1.

[3] Ibid.

[4]Kenneth S. Hemphill, *The Names of God* (Nashville, TN: Broadman & Holman, 2001), 36.

heads of the sons of Joseph and, invoking the blessings, began by saying, "The God before whom my fathers Abraham and Isaac walked, the God who has been my shepherd all my life to this day . . ." (Gen 48:15).

Shepherd as a Metaphor for Kings and Rulers

"Throughout the ancient Near East the name Shepherd is a commonly used metaphor for kings."[1]

> The shepherds are native kings and rulers, as often in ancient literature, both Eastern and Western, e.g. the Akk. Reu='shepherd regent' (a ptcp., as in Hebr.), Homer Od. iv. 532 [Agamemnona Poimena Laon], and often, Dante Par. xxvii. 5f., Milton Lycidas 114ff.; so Moses [Is. 63:11], David [Ps. 78:1f.], Cyrus [Is 44:28], the Davidic prince infr. [v.23 37: 24]. In Jeremiah the figure is used most frequently of cruel and selfish rulers."[2]

In 2 Sam 5:2 the Elders of the tribes of Israel came to David at Hebron and recounted his anointing of God to "Shepherd" His people Israel. And through the prophet Nathan God told King David, "I took you from the pasture, from following sheep, to be the ruler over My people Israel" (2 Sam 7:8). Bruce Juhl writes:

> Thus is born the conceptual model of shepherd-king. The duties performed on behalf of woolly animals were now translated into a caring, compassionate, protective provider for a nation. Unfortunately, few kings measure up to the standards of a good shepherd in the dispatch of their realm. They forgot that they were under-shepherds, responsible to God for the care of His people. Some acted as if their authority was self-derived and their power unlimited with respect to managing the flock. Few measured up to the lofty ideals of the office of shepherd-king because they refused to

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[1]David L. Peterson, Commentary on 1 Kings 22: 13-28, the Lone voice of Micaiah, son of Imlah, *The New Interpreter's Bible*, Vol. 3. (Nashville: Abingdon Press, 1994), 164.

[2]G. A. Cooke, *The Book of Ezekiel,* The International Critical Commentary, (Edinburgh: T. & T. Clark, 1951), 373.

acknowledge the lord as their shepherd as King David so beautifully did in Ps 23.[1]

Israel's history is a tapestry of liberation and lamentation, of prosperity and impoverishment, of living under siege and living in safety as free people in their inherited land. Through many prophets God sought to counsel and guide His leaders and people. When the kings heeded the word of God and led the people in paths of righteousness, the nation flourished. More often than not, however, the kings were idolatrous and led or caused the people to go astray. The kings did not act as men appointed by God to shepherd His people judiciously and with a deep sense of reverence for Him. The rulers of Israel had become like their former captors, the Egyptians, in their treatment of their own people, the Children of Israel. They were responsible for the moral, spiritual, educational, and cultural well-being of their people. Rather, they more often than not treated their people as vassals. They showed little or no sympathy or concern for their well-being. In Ezek 34:4, God accuses the leaders of dominating the people/flock "with force and with severity." Commenting on this verse, G. A. Cooke says, "With rigour [severity] is connected with the harsh treatment of slaves, which may be alluded to here; in Ex 1:13-14 with the oppression of [Israel] in Egypt." Finally, Israel is again in captivity in a strange land, the land of Babylon. Almost twenty years earlier through the prophet Jeremiah God tried to keep His sheep/people from this calamity with a searing rebuke. Israel's leaders, their shepherds, will be brought to ruins. But in their destruction

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[1]Bruce Teel Juhl, "The Development and Implementation of Role Negotiation between the Pastor and the Members of the Anoka/Maple Plains, Minnesota Seventh-Day Adventist Multi-Church Parish" (D.Min. dissertation, Andrews University, 1990), 34.

the people will also be brought to ruins. There is a shared responsibility of not only the leaders to lead aright but the people for not desiring after God and thirsting for Him (Jer 16, see especially vss. 10-15).

Ezek 34 gives a scathing portrait, in metaphoric and prophetic language, of God's view of the leaders, how they discharge their duties, the consequences and how He is going to remedy the situation. Probably nowhere else in the Bible will one find such a rich gathering of diagnostic language as that found in Ezek 34. God does a diagnostic assessment both on the shepherds and on the sheep. In vss 2 and 3 the shepherds are diagnosed as self-serving, slothful, greedy, murderous, derelict of duty, abusive, and violent. In vs. 4 God diagnoses the people as sickly, diseased, broken, scattered, lost, abused, and neglected. Like Moses before and Jesus after, the shepherds were to give the people the words of the Lord, learn their characteristics, and know how best to attend their spiritual needs. Israel's kings were to help the prophets do spiritual diagnosis and provide pastoral care for the people of God. Although the nation was a monarchy, they were still under the dictates of God. The kings were viceroys. The prophets were God's *nabi*, His mouthpiece. They were to proclaim the word of God to His people including the kings. The wicked kings would not hear the words of the prophets nor heed the counsel of the Lord unless those words were favorable to them. Israel's history of her relationship between her prophets and kings tells a dark tale. It is one of prophets being killed and persecuted by the kings. Jesus in His lamentation over Jerusalem recounted her past by saying, "O Jerusalem, Jerusalem, who kills the prophets and stones those who are sent to her" (Matt 23:37; see also Heb 11:32-38).

The remedy is prescribed. Prescription follows diagnosis. God sees the treatment of His people by their kings and leaders. He hears their cries as He did in the days of their forefathers in Egypt, (see Exod 3:7), and again He will personally intervene and deliver them from the tyranny, (cf. Exod 3:8-9). The deliverance from Egypt was through Israel's first-appointed shepherd, Moses. The deliverance from the tyrannical shepherds has an eschatological significance. The shepherd whom God will appoint over them will be like David, Israel's first king who was after God's heart. The Messiah will be like David in function, service, surrender, and commitment to God. When Israel insisted on a monarchal rule contrary to the Prophet Samuel's opposition, God gave them one after their hearts, Saul. David, however, was after God's heart and so will be the future, God appointed king. G. A. Cooke writes:

> Not a David brought to life again, nor 'a king from his seed' (Rashi), for in 37:25 David is to be prince for ever; but an ideal ruler such as David was (He. Ezechielst. 123). The conception is treated more fully in 37:22-25, and goes back to Jer 23:5f. 30:9; Zech 11:16 is founded upon both. Kimhi agrees: 'David he said is the messiah who shall arise from his seed in the time of salvation.' The hope of a new and better type of king seems to have sprung up in the closing days of the monarchy, when in despair of the present men looked to the future for relief.[1]

Using the Scriptures to Do Diagnosis

If the pastors needed a theological mandate to do pastoral diagnosis they would find a foremost example in Ezek 34. To shepherd the people of God with a divine calling the pastors as counselors must diagnose the spiritual condition of those who seek their help. They must inform them of the prognoses with holy boldness mingled with

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[1]Cooke, 377.

compassion. Then using the scriptural narratives they must determine a treatment plan to remedy the problem. Only then can they escape the indictment set forth by God over the treatment of His people by them. Adam Clarke writes:

> No person is fit for the office of a shepherd who does not well understand the diseases to which the sheep are incident and the mode of cure. And is any man fit for the pastoral office, to be a shepherd of souls, who is not well acquainted with the disease of sin in all its varieties, and the remedy for this disease and the proper mode of administering it in those various cases? He who does not know Jesus Christ as his own Saviour [can] never recommend Him to others. He who is not saved will not save.[1]

The pastor's manual for spiritual diagnoses is the Bible. In the second letter to Timothy, Paul states that "all Scripture is inspired by God and is profitable for teaching, for reproof, for correction, for training in righteousness; so that the man of God may be adequate, equipped for every good work" (2Tim 3:16-17). I am not suggesting that the Bible be used on the order of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) to diagnose people on different axes. The Bible is not for codifying mental health problems, but it can be used by the pastoral practitioner to help people whose challenges in life interfere with their understanding of/or relationship with God. Adam Clarke listed a number of qualifications the True Shepherd must have.[2] Notice the

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[1]George Barlow, *Homiletic Commentary on the Book of the Prophet Ezekiel*, The Preacher's Complete Homiletic Commentary on the Old Testament (New York: Funk & Wagnalls, 1890), 360.

[2] "1. He knows the disease of sin and its consequences, for the Eternal Spirit, by whom he is called, has convinced him of sin, of righteousness, and of judgment. 2. He knows well the great remedy for this disease, the passion and sacrificial death of the Lord Jesus Christ. 3. He is skilful and knows how to apply this remedy. (1.) [*Sic*] The healthy and sound he knows how to keep in health, and cause them to grow in grace and in the knowledge of Jesus Christ. (2.) Those in a state of convalescence he knows how to

training and skills the pastor must acquire through training and connection with God before he can be an effective diagnostician. What follows is a clear understanding of the spiritual disease of the sheep and the remedy for restored health through a relationship with Christ.

In the New Testament: John 10:1-16, the Good Shepherd

> Truly, truly, I say to you, he who does not enter by the door into the fold of the sheep, but climb up some other way, he is a thief and a robber. But he who enters by the door is a shepherd of the sheep. To him the doorkeeper opens, and the sheep hear his voice, and he calls his own sheep by name and leads them out. When he puts forth all his own, he goes ahead of them, and the sheep follow them because they know his voice. A Stranger they would simply not follow, but will flee from him, because they do not know the voice of strangers. This figure of speech Jesus spoke to them, but they did not understand what those things were which He had been saying to them. So Jesus said to them again, truly, truly, I say to you, I am the door of the sheep. All who came before Me are thieves and robbers, but the sheep did not hear them. I am the door; if anyone enters through Me, he will be saved, and will go in and out and find pasture. The thief comes only to steal and kill and destroy; I came that they may have life, and have it more abundantly. I am the good shepherd; the good shepherd lays down His life for the sheep. He who is a hired hand, and not a shepherd, who is not the owner of the sheep sees the wolf coming, and leaves the

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cherish, feed, and care for, that they may be brought into a state of spiritual soundness. (3.) Those still under the whole power of the general disease, how to reprove, instruct, and awaken. (4.) Those dying in a state of spiritual weakness, how to find out and remove the cause. (5.) Those fallen into sin and sorely bruised and broken in their souls by that fall, how to restore. (6.) Those driven away by temptation and cruel usage, how to find out and turn aside the temptation and cruel usage. (7.) Those who have wandered from the flock, got into strange pastures, and are perverted by erroneous doctrines, how to seek and bring them back to the fold. (8.) Those among whom the wolf has got and scattered the flock, how to oppose, confront, and expel the wolf. He knows how to preach, explain, and defend the truth. He is well acquainted with the weapons he has to use, and the spirit in which he has to employ them. In a word the true shepherd gives up his life to the sheep, in their defense, and in laboring for their welfare. And while he is thus employed, it is the duty of the flock to feed and clothe him, and see that neither he nor his family lacks the necessaries and conveniences of life." Adam Clarke, "Ver:6. The Qualifications of the True Shepherd," in ibid.

> sheep and flees, and the wolf snatches them and scatters them. He flees because he is a hired hand and not concerned about the sheep. I am the good shepherd, and I know My own and My own know Me. Even as the Father knows Me and I know the Father; and I lay down My life for the sheep. I have other sheep, which is not of this fold; I must bring them also, and they will hear My voice; and they will become one flock with one shepherd.

John 10:1-16 is the Messianic fulfillment of Ezek 34:23-24. Jesus is the embodiment of God's promised shepherd, David, whom God will set over His sheep. David is God's viceroy, appointed and anointed by Him to keep a faithful charge over Israel, God's flock. The last part of John 10:9 echoes the promise in Ezek 34:13-15. Both speak of God's people finding pasture, "good" pasture. Through the prophet Ezekiel, God told Israel that His servant David, the one whom He has chosen to shepherd His people, "will feed them himself and be their shepherd" (Ezek 34:23). According to the Gospel of Luke, Jesus began His public ministry with a definition of His mission, His term in His earthly office as Israel's shepherd and mankind's promised Messiah. Reading from Isaiah's scroll, Jesus turned to what is known today in Christendom as chap. 61, and cites vss. 1-2a and applied them to Himself. He said, "The Spirit of the Lord is upon Me, because He anointed Me to preach the gospel to the poor. He has sent Me to proclaim release to the captive, and recovery of sight to the blind, to set free those who are oppressed, to proclaim the favorable year of the Lord" (Luke 4:18-19). Throughout the book of John, Jesus speaks of being "sent" by the Father: John 3:17; 5:36, 38; 6:29, 57; 7:24; 8:42; 10:36; and 11:42. Jesus uses the phrase six times in His priestly prayer hours before His death (John 17:3, 8, 18, 21, 23, and 25). He even closed His ministry, according to John's account, the way He began it, by heralding Himself as

the one "sent" by or from God (3:17 cf. 20:21). There seems to be a clear sense on the part of Christ of His Davidic function as Israel's promised shepherd.

Jesus in John 10:9 says that those who enter through Him "will go in and out and find pasture." The message here is that of sustenance and salvation. What keeps the sheep healthy is the ability to graze on nourishing succulent grass without fear of predators and while being free from parasites and infestations. On an earlier occasion, Jesus also told the crowd that He is the "Bread of life"; those who eat His flesh and drink His blood shall have eternal life (see John 6: 41-58). To be sure, the believer's food is none other than Jesus Himself. Not only does He, in fulfillment to Ezekiel's prophecy, feed the flock, the church, He is also the life-giving food for the flock. Through His life and death, He provides the nutrients—salvation—the flock/church needs to become healthy and be reproductive and to be re-produced into the righteousness of Christ.

John 10 also has an eschatological reality. Both John and Ezekiel alluded to migration in their shepherd narrative. In Ezekiel, God says that He "will bring them out from the peoples and gather them from the countries and bring them to their own land" (Ezek 34:13). In the Gospel of John, Jesus declares, "I am the door; if anyone enters through Me, he will be saved, and will go in and out and find pasture" (John 10:9). In Ezekiel the "good pasture" is metaphorical for Israel's restoration to her inherited land. This restoration, however, takes on an eschatological meaning in the life of Christ. The Good Shepherd, through His death, comes to restore to the people of God what was lost in Adam: "For as in Adam all die, even so also in Christ all will be made alive" (1 Cor 15:22). Adam through disobedience was cast out from his garden home. Jesus through

His obedience has secured a place for the obedient children of Adam. He can, by the authority of His substitutionary death, promise that He is going ahead to "prepare a place for you and if I go and prepare a place for you I will come again and receive you to Myself, that where I am, there you may be also" (John 14:2-3). Commenting on the timing of the good shepherd discourse by Jesus, Witherington writes:

> If this message was delivered at a Feast of Dedication, it would have had a peculiarly appropriate character. In the midst of celebrating the military victory of the Maccabees and the recovery of the holy City, Jesus delivers a discourse indicating that the true leadership does indeed mean laying down one's life for the sheep, as some of the Maccabees had in fact done. Only now, instead of many heroic shepherds, Jesus spoke of only one true shepherd for God's people; and when he speaks of his death, he is talking about not only a martyr's self-sacrificing act but a death that amounts to both the lifting up of the Son and his return to glory from whence he came.[1]

In John 10:9, "finding pasture" is also a metaphor for God's people's eternal salvation. They find or rather receive salvation through Jesus Christ. The sheep' spiritual, physical, and emotional conditions are the result of sin, disobedience, and lack of care on their own part and that of their unfaithful leaders. Israel's leaders in the time of Christ were described by Him as thieves and robbers (John 10:8). They were shysters, like the wicked, kings who preceded them. Not all the kings were wicked but those who were cared more about themselves than the people they were appointed to guide and govern. God referred to those who were not faithful in their duties to Him as "false shepherds." Israel's monarchal history is replete with ascensions to the throne by way of murder, treachery, and intrigue.

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[1]Witherington III, Ben. *John's Wisdom: A Commentary on the Fourth Gospel* (Louisville, KY: Westminster John Knox Press, 1995), 187.

The Hirelings

In the New Testament, Jesus referred to the leaders of His day as a hireling or a hired hand: *misthotos* is the Greek rendering. *Misthotos* is one who is hired. He has no vested interest in his duties and is therefore unfaithful in the discharge of his responsibilities. He is not dependable and as a result he causes more harm than good. On one occasion Jesus was reclining at the table of a Pharisee who had invited Him to lunch, without first washing His hands. The Pharisee was surprised by this behavior. Jesus seized upon the opportunity and said, "Now you Pharisees clean the outside of the cup and of the platter; but inside of you are full of robbery and wickedness" (Luke 11:39) or "self-indulgence" (Matt 23:25). Here He diagnosed the leaders as "full of robbery and wickedness." In the parable found in John 10:1-16, the hirelings could be diagnosed as frightful, derelict, and lacking concern for those in their charge. Jesus says that they see the wolf and abandon the sheep to the onslaught of the predator. The Good Shepherd (owner) on the other hand sees danger and risk and lays down his life for the safety of the sheep. D. Moody Smith in his commentary of this chapter states: "Not surprisingly the Good Shepherd's role in the economy of salvation corresponds to Jesus' actual fate (v. 11; cf. 15:12-13). The description of what Jesus does—from the standpoint of the Gospel what he has already done—stands in contrast to the behavior of the hired hand (vv. 12-15; cf. vv. 1, 8), which is foreshadowed already in Ezek 34:1-10 (especially vv. 5-6, 8, 10)."[1]

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[1]D. Moody Smith, "John," *Abingdon New Testament Commentaries* (Nashville, TN: Abingdon Press, 1999), 208.

The hirelings are the thieves and robbers. They follow the sheep while the Good Shepherd leads the sheep. In the care of the hired hands, the sheep lead. They encounter danger ahead of their keepers, giving the hirelings time to flee. In the care of the Good Shepherd, the sheep follow. He encounters the danger ahead of the flock, and vanquishes the enemy thereby securing and preserving the safety of the sheep even at the cost of His own life. D. A. Carson writes:

> The words 'for (*hyper*) the sheep' suggest sacrifice. The preposition, itself ambiguous, in John always occurs in a sacrificial context, whether referring to the death of Jesus (6:51; 10:11, 15; 11:15ff; 17:19; 18:14), of Peter (13:37-38), or of a man prepared to die for his friends (15:13). In no case does this suggest a death with merely exemplary significance; in each case the death envisaged is on behalf of someone else. . . .The assumption is that the sheep are in mortal danger; that in their defence the shepherd loses his life; that by his death they are saved. That and that alone, is what make him *the good shepherd.*[1]

Leon Morris comments on Jesus' use of the words "thieves" and "robbers" together to describe the works and behavior of the hirelings. He writes, "In strictness *kleptes* denotes something like a sneak-thief (it is used of Judas, [John] 12:6), and *lestes* a brigand (it is used of Barabbas, [John] 18:40). The combination may denote a readiness to engage in violence as well as dishonesty (cf. v. 10), though we should not make too sharp a distinction between them. Incidentally we find the same two words employed in Obadiah 5."[2] The description of the leaders by Christ is reminiscent of God's words to Israel through the prophet Samuel. God told the people that the king will take the best of

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[1]D. A. Carson, *The Gospel According to John* (Grand Rapids, MI: William B. Eerdmans Pub. Co., 1991), 386.

[2]Leon Morris, *The Gospel According to John* (Grand Rapids, MI: W. B. Eerdmans, c.1995), 501.

what they have for himself; from among their children, their animals, even from the produce of the ground (see 1 Sam 8, cf. Ezek 34). Jesus told the leaders in doleful words that they occupy places of honor in the synagogue; they love to be honored in public; they are painstaking about tithing while perverting justice and the love of God; they weigh the people down with heavy burdens they themselves would not even touch, and they confiscate the key of knowledge, keeping both themselves and the people out of the kingdom (see Luke 11:43-52).

Jesus compares and contrasts Himself as the door and the good shepherd with that of the robbers, thieves, and hirelings who came before Him. Whitherington writes that Jesus' statement implies that

> the existing or preexisting leadership in Jerusalem was illegitimate, involving robbers, thieves, and hirelings. This is especially clear when one reads this text in light of its Old Testament background in Ezek. 34, which speaks not only of Israel's false shepherds but of God as the true shepherd of Israel, and David, God's anointed and appointed agent, who will be set up to feed God's flock.[1]

The Door as a Symbol of Salvation

The description and derogatory terms for the hireling by Jesus are in contrast to Himself as the "door" and "Good Shepherd." As the "door" Jesus sees thieves and robbers who attempt access to the sheepfold erroneously, while as the "Good Shepherd" He sees hirelings whose dereliction of duty makes them unfit for service. As the door, Jesus grants entrance, determines admittance, and provides protection for His followers. Through Him they find salvation. They go in or through Him and find pasture. The

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[1]Witherington, 187.

metaphor of the door challenges many commentators as to its meaning and a historical situation for its usage in the church in the time of John. James Martin writes of four possible hypotheses.[1]

In light of the fourth hypothesis, John's message to the still-young church community in flux is that though the Jews have shut you out from their community, you

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[1] "Several hypotheses have been proposed to explain the historical reality behind the figure. Each must be understood in terms of a contrast between Jesus as the open door and others who function as closed door: (1) the closed door is represented by the Jews who exclude Christian Jews from the community of the synagogue. The casting out of the synagogue (9:22) may be explained either as an act of formal excommunication or as a reference to the *Birkath ha-minim*, introduced in AD 85. (2) The reality of a closed door is interpreted more specifically to refer to rabbis such as Johanan ben Zakki and Akiba. The Jews' loss of nationhood after the fall of Jerusalem led the rabbis at Jamina to redefine the community along rigid lines. Both Judaism and Christian communities were in a state of flux at that time. Chapters 7 through 10 [are] a matrix that reveals this situation. The Christian-Jewish community reached out for other sheep—Samaritans and Gentiles, but the community of Jamina does not. (3) The figure is to be explained by the action of the Jewish Zealots who in effect closed the door to a people of God which would include Gentiles. Against this the way of Jesus functions as an open door. The zealots, then, are identified with the thieves and robbers who steal, kill, and destroy the flock. Jesus laid down his life for the flock. The zealots ravaged the community and led it to destruction. Jesus re-gathers it and reconstitutes it. (4) Still another possibility is that thieves, robbers, and hirelings refer to false priests or faithless high priests who cared more for their position than for the flock. This interpretation would fit well with the role of Caiaphas in this Gospel who was high priest in the year that [Jesus the] Messiah was crucified (John 11:49; 18:13, 14). This view would also open up a connection with the cleansing of the Temple episode at the beginning of the Gospel and with the true worship discourse with the woman of Samaria (in the context of mission to the Samaritans) as well as with the Lamb motif. . . .Certainly, the Johannine passion narrative and the situation behind the text are to be seen in light of each other in accordance with the view that the Johannine passion narrative was written as a prophetic reenactment of the events of A.D 66-70. By His death and resurrection Jesus has become the door to an open community and the door of an open community." James P. Martin, "Expository Articles: John 10:1-10," *Interpretation* 32 (1978): 171-172.

are not shut out by God or from God. Jesus as the open door has granted you access to God. He is now the "new and living way which He inaugurated for us through the veil, that is His flesh" to God (Heb 10:20; see also John 14:6). God through Christ is nearer to you than He was to your fathers through Moses, Israel's first established shepherd and the prophets and priests who followed. The setting of this the seventh discourse by Christ is the rededicating of the temple. This was the yearly commemoration of Judas Maccabeus' triumphant revolt and cleansing of the temple in 164 B.C. after its desecration by Antiochus Epiphanes, king of Syria. Martin writes of a link between Jesus healing the blind man on the Sabbath and Ezekiel's prophecy about the new temple whose gate to the "inner court" shall be opened on the Sabbath. He states:

> Since Jesus healed the man born blind on the Sabbath day, he acts as the door to God's new and true sanctuary now located neither on Mount Gerizim nor Jerusalem, where the people will worship the Father in spirit and in truth (John 4:21-24). The old temple has been destroyed but the new true worship of God continues, free from place and central sanctuary, located in the risen body of Christ the new community and open to all the peoples of the world (John 2:21, 22). The Johannine Jesus as door functions in a similar way to the Pauline Jesus as Mercy-seat (Rom 3: 21-26). [1]

Jesus' healing of the blind man on the Sabbath, in essence, is a celebration of freedom through Christ the "door" and a liberation from darkness, not only physical—being born blind but spiritual, being shut out from the temple, the place to meet with God. Ironically, at the dedication of Solomon's temple by him, Solomon prayed, asking God to hear the prayers offered in His temple (2 Chro 6: 12-42, see especially 29-31). God for His part promised that He would hear and answer (7:11-16). Correctly Jesus

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[1]Ibid.: 173.

asserted that those who are well do not need a physician (see Matt 9: 12; Mark 2:17; and Luke 5:31).

Sociologically, in keeping with the door motif, the Jewish leaders shut out or excommunicated those they felt had physical or spiritual infirmities from the house of mercy and access to God. They closed the door—shutting the needy out from the place where God promised to answer the prayers of His people. They closed the door to God for the people who were in the greatest need. They also created a closed community and a national pride that had no redemptive purpose. Jesus on an earlier occasion said that "those who are well do not need a physician, but those who are sick" (Matt 5:12-13, cf. Mark 2:17; Luke 5:31-32). By declaring Himself the door, Jesus was introducing a new religious paradigm. No one was going to be rejected or turned away who needed healing (*Iaomai)* and or fellowship-community (*Koinonia)*. There is now an open community in which there are no distinctions made between race, color, or national origin. After the destruction of the temple in A.D. 70 and the decision of the council at Jamina there would have been conflict between the open and closed door community. To one, the gospel must be preached to all. To the other, the need for survival determines that the community be closed to all.

Jesus as the (open) door also has an evangelistic application. When Andrew heard of Jesus, he went and found his brother Peter and said to him, "We have found the Messiah" (John 1:41). Jesus invites all to come to Him for rest. He also sends those who are His to call others to come to Him for rest. "The door saying must be heard also as a

revelation of Christ in the wider framework of world Christianity."[1]

As the Good Shepherd, Jesus contrasts Himself with that of the hireling. The hireling is derelict of his duties. He abandons the flock in the face of danger. Under him the sheep become food—prey for the predators. The Good Shepherd, however, goes ahead of the sheep. He encounters the danger first and lays down His life for the well-being of the flock. A sharper contrast can hardly be made. The hireling, self-serving and self-preserving, by his actions slaughtered the sheep. The owner of the flock, self-sacrificing, others serving, was slaughtered for the sheep. He provides life in abundance to the sheep. "Among many—or at least more than one—shepherds Jesus is the one good, true shepherd. The figure of the shepherd as not only leader but provider is assumed in the Gospel of John (cf. 21:15-17). It is a manner of speaking well known in antiquity, and, as we have observed in scriptures."[2]

As the Good Shepherd, Jesus' intimate-*idia*-relationship with and self-sacrificing life for the sheep unreservedly qualifies Him to diagnose their conditions and prescribe treatment, sometimes with a prognosis and even pathology. Diagnosis is discussed more fully in chapter 7. Commenting on this parable Ellen White writes:

> As the shepherd leads his flock over the rocky hills, through forest and wild ravines, to grassy nooks by the riverside; as he watches them on the mountains through the lonely nights, shielding from robbers, caring tenderly for the sickly, and feeble, his life comes to be one with theirs. A strong and tender attachment unites him to the object of his care. However large the flock [may be], the shepherd knows every sheep. Every one has its name, and responds to the name at the shepherd's

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[1]Ibid., 174.

[2]Smith, 207.

call.[1]

The Twofold Purposes of Jesus' Diagnoses

Each diagnosis had a twofold purpose: to heal and redeem; to make whole and to restore what was lost in Adam. In the case of the rich young ruler, Jesus diagnosed him as lacking compassion for the poor. Jesus' prognosis was that it is difficult for those who are wealthy to enter the kingdom of God (Mark 10:17-25) and the pathology is that they have their rewards now; there is nothing in the coming kingdom for them (Luke 6:24). Matt 23:13-36 records the eight woes of Jesus to the Scribes and Pharisees. A diagnosis can be extrapolated from each woe. The pathology of the scribes and Pharisees is the result of their hypocrisy and tyranny towards their people and the prophets of God. Jesus denounces them, saying they cannot escape the "sentence of hell" (vs. 33; see also Luke 11:37-52. Jesus immediately laments over the city He loves saying "Jerusalem, Jerusalem, who kill the prophets and stone those who are sent to her! How often I wanted to gather your children together, the way a hen gathers her chicks under her wings, and you were unwilling," (Matt 23:37). The desire by Christ is to heal and redeem His people, but they were unwilling. With authority He diagnosed Nicodemus as having a spiritual condition that requires a new birth (John 3:1-9). In the story of the two men who came to pray in the temple, Jesus diagnosed the Publican with the spirit of humility. He departed for home being justified by God because he humbled himself before Him. The

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[1]Ellen G. White, *The Desire of Ages* (Mountain View, CA: Pacific Press Pub. Association, 1998), 479.

Pharisee however, was diagnosed with the spirit of pride; he informed God of all the reasons why he stood before Him justified. The Pharisee, according to Jesus, went away in his sin because of a prideful heart that was full of self-righteousness (Luke 18:9-14). The woman at the well was diagnosed as needing the Water of life (John 4:7-26), while the man living among the tombs as demonically possessed and in need of deliverance from his legion of demons (Mark 5:1-20).

Jesus diagnosed the Jewish leaders with the sin of hypocrisy. He said that they were as "whitewashed sepulchers, clean on the outside but inwardly full of dead men's bones and uncleanness" (Matt 23:27). Zaccheus, the tax collector, was diagnosed with the need for belonging. He had abandonment issues by reason of his profession. Jesus saw him as, "a son of Abraham" (Luke 19:9). The same case can be made regarding the woman with a demonic sickness for eighteen years. Her sickness made her an outcast among the Jewish leaders. Within her was a longing to belong, to feel a part of her birthright society. Jesus called her "a daughter of Abraham" (Luke 13:10-16). In Simon, the Pharisee, Jesus experienced a heart He diagnosed as lacking gratitude and the woman who washed His feet with her tears and wiped them with her hair as a heart transformed by forgiveness, overflowing with gratitude (Luke 7:40-50). Thomas can be diagnosed with the spirit of doubt (John 20:24-29). The disciples were diagnosed as having too little faith (Matt 17:20). Peter could have been diagnosed as boastful or having too much self-assurance (Matt 26:33-35). The Publicans and sinners were diagnosed by Jesus as: (1) lost sheep that could not find their way back to safety; (2) lost coins that were not even aware they were lost and in need of finding; and (3) a lost child who is lost by

choice but finds acceptance when he returns home. The Jewish leaders were diagnosed as lost at home for not accepting the father's gracious and benevolent love, believing instead that it can be earned (Luke 15:1-32).

Jesus' Ministry Is a Model for Pastors

By using this metaphorical language to describe Himself as Israel's good shepherd, Jesus connects His audience with a theme that is very familiar to them. In several places in the Synoptics Jesus employs shepherding language and imagery in His teachings (Matt 10:6, cf.. 15:24,16; 25:32-33; Luke 15:4). When Jesus and His disciples came ashore in Bethsaida on the northeast shore of Galilee upon seeing the large waiting crowd, He felt compassion for them because they "were like sheep without a shepherd" (Mark 6:34, cf. Num 27:16-17). Incidentally, this was Moses' (Israel's first deliverer) prayer. In answer to him, God told Moses to lay his hand upon Joshua as his successor. In the Gospel of Mark, Jesus applies Zechariah's prophecy to Himself when He said, "You will all fall away, because it is written, 'I will strike down the shepherd and the sheep shall be scattered'" (Mark 14:27, cf. Zech 13:7). The shepherd language is deeply rooted in Israel's tradition both as a way of life and symbolically referencing their leaders. Gary M. Burge writes that "Jesus is stepping into a venerable Old Testament tradition when he describes himself as the good shepherd of Israel. The culture of Jesus' day understood shepherds and their sheep well. . . . Moreover shepherding became a helpful image explaining the spiritual and practical leadership among God's people (see

Isa 56:9-12; Jer 23:1-4; 25:32-38; Eze 34; Zech 11)."[1]

The Chief Shepherd is appointed by God to be like David over the flock. The undershepherds are called by God to be His agent in caring for His sheep. Jesus said, "All that you see me do, you will do and greater than these because I go to My Father." Pastors as Undershepherds are duty-bound to model their ministry after that of Christ's when He was on earth. To do so the pastors must develop and maintain a vital connection to God. Jesus told His disciples to wait for the baptism of the Holy Spirit before they could be witnesses for Him. He also says that God wants to give to us the Holy Spirit more than our earthly parents want to give us good gifts. See Luke 11:13. The first duty of pastors is to become fitted to carry on the work of Christ through a disciplined life. Richard Foster writes of twelve disciplines that individuals must develop in their lives. He divides them into three categories: First is the inward disciplines, which consist of meditation, prayer, fasting, and study; second, the outward disciplines, which are simplicity, solitude, submission, and service; and third, the corporate disciplines that are confession, worship, guidance, and celebration.[2] Most of these disciplines were seen in the life of Christ beginning with His submitting to be baptized by John the Baptist, to His time in the wilderness with His father, to His life of service, to His eventual sacrificial and substitutionary death on the cross.

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[1]Gary M. Burge, "John," *The NIV Application Commentary*, ed. Terry Muck (Grand Rapids, MI: Zondervan Publishing House, 2000), 287.

[2]Richard J. Foster, *Celebration of Discipline: The Path to Spiritual Growth* (New York, NY: Harper & Row, 1978).

The Bible speaks of Jesus as being often in prayer or spending the night in prayer in some secluded place. See Matt 14:23; 26:36, 39, 42, and 44; Mark 1:35; 6:46; 14:32, 35, and 39; Luke 3:21; 5:16; 6:12; 9:18, 28-29; 11:1; 18:1, and 22:41, 44. Spiritual discipline is a longing after God to be close to Him and be transformed by His grace. In Ps 42:1-2 we read, "As the deer pants for the water brooks, so my soul pants for You, O God. My soul thirsts for God, for the living God; when shall I come and appear before God?" This psalm befits the life of pastors. For lives that experience sadness, even depression in the absence of God, Foster writes that "God has given us the Disciplines of the spiritual life as a means of receiving His grace. The Disciplines allow us to place ourselves before God so that He can transform us."[1] For the pastors to be effective undershepherds and not be classified as a hireling, they must become ongoing students of the Word of God. Prayer is the single greatest resource pastors have at their disposal. Through prayer, the pastors' life becomes intertwined with that of Christ, thus removing the baggage so as to not do harm to the flock in their care. According to Foster:

> It is the Discipline of prayer itself that brings us into the deepest and highest work of the human spirit. Real prayer is life creating and life changing. . . .To pray is to change. Prayer is the central avenue God uses to transform us. If we are unwilling to change, we will abandon prayer as a noticeable characteristic of our lives. The closer we come to the heartbeat of God the more we see our need and the more we desire to be conformed to Christ.[2]

Ellen White draws a parallel between the prayer life of Jesus and that of the pastors when she writes:

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[1]Ibid., 6.

[2]Ibid., 30.

Prayer is the opening of the heart to God as to a friend. Not that it is necessary in order to make known to God what we are, but in order to enable us to receive Him. Prayer does not bring God down to us, but brings us up to Him. When Jesus was upon the earth, He taught His disciples how to pray. He directed them to present their daily needs before God, and to cast all their care upon Him. And the assurance He gave them that their petitions should be heard, is assurance also to us. Jesus Himself, while He dwelt among men, was often in prayer. Our Saviour identified Himself with our needs and weakness, in that He became a suppliant, a petitioner, seeking from His Father fresh supplies of strength, that He might come forth braced for duty and trial. He is our example in all things. He is a brother in our infirmities, "in all points tempted like as we are;" but as the sinless one His nature recoiled from evil; He endured struggles and torture of soul in a world of sin. His humanity made prayer a necessity and a privilege. He found comfort and joy in communion with His Father. And if the Saviour of men, the Son of God, felt the need of prayer, how much more should feeble, sinful mortals feel the necessity of fervent, constant prayer. Our heavenly Father waits to bestow upon us the fullness of His blessing. It is our privilege to drink largely at the fountain of boundless love. What a wonder it is that we pray so little! God is ready and willing to hear the sincere prayer of the humblest of His children, and yet there is much manifest reluctance on our part to make known our wants to God. What can the angels of heaven think of poor helpless human beings, who are subject to temptation, when God's heart of infinite love yearns toward them, ready to give them more than they can ask or think, and yet they pray so little and have so little faith? The angels love to bow before God; they love to be near Him. They regard communion with God as their highest joy; and yet the children of earth, who need so much the help that God only can give, seem satisfied to walk without the light of His Spirit, the companionship of His presence. [1]

Diagnostic Language in the Writings of Ellen White

Seventh-day Adventists hold Ellen White in high esteem for her theological insight. She has had great influence on theological thinking in Seventh-day Adventism though not a theologian herself. In her prophetic role, Ellen White at times confronted both lay-people and the clergy on lifestyle practices and behaviors that were not in harmony with God's word. This is not intended to be an exhaustive study of diagnostic

[1]White, *Steps to Christ*, 93-94.

language in the writing of Ellen G. White. I will limit the scope of this research for diagnostic languages in her writings to: (1) *Testimonies for the Church,* volume 5 (a compilation of her letters and manuscripts; (2) *Testimonies to Ministers and Gospel Workers*; and (3) *Testimonies on Sexual Behavior and Adultery* (a compilation of her writings counseling and admonishing leaders and individuals in the various congregations regarding sexual practices and unholy lifestyles). Morally and spiritually, Ellen White believed that the Seventh-day Adventist church must be beyond reproach. The credibility of the fledging church's work stood or fell on these and other principles. In a statement to the church written May 17, 1887, in the *Review and Herald,* Ellen White stated:

> It is now the duty of God's commandment-keeping people to watch and pray, to search the Scriptures diligently, to hide the word of God in the heart, lest they sin against Him in idolatrous thoughts and debasing practices, and thus the church of God become demoralized like the fallen churches whom prophecy represents as being filled with every unclean and hateful bird.[1]

In 1882 she wrote about the behaviors of members in the young but rapidly growing Seventh-day Adventist church. Her diagnostic language came as warnings and reproofs. They were often directed to leaders of the church, but there are, in her writings, letters to lay individuals as well as couples, local congregations, and families. Speaking about the prevalent and insidiousness of gossip she writes:

> It pains me to say that there are unruly tongues among church members. There are false tongues that feed on mischief. There are sly, whispering tongues. There is tattling, impertinent meddling, [and] adroit quizzing. Among lovers of gossip some are actuated by curiosity, others by jealousy, [and] many by hatred against those through whom God has spoken to reprove them. All these discordant elements are at

[1]Ellen G. White, *Testimonies on Sexual Behavior, Adultery, and Divorce* (Silver Spring, MD: Pacific Press Pub. Assoc., 1980), 86.

> work. Some conceal their real sentiments, while others are eager to publish all they know, or suspect, of evil against others. I saw that the very spirit of perjury, that would turn truth into falsehood, good into evil, and innocent into crime, is now active. Satan exults over the condition of God's professed people. . . . All have defects of character, and it is not hard to find something that jealousy can interpret to their injury.[1]

Among the diagnoses one can surmise from her above statement are: unruly tongues, false tongues, and sly whispering tongues. There were the spirit of gossip, jealousy, and hatred. These spiritually shallow church members she diagnosed as tattling, impertinent meddling with adroit quizzing. The members in question were evidencing the spirit of perjury, criticism, and condemnation towards others. In another letter warning against unwise marriages, she admonished a brother for refusing the counsel of his parents, sister, and friend of the church to not marry a particular young lady. He was diagnosed as living in violation to the fifth commandment by not heeding the objections of his parents in regard to his impending marriage. Ellen White diagnosed the prospective bride as lacking "depth of thought or character," one whose life has been "frivolous, and her mind narrow and superficial." She diagnosed the groom as high-minded, weak natured, and driven by blind impulse. The bewitching influence of unholy, unwise marriages is a death to spirituality. She writes:

> Every faculty of those who become affected by this contagious disease--blind love--is brought in subjection to it. They seem to be devoid of good sense, and their course of action is disgusting to all who behold it. . . .With many the crisis of the disease is reached in an immature marriage, and when the novelty is past and the bewitching power of love-making is over, one or both parties awake to their true situation. They then find themselves ill-mated, but united for life. Bound to each other

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[1]Ellen G. White, *Testimonies for the Church*, 9 vols. (Mountain View, CA: Pacific Press Pub. Assoc., 1948), 5:94.

> by the most solemn vows, they look with sinking hearts upon the miserable life they must lead. They ought then to make the best of their situation, but many will not do this. They will either prove false to their marriage vows or make the yoke which they persisted in placing upon their own necks so very galling that not a few cowardly put an end to their existence.[1]

In a letter dated June 8, 1888 to a young lady who was attempting to get out of a marriage without cause, Ellen White wrote:

> Your course of life has been of that character that all your good is evil spoken of. You [have] become soured, unsanctified, and unholy. In order to gain that which you think is liberty you pursue a course which, if followed, will hold you in a bondage worse than slavery. You must change your course of conduct and be guided by the counsel of experience, and, through the wisdom of those whom the Lord teaches, place your will on the side of the will of God.[2]

From her counsel to this person many diagnoses can be made. This parishioner had a sour disposition. She was stubborn, prideful, reckless—lacking patience, fidelity, and kindness. She was spiritually disconnected, and disobedient to her faith and teachings. She exhibited spiritual coldness and declension. She had little regard for the seventh commandment, and held her marriage and husband in contempt. Each one of the above-mentioned diagnoses can be supported and treated from the Scriptures. Ellen White also counseled the lady to get out of her melancholy. Melancholy is associated with gloominess, crying, depression, irritability, sadness, lamentableness, and a pensive disposition. This person can even develop a mood disorder leading to psychotic episodes. Another individual in the church was diagnosed as having a dyspeptic religion, filled with self, lacking in almost every grace, spiritually starved, defiled, debased, and

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[1]Ibid., 110.

[2]White, *Testimonies on Sexual Behavior, Adultery, and Divorce*, 54-66.

weak in moral powers. Writing about the same person, she said:

> Dear brother, Satan has controlled you to a great extent; your thoughts are unsanctified, your actions are not in accordance with the spirit of a true Christian. You have brought on your own disease; you must be your own restorer through the help of the divine Physician. Your moral powers are weak for want of nourishment. You are starving spiritually for Bible truth--the bread of life. You need to draw daily nourishment from the living Vine. The church receives no strength from you and in your present condition would be better off without you, for now, if anything arises to cross your track and you cannot control matters, you settle back with stubbornness, a dead weight on the church. You bear no burden or weight of the cause. God has borne long with you, but there is a limit to His forbearance, a line beyond which you may venture, when His Spirit will no longer strive with you, but leave you in your own perversity, defiled with selfishness, and debased with sin.[1]

Counseling someone who fits this diagnostic profile, the pastor would from a biblical standpoint address issues about holiness, renewal of the mind, the Ten Commandments as a moral framework for making choices, the spiritual gifts and their relationship to the body of Christ, the priesthood of all believers, stubbornness, God's forbearance and grace, repentance, and reconciliation.

In a letter of reproof and admonition to the brothers and sisters of a church in Oakland, California, Ellen White diagnosed them as lacking practical godliness, having the spirit of unbelief, and a halfhearted faith. In the same letter she counseled the ministers to die to self. She wrote:

> I wish that every minister and every one of our workers could see this matter as it has been presented to me. Self-esteem and self-sufficiency are killing spiritual life. Self is lifted up; self is talked about. Oh, that self might die! When this proud, boasting self-sufficiency and this complacent self-righteousness permeate the soul, there is no room for Jesus. He is given an inferior place, while self swells into importance and fills the whole temple of the soul. This is the reason why the Lord can

[1]White, *Testimonies for the Church*, 5:117-118.

do so little for us.[1]

The primary issue here for the minister as clinician is control. At the heart of the self-directed life is the need to be in control. This is the direct antithesis to the Christian teaching that says "cast all your anxieties upon Him, because He cares for us" (1 Peter 5:7). Some of the other diagnoses are self-esteem (too much of it), self-sufficiency (lack of total dependence of God), pride, boastfulness, complacency, self-righteousness, grandiosity, the lack of a Christ-centered life, and not living in the abundance of God's benevolence.

There was a case in which Ellen White counseled the husband to separate from his wife in order to save his soul:

> Unless there is a change, a time will come soon when this lower nature in the wife, controlled by a will as strong as steel, will bring down the strong will of the husband to her own low level. . . . In this case it is not the woman whom Brother D is dealing with, but a desperate, satanic spirit. The Lord has a work for Brother D to do; but if he is overcome by these outbursts on the part of his wife, he is a lost man, and she is not saved by the sacrifice. His best course [of action] with this child-wife, so overbearing, so unyielding, and so uncontrollable, is to take her home, and leave her with the mother who has made her what she is. Though it must be painful, this is the only thing for him to do, if he would not be ruined spiritually, sacrificed to the demon of hysterics and satanic imaginings. Satan takes entire control of her temper and will, and uses them like desolating hail to beat down every obstruction. Her husband can do her no good, but is doing himself incalculable harm, and robbing God of the talents and influence He has given. God has placed the husband at the head of the family, and until Sister D shall learn her place and duty as a wife, it will be best for him not to be connected with her in any way.[2]

Here again are multiple diagnoses made, a style common in her writing. The

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[1]Ibid., 538.

[2]White, *Testimonies on Sexual Behavior, Adultery, and Divorce*, 76-77.

wife—Sister D—is diagnosed as being whimsical and desiring to be the idol in her husband's life and the object of his worship. She is also diagnosed as having a satanic spirit, being a child-wife (immature), overbearing, unyielding, and uncontrollable. She had episodes of demonic hysteria and satanic imaginations, and threw tantrums. Her temper and will are entirely controlled by Satan. She lacks integrity to her marital vow and is the sport of Satan's temptation (yields easily to temptation). She lacks spiritual maturity and is living outside of God's grace. Her life is self-directed or strongly influenced by Satan. She is capricious and violent. She is determined to rule or ruin (strong self-will). The language describing the husband—brother D—is that of having a strong will (for Christ), experiencing demonic assaults (through his wife), losing his manhood, being influenced and molded by his wife, being in a marriage that is a snare of Satan, and being a slave to his wife's capriciousness. He is further diagnosed as terrified by his wife's violence. A diagnostic assessment can be made of both of them as being in an ill-fated, unholy, and unwise marriage resulting in emotional, spiritual, and psychological distress.

A pastor counseling this couple should look at and ask questions about such things as: sleeping, eating, shopping, as well as role/rule in the home, and working behaviors. Are there any changes in any of these areas? What are they overdoing or under-doing. How are their coping skills? What if any kind of support systems do they have? What are they substituting for the deficiency they are experiencing in their marriage? How are they meeting their sexual and intimate needs? There may also be periods of suicidal thoughts or preoccupation with the contemplation of suicide. That

possibility should be checked out by the pastor as well. The questions should be asked of them as a couple and individually.

The following diagnoses can be extrapolated from a compilation of Ellen White's writings on Christian conduct in a book entitled *Testimonies on Sexual Behavior*: Those she says who honor the commandments will have a pure atmosphere surrounding them. Those whose characters are not transformed by the converting power of God are diagnosed as having weak souls that are polluted and debased. Residing among church members are the sins of adultery, idolatry, lewdness, and licentiousness. "Those who have not brought the lower passions into subjection to the higher powers of their being, those who have allowed their minds to flow in a channel of carnal indulgence of the baser passions, Satan is determined to destroy with his temptations—to pollute their souls with licentiousness."[1] The heart is diagnosed as having earthliness and sensuality. Married couples are diagnosed as bringing sensuality and debased practices into the marriage thereby disregarding the marriage vows. Many married people were diagnosed as being more animal than divine because of their excessive and debasing sexual practices. The spirit of lust she believed attended them more that the spirit of purity and holiness. In a manuscript written in 1897, Ellen White wrote:

> Let the husband and wife in their married life prove a help and a blessing to one another. Let them consider the cost of every indulgence in intemperance and sensualism. These indulgences do not increase love, nor ennoble and elevate. Those who will indulge the animal passions and gratify lust will surely stamp upon their offspring the debasing practices, the grossness of their own physical and moral

[1]Ibid., 84.

defilement.[1]

The leaders and pastors of the church were also given scathing rebukes for lives and lifestyles that were doing more harm than good. In positions of trust they are tempted to follow the desires of their unconsecrated hearts, thus revealing their defects as earthly, sensual, devilish, and carnally minded. Those under their care are led into licentious and lewd behavior.

Following the examples and language of the Old and New Testaments as well as non-canonical writings, the parish pastor has biblical authority to spiritually diagnose those in his/her pastoral care while keeping in mind that "all Scripture is inspired by God and is profitable for teaching, for reproof, for correction, for training in righteousness so that the man of God may be adequate, equipped for every good work" (2 Tim 3:16-17). The diagnosis must be a precursor to redemptive counseling. The crux of pastoral diagnosis and counseling is for the counselor to create an environment for the parishioner to "be reconciled to God" (2 Cor 5:20). Jay Adams states:

> Counselors must be careful not to represent Christ as the member of a first-aid squad who offers bandaids to clients. Redemptive counseling is radical surgery. Because of the radical nature of man's problem, radical measures are required. The diagnosis leading to radical surgery must be open, frank honest and to the point—man has sinned and needs a Savior. Nothing less that death to the past and resurrection to a brand new way of life can really solve one's problems (cf. Romans 6).[2]

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[1]Ibid., 115.

[2]Adams, *Competent to Counsel*, 67-68.

CHAPTER 6

QUALIFICATIONS FOR PASTORAL DIAGNOSIS

What set of qualifications does the pastor need to adequately diagnose the problem(s) of those who come to him/her? An attempt is made here to answer that question. I am using diagnosis as descriptive of a careful and systematic analysis of the facts elicited from the pastor–parishioner dialogue for the purpose of circumscribing the nature of the presenting problem. The different types of ethics the pastors need to practice as they do counseling are also discussed. The chapter concludes with a look at the pastors' ethical behavior in counseling.

Moral Qualification

The pastor is by vocation and education a teacher and guide to the Church, the body of Christ. The pastor is called to be a Christo-centric teacher and an ethical guide. He/she is to be, among other things, fair, judicious, emotive, and morally responsible in the exercise of his/her calling. Rebekah Miles states: "Every pastor is both an ethicist and an ethical teacher, a moral guide. These claims are true for ancient times and our times. In our time, we face a crisis of moral responsibility . . . . Many look to pastors for help when they face questions of moral responsibility."[1]

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[1]Rebekah Miles, *The Pastor as Moral Guide* (Minneapolis, MN: Fortress, 1999), 1.

Technology has brought our world into a global community. As a world we face AIDS and the HIV epidemic; famine, starvation; cultural annihilation, religious intolerance, and genocide; air and water pollution; population explosion; and medical issues regarding the sanctity of life (abortion, cloning, and euthanasia). There are growing concerns about the ozone layer depletion, natural resources depletion, the plight of the homeless, life in the inner city, and the rapidly expanding prison population. Then there are the greed and corruption of corporate bosses and elected officials, the sexual crises within the Church, chemical and biological warfare, terrorism, rogue nations with nuclear weapons, and political leaders who choose not to be responsible to the world community.

In this global society, pastors and Christian counselors are called by God to be moral guides, and beacons of ethical light amidst the sea of darkness, uncertainty, and moral depravity. They provide guidance using Scripture and the traditions of their particular faith. The story of the actions of a moral God in history and especially the incarnation becomes the framework and context for interpreting human behavior in relationship to the environment and fellow humans. Humanity is not only the steward of this world, but we are also a keeper of each other (Gen 1: 26-28). We are called to be neighbors (Luke 10: 30-37, the Good Samaritan story) and debtors (Rom 1:18, the Apostle Paul's indebtedness to others).

> Our decisions and character are shaped by faith. We are always both ethicists and theologians, because Christian moral reflection is interwoven with theology. We ask what is right or good, given our relationship to God and to each other. We learn to be moral in communities of faith. We are able to live according to the moral law because of the freeing power of God's grace experienced in these communities.

> Pastors, as leaders of congregations and preachers of the gospel, are crucial in these moral communities.[1]

Beginning in the 1980s with the very public scandals of some high-profile television evangelists, and more recently the priests' abuse of boys, the clergy has taken some very heavy blows. Sexual misconduct with women is much more pervasive and frequent among clergy and is not treated as "news"– to a certain degree it is considered "normal." But when it is with minors it gets media hype. And when it is with "boys," the homosexuality issue comes to the forefront and the story becomes more "newsworthy."

Ezek 34 portrays a chilling rebuke from God regarding the treatment of His sheep by the ones who are supposed to be guarding and providing for them. The moral guides of the church have become the ones against whom the church must guard. Because of a continuous breach of moral ethics, the pastor, as perceived by many, is losing the moral authority to be an ethicist and a teacher of ethics. The breakdown of moral integrity in the pastor and in the pastor's family is at the root of much of the increase of sexual and ethical misconduct in ministry. The pastor must once again be guided by moral absolutes and not situational ethics. At the same time pastors must remember that God is morally absolute and the moral authority and in their ministries should point to Him and not to set themselves up as moral authorities.

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[1]Ibid., 4.

Spiritual Qualification

Judeo-Christianity teaches that this world and everything in it was created by God (the creation motif). The Triune God at creation said, "Let us make man in our image, according to our likeness" (Gen 1:26). Adam was formed out of dirt and God breathed His breath (*ruah*) into Adam's nostrils and he became a living being. Humans are spiritual beings. Jesus taught that "God is spirit and those who worship Him must worship Him in spirit and truth" (John 4:24). Therefore, spirituality comes from God as part of the essence of humanity. This implies that humans have awareness of and seek connectedness with their Creator. Johnson states that:

> Spirituality originates in the call of God. As a person becomes aware of the interventions of God in life and responds to those invitations to faith and love, the result is a deepening awareness of God. Awareness of the call of God and responsiveness to this call stands at the heart of pastoral spirituality.[1]

Humans were made with the capacity for intimacy and relationship. In the creation story, God orchestrated a situation for Adam to develop a desire for a relationship with someone like him by allowing him to name the animals and become aware of the animal companionship. Adam's desire was fulfilled by God in giving him Eve. Both Adam and Eve met with God, who wanted to develop and maintain an intimate relationship with them, "in the cool of the day" (Gen 3:8).

Spirituality is experienced through relationship. "To have a relationship, one must have a self, an I who encounters a Thou. This encounter is possible only when one has an

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[1]Ben Campbell Johnson, *Pastoral Spirituality: A Focus for Ministry* (Philadelphia, PA: Westminster, 1988), 13.

identity."[1] Humans were not only created by God but also in His image to have self-and other-awareness. Humans as opposed to animals possess the capacity to know and shape their environment, to be in relationship with others and the biosphere. They can plan, envision, remember, celebrate, empathize, name, interpret, and anticipate.

The pastor's spirituality is shaped by all the aforementioned plus his/her theological discipline and ongoing dialogue with God. Undershepherds must therefore be feasting from the hands of the Chief Shepherd. Before they can have I/Thou relationships with the parishioners, there must be an ongoing relationship with God.

The pastor must also grow spiritually by being nourished by the divine acts of God in creation, the fall of humankind, the Incarnation, the substitutionary death of Christ, the resurrection, and the Second Coming. For in the divine call is the divine election. God is present and actively involved in the life and call to ministry. The pastor's and Christian counselor's spiritual qualification comes from a divinely connected origin, an ongoing intimacy with God and fellow humans, and living by the standards set both by personal discipline and by their faith community.

Ethical Qualification

The Catholic Church has been plagued with a long history of sexual misconduct by some of their clergy in their relationships with the people they are entrusted to serve. A recent highly publicized rash of scandals in several states involved male pedophilia, much of which was in the distant past. The church has been spending dollars in the

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[1]Ibid., 24.

multi-millions to settle the legal claims. The situation is of such magnitude that Cardinal Law of Boston flew to Rome to hand the Pope his resignation. It was accepted and a temporary successor installed.

In the light of those events, one may be tempted to think that there is no ethical protocol to help those in the pastoral profession to navigate their therapeutic relationships. The question then is, how do you get everyone to religiously adhere to those guidelines? This problem is not unique to the Catholic clergy. Their woes are experienced by clergy of all faiths. The clear and concise ethical protocol that helps to govern the pastoral care and counseling practices of all faiths will be examined next. The importance of this hinges on the reality that pastors are expected to be a group of moral agents representing a God who is absolutely moral in His dealings with human beings.

Definition of Ethics

"Ethics is a normative science."[1] It is the study of humanity as a group of moral agents whose behaviors, habits, and character are viewed in terms of rightness and wrongness. Our behaviors or dispositions are morally good or evil. We are either enhancing or diminishing the quality of life. Ethics sets a standard by which individual and group actions are measured and sanctioned. It directs attainment and governs behavior. These are moral imperatives. According to Sanders, "Ethics pertains to decisions and behavior having to do with what is good, right, obligatory and/or

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[1]David Stow Adam, *A Handbook of Christian Ethics* (Edinburgh: T. & T. Clark, 1925), 1.

virtuous."[1] Ethics also deals with the "nonmoral question of goodness and value."[2]

The word derives from the Greek word "*Ethos*" meaning custom or habit. It has come to convey the meaning of standards, norms, and moral judgments by which a person, group, or society conducts itself and is judged. Ethics in part is the formation of character whether in a person or in a society. Character is the essential quality of a person; the pattern of behavior or personality found in an individual or group.[3] Judeo-Christians contend that we are in character moral beings because we were created by a moral, absolute, holy, eternal, and transcendent God–in His image, after His likeness, the *imago Dei.*

God as an Ethical Being

God in His very nature is holy. Lev 11:44-45 says "I am the Lord your God. consecrate yourselves therefore, and be *holy*, for I am *holy* . . .for I am the Lord who brought you out of the land of Egypt to be your God; thus you shall be *holy*, for I am *holy*" (italics mine). God "cannot lie" (Titus 1:2), nor does He need to "repent" (Num 23:19) for what He has spoken. According to Jas 1:13, God "cannot be tempted by evil" because there is nothing in His nature that is attracted to sin. There is no propensity for evil in His nature. God is absolutely moral because and for Him, morality is a state of

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[1]Randolph K. Sanders, *Christian Counseling Ethics: A Handbook for Therapists, Pastors & Counselors* (Downers Grove, IL: InterVarsity, 1997), 29.

[2]Ibid., 30.

[3]*Webster's New World Dictionary*, 2d ed. (1970), s.v. "*Character.*"

being which precedes doing. The Bible states, "In the beginning God created . . ." (Gen 1:1), and when God recalled Israel's liberation from Egypt, He states, "I Am the Lord your God who brought you out of the land of Egypt, out of the house of slavery" (Exod 20:2). God in His essence always precedes what God does. Who He is forms the basis for His relationship and dealings with humanity. Thus for the Christian minister, every unfolding drama of the client's life must be interpreted in the context of the creation, the fall, redemption, and restoration. The human existence is the drama that is played out between paradise lost and paradise restored, from the first human pair with whom God walked in the "cool of the day" (Gen 3:8), to the "multitude which no one could count" (Rev 7:9), among whom God will dwell forever in the New Earth. Into this human experience the pastor is called to journey alongside those who are hurting and help restore the redemptive image of God. In this process God is an "active presence."[1]

Ethics in Pastoral Counseling

In the pastoral care, and in the pastoral counseling relationship, the pastor does not journey alone with the one who is hurting. He or she is one of several in this very real human experience. Since the Christian community is part of the body of Christ both visible and cosmic, Christian ethics is systemic. It embraces the parishioner, the pastor, the faith community, as well as the Triune God. God is not only "a very present help in time of trouble" (Ps 46:1), but also a present Witness who is "Faithful and True" (Rev

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[1]James M. Gustafson, "The Minister as a Moral Counselor," *Journal of Psychology and Christianity*, no. 3 no. 4 (1984): 86.

3:14). Tjeltveit believes that: "the context of Christian ethics means that psychotherapy can never be seen simply as a relationship between therapist and client. Rather, it is a relationship taking place in the greater relationship of client, therapist, the family of each, the church (in local and global manifestations, as both visible and invisible body of Christ) and God."[1]

The pastors' conversation is informed by their theology, which in turn is shaped by their beliefs shared by their faith community about God. According to Gustafson, the pastor

> is not simply the sage generalist with great moral sensitivity and critical ethical acumen, though these are necessary gifts and talents. He also has a specialized knowledge and discipline of thought to bring to bear in the interactions of perspectives, technical knowledge, moral beliefs and opinion, out of which come the convictions and actions that shape the future. He represents the point of view about what the primary purposes of human existence in community and history are, about what the qualities of life ought to be, about what values are in accord with God's activity and intention for His creation. . . . He brings to bear the insight and wisdom of the Christian community's long historical reflection about the chief end of man.[2]

Different Types of Ethical Thinking

Pastoral counselors and clinicians are called to work in a pluralistic and highly relativistic society. Yet Christian counseling should be done from a moral absolute point of view. To do so, Christian counselors must recognize that God is morally absolute and that they in their ministries should point to Him and not set themselves up as moral authorities. Counselors must be able to name the pain or point out brokenness in a

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[1]Sanders, 30.

[2]Gustafson, 84.

humane, non-judgmental, non-coercive, caring way. In order to do that, the counselors must be aware of the different styles of ethical thinking. There is a teleological and a deontological method of ethical thinking. The teleologist, one who evaluates conduct in relation to the end it serves, believes in doing that act that will produce the greater good over evil or the lesser of two evils. For the teleologist, good has a nonmoral value. It is not that which one attains as virtue but an experience. It is without moral value. Don S. Browning cites a distinction widely used in contemporary moral philosophical thinking. Browning states that "by introducing this academic distinction in a book written primarily for ministers, I am in effect recommending to clergy readers knowledge of moral philosophy. Such knowledge of the academic ethical tradition can be helpful especially for those ministers who want to develop a critical practical theology that can function in a pluralistic situation in a public way."[1]

Teleological Ethics

Within the teleological school there are two modes of thought: ethical egoism and utilitarianism. Browning states that "there are both secular and religious teleologists and hence both secular and religious ethical egoists and utilitarians."[2] The ethical egoist is self-serving and will do the thing that produces the greatest amount of good for himself/herself. The utilitarian is community oriented and will act so as to produce the most good for the community.

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[1]Browning, 25.

[2]Ibid., 26.

There are further subdivisions within the utilitarian school of thought. Those who are driven by specific acts that will benefit the community in general are "act utilitarian" or "situation ethicists."[1] Those who are motivated to follow specific rules that will promote the well-being of the greater community are "rule utilitarian."[2] The former do what is believed will benefit the community the most. The latter follow what is established and understood by the community.

The "egoist" is primarily concerned about the individual's self-fulfillment, the actualization of personhood. The "utilitarian," whether carrying out the act or the rule, focuses on the community, what is beneficial for the majority.

Deontological Ethics

Deontologists, according to Browning, "deny that the right, the obligatory, and the morally good are wholly, whether directly or indirectly, a function of what is nonmorally good or what promotes the greatest balance of good over evil for self, one's society, or the world as a whole."[3]

For the deontologist, serious thought is given more to the moral act itself than to what it promotes, however valued it may be. For when an act is in keeping with a higher good or a command of God, the consequence need not matter. Browning speaks of four kinds of deontologists:

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[1]Ibid.

[2]Ibid.

[3]Ibid., 26.

1. The divine-command deontologist believes an act is morally correct only when willed by God through inspiration of the heart guided by God's acts in history or His laws.

2. A second type of deontologist believes that an act is moral when one keeps a promise or acts justly without fear of consequences.

3. A third type believes that an act is moral only when it is 'authentic,' whatever that means.

4. The fourth type of deontologist professes that one should 'act only on that maxim which you can at the same time will to be universal law'. It is the willingness of someone to act without concern of consequences and universalize the principles by which he/she is guided.[1]

Number 4 above, according to Browning, is part of the Kantian philosophy of the "categorical imperative."[2]

Can Christian counselors and clinicians be "absolutist" in a pluralistic and highly relativistic society? Tjeltveit believes they can. They must, however, practice their ethics in "content and context."

There is content of particular principles as enjoined by the Bible and the Christian tradition in seeking ethical answers, but to that "content," "context" must be applied.

Every session of psychotherapy, every moment of human life must be seen in the context of creation, fall, redemption and eschaton. We are all created by God, have

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[1]Ibid., 27.

[2]Ibid.

sinned, were redeemed through the death and resurrection of Christ, and are heirs of the promise of His coming again in glory. As forgiven children of God, we are free in Christ, saved by grace through faith. As such we strive to 'lead lives worthy of the Lord, fully pleasing to Him' (Col 1:10). Christians striving to make ethical decisions must take context into consideration when making judgments, but should not be relativistic. It is usually necessary to balance flexibility and firmness in addressing ethical issues.[1]

Relativism

Since ancient times, relativism as a philosophical concept has meant different things to different scholars. According to Norman Geisler, "at least three movements in the ancient world influenced ethical relativism: Processism, hedonism and skepticism."[2] Heraclitus (ca. 540 BC), one of the main proponents of Processism, believed that everything in the world is in a constant state of change. Epicurus, the Greek philosopher (341–270 BC), advocated a life of simplicity. In one of his letters he wrote:

> We must also reflect that of desires some are natural, others are groundless; and that of the natural some are necessary as well as natural, and some natural only. And of the necessary desires some are necessary if we are to be happy; some if the body is to be rid of uneasiness, some if we are even to live. He who has a clear and certain understanding of these things will direct every preference and aversion towards securing health of body and tranquility of mind, seeing that this is the sum and end of a blessed life. For the end of all our action is to be free from pain and fear. . . . When we are pained because of the absence of pleasure, then, and then only, do we feel the need of pleasure. Wherefore we call pleasure the alpha and omega of a blessed life. Pleasure is our first and kindred good. It is the starting point of every choice and of every aversion, and to it we come back, inasmuch as we make feeling the rule by

[1]Sanders, 29.

[2]Joseph Fletcher, *Situation Ethics,* quoted in Norman Geisler, *Options in Contemporary Christian Ethics* (Grand Rapids: Baker Book, 1981), 10.

which to judge of every good thing.[1]

The Epicureans believed that pleasure was the intrinsic nature of good and pain the intrinsic nature of evil. This, however, is relative to the individual. This gave rise to Hedonism. Another school was Skepticism. The skeptics simply reserved judgment on everything. For them every issue is two-sided; both equally valid. The interpretation depended upon one's point of view.

By the Middle Ages, Peter Abelard (b. AD 1079.), "argued that an act is right if it is done with good intention and wrong if it is done with bad intention."[2] The ethical nature of one's behavior is therefore ascertained solely by the intention of the person carrying out the act. This is called Intentionalism. William of Ockham (ca.1280–1349) taught that God's will is behind all moral principles and that God's will is subject to change. This school of teaching is called Voluntarism. William of Ockham also taught the concept of Nominalism. He denied the existence of anything universal. He believed that "universals, essence, or form exist only conceptually, not actually. All realities according to this school are radically individual."[3] Good, justice, and evil are concepts of one's mind and do not exist as universal principles.

In the Modern World (beginning in the 19th century) relative ethics runs the range of human existence and encounter. A quick overview follows. Jeremy Bentham (1748–

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[1]Jason Lewis Saunders, *Greek and Roman Philosophy after Aristotle* (New York: Free Press, 1966), 50-51.

[2]Geisler, 12.

[3]Ibid., 14.

1832), a proponent of Utilitarianism, thought that a person should act in such a way as to do the greatest amount of good for the greatest number. Some Utilitarians believe one act as a leap of faith, while others believe that everyone has a right to do what is pleasing to self. The Existentialist Soren Kierkegaard (1813 –1855) believed that a person's highest duty is to God and that duty transcends all ethical laws. When one is directed by God to carry out an act that violates the moral law, that person is under obligation to perform the directive by a "leap of faith."[1]

The Emotivist, A. J. Ayer (1910 –1970), according to Geisler, believed that all "ethical statements are emotive. 'Thou shall not . . .' really means 'I feel it is wrong' or 'I dislike it.' Ethical pronouncements are merely ejaculations of our subjective feelings and not divine imperatives about moral duty."[2]

The Subjectivist Jean-Paul Sartre (1905 – 1980) believed that there is no God, "Man is absolutely free and everything is relative to what the individual wills to do. . . . There are no objective meanings or values to be discovered; all values are made subjectively to those who will them."[3] People formulate their own meaning to life. Meaning is what you make it. Everyone must find their own way.

The Situationist believes that the end justifies the means. He/she would say that there are no absolutes and for everything that is true or absolute there are exceptions.

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[1]Ibid., 16.

[2]Ibid., 18.

[3]Ibid., 19.

"The only thing that is absolute, says Fletcher, is love. However, one cannot know what love means in advance of the situation. Love's decisions are made situationally, not prescriptively."[1] For Fletcher, the best known Situationist, there is only one true unbreakable norm for everything and that is love.

Finally, the Legalist believes that law must be principled above love. In contrast, Antinomians like Jean-Paul Sartre and A. J. Ayer believe that there is neither law nor love to their moral decision making, it is all spontaneous. You do what is right to you. The Situationist falls between these two extremes, placing love over law to guide moral decision making.

Pastors using situational ethics would agree that stealing to satisfy hunger is justifiable. Or at an extreme, pro-lifers would feel justified in blocking or even resorting to acts of violence to prevent women from going into an abortion clinic. Regarding situation ethics, Fletcher writes: "As far as other moral rules are concerned, they are helpful but not unbreakable. The only ethical imperative one has is this, 'act responsibly in love.' Literally everything else without exception, all laws and rules and principles and ideals and norms, are only contingent, only valid if they happen to serve love in any situation."[2] Love is determined by the individual at the time and place of the experience. From this school of thought, love, although claimed to be an absolute, is subjective and situational. And since humans are flawed, the application of the ethical imperative will

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[1]Ibid., 20.

[2][Fletcher] quoted in Norman L. Geisler, *Ethics: Alternatives and Issues* (Grand Rapids, MI: Zondervan, 1971), 61.

be flawed. Therefore the motivation should be viewed as suspect at best, and the outcome questioned regardless of its end.

The Pastoral Voice as a Moral Absolute

In this very pluralistic and highly relativistic culture the pastor's lifestyle and voice need to be unambiguous and resolute. For the pastors to be the moral light in an ever-darkening world, they must stay connected to the One who is morally absolute. They must ever remember that the One who placed a divine calling on their lives is also a very present help and the invisible Counselor in these human dynamics.

To avoid many of the pitfalls that accompany so many in their daily working with people, especially of the opposite sex, pastors must be deliberate about putting in place a system of accountability and hold true to their Judeo-Christian teachings about moral values and ethical behavior. Pastors are thus morally, spiritually, and ethically qualified to do pastoral diagnosis with the people with whom they enter into a therapeutic relationship. Additionally, as part of their systems of accountability, pastors and or clinicians must ask themselves some very important questions they may wish to avoid asking. Some of the questions are: What are the moral implications of my calling? Is what I ought to do consistent with what I want to do? To whom am I accountable? How is my life a fleshing out of my divine calling? And am I a moral change agent?

Ethics in Pastoral Diagnosis

When the word "diagnosis" is used it often conjures up medical images and/or

forebodings of disease. A pastor with this kind of mind-set would have a difficult time describing part of the counseling process as diagnostic and yet it is just that and it is necessary. Pastoral diagnosis provides guidance in forming the most appropriate response.

Diagnosis says Donald Denton, has two tasks, which "are to name the pain and guide the care."[1] This according to Browning is done within the context of a system. Pastoral care is "primarily the care of systems and secondly the care of individuals within these systems."[2] The pastor by vocation is called to provide guidance to families (here referred to as systems) through religious teachings, worship, general pastoral care, and pastoral counseling. Therefore the pastor must be aware of his/her role and responsibility not only to the person in the other chair, but also to the larger system of which he/she is a part.

The system, however, should not be maintained at the expense of the pain suffered by individuals in that system. For example, the pastor in the role of providing either pastoral care or counseling should not ignore the abusive behavior by a member of that family system. Pastors should also not subtly or overtly use scripture, their pastoral presence, or influence to encourage a member of that system to stay in it in while the abuse is ongoing. Pastors need to understand both the socio-systems and the individuals who are being influenced by them. To do that, Browning developed what he calls "the

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[1]Donald D. Denton, Jr., "No Sterile Field: The Role of Ethics in Pastoral Diagnosis," *Journal of Pastoral Care* 49 (1995): 50.

[2]Browning, 19.

four steps of practical theological action." They are:

1. Experiencing and defining the problem

2. Attention, listening and understanding

3. Critical analysis and comparison

4. Decision and strategy[1]

At step 3 above during the pastoral dialogue with the parishioner, the pastor must process the information through what Browning calls "the five levels of practical moral thinking," especially when faced with a moral issue. These are:

1. The metaphorical level: What kind of world or universe constitutes the ultimate context of our action?

2. The obligational level: What are we obligated to do?

3. A tendency-need level: Which of all our human tendencies and needs are morally justified in satisfying?

4. A contextual-predictive level: What is the immediate context of our action and the various factors that condition it?

5. A role-rule level: What specific roles, rules, and processes of communication should we follow in order to accomplish our moral ends?[2]

But more than being normative or descriptive in the counseling setting, the pastor is a person with a history. Pastors bring their historical, cultural, and family of origin

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[1]Ibid., 100.

[2]Ibid., 53-55.

selves into the counseling experience. They are neither value-neutral nor unbiased. "The strength of Browning's system lies in its ability to lead the clinician into a substantive understanding of the ethical and religious dimensions of his life."[1]

People's life experiences are what help shape their lives. There are times when it is both helpful and necessary to share those values or biases. Pastors with negative biases about homosexuality are ethically responsible to share their inability to work with the homosexual person seeking counseling. They are also ethically bound to assist by making referral to someone reputable who can be of help.

The same would be true in cases of severe past abuse and/or trauma in the pastor's background. Those experiences may hinder the counseling process through over-identification or detachment. Care-givers must be aware of their background and how it can help or hurt the one seeking help.

It is my position that all care-givers, in order to be persons of integrity, should receive professional counseling to deal with their own issues before doing counseling. The care-givers should also develop and maintain ongoing supervision with a trusted, professionally competent person, thus minimizing the possibility of being entangled in the transference and counter-transference trap.

Transference and Counter-transference

Transference is projection onto the pastor of the unmet needs or unresolved conflicts by the person seeking help. According to Schwartz, Freud believed transference

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[1]Denton, 41.

to be "a distorted and inappropriate response derived from unresolved unconscious conflict in (a person's) past."[1] The counselor may be expected to take the place of a parent, a lover, or even God. The projection can be positive or negative. Positive transference might be where the pastor is viewed as taking the place of a deceased parent with whom the parishioner had a healthy relationship. There is a thin line between negative and positive transference. The pastor must be very vigilant in making sure that line is not crossed. Richard Gula states that "transference occurs more because of the role than because of any special attractiveness of the minister. A person seeking a lot of touching and hugs can be reviving a childhood need for nurturance from parents." [2]

Transference can become seductive because of prior relationships in which closeness and sexuality became distorted. The parishioner has come to believe that his/her value as a person is determined by his/her sexual desirability to others. What can start as innocent or even caring behavior can end up becoming an environment for misconduct and abuse of power by the pastor.

Distortion on the other side of the relationship is counter-transference. Counter-transference takes place in two ways: the first occurs when the pastor begins to see the parishioner as the recipient of his/her own projected fantasies. "In counter-transference, the pastor's unmet needs, feelings, or unresolved personal conflicts get superimposed onto those

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[1]Richard S. Schwartz, M.D., "A Psychiatrist's View of Transference and Countertranference in the Pastoral Relationship," *The Journal of Pastoral Care* 43, no. 1 (1989): 41.

[2]Richard M. Gula, *Ethics in Pastoral Ministry* (New York, NY: Paulist, 1996), 110.

of the one seeking help."[1] Schwartz believes that "[it] is transference in the therapist that is a distorted and inappropriate response derived from unconscious conflict in the therapist's past."[2]

Counter-transference may also be the pastor's response to the parishioner's transference. It is the pastor living up to the distorted fantasies of the person he/she is counseling. This emotional quagmire is the most fertile environment for behavioral misconduct to occur. Both parties give in to their unfulfilled, unmet, unresolved conflicts or fantasies. Who they are to each other professionally is negated and replaced with the identity of others from their distorted relationships. This results in role confusion and a serious breach of ethics. Schwartz states:

> Our experience of people in the present is colored by how we have experienced important figures in our past. The more problematic past relationships have been and the less successful we have been in seeing them clearly, the more likely they are to color our present response in ways of which we are unaware.[3]

Incorporation of Values in Pastoral Counseling

As stated earlier, pastors are not value-neutral. They bring to the counseling dialogue a host of values and teachings from their background, theology, faith community beliefs, and teaching. The laws and expectations of the larger community and the state also serve to guide and/or influence the pastor's thinking. Pastors should

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[1]Ibid.

[2]Schwartz: 42.

[3]Ibid.

take steps through Clinical Pastoral Education (CPE) and/or counseling to understand their background and life experience and how it might negatively impact the counseling process. Their past may be of sufficient distortion to be injurious to the people seeking help. If that is likely to be the case, they are ethically bound to put off any attempt to help others until they have personally sought professional help to address those distortions and work towards experiencing wholeness.

Pastors are obligated to be people of integrity. The call of God demands it. The faith community that supports and nurtures the call expects it. As representatives of the Lord to the world, the larger community interprets and experiences the grace of God through the fleshing out of the call in the life and lifestyle of pastors.

> The ethics of ministry, therefore, involves a personal focus of attention. The ordained minister who allows centrifugal temptations and frenetic activism to crowd out the possibilities for reflection, patience, and caring is violating–we may extend the meaning this far–his or her professional norms.[1]

Among other values pastors bring to the counseling process are the following: the appropriate use of prayer and the scriptures, the sacraments or rites of the particular faith community, respect for the counseling process, listening actively and without judging, advising when needful without coercion; self-discipline, goodness, rightness, virtue, respect, sexual integrity, and knowing when to terminate and/or refer.

The Role of Confidentiality

By virtue of the office, pastors are in a position to have much intimate knowledge

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[1]Gaylord B. Noyce, *Pastoral Ethics: Professional Responsibilities of the Clergy* (Nashville, TN: Abingdon, 1988), 31.

about the people they counsel. Generally, people trust their pastor unless they have had prior negative experiences. Trust is crucial to effective ministry. Pastors must be deliberate about building and maintaining trust.

Perhaps more than any other helping profession, trust is pivotal to the ongoing effectiveness of pastoral care and counseling. What the pastors know about the people they see can put them in a position of power over those people. Pastors can use that knowledge in harmful or even abusive ways: what is said from the pulpit in a sermon; what is spoken in casual conversation; and what is said to one's spouse at the end of the day. In all those settings, the pastors are to be conscious of the fact that they have intimate and, often, very private knowledge of others that cannot be shared or alluded to without prior consent from the individual(s).

Throughout history it can be said that a cause of human suffering has been the abuse of power. "The things pastors hear from people also place them in positions of power over others. What pastors know about people can be used to denigrate or even abuse."[1]

There are three concepts to consider when dealing with the issue of trust: privacy, confidentiality, and privilege. According to Sanders:

> Privacy is: the individual's right to be left alone and to decide the time, place, manner and extent of sharing oneself (one's thoughts, behavior or body with others). Confidentiality is: the quality of private information that is divulged with the implicit or explicit promise and the reasonable expectation that it will not be further disclosed except for the purpose for which it was provided. Privilege is: a legal protection

[1]Craig L. Nessan, "Confidentiality: Sacred Trust and Ethical Quagmire," *The Journal of Pastoral Care* 52, no. 4 (1998): 349.

against being forced to break a promise or expectation of confidentiality in legal proceedings[1].

While confidentiality is or should be very high on the pastor's list of virtues, there may be times when other values must take precedence. Among such values are: when the individual threatens to do harm to self and/or another and in cases of child, elder, and spousal abuse as required by state laws. There may be other forms of abuse or crimes such as rape and incest where the law may also require pastors to tell what they know. Every attempt should be made to get the individual to go to the proper authority with the information. It would be advisable for the pastor to offer to accompany the individual. But where there is a refusal, the pastor must act to protect all and serve the cause of justice by intervening "to prevent imminent harm. Such a disclosure is in service of a larger good, although it always involves careful discernment of the particular circumstances."[2]

As part of the pastors' or clinicians' value system, the following should be part of the therapeutic dialogue early in the counseling relationship: role expectations, how information will be handled, and what is sacred, that is, what will be shared and under what circumstance, and by and to whom.

The Pastor as a Sexual Being in Counseling

There are three things pastors and clinicians must recognize and acknowledge:

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[1]Sanders, 44.

[2]Nessan, 355.

their humanity, their spirituality, and their sexuality. Harm or misconduct occurs when they fail to do so. But to do so is to be constantly reminded that "but for the grace of God there go I." When they choose to act independently of the grace and power that God supplies, they are in danger of becoming "gods." Instead of "being all things to all men," in the hope of "saving some" (1 Cor 9:22), they do so in an attempt to boost their inflated ego. When the pastor and clinician neglect to stay in constant communion with God for spiritual growth and insight they become more prone to living out their fantasies, part of which can be their sexuality. And when they fail to recognize that they are sexual beings made so by God for intimacy that is pleasing to Him within the covenant relationship of marriage, they put themselves in the way of sexual temptation without the armor of God.

The therapeutic relationship is emotive. It is a relationship between two people in a close setting dealing with deep emotional wounds. To be authentic in the therapeutic process both the pastor and the parishioner must make themselves vulnerable. The pastor makes him/herself vulnerable by entering into the experience and journeying with the person. The parishioner becomes vulnerable by opening to the pastor the pain or trauma of the presenting problem. That level of vulnerability draws both parties into an intimate bond.

Oftentimes sexual issues are discussed. The reason for the counseling may be of a sexual nature. The parishioner may have lost sexual interest in the spouse or vice versa. He/she may describe the presenting problem as not being made to feel like a man/woman. There may be feelings of inadequacy on the parishioner's part in the marriage. The

person may be questioning his/her attractiveness to the opposite sex due to being single past their expected time.

At this point the pastor must be clear on the difference between *care-taking* and *care-giving*. In my view, *care-taking*, on the part of the pastor, is taking from the clients the ability to do their own self-care. The person comes to rely on the therapist to not only tell them what is wrong but to also shield them from the experience that is necessary for them to grow and heal. *Care-taking*, on the part of the pastor, is enabling the dependency of the parishioners. Conversely, *care-giving* is engaging the clients in responsible and active involvement in their own healing. The client comes to believe that it is within them to learn, heal, and grow in relationship with Jesus Christ and that the pastor is there to journey with them and help guide the process towards wholeness. *Care-giving* is empowering the parishioners. The pastor who is a caretaker may not allow the people in counseling to experience their pain as a part of healing nor recognize the messages (if any) being sent by the parishioner or may recognize it and feel affirmed by it.

The presenting problem may be a reflection of the pastor's marital dissatisfaction or a romanticizing of being single and available. The pastor may be a sexual predator, a voyeur, or a sex addict, thus the opportunity for exploitation and misconduct is present.

> All the safeguards in the world will not help the counselor who has not come to terms with his own sexuality, who does not loathe the idea of sex with a counselee, and who does not feel the terrible responsibility for helping, not hurting, that soul who comes for assistance.[1]

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[1]Andre Bustanoby, "Counseling the Seductive Female: Can We Offer Help and yet Remain Safe?," *Leadership* 9 (1988): 51.

The pastor must be clear as to what the Bible says about the sexual relationship. Exod 20:14 states: "Thou shall not commit adultery" (see also Matt 5:27-28; Lev 20:10 ff.; 1 Cor 6:17-20). Rebekah Miles writes:

> The statistics on clergy sexual misconduct are sobering. For every case we see in the newspaper, many others are never reported. Though most victims remain silent, the statistics speak loudly. In the best known study, 12.7 percent of pastors admitted to having had sexual intercourse with a parishioner; 38.6 percent admitted to some 'sexual contact.' The rate of sexual misconduct is higher for clergy than for other professions, including physicians, social workers, and therapists.[1]

The moral breakdown in our society has affected the moral guide, the pastor. What affects the greater society also affects the pastor. A primary cause of the societal shift was women entering the workplace in huge numbers during World War II. That in a large measure marked the end of the agrarian society and the traditional gender roles. The couple on the farm working together gave way to the wife and husband, in pursuit of the better life, being away from each other most of their waking hours. The strong rise of the feminist movement and the increased presence of women in the workplace also resulted in closer contact of the sexes. The strong need for emotional intimacy is another factor. These factors also hold true for the overworked, often under-appreciated pastor in search of self and significance. The moral tragedy among clergy is a human and societal tragedy.

Pastors must take deliberate steps to preserve the moral integrity of the Call while being available for authentic and intimate relationships with the people with whom they journey. Among some of the ways pastors can do that are: maintaining a close

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[1]Miles, 103.

relationship with God, actively investing in their marriage relationships (if married), and conducting the counseling sessions in an area that is not too secluded but which allows for parishioner anonymity.

Pastors must be aware of the invisible presence of God, who has called them to be faithful and true undershepherds. They must feed the flock and keep them from predators. But if they are predators it will be impossible to do so. Usually, individuals are aware of their unmet needs even when they are not able to articulate what they might be. One way pastors can keep from preying on the people they serve is to educate the congregation regarding the signs and characteristics of predatory behavior, thereby providing a safety net. Another way pastors can take steps to avoid doing harm is to adhere to a code of ethical guidelines in their ministry both in and out of the counseling relationships. A set of guidelines is provided in the appendix.

CHAPTER 7

A PROFILE OF PASTORAL DIAGNOSIS

What is pastoral diagnosis, and what are the criteria used in diagnosing from a pastoral perspective? These and other questions will be addressed in this chapter. I will also look at the setting for making pastoral diagnosis. The *DSM-IV* has a category entitled "Religious and Spiritual Problems" that will be addressed briefly at the end of the chapter. The sources for this chapter are primarily the works of Paul W. Pruyser and Nancy J. Ramsey. George Fitchett wrote a book on *Assessing Spiritual Needs.*[1] He uses assessment and diagnosis interchangeably. His 7x7 model is developed and discussed in chapter 4. William T. Kirwan has a chapter on pastoral diagnosis in his book.[2] Carroll Wise also devoted a chapter to pastoral counseling in his book.[3] Robert J. Wicks and Richard D. Parson also wrote a chapter on pastoral diagnosis.[4] Their works were

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[1]George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Minneapolis: Augsburg Fortress, 1993).

[2]William T. Kirwan, *Biblical Concepts for Christian Counseling: A Case for Integrating Psychology and Theology*(Grand Rapids: Baker book House,1984).

[3]Carroll A. Wise *Pastoral Psychotherapy: Theory and Practice* (New York: Jason Aronson, Inc., 1980).

[4]Wicks and Parsons, eds., *Clinical Handbook of Pastoral Counseling Vol. 2* (Mahwah: Paulist Press).

recognized in chapter 2 and cited here and other places in the dissertation. There were not many books that dealt solely with pastoral diagnosis at the time of the research.

The Pastors and Diagnosis

When asked in the pre-questionnaire, "Do you counsel from a Scriptural perspective, for example, using scriptural passages?" The six pastors in the survey indicated, yes, they do spiritual counseling. They were also asked in the pre-questionnaire, "When you hear the term diagnosis, do you think of: (1) medical doctor; (2) auto mechanic; (3) computer analyses; (4) other; and (5) not familiar with the term. Five of the six checked the box for medical doctor. They were then asked, "When you hear the term *pastoral diagnosis*, do you think of: (1) a troubled parishioner; (2) a spiritually troubled parishioner; (3) an addicted parishioner; (4) other; and (5) not familiar with the term. Five of the six pastors indicated *a spiritually troubled parishioner*. Three of the six checked *a troubled parishioner*. During the training which I conducted with them, I discovered that none of them used a specific set of criteria to do assessments or diagnoses of the people they counseled. Before the right cure can be administered, the pain must be named. We cannot correctly treat what we have not correctly named. For pastors to have not named what they are treating is to apply the spiritual balm for what might not be spiritually ailing. Pastors can develop a blanket approach to ministering where one set of Theocentric language takes care of every need. In such a one-size-fits-all approach to the various demands of interpersonal ministries, the pastor shoots into the emotional and spiritual darkness of the person's life, and hopes for the best. The problem

with the blanket approach to the counseling ministry is that about the only things we have in common as human beings are that we are broken and we experience pain, loss, and estrangements from time to time. The meanings we derive from those experiences when they occur are as different in nature, intensity, and duration as we are. Paul W. Pruyser, a Clinical Psychologist, can rightly be called the modern pioneer writer in the field of pastors doing diagnoses with their clients in counseling. He is a strong advocate on the subject of pastors doing diagnosis in their counseling ministries. He states that

> the first duty of any professional is to achieve clarity about the problems brought before him for the sake of guiding the interventions he is to contemplate. This is the first duty to his client or patient as well as to his science. If he does not fulfill this duty, he is a charlatan, albeit perhaps a very 'nice' one —whatever his shield proclaims him to be. Or he is only a variant of the old-fashioned vendor of patent medicines standing on his soapbox in the marketplace, selling his one little vial of liquid as the remedy for 'seventy-eight known diseases"[1]

What Pastoral Diagnosis Is Not?

The pastor must be clear in his/her understanding of what pastoral diagnosis is not and what it is. It is not:

1. An occasion to label people
2. An occasion for smugness
3. An occasion to be judgmental
4. An occasion to play psychologist or psychiatrist
5. An opportunity for self-adulation
6. An occasion to be autocratic or dictatorial

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[1]Pruyser, 58.

7. An occasion to be a religious over-lord

8. An occasion for pontification or condemnation.

Pastoral Diagnosis Is Not an Occasion to Label People

By the term *label* I mean to define people by their actions or behaviors. For example, the pastor might label a person who has had or has been having an extramarital relationship as an adulterer. While the name for the person in such a behavior is accurate, wearing the label might get in the way of counseling. It might be more prudent to help the person see from Scriptures that the act is called adultery by God and that He is displeased with anyone who engages in such behaviors. If the focus is moved off the person and onto the action or behavior, the likelihood of being able to work with that person towards positive change is greater. A label from the pastor, unfortunate as that would be, could be internalized as condemnation from God. If the pastor is perceived as the dispenser of or a beacon to God's grace, then to be labeled might mean to be outside or beyond the grace and graciousness of God. Negative perception on the part of the client would create an emotional disconnect and/or roadblocks in the counseling process. Wise believes that

> the concern of the pastor is for the quality of life, the inner condition. But he must not jump to conclusions or generalize about this. His task is to help the person deal with his actual condition as he experiences it. This means that he must deal with the symptoms the person presents as indication of deeper issues. He must make an evaluation of the person and his experiences. He is not interested in labeling people. He is interested in understanding them, and whatever vocabulary he uses should convey that understanding.[1]

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[1]Wise, 83.

Pastoral Diagnosis Is Not an Occasion for Smugness

One of the most destructive presences a pastor can have in ministry is self-centeredness. The life and ministry of Jesus are the epitome of other-centeredness. He said, "I am among you as one who serves" (Luke 22:27). Paul's admonition to the church in Galatia is very apropos for pastors in the exercise of their ministry. He writes, "Brethren, even if anyone is caught in any trespass, you who are spiritual restore such a one in a spirit of gentleness, each one looking to yourself, so that you too will not be tempted. Bear one another's burden, and thereby fulfill the law of Christ. For if anyone thinks he is something when he is nothing, he deceives himself" (Gal 6:1-3). The pastor must guard against becoming self-absorbed with his/her own accomplishments, beliefs, successes, or victories while remaining ever conscious to the true nature and focus of Christian counseling. Wayne A. Mack writes:

> In Christian counseling, the Christ of the Bible is not to be an appendage. He is not a 'tack on' for surviving life in the 'fast lane.' He needs to be at the core, as well as the circumference, of our counseling. If we want to understand the nature and causes of a person's human difficulties, we need to understand the ways in which that person is unlike Christ in his or her values, aspirations, desires, thoughts, feelings, choices, attitudes, actions, and responses. Resolving a person's sin-related difficulties requires him to be redeemed and justified through Christ, receive God's forgiveness through Christ, and acquire from Christ enabling power to replace unChristlike (sinful) patterns of life with Christlike (godly) ways of life.[1]

I do not know how Mack is using the term *sin-related difficulties* here. While the difficulties of life are the results of original sin, not every difficulty people find themselves in is the result of specific actions on their part. Bad things do happen to

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[1]Wayne A. Mack, quoted in Ed Hindson & Howard Eyrich, eds., *Totally Sufficient* (Eugene, OR: Harvest House Pub., 1997), 27.

innocent people, and they and their loved ones do suffer loss and even death at times.

Pastoral Diagnosis Is Not an Occasion to Be Judgmental

People bring two basic human flaws into counseling. The first flaw is a distorted view of reality, although it may seem possible or even plausible at the time. The second flaw is the tendency to blame. The person could be blaming himself/herself, someone else, or God. Rabbi Kushner writes, "One of the ways in which people have tried to make sense of the world's suffering in every generation has been by assuming that we deserve what we get, that somehow our misfortunes come as punishment for our sins."[1] The pastor should be careful not to encourage these two tendencies in the client but rather help the person to process and correct those behaviors, should they arise, during the therapeutic process. Above all, the pastor should take deliberate steps to avoid blaming, judging, or sounding judgmental. Jesus said, "Do not judge so that you will not be judged. For in the way you judge, you will be judged; and by your standard of measure, it will be measured to you" (Matt 7:1-2). The pastor must be ever mindful of the saying, "Were it not for the grace of God, there goes me." The pastor must develop the ability to journey with the client all the while inviting the person to look into the windows of his/her life and address what he/she might see or discover. Among the many responsibilities the pastor has to the client, one of them is to provide guidance during and through the counseling process. Clinebell writes:

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[1]Harold S. Kushner, *When Bad Things Happen to Good People* (New York, NY: Anchor Books: A Division of Random House, 1981), 12.

> The fact that ministers are perceived as representatives of certain ethical values and religious beliefs (whether or not these perceptions are valid) probably prevents some guilt- and doubt-laden people from seeking their help. The fear of being judged causes some persons to avoid clergypersons. Yet ministers who are, in fact, self-accepting and therefore able to be nonjudgmental towards others, communicate acceptance through their total ministry.[1]

Pastoral Diagnosis Is Not an Occasion to Play Psychologist or Psychiatrist

Psychiatrists are medical doctors with a specialty in treating psychological disorders. They prescribe psychotropic medication. Medication is the primary treatment methodology of psychiatry. Psychologists in general do not prescribe medication but focus more on various psychological therapies. Pastors should not gravitate towards nonbiblical disciplines for the purpose of developing the nomenclature method in the place of biblically based counseling. The pastor does not need psychological jargon to diagnose the congregants in need of counseling.

> [People] come to their pastors because they wish to be understood within a spiritual context; as whole people. They do not, in most cases, view the pastor as a psychological professional who happens to charge less [money], but as a spiritual leader who will be able to help them in their journey towards wholeness.[2]

People come to the pastor because, among other things, he/she is accessible. The pastor most likely would already have a pastoral, familial relationship with the person desiring counseling. The pastoral image is or should be an invitation to Christ. The pastor, unlike secular helping professions, deals with the integration of the whole person.

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[1]Clinebell, 70.

[2]Miller and Jackson, 3.

The person's physical or emotional hurts or distresses affect the other areas of his/her life. Other professions specialize in dealing with various aspects of the person, whether it is the physical, mental, or psychosocial as the needs warrant. Within these three areas of the person's life are further sub-categories of specialization. The pastor, however, works with the client through all the different life-challenging events and suffering while recognizing the need for other disciplines specializing in the client's various areas of needs and working collaboratively with them.

Pastoral Diagnosis Is Not an Occasion for Self-adulation

One of the most injurious effects of the counseling process is when pastors set themselves or their families as the standard for what is the right thing to do. Pastors' diagnoses are not a display of their wealth of knowledge. The purpose is not to impress the person seeking help but through dialogue and collaborative assessments determine what the presenting problem is and how best to address it from a scriptural perspective. The biblical process of restoration and reconciliation is one in which the helper must be humble. He/she must guard against pride and haughtiness. Scriptures counsel us on how to deal with those who are erring. "Brethren, even if anyone is caught in any trespass, you who are spiritual restore such a one in a spirit of gentleness, each one looking to yourself, so that you too will not be tempted. For if anyone thinks he is something when he is nothing, he deceives himself" (Gal 6:1, 3). McMinn writes:

> Even a counseling relationship, though a significant part of effective treatment, is prone to self-serving distortion, manipulation, and abuse. When the counseling relationship works well, it is because it mimics the redemptive relationship Christians experience with God through Christ. Unfortunately, we counselors sometimes forget

that our best work is only a poor imitation of God's redemptive nature, and we start seeing ourselves as powerful saviors.[1]

Pastoral Diagnosis Is Not an Occasion to be Autocratic or Dictatorial

One of the primary roles of the pastor in counseling is that of reconciler (2 Cor 5:20). As far as possible the pastor must work towards being successful in helping the clients become reconciled to or renewed in their faith walk with God. I am referencing Paul's letter to the church at Corinth with the awareness of his second letter to Timothy in Ephesus—in which he told Timothy to "preach the word; be ready in season and out of season; reprove, rebuke, exhort with great patience and instructions" (2 Tim 4:2). The Greek word for preach here is *kerusso* which means to herald, to proclaim. There are times when in the interest of preserving and maintaining the biblical integrity of the congregation the pastor must take a firm stance on an issue. When pastors enter into counseling relationships with members of their congregations, their primary roles switch from that of shepherds/sheep to counselors/clients relationships. See figures 1 and 2 in chapter 4. Therefore, during counseling a dual relationship exists between the pastor and the parishioner—that of shepherd/sheep and counselor/client. The former is primarily a pastoral care role. The latter is a pastoral counseling role which is a specialized part of pastoral care. In the pastor's clinical function, the primary focus is on pastoral counseling, not pastoral care. Paul's counsel to Timothy fits more in the role of pastoral

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[1]Mark R. McMinn, *Psychology, Theology, and Spirituality in Christian Counseling* (Wheaton, IL: Tyndale, 1996), 43.

care. The Greek word for therapy is *therapeuo* which means to heal or cure. As a therapist in counseling, the pastor is seen as the healer or the one who connects the spiritually sick to the source of healing, health, and cure. There are also times when pastors in their pastoral care role are perceived as healers, especially when visiting and working with the sick in the congregation.

Pastoral Diagnosis Is Not an Occasion to be a Religious Over-Lord

Pastors are authority figures both in the larger community and in their faith community. This authority according to Ramsay "reflects the clarity of orientation and confidence of purpose that arise as the theological claims of one's faith community and one's religious experience are integrated into the core of one's identity and practice of ministry."[1] Pastors bring that authority into their greater relationships with the parishioner; that is, as a shepherd/spiritual leader. The pastor's most significant role is that of prophet and priest—the one who speaks to the congregation on behalf of God and who prays to God on behalf of the people. As such the pastor's words and actions have impact and carry weight. The primary context for a person who enters into a counseling relation with the pastor is that of spiritual connectedness. Clinebell states that "pastors are unique among counselors in their social and symbolic role. They are 'representative Christian persons' — representatives of the beliefs, values, and life together of a

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[1]Ramsay, 109.

congregation—who 'bring Christian meanings to bear on human problems.'"[1] The Apostle Peter's counsel to pastors is to "shepherd the flock of God among you, exercising oversight not under compulsion, but voluntarily, according to the will of God; and not for sordid gain, but with eagerness; nor yet as lording it over those allotted to your charge, but proving to be examples to the flock" (1 Pet 5:2-3).

Pastoral Diagnosis Is Not an Occasion for Pontification or Condemnation

Jesus said, "Be merciful, just as your Father is merciful. Do not judge, and you will not be judged; and do not condemn, and you will not be condemned; pardon, and you will be pardoned" (Luke 6:36-37). Wicks and Parsons believe that "the pastoral counselor needs to have a healthy form of respect, reverence and love for himself or herself if he or she is going to be able with God's help to have a healthy love and respect for others."[2] Key to pastoral counseling is acceptance and trust. Acceptance is needed by the pastor of the client, a fellow broken human being with the capacity and potential for wholeness and change through Christ. The clients trust that they can bring their pain and distortions to another human being who will help them sort things out in an environment that is safe and allows for vulnerability without fear of reprisals. Bill Blackburn writes:

> In a more direct approach to guidance, a pastor listens carefully and explores through questions and clarification what the client's issues are, and how they are

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[1]Clinebell, 70.

[2]Wicks, Parsons, and Capps, eds., 60.

viewed by him or her, how they have been responded to and what the person sees as the options. Then the counselor shares what he or she has heard from the counselee, some perspective on what is happening, and initial guidelines or suggestions about how to deal with the issue. Here the pastor can deal with biblical principles that seem pertinent and can point to particular Scripture passages, and can even assign some specific task to do, such as reading certain Bible verses or other books. Here the pastor may also discuss with the counselee the importance of taking care of him-or herself in regards to diet, exercise, sleep, hobbies, social contacts and spiritual disciplines.[1]

What Pastoral Diagnosis Is

Pastoral diagnosis is:

1. An opportunity to name the pain for the purpose of care

2. An opportunity to use the authority of Scriptures to determine the client's spiritual needs

3. An opportunity to correct any distortions the client might have of God

4. An opportunity to journey with someone into their life's experience to gain a better understanding and insights

5. An opportunity to show positive regard and empathy to the one in crisis

6. An opportunity to shepherd a soul with humility

7. An opportunity to explore the client's understanding of grace

8. An opportunity to explore the significance of the religious rituals in the client's life.

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[1]Sanders, 78.

Pastoral Diagnosis Is an Opportunity to Name the Pain for the Purpose of Care

Pastors in their religious roles of caring for souls in crisis have been spiritual diagnosticians. They have used the Christian faith and theological language to inform their thinking and to understand and label the human experiences. Then what is it to diagnose someone? What is involved in the process? Is it static or ongoing throughout the counseling relationship between the healer/helper and the one seeking healing or help? How is the process informed? By whose or what authority is diagnosis done?

Diagnosis is the process of naming a condition or experience for the purpose of providing the appropriate or most helpful intervention. "Diagnosis is the practice of strategic knowledge in the sense that how a situation is named has everything to do with the intervention one develops in order to respond."[1] Pruyser states that "to diagnose means grasping things as they really are, so as to do the right thing. . . . One might say that whenever we are presented with a condition, especially one that entails stress, suffering, or unhappiness, which in turn elicits a desire for relief or melioration, the first thing to do is to diagnose."[2] Diagnosis comes from two Greek words, *Dia* meaning through or by means of, and *Gnosis*, meaning to know or knowledge obtained through careful observation that can be verified. Although the word is mostly associated with medicine, it can also be used in many professional disciplines to ascertain the nature of a problem so as to devise the most effective and applicable resolution. As a theological

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[1]Ramsay, 1.

[2]Pruyser, 30-31.

professional and based on his or her educational background, the pastor is equally qualified to diagnose the people he/she is helping so as to employ the best method by which healing and restoration might be realized.

> Any would-be helper must know what he is dealing with; otherwise his moves are only shots in the dark. Thus regarded, diagnosis is very much a pastoral task also. It should be a substantial part of any pastor's daily activities. Who would deny that pastors need to approach their charges with a discerning knowledge of their condition, their situation, or their plights, and with discriminate ideas about desirable aid or intervention?[1]

Ramsey states that, "diagnosis is not a neutral process; it has both interpretative and constructive functions. Diagnosis reiterates the anthropological and philosophical assumptions of the practitioner and validates the usefulness of those assumptions for naming a reality."[2]

Pastoral Diagnosis Is an Opportunity to Use the Authority of Scriptures to Determine the Client's Spiritual Needs

"All Scripture is inspired by God and profitable for teaching, for reproof, for correction, for training in righteousness; so that the man of God may be adequate, equipped for every good work" (2 Tim 3:16-17). The Word of God is not static but active, dynamic (Heb 4:12). Biblical truths help direct our lives and liberate us from spiritual and emotional destruction. The Bible aids in our comfort (2 Cor 1:3-4), guides in our decisions (Prov 3:5-6), gives us counsel (Ps 119:45-46), offers hope (119:74),

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[1]Ibid., 31.

[2]Ramsey, 9.

gives us assurances for the sin problem (1 John 1:9), and provides inner peace (Matt 11:28-30). Formally or informally, the Bible must inform the counseling and therefore the diagnostic process. Skillfully managed and applied, the Bible is deeply resourceful in helping to determine a person's spiritual needs. It can aid in exploring the dynamics of a person's inner life, awareness of the holy, celebrate wholeness, address sin and its consequences, and bring emotional comfort as a balm for human brokenness. Aden and Ellens write, "The Bible was seen as a 'religious source' that could offer comfort and moral guidance. It could also aid exploration of the counselee's inner dynamics. Some call it a diagnostic instrument that, in the hands of a skilled pastor, can reveal much about a person's inner conflicts and emotional distress."[1]

Pastoral diagnosis is a process that serves to provide the pastor with a more accurate knowledge of the parishioner's predicament for the most helpful intervention, and the Bible is the main instrument. There is a direct correlation between diagnosis and treatment. To misdiagnose is to mistreat. Therefore, Scriptures should be chosen contextually and hermeneutically. The anthropological questions the pastor should ask him/herself are: What are the historical, social, and cultural settings for that particular passage of Scripture? How was it helpful to the hearer then? How has it changed the hearer's worldview? How is it rooted in the incarnation, God's act in salvation history? And is it relevant to the person who, now, seeks support at a time of personal crisis? Ramsay believes that

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[1]Aden and Ellens, 43.

> pastoral diagnosis offers importance resources for such a time as this. Diagnosis is never neutral. It always reiterates the anthropological and philosophical assumptions of the practitioner. It is an inherently hermeneutical process. It has constructive possibilities, especially when practiced collaboratively with those whose operative worldview is inadequate for their predicament. Pastoral diagnosis is such a resource with those whose theological worldview is not sufficiently developed to sustain them at a time of crisis or needs revision in order to be adequate.[1]

Pastoral diagnosis is hermeneutical in that it is an interpretation of God and the biblical narratives. It reflects the values and theological assumptions the pastor holds based on the beliefs and practices of his/her faith community. Because hermeneutics is a method by which we understand something, it is interpretative and therefore subjective. Pastors bring their experience, theological understanding, and faith development subjectively into the diagnostic process. What the pastor believes theologically, what shapes the pastor morally, his/her life experience and pastoral identity, all help to determine the pastor's diagnostic approach. Among other things both Nancy Ramsey and Steven Ivy see pastoral diagnosis as a hermeneutical process. Ivy writes:

> Pastoral activity interprets scripture and theology. It is hermeneutical. Both diagnosis and scriptural interpretation look to texts and seek to discover their meaning. Scripture interpretation depends upon definite canon which the interpreter must respect. These include accurate translation, accurate knowledge of the historical setting of the passage, knowledge of the history of interpretations of the text, comparing the text with other texts which illuminate it, and sensitive application of the text meaning to contemporary life. Likewise, there are key diagnosis canons which the interpreter of the 'living human document' must respect. The comparison goes beyond simple method, however, to include our root theological purpose.[2]

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[1]Ramsey, 1.

[2]Steven S. Ivy, "Pastoral Diagnosis as Pastoral Care," *The Journal of Pastoral Care* 42, no. 1(1988): 81-82.

Pastoral Diagnosis Is an Opportunity to correct any Distortions the Client Might Have of God

Part of pastoral diagnosis is to look at how the person's beliefs about God have been affected. How is God viewed in the midst of crisis? Since Christian counseling is Theocentric, the success of the counseling is dependent on both the parishioner and the pastor establishing a biblical frame of reference as early as possible in the counseling. This is especially true if the client's level of distress has caused him/her to blame or harbor angry feelings towards God for what he/she has come to believe God should have prevented. Jurgen Moltmann writes:

> Anyone who suffers without cause first thinks that he has been forsaken by God. God seems to him to be the mysterious, incomprehensible God who destroys the good fortune that He gave. But anyone who cries out to God in his suffering echoes the death-cry of the dying Christ, the Son of God. In that case God is not just a hidden someone set over against him, to whom he cries, but in a profound sense the human God, who cries with him and intercedes for him with His cross, where man in his torment is dumb.[1]

It is good pastoral care when the pastor can gently and patiently help the person in crisis, though emotionally and spiritually blinded by tears and agony, to see the Servant suffering with him/her all the while saying, "I will never desert you, nor will I ever forsake you" (Heb 13:5). The pastor can cite the scriptural narratives and history to show how the good do suffer. In cases where the client is angry towards God, the prophet Jeremiah's anguish in Lam 3:1-20 might be a good reference point. Job, the God-fearing man from Oz, might be another. Job's experience depicts the conflict between good and evil over the human race. Here a righteous man for no apparent reason

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[1]Campbell, 47.

suffers some gut-wrenching, life-altering, excruciatingly painful experiences. His comforters only added to his misery. In the end God declared to Job that in his humanity he could not possibly understand eternal realities. King David's baleful cries in response to both his own anguish and that of the people around him recorded in the Psalms are also a helpful resource in a clinical setting to help individuals face their own "dark night of the soul." To the person who blames God for his/her predicament, God can be known as "the Father of compassion and God of all comfort" (2 Cor 1:3) and "a present help in times of need" (Ps 46:1) only after he/she has experienced a catharsis. This is where the pastor can be extremely helpful if gentleness, empathy, and the effective use of Scriptures are employed. Speaking of our ability to have a distorted view of God, Ellen White writes:

> [Satan], the enemy of good blinded the minds of men, so that they looked upon God with fear; they thought of Him as severe and unforgiving. Satan led men to conceive of God as a being whose chief attribute is stern justice,--one who is a severe judge, a harsh, exacting creditor. He pictured the Creator as a being who is watching with a jealous eye to discern the errors and mistakes of men, that He may visit judgments upon them.[1]

Jesus, after been told about the slaughtering of some Galilean zealots by order of Pilate while they were offering their sacrifices in the temple, cites the killing of the eighteen people upon whom the tower of Siloan fell to show that disastrous things happen to people irrespective of their moral lifestyle. See Luke 13:1-5. A commonly held belief at that time was calamitous things befell those who were really sinful.[2] What they were

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[1]White, *Steps to Christ*, 10.

[2]Norval Geldenhuys, *The Gospel of Luke* (Grand Rapids, MI: Wm. B. Eerdmans Pub. Co., 1979), 370.

experiencing was a result of God visiting judgment upon them for their dreadful life-style. Their fate was not a result of their sins—Jesus says that they were not worse than others—but serves as a reminder of the urgent call of the Gospel to change life paths that will ultimately lead to destruction. Commenting on these two passages of Scriptures, Geldenhuys writes, "Through these words the Saviour teaches that 'physical disasters like physical advantages are not indication that those who experience them are either worse or better than their fellow-men.'"[1]

An Opportunity to Journey with Someone into Their Life's Experience to Gain a Better Understanding and Insights

People in crisis usually want someone to understand what they are going through and how they are feeling. They need time to sort things out, assurance, understanding, hope, and encouragement. In order to provide such care, the counselor/caregiver must become vulnerable. In my training with the pastors I discovered that some of them believed that to avoid sexual allegations, they must be aloof and emotionally detached in counseling. Thus they found it safe but difficult to be emotionally present with hurting people. The pastor must be willing to explore aspects of the person's past with him/her in an attempt to better understand their present functioning. Kirwan and others believe that the stages of early childhood development have a significant effect on the adult life. How children experience their parents becomes part of their emotional disposition, which in turn helps define their behavior.

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[1]Ibid., 371.

> The attitudes that children absorb from their parents will stay with them throughout life. That early learning, it has been said has a hundred times more power than does what we later learn as adults. Since the Bible and psychological research both emphasize that how one develops in childhood is a basic cause of later personality and behavioral traits, a counselor should be fully informed about a client's early environment. Was the home atmosphere warm, loving, and accepting, or cold, punitive, and rejecting? It is essential that the counselor be aware of the unique factors which have contributed to the counselee's present problems.[1]

Human beings after the sin of Adam lost their eternal life and, along with that, a strong moral image—the image of God. "Let Us make man in our image, according to Our likeness" (Gen 2:26). The result is that we are all damaged in various ways and experience different degrees of brokenness. The theological and psychological implication is that God in Christ has granted us eternal life (justification) and is at work restoring His moral image in us (sanctification). We are all part of a system, the family of origin. As part of the assessment and so as to inform the diagnosis, the pastor must look at the system of which this person is a part. How is that system impacting or contributing to the present problem? Is the person's family system a resource in his/her life? Are the resources in that system sufficiently equipped or adequate to meet the person's needs? If the family system is a major contributor to the presenting problem, can the system be corrected enough to accommodate growth and wholesomeness?

The pastor must also be willing and able to journey with the person in crisis out of his/her own experience of pain and suffering. As human beings, we differ in the amount of suffering we have experienced. It is possible for pastors to be undamaged and still have empathy for the parishioner's experience. Regardless of the amount of suffering

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[1]Kirwan, 163-164.

pastors might have had, it is important for them to embrace their own suffering so as to not attempt to explain human suffering nor justify God's action in suffering. Pastors must be careful not to become too detached from or enmeshed with the client's experience. Any theodicy about God in suffering is an attempt to assume the mind of God. If we can explain God, then He ceases to be God and we become god. The created presumes to explain the rightness or wrongness of the Creator's actions. Rather than trying to explain suffering or God's purpose in it, the pastor should allow his/her own experience with pain and suffering to guide him/her in being a comforting presence—one who has few words but is abundantly available. In this way the focus of care and counseling is on the one in crisis rather than any attempt to explain or justify God's action.

One of the goals of pastoral counseling for a person in pain and suffering should be to help the individual not to abandon his/her faith, but rather, like Job, believe steadfastly in the Providence of God. The pastor does not accomplish this by denying the person's pain or anger, if present. Nor does he/she attempt to justify the ways of God. The person's grief may even spill over into anger or disrespect towards God. In the early stages of counseling and care even such behaviors or outbursts should be patiently tolerated while the pastor helps the sufferer rediscover the God of grace and mercy and eventually come to rest in His wisdom and sustaining grace. Richard Eyer believes that people's "anger towards God needs to be encouraged to come out, but sometimes the acclaimed absence of God's caring is due to a spiritual ignorance of how God makes

Himself known."[1] If the outbursts and anger towards God continue after several visits, the pastor should explore what, if anything, is the root causes of them. There may be earlier experiences of lost or distorted images of God from father figures that need correcting. Richard Eyer writes, "While theodicy attempts to justify the ways of God to a suffering person, what a person really needs in order to face suffering is to stand justified before God. . . . In fact, interpretation of suffering is better made by the sufferer than any person, and retrospectively rather than prospectively."[2]

The pastor's ability to wait in silence and allow the person to take the lead is possibly the most effective tool in his/her counseling repertoire in times of sorrow. Campbell believes that "pastoral care is a relationship founded upon the integrity of the individual. Such a relationship does not depend primarily upon the acquisition of knowledge or the development of skill. Rather, it depends upon a caring attitude towards others which comes from our own experience of pain, fear, and loss and our own release from their deadening grip."[3]

The pastor must resist the temptation to free the person from the painful experience because it is discomforting to the pastor. The pastor should get in touch with his/her own pain and loss and become the "wounded healer." Understanding in such instances comes from the shared experience of human suffering. The pastor comes

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[1]Richard C. Eyer, *Pastoral Care under the Cross: God in the Midst of Suffering* (St. Louis, MO: Concordia Pub. House, 1994), 68.

[2]Ibid., 47.

[3]Campbell, 46.

alongside the sufferer and helps him/her interpret the suffering, be it physical or emotional, its impact of his/her spirituality and understanding of God in the midst of it.

If executed carefully and successfully, the pastor will help the sufferer comprehend the involvement of God through the motif of the suffering Servant, thereby, deepening his/her faith, encouraging hope, and reducing anxieties. According to Richard Eyer:

> If a pastor tries to relieve a parishioner's anxiety without helping him look at his suffering, the parishioner may be denied an opportunity for spiritual growth. Merely to aim at removing suffering may be to succumb to the theology of glory. The theology of the cross helps a parishioner wrestle with his relationship with God in suffering. The fact that God chooses mysteriously to come to us in the person of His son, Jesus Christ, in the midst of His suffering on the cross, is significant. Learning to carry our crosses faithfully is also significant.[1]

The journey into acceptance and/or believing in the providence of God begins with validation of the person's feelings. The apostle Paul writes, "Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort who comforts us in all our affliction so that we will be able to comfort those who are in any affliction with the comfort with which we ourselves are comforted by God" (2 Cor 1:3-4). The Greek root word for comfort is *parakaleo* (to call). The noun form of the word is *paraklesis*. It means to walk alongside, to come to the side of someone to aid and guide. In this passage, according to Vine, it signifies exhortation.[2] This is the true calling of pastors in times of the parishioners' crises. Pastors, using Scriptures and the pastoral

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[1]Eyer, 44-45.

[2]W. E. Vine, "Paraklesis," *An Expository Dictionary of New Testament Words*, (Old Tappan: Fleming H. Revell Co., 1966), 207.

relationship and image, helps and even challenges the sufferer to encounter God in the suffering and in the silence, as unknown and yet known, as absent and yet present, as a stranger and yet a friend who is closer than any earthly ties, in the confusion yet having a clear knowledge of Him, in the darkness yet being in the light. Charles Gerkin believes that

> good pastoral care is not simply talk about the gospel or some general statement of its applicability to people's lives. Rather, good pastoral care embodies the gospel in relationships by speaking to the inner being of individuals. Good pastors seek to relate to persons in ways that make possible what the theologian H. Richard Niebuhr calls 'moments of revelation.' What is communicated to the relationship makes a connection with the internal history of the person in a new and potentially transforming way.[1]

An Opportunity to Show Positive Regard and Empathy to the One in Crisis

According to Corey, Carl Rogers, the humanistic psychologist in his Person-Centered model for counseling, believes that for the client to experience the freedom to start their journey towards personal growth, the counselor must, among other things, communicate "a deep and genuine caring for him or her as a person. The caring is unconditional, in that it is not contaminated by evaluations or judgments of the client's feelings, thoughts, and behavior as good or bad."[2] Rogers also advocated that the counselor must show "empathetic understanding" towards the client. By that, Rogers advocates that the counselor must act towards the clients in such a way that will allow

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[1]Gerkin, 88-89.

[2]Corey, *Theory and Practice of Counseling and Psychotherapy*, 206.

them to have a deeper understanding of himself/herself so as to recognize the incongruity within. The counselor then senses the client's feelings as if they were his/her own without getting lost in those feelings.[1]

While Roger's theory has some strength for Christian counseling, it also poses some challenges. Among the strengths are: (1) the focus is on the client as a person, (2) the client is treated as an equal, (3) the counselor must show unconditional positive regard to the client, and (4) the counselor senses the client's feelings as his/her own. Applying those four principles to Christian counseling I would say that the pastor as counselor must: (1) be a shepherd to the sufferer, (2) walk with the parishioner in crisis as a fellow sinner saved by grace, (3) show *agape love* to the client, and (4) make himself/herself vulnerable by feeling his/her own pain and woundedness all the while staying focused on the needs of the client.

One of the weaknesses in Roger's theory is that there is no room for God. His view is humanistic. The client searches within himself/herself for meaning. This may be an attempt by Carl Rogers to distance himself from his Christian past of growing up in a Protestant home where play was discouraged and strict religious standards were adhered to. But I affirm that, at our core, even when we are not aware of it, lies an inner longing for someone or something. That someone or something is God. Mankind's restlessness can only be satisfied through an intimate relationship with the Creator. Our search for meaning only makes sense as we discover our purpose in the Creator, and human

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[1]Ibid., 207.

suffering is tolerable only as we surrender to the Providences of the Creator believing that it serves a noble purpose in His grand design. Speaking as a psychologist, Chris Thurman writes:

> My own experience as a psychologist indicates that many of the psychological 'cures' being offered today are as destructive as the original 'disease' they were designed to help. . . . Much of the counseling done today is based on the humanistic assumptions that people are basically good, that people have the answers to their problems inside themselves, and that everyone has the personal power to solve any problem he or she faces. These ideas are not only wrong, but dangerous. They lead people further into the self-centered abyss of 'looking out for number one,' 'pulling your own strings,' 'being your own best friend,' 'awakening the giant within,' and 'winning through intimidation.'[1]

A benchmark statement of Jesus' ministry is that "He was moved with compassion" or "had compassion" (see Matt 9:36; 14:14; 15:32; 18:27; 20:34; Mark 1:41; 6:34; 8:2; 9:22; and Luke 7:13; 10:33, and 15:20). Compassion as a characteristic of God is frequently mentioned in the Psalms. See Pss 78:38; 86:15; 111:4; 112:4; and 145:8. True compassion is demonstrated in the pastor's ability to show deep and genuine care towards the person who comes to him/her for counsel in spite of the nature of the problem or how debasing the person by his/her action might be considered to be. There may be a time during the counseling process when the pastor would have to address sin and challenge the parishioner to repent and return to God. But should that time come, admonition should be given in the context of a genuinely caring and non-judgmental relationship between the pastor and parishioner. To do otherwise too early in the counseling is to risk losing the opportunity to help someone alienated from God,

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[1]Hindson and Eyrich, 99-100.

experience His saving grace flowing through the pastor—the suffering servant—of Christ. The counseling ministry should be modeled after Christ's method of ministering to the people during His earthly ministry. Ellen White counsels that

> Christ's method alone will give true success in reaching the people. The Saviour mingled with men as one who desired their good. He showed His sympathy for them, ministered to their needs, and won their confidence. Then He bade them, "Follow Me." There is need of coming close to the people by personal effort. . . . The poor are to be relieved, the sick cared for, the sorrowing and the bereaved comforted, the ignorant instructed, the inexperienced counseled. We are to weep with those that weep, and rejoice with those that rejoice. . . . By beholding Him, they will be changed into His likeness. We are to encourage the sick and suffering to look to Jesus and live. Let the workers keep Christ, the Great Physician, constantly before those to whom disease of body and soul has brought discouragement. Point them to the One who can heal both physical and spiritual disease. Tell them of the One who is touched with the feeling of their infirmities. Encourage them to place themselves in the care of Him who gave His life to make it possible for them to have life eternal. Talk of His love; tell of His power to save.[1]

In this descriptive statement about the manner in which Christ carried out His work is a systematic approach for the pastor to do assessment and diagnosis. The Synoptic tells of His motivation for working with hurting people, "compassion." The above quote by Ellen White is a mosaic woven into the tapestry of His ministry. Jesus was intimately in community with the people He served. His interest was not in how well people thought of Him, but in the genuine wellness of the people—His parishioners. He identified with their pain and suffering, knowing that He too would soon suffer unimaginable pain and eventual death. He diagnosed their needs—in some cases they self-diagnosed and asked for relief/healing—and He provided the cure. By His words

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[1]Ellen G. White, *The Ministry of Healing* (Boise, ID: Pacific Press Pub. Assoc., 1942), 143-144.

and action the people came to believe that they could place their trust and confidence in Him.

> Christ Himself did not suppress one word of truth, but He spoke it always in love. He exercised the greatest tact and thoughtful, kind attention in His intercourse with the people. He was never rude, never needlessly spoke a severe word, [and] never gave needless pain to a sensitive soul. He did not censure human weakness. He fearlessly denounced hypocrisy, unbelief, and iniquity, but tears were in His voice as He uttered His scathing rebukes. He wept over Jerusalem, the city He loved, that refused to receive Him, the Way, the Truth, and the Life. They rejected Him, the Saviour, but He regarded them with pitying tenderness, and sorrow so deep that it broke His heart. Every soul was precious in His eyes. While He always bore Himself with divine dignity, He bowed with the tenderest regard to every member of the family of God. In all men He saw fallen souls whom it was His mission to save.[1]

In the life of Christ were congruity, empathy, and genuinely positive regard for the people He served. As the Suffering Servant, He could feel their pain, despair, and desperation, while not being overwhelmed by them. He can be moved with compassion and maintain good ethical boundaries. People often change through relationship with another person towards whom they feel unconditionally loved and accepted. Another vehicle for change is for the pastor to show love and acceptance to the erring one while holding them accountable. Whether a person is in counseling because of personal or family crisis, or struggling with sinful habits, the pastor is to be accepting of the person as a person independent of their behavior, and prayerfully and patiently work towards their spiritual growth in Christ.

An Opportunity to Shepherd a Soul with Humility

The heart of any type of pastoral work is shepherding. To shepherd is to provide

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[1]White, *The Desire of Ages*, 353.

care, protection, guidance, and nourishment for healthy growth emotionally and spiritually. The pastor as shepherd is concerned about the whole person: spiritual, psychological, and physical. He/she is concerned with the growth in Christ of the members of the congregation and their call to discipleship. Pastors shepherd in different ways. The different shepherding roles take on specificity based on what the functions of the pastor are and the training necessary to rightly and efficiently execute them. For instance, the pastor in his/her role as teacher is shepherding but the specific label is teaching. A pastor chairing meetings or functioning in other aspects of the business part of ministry is shepherding, but the specific role is administration. A pastor caring for people within institutions is shepherding, but the rubric for it is that of chaplaincy. So too is the pastor in his/she role as counselor. The name of the ministry is counseling, but the role is that of shepherding the souls under his/her care. Watson calls biblical counseling "a way to shepherd souls."[1]

> Jesus knows us individually, and is touched with the feeling of our infirmities. He knows us all by name. He knows the very house in which we live, the name of each occupant. He has at times given directions to His servants to go to a certain street in a certain city, to such a house, to find one of His sheep. Every soul is as fully known to Jesus as if he were the only one for whom the Saviour died. The distress of every one touches His heart. The cry for aid reaches His ear. . . . He says, "My sheep hear My voice, and I know them, and they follow Me." He cares for each one as if there were not another on the face of the earth.[2]

The pastor as a diagnostician has the opportunity to provide a shepherding ministry in a very unique way. Pastors enter into relationships that allow them to

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[1]Watson, 70.

[2]White, *The Desire of Ages*, 479-480.

experience other human beings at the point of their brokenness, disillusionment, estrangement and loss—loss of self, self-esteem, self-identity, or self-direction. The person, for whatever reason, may be disconnected emotionally and adrift spiritually. It is the pastor's responsibility to help such a person reconnect to supportive relationships and reintegrate into that which has salvific meanings. People often come to pastors in times of crisis for an informed understanding of their faith as relevant to their current predicament. Paul Pruyser writes a chapter asking the question, "Why do people turn to pastors?" In it he poses a series of questions; the last two are: "By virtue of their choice of first seeking pastoral help, are they not asking for their problems to be placed in a pastoral perspective? In seeking a pastoral answer, even if recognizing that his may be only a first or tentative answer, are they not placing themselves voluntarily into a value system, and into an ambiance of special tradition and communion which they consider relevant? My answer to these questions is an unhesitating yes!"[1]

In order to shepherd someone, the pastor must get to know him/her. Part of the pastoral dialogue and assessment is an attempt to make discoveries about the person seeking help for the purpose of providing diagnosis and, hence, the appropriate care. William Kirwan has written a book advocating the integration of psychology and theology. In it he says:

> It is essential that the counselor be aware of the unique factors which have contributed to the counselee's present problems. It is possible that these factors may not be exclusively environmental in nature. There may also be organic factors, including genetically transmitted tendencies such as a predisposition to schizophrenia,

[1]Pruyser, 45.

> depression, or some other major affective (mood) disorder. Understanding the unique factors will help Christian counselors, guided by the Holy Spirit, discern which doctrine should become an integral part of the counseling process so that the client may internalize and apply them. The reason for exploring the past is not to place blame but to produce understanding.[1]

It is possible that average pastors in parish ministry need to have significantly more training than they currently have to effectively engage in the level of clinical exploration that Kirwan is proposing. This thesis is not a proposal advocating that pastors become disciplined and adept in the use of psychological nomenclature for counseling. I do agree, however, that pastors need to have some basic understanding of the parishioner's past or family system to better understand him/her and how he/she makes decisions and handles crisis. A person's resistance to change or cyclical behavior may be best understood in the context of familial history. A genogram can be very helpful in revealing patterns of behavior across the family tree. A genogram goes back three generations on both sides of the family. For example, a person coming to the pastor for the same offense again and again may not be remorseful but fearful of God's wrath or experiencing episodes of guilt. The pastor may want to do a genogram of the family to discover if that particular behavior is evident in the ancestors. The moral and cultural values that formed a part of the person's child rearing are another area for investigation. The counselor must exercise restraints so as not to delve too deeply into the person's past. He/she is not to do a psychoanalytical study of the person. Kirwan writes, "It is ironic that while the church eagerly proclaims that Christian character is produced by positive

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[1]Kirwan, 164.

home influences; at the same time it stubbornly resists the notion that past influences may explain negative personality traits in adults. We cannot logically accept the one without the other. . . . We should focus on the general direction of the individual's history."[1]

The Eastern shepherd imagery is that of a person leading his flock. He puts himself in harm's way for the safety of the flock. He braves the elements, caring for the lambs, and ewes, and disciplining the butting rams. He becomes all things to the sheep with the hope of preserving them from harm and self-destructive behavior. Pastoral counselors enter a separate and special relationship during counseling. With the aid of the Holy Spirit they use their biblical and broad knowledge from other disciplines to serve as a guide to the people in crisis, helping them to clarify issues, resolve life's problems, and become resolute in their willingness to surrender to the Lordship of Jesus Christ.

An Opportunity to Explore the Client's Understanding of Grace

"A Human Body: My Crucifix"

A human body, in front of me, dead.
All year long, before my mourning eyes
  to remind me, remind me of the way life is.
A human body, on wood, nailed, hanging.
A strange sight, always there, when I'm not
  to keep me straight about the way things are.
A human body, so cold and lifeless, dead.

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[1]Ibid., 165.

As alive a memory as ever there was
to balance my seeing the horror in a new light.
A human body, a mystery that sends life from death.
Answer to my hopeless fear and pain
to crack the window of my life with hope.
A human body, still . . . alive, quiet . . . rejoicing with me.
Another life is mine in life and in death
to make me courageous in the face of death or worse.[1]

As part of the assessment and diagnostic process, the pastor should explore with the sufferer his/her theology of grace. The evidence of God's grace is Christ, the Suffering Servant on the cross. Grace places a value on us from God's point of view. Oftentimes, people in Christian counseling have unanswered questions about God, justice, fairness, their faith overall, and the beliefs they hold dear. In their pain and or crisis they struggle to see or internalize the grace of God as operating in their lives; all the more so when they have come to believe that God could have prevented what has occurred. At the heart of their query is the question, "Why did God not stop this from happening, or why did He allow it to happen to me?" Depending on the nature of the tragedy the sufferer may ask, "Why would a loving and kind God let this happen?" Eyer believes pastors can play a significant role in the lives of parishioners during their suffering.

> Pastoral care consists not in removing someone's suffering but in helping the sufferer learn to interpret his or her suffering in the light of the cross. Apart from the cross, the sufferer experiences a meaningless and out-of-control world that offers no hope. Such hopelessness makes suffering people vulnerable to our world's desperate

[1]Eyer, 24.

> invitation to take matters into their own hands and, if all else fails, to eliminate suffering by eliminating the sufferer. This elimination of suffering people can be accomplished through neglect, abandonment, or even suicide and euthanasia. Anything to relieve the pain.[1]

It is very appropriate for the pastor to ask the person in counseling if he/she has thought about harming himself/herself or to inquire about their coping skills and support base. While the question about self-harm may seem awkward on the surface, if done empathetically and compassionately, the clients may even appreciate being thought of enough by the pastor to be concerned about their personal safety in the midst of their pain. The pastor becomes a prism through which the hurting person can see and experience the grace of God. Carl Rogers's doctrine of "unconditional positive regards" towards the counselee by the counselor is the Christian counselor's demonstration of God's grace towards us. To be effective in counseling the pastor must genuinely show unconditional positive regard to the person regardless of what they might have done. The pastor must also accept the person when he/she has felt unacceptable. David Augsburger writes:

> The thoroughgoing assurance of God's affirmation of our worth comes through an all-inclusive love called grace. Grace is the acceptance and affirmation of the person before and independent of any action a person can take in the world. Grace affirms that each human being is irreducibly valuable—nothing done or not done can increase of decrease the worth given in the love of God.[2]

This level of intrusion into the soul of another person should be done by a pastor

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[1]Ibid., 24-25.

[2]David W. Augsburger, *Pastoral Counseling across Cultures* (Philadelphia, PA: Westminister, 1986), 140.

who has journeyed into his/her own inner darkness and has experienced first-hand what it is to feel lost, hopeless, alone, and desperate. The counselor must by experience come to know about God what Job learned, having gone from being a prince among men to living among ashes, covered with sores, and scraping with a potsherd. Job lost everything that had value and meaning to him—his children, friends, and fortune. He became the joke and laughing-stock of children. Job not only maintained his innocence, but in the midst of immense tragedy he celebrated the grace and justice of God. He contended that he brought nothing into the world and he cannot take anything out, and that the Lord gives and He has a right to take away. In spite of his deep sorrow, Job used the occasion to bless God. All the while, unseen by and unknown to humans, Job was being held up by God as "My servant . . . for there is no one like him on the earth, a blameless and upright man, fearing God and turning away from evil" (Job 1:8). "All human activity, whether honorable or shameful, responsible or guilty, occurs in this context of the unchanging steadfast love of the Creator which constantly draws all creatures towards wholeness and healing."[1]

What the pastor can help a person to learn or relearn about God is seen in Christ on the cross and expressed in Scriptures such as: Pss 23; 46; Isa 43:1-2; 53; Lam 3:1-33; Heb 4:14-16 and many more.

An Opportunity to Explore the Significance of the Religious Rituals in the Client's Life

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[1]Ibid., 139.

Exploring the rituals of a person's faith as part of the assessment to inform the diagnosis is important. Individuals seek counseling in times of crisis. Often, they come to voice their anger, sorrows, rage, loss, and fears. Their hopes and faith in God, both which might be shaken at that time, along with their religious practices should also be part of the assessment for the purpose of making a diagnosis. Questions about what meanings they place in the rituals of their faith community also need to be addressed. In times of anguish, for the Christian, religious rituals can be significant. They can serve as a conduit to move the individual to a spiritually safe place. Rituals can also serve to help the individual experience the nearness of God, or invoke aid to supplicate on behalf of the sufferer.

> Although pastoral care is more a matter of helping people learn to interpret suffering than doing something to remove it, there are things pastors should do in order to help people live with their suffering—things such as baptizing, providing Holy Communion, praying, and reading Scripture. But even these pastoral doings presuppose the context of the cross of Christ. It is therefore the task of pastoral care to help the sufferer interpret all such 'doings' in terms of the cross in the midst of a parishioner's suffering.[1]

There are ritual observances in regard to the death of someone, and there are ritual observances relating to the celebration of life. I will only address briefly some of those pertaining to the celebration of life according to the traditions of one's faith. Life in the Christian tradition is celebrated in Christ. All faiths have ritual observances pertaining to life and that of death that are indigenous to that particular belief system. For example, the Rosary plays a central role in Catholics' worship and devotional lives.

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[1]Eyer, 25.

The confessional booth is another very important symbol in Catholic worship. The sufferer may ask the priest to hear his/her confession as a part of counseling. The priest may inquire and discover that the person has not been to confession or received communion for quite some time thus helping to inform his diagnosis. There are also the special masses and the service around Penance. One recognized source for rituals in the Episcopalian tradition is the Book of Common Prayer and the liturgies regarding the Eucharist. Forms of prayers, chants, and communion are also rituals that can help people who are in crisis or feel disconnected from God to navigate their troubled water.

Anointing with oil and the laying on of hands can be another vehicle whereby persons are helped to experience the grace, nearness, and/or favor of God in their lives. The Apostle James advises that those who are suffering should pray, those who are happy should sing praises, and those who are sick should call for the elders of the church to pray and anoint them with oil. See Jas 5:16. James puts healing opposite to that of confessing to one another and praying for one another. Applying James's statement to healing at the physical, emotional, and spiritual level, inquiry should be made as to the client's psychosocial relationships. Are there any grudges, anger, or ill will towards others? If a discovery is made, the person in counseling should be helped to address them and, where possible, if further harm will not be done, make appropriate restitutions or amends. Some other rites or rituals in the Christian tradition are (1) baptism, (2) baby dedication, (3) exorcism, (4) the Communion service—including foot washing—in some faiths, and (5) special services with specific observances such as Easter and Palm Sunday, Lent, fasting, and daily devotions at specific times and for a specific length of time. All of them play

an important role as visible and stationary imageries to connect or invite the presence of the invisible God.

Pruyser and Pastoral Diagnosis

Pastoral diagnosis is done in an interdisciplinary environment directly and indirectly. It is done directly when the pastor, most likely as a chaplain, is part of a multidisciplinary team. It is done directly when the person receiving pastoral care is under the direct care of other disciplines. How any or all of the other disciplines are affecting the client must be taken into consideration by all the different professions. For example, the person in care may also be on medication for a psychological or biological reason. The medication may have side effects that alter the person's affect and disposition. The medication, depending on the nature of it, may cause a negative or socially undesirable psychological or physiological response. This condition, if it exists, must be taken into consideration by the pastor during the assessment so as to arrive at an informed diagnosis. A pastoral diagnosis in such an instance would be a result of the collaborative knowledge of all the disciplines actively involved in the client's life, their individual contribution to the person's welfare, and their cumulative effect on the client.

As I view Pruyser's work I come to the conclusion that pastoral diagnosis also takes place in an indirect interdisciplinary environment. That is when the pastors are working alone in their districts with members of the church whose concerns must be viewed through the wider prism of culture and other helping professions that has or is contributing to the person's life. The pastors may not collaborate with other disciplines

when assessing for a spiritual diagnosis but their involvement in the person's life should be considered. For example, the parishioner may have cultural or tribal beliefs that give them permission to seek advice and remedies within that culture that are different from that of the pastor, which must be considered before making a diagnosis. The person may be under medical or mental health care at the time of service or shortly before, and the reason for the other disciplinary care is still relevant. In the second example three disciplines outside of theology and philosophy need to aid in informing the pastor's diagnostic decision: that of sociology, medicine, and psychiatry or psychology. Pruyser contends that on a multidisciplinary team the pastor/chaplain cannot allow questions about his/her contribution to the team to go unanswered, for he/she brings a unique perspective to the team.[1]

Pruyser looks at how the disciplines of theology and psychiatry have influenced each other. Pastoral theology is greatly influenced by psychiatry, psychology, and the medical practice. Conversely, clinical psychiatry has been affected by biology, pharmacology, psychology, sociology, and theology. Both of these disciplines focus on human restoration, be it health or salvation. Pruyser, a clinical psychologist directing the clinical program in a psychiatric institution, sees the need for pastors to develop their own diagnostic identity. He urges pastors to move away from the diagnostic language of other disciplines and use their rich theological heritage in making diagnoses.

Pruyser makes two historical references to diagnosis among the clergy. The first

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[1]Pruyser, 41-42.

dates back to two Dominican monks in the fifteenth century. Their endeavor was to develop a manual, "*The Malleus Maleficarum*, to diagnose the presence of demon possession from other conditions by practicing exorcists. The purpose was to purify the victim's soul. The second body of diagnostic literature dates to Jonathan Edwards's work in 1746 entitled *A Treatise Concerning Religious Affections.* Its purpose was to identify the truly pious from the religious pretenders. In it he spoke of the "signs of gracious affection," how to distinguish saintliness and the qualification for those who are in favor with God and entitled to His eternal rewards. According to Pruyser, Edwards was "a penetrating diagnostician who went well beyond surface impression. He distinguished between good and poor diagnostic indicators and felt that some 'signs' are suspect, if not worthless." Edwards was suspicious of god-talk, or too much use of biblical texts by clients. He did not put much stock in the mere frequency of worship. Pruyser found both approaches to be too authoritarian.[1] Historically, theologians were the ones dealing with what we know today as mental health issues. They dealt with them under the category of the "seven deadly sins."

Why do people come to pastors? This question is at the heart of the book. According to Pruyser, people come to pastors because, by virtue of their choice to seek pastoral assistance, they want just such a theological perspective for themselves and their problems. They are placing themselves in a value system and an ambiance of special tradition and communion which they consider to be relevant, and clergy should not

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[1]Ibid., 31-33.

sidestep this request.[1] In chapter 5, Pruyser offers "guidelines" for such pastoral perspective (see appendix E). The chapter discusses the phenomenology of the religious life under the rubrics of the awareness of the holy, providence, faith, grace, repentance, communion, and vocation. Pruyser closes with a chapter of case reports showing how the "diagnostic guideline" could be used in counseling, which I found helpful.

While I found Pruyser's work very helpful in doing diagnoses, it did not address how a pastor should deal with the psychological aspects of the presenting problem. He does not address the fact here that there may be good reasons for a pastor to be psychologically tuned at times, not just religiously. The pastor as counselor may need to help the people to view their problems in terms of sin, of God's holiness and expectations, and in communion for sure but also psychologically and physiologically. Each person coming to the pastor is a physical, emotional, and spiritual being. These entities of the personhood are interconnected and interrelated. No practitioner can adequately address one without giving some level of attention to the other aspects. Pruyser speaks of the interdisciplinary work in pastoral diagnosis but does not correlate them in these case studies. None of the other disciplines are addressed in these vignettes. Yet at some level every sufferer experiences anxiety to say the least. Pruyser also does not talk about the subjectivity and objectivity inherent in pastoral diagnosis. An assumption is made regarding the pastor's wholeness. There is no apparent diagnosis of the minister's own self-awareness or issues in the pastoral theological terms—the dilemmas of faith and trust

[1]Ibid., 45.

and communion and vocation—which Pruyser recommends the minister use for others' difficulties.

Ramsey and Pastoral Diagnosis

Ramsey believes that all diagnoses are dependent on three criteria that are dynamically interdependent. They are the anthropological assumption, commonly shared guiding values of the counselor and counselee, and mutually understood dynamics of authority in the helping relationship. She says that pastors must be able to articulate their theological assumptions in order to have a mutually critical conversation in pastoral diagnosis. She did not say if the parishioner must also be able to articulate his/her theological assumption so as to be able to participate in this "mutually critical" diagnostic conversation. She proposed that both pastor and parishioner share the guiding values of their faith community. But how is the critical conversation mutual when the person in counseling is spiritually and emotionally disconnected? How is the conversation mutual when the person has questions about their faith or is not able to be sustained by the teachings of their faith at the time of counseling? People often come to pastors in times of crisis for an informed understanding of their faith that is relevant to their present predicament.

Pastoral diagnosis is hermeneutical because pastors bring a theological identity that reflects their internal and external orientation to their faith tradition and perspectives. Guided by Scriptures and the teachings of their respective faith community, pastors can provide help and hope to sufferers seeking help with their problems. Pastoral diagnosis is

both objective and subjective because it is influenced by the theology and traditions of one's faith. Objectively, pastors must know what their theological orientation teaches about the human condition and the biblical response. Subjectively, pastors must themselves know what they believe about the human condition. Like all others, what the pastor believes is shaped by his/her life experience. Therefore, is the pastor an integrated self or dichotomized self? There could be a dichotomy between the pastors' beliefs and their theological orientation; therefore, which self is present with the sufferer in the counseling session is a question the pastor must constantly ask and answer. As a possible answer to this last question, Ramsey suggests that pastors work at developing an identity that is "fluid" so as not to become stagnant, maintain an ongoing engagement with those who are able to renew and enlarge their self-understanding, and develop theological responses to the ideas and situations that confront them.

Ramsey states that pastoral diagnosis relies on three assumptions. They are: an anthropological assumption, a specific world view commonly shared by the pastor and parishioner, and a mutually understood dynamic of authority in the helping relationship. Pastors, according to Ramsey, need to develop the skills to voice their theological assumption in the foundation of other disciplines. She sates that "pastoral diagnosis underscores our need to be multilingual conversationalists, for such conversation may include theological disciplines, ethics, philosophy, cultural anthropology, and theories of personality and therapy."[1] Ramsey does not believe pastors can do effective pastoral care

[1]Ramsey, 14.

guided only by the discipline of theology. The pastor must be aware of and become adapted to being part of other disciplines. In a sense the pastor is part of a multidisciplinary team even when he/she is working alone. Pastoral diagnosis is a rubric for developing and understanding a theological world view which Ramsey calls the "ecclesial paradigm." It is a Christian theological worldview. It describes how Christians see the world and live in it. This ecclesial paradigm, according to her, rests in the redemptive, transforming love of God through Christ.

Ramsey's diagnosis is more theoretical than practical and centered in the tradition of her Reform heritage. While that in and of itself is not bad and is in keeping with her teaching that pastoral diagnosis takes place with a "communally shared guided values," it does not give a practical set of tools by which an informed opinion is formed. She advocated four paradigms through which to view human suffering comparatively across the four paradigms. The four paradigms give pastors a cursory understanding of how to interpret suffering using a medical-psychiatric model, a humanistic-growth psychological model, a transgenerational family system model, and an "ecclesial paradigm" model. She uses the four paradigms to explain and interpret how the person in the case study's brokenness and suffering might be understood in the historical context of sin and salvation as well as its present application to misery, suffering, abandonment, low self-esteem, and alienation. It is not clear to me how a pastor during the pastoral dialogue would form his/her questions to the parishioner using Ramsey's four paradigms. It is possible that with careful note taking, having an excellent memory or an adequate working knowledge of the other disciplines, pastors might be able to understand and

diagnose the people seeking care through the different paradigms that Ramsey proposes; but that is highly speculative by me. Ramsey seeks to (1) retrieve the theological and ethical foundations of the Judeo-Christian tradition for pastoral care; (2) develop lines of communication between pastoral theology and the other disciplines of theology; (3) create an ecumenical dialogue on pastoral care; and (4) move beyond the current preoccupation with secular psychotherapy and the other social sciences. While I applaud her work, I find her book to be too heavy on the theoretical and too light on the practical.

Religious and Spiritual Issues in the *Diagnostic and Statistical Manual of Mental Health Disorders*, Fourth Edition

There has been a long history to bridge the gulf between biblical counseling and that of secular. The *Diagnostic and Statistical Manual of Mental Health Disorders* Fourth Edition codifies religious and spiritual problem as V62.89. It reads, "This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution."[1] This recognition by secular psychologists of religious and spiritual issues that may impact the individual's functioning forms a useful bridge for interdisciplinary communication.

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[1]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 1994), 685.

CHAPTER 8

DEVELOPING A PROGRAM TO TRAIN PASTORS TO DO PASTORAL DIAGNOSIS

Introduction

This chapter discusses three things: (1) The selection of the six pastors, (2) the development and utilization of the training program with the pastors, and (3) some analysis of the questionnaire.

The Selection of the Pastors

I chose the pastors for this study on the basis of three criteria: (1) relationships, (2) phone and personal interviews, and (3) the distance of their districts from the University. I chose pastors with whom I share an especially warm and close connection. Relationally these pastors can be placed into two groups: (1) those with whom I have close friendships and (2) those with whom our friendship is less close but with whom I have good working and social relationships. In choosing these two groups, I hoped to have pastors who are willing to take part in the workshop and at the same time not let our friendship interfere with maintaining a high degree of integrity in the study and its outcome. I interact with the pastors on a weekly basis. We often call each other on the phone to share information and news relating to the field or that might have an effect on

one of us or someone we know. At times we brainstorm about different options to issues we are dealing with in our districts. We call each other, sometimes weekly, to pray and encourage one other in ministry. My contact and interaction with the other three is more sporadic and less specific. However, we are all fairly open and transparent with each other.

They are all African-American. They are from different parts of the conference field. They pastor a diverse group of people across the socio-economical and educational spectrum. They are chosen based on their willingness to commit the necessary time to this training and to using what they have learned in their current counseling relationships. Due to the time constraints of the pastors, three of whom work in multi-church districts, the program was taken to them. I spent two hours a month for three months with each of the six pastors. The time was spent in training, fielding questions, and dealing with scenarios the pastors encountered in the process.

The six pastors were selected, not by random sampling, but in phone conversations and in personal interviews during a conference Workers' meeting. I explained to each the training I was developing and what I hoped to accomplish. I informed each one that he was going to be part of a group of six pastors and solicited their aid as a test group. I asked if any one of them would have a problem working with some of their colleagues in dyads, triads, or even as a group of six if the opportunity occurred. Each consented.

Great care was taken to assure them of how confidentiality would be maintained. Each one of them would be assigned a number, P1 through P6. Each of them would be

known outside of the group by name only by me. Anyone reading the paper or questionnaire would know them only as P1, P2, P3, P4, P5, and P6. The consent form with their names would be kept by me in a locked file in keeping with Andrews University standards governing live research subjects. They were given assurance that they could choose not to continue at any time if for any reason they were not comfortable with the training. Each of them was given the name and office number of Dr. James North, my dissertation adviser. With his permission as the contact person, they could discuss any concerns they might have.

I explained to the pastors that I was doing a Doctor of Ministry degree in pastoral diagnosis. I told them that being able to work with ministers and their families is a passion I developed early in ministry. I shared with them my belief that pastors can use the Bible as their main tool in counseling and not be dependant solely on psychological approaches. I related that I was developing a training manual using some psychological theories and a biblical approach and that I needed a pilot group to do the training. I also shared my personal desire to someday use this manual in our local conference and throughout the denomination. I told the pastors that this training would require them to meet with me twice a month for three months. The training would be given in four-hour segments. While some agreed, others felt that there would be too many sessions. We finally agreed to three sessions of between four to six hours each held in their respective districts. After clarifying what is expected of each of them and addressing their questions, a consent letter was given to each to read, sign, and return to me (see appendix

A). A copy of the consent form was left with each pastor after I retrieved the signed copy.

A number of questions surfaced concerning the nature of my dissertation, how challenging the effort was, why I chose Andrews University, how long the doctoral process was, what I was hoping to accomplish, and how this training would benefit them. Each also asked if they could have a copy of the manual at the end of the training program. To this I assented.

The Demographics of the Study Group

Six pastors were chosen because that is a manageable number for me. Another reason I chose six is that during my preliminary discussions with some of my colleagues, I discovered that they were not willing to travel out of their districts. To have chosen a larger size group would have also increased my travels to an unacceptable level. This would have added a tremendous burden to my already very demanding professional life. I am pastoring two churches while doing this doctoral study, and both churches are engaged in major renovations due to years of structural neglect. I worked with the pastors individually, in dyads, and in triads. Three of the participants live within a 25-mile radius of the campus. The other three live between 90 and 200 miles away. All of the pastors are employed by the Lake Region Conference of Seventh-day Adventists. Three of the pastors are from large cities ranging in size from 791,000+ to 1.9 million. One of the pastors is from a medium-size city of 107,000+. And two of them are from a town of 3,000.

All of them are in congregations that are predominantly African-American. In the questionnaire, I did not ask the size of their congregations because that information is available to me through the Conference. As part of the agreement to preserve their anonymity, the precise membership of the various congregations is omitted. At the time of the training program, their church sizes are as follows: Three of the pastors are in congregations of over 500 members. Three are in multi-church districts. Two of the multi-church district pastors have total congregation sizes of over 400. The other pastor's total congregation size is under 300. Two of the pastors are in dual professions in the denomination. Two of the pastors in the multi-church districts have to travel more than 50 miles one way to their farthest congregation. The counseling load on the pastors is discussed in chapter 9.

My Relationship with the Six Pastors during the Training

Doing this training meant being in close proximity with the pastors for hours at a time in their homes, offices, and in public places. For reasons of propriety I chose six male pastors. On three occasions I met with pastors in their home offices. On one occasion I met with a pastor in my home office. On another occasion I met with a pastor at the Conference office. On two occasions I met with pastors at their church offices. And on one occasion I held the training with three of them in a classroom at Andrews Theological Seminary. The meetings were warm and conducive to learning. All of the pastors ignored or delayed their phone messages for the duration of the presentations. When we were in dyads and triads there was a lot of group interactions. Members of the

group would reach into their past and bring supporting or conflicting information to the discussion. This would take the discussion in directions that were not scripted, but very informative.

All of the participants had taken some psychology courses in college. As a result the language was not foreign to them. Several of the pastors in the study group shared their school-of-counseling preference with me during the presentation. One of the pastors shared that before the sessions he was more comfortable counseling from the Behavioral school. He was not comfortable getting too emotionally involved during the counseling process. Another wanted to get a deeper understanding of Person-Centered theory. All of them were actively engaged in the discussion of Family Systems theory. They wanted to know more about the use of the genogram. Information was given on how to obtain it online. We role played using a vignette of a fictitious family for each of the five theories, the biblically based approach, and application of the categories from the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition *(DSM-IV)*[1]. There was not enough information on the main character in the vignette to do a complete intake interview, but enough to get the sense of how to go about doing an intake.

Analysis of the Survey Instrument

The pre-test questionnaire is made up of two sections with a total of 24 questions. Section 1, consisting of 5 questions, deals with background information. Section 2 has

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[1] From here and throughout the dissertation the acronym *DSM-IV* is used for the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition. (Washington, DC: 1994).

19 questions regarding the pastors' professional experience in pastoral counseling. Section 2 is discussed and highlighted in chapter 9. Section 2 also ascertains the pastors' level of knowledge regarding some *DSM-IV* concepts. The questions are sequenced to deal first with the least intrusive information, which is a more general understanding of the pastor and his knowledge. The questions progress to more personal information and a more specific understanding of the pastor and his knowledge. The questions are designed to give the researcher a working insight and knowledge of the six pastors that he did not have before.

The background questions looked at the pastors' gender, age, and years in active ministry in the church. It also sought information on whether or not the pastors were ordained and, if so, how long, and about their highest level of educational achievement. There were some similarities in the pastors that were discovered and not expected. There were also dissimilarities among them that forced me to discard some previously held assumptions. These will be discussed in this chapter and more fully in chapter 9.

The survey was given to the six pastors over a two-day period at a Workers' meeting. All six pastors were given the instrument the same day and within half an hour of each other. Three of them returned it by the end of the first day. Two of them gave it to me the morning of the second day. I had to ask the sixth pastor more than once for the survey. He turned it in by the end of the second day. The pastor who took the longest did not give any indication of why he took longer, nor did he show any unwillingness to comply. They were each asked to look over the questionnaire before they began to fill it out and if there were any concerns to make them known. None were identified.

The pastors' ages were similar. This was not planned but discovered. See table 2. There were no apparent patterns between their ages and the amount of counseling they do. There was a wider range in their years of active service. See table 2. Some of them have served the church in areas other than parish ministry before transitioning into pastoral work. Pastoral ministry is the only professional job one pastor has done. One pastor's active ministry ranged between one and five years. Three of them were in ministry from between six to ten years. And two of the pastors' years in ministry ranged from sixteen to twenty. The pastors with the longest service record spent most of it in a dual professional role within the denomination.

TABLE 2

BACKGROUND INFORMATION

Year	P1	P2	P3	P4	P5	P6
Question 2: Please indicate your age range						
31-40			x			
41-50	x	x		x	x	x
Question 3: How many years have you been in active ministry?						
1-5			x			
6-10	x			x		x
16-20		x			x	

On the question of years of ordination, the responses were quite unexpected and educating. The question was "Are you an ordained minister? If yes, how long?" It was assumed on my part that pastors generally are ordained with four to six years of pastoral work. That was not always the case among these ministers (see table 2 and compare with table 4). While four of the six pastors were already ordained, two were not (see table 2). Of the two unordained pastors, one had the least number of years in ministry—from one to five. The other unordained pastor had the most number of years in ministry—from sixteen to twenty. Ministry in the latter's case meant working for the church in another capacity while pastoring part-time. The former was understandable and within the norm for pastors in parish ministry; the latter was not. Upon further discussion with this pastor (outside of the questionnaire), it was learned that ordination was not necessary for him to function in his former professional role in church work. He is currently in full-time ministry and soon to be ordained.

No pattern could be made between ordination and counseling. When asked how often they engage in pastoral counseling, the two unordained pastors' responses were the same as the ordained pastors. All six pastors are doing counseling one to three times per month. Because of the strong concerns raised by administration in regard to counseling and litigation, my presupposition was that pastors who were not ordained would not counsel because ordination is often associated with a pastor's ability to meet the conference administration's expectations.

The ordained pastors in the survey were either ordained five years or less, or between eleven and fifteen years. None of them were ordained for longer than fifteen

years and that is consistent with their years in ministry. Typically, pastors are ordained after four to five years of pastoring. I assumed that there would be a strong link between the number of years in ministry or years of ordination and the amount of counseling done. There was not a strong link. Both ordained and unordained did counseling. However, the two pastors who held the most sessions in counseling were in ministry for between six to ten years and were ordained the least number of years between one to five years. The other four held the same amount of sessions.

Two of the six pastors hold doctoral-level degrees in disciplines other than Theology or Divinity (see table 3). The level of education did not seem to have a significant influence on their level of knowledge of the *DSM-IV,* which was part of the questionnaire. The other four pastors had completed master's degrees. There was a link between level of education and counseling. This and other observations in the survey are highlighted and discussed in chapter 9.

The Training Program

The training program (see appendix F) is organized in a three-ring binder with ten sections. Section one details the course objectives and course outline, and explains the vignette and the evaluation at the end of the presentation. In Section two the pastors are shown how to do an intake interview and how to maintain pastors' records. Gathering intake information about the clients is a clinical way of helping the pastors to identify the specific problem and select the appropriate intervention. Training on the usage of the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (*DSM-IV*), is

discussed in Section three. In this section the participants are also given a brief understanding of how to assess a client's psychological, social, and occupational functioning along a hypothetical continuum of mental health/illness. This assessment tool is known as a Global Assessment of Functioning (GAF) Scale. This section is only an introduction to the *DSM-IV* and its application and is not intended to make the participants proficient in its use.

TABLE 3

ORDINATION AND LEVEL OF EDUCATION

Responses	P1	P2	P3	P4	P5	P6
Question 4: Are you an ordained minister?						
Yes	x		x		x	x
No		x		x		
How long have you been ordained?						
1-5 years	x					x
11-15 years				x	x	
Question 5: What is your highest level of education?						
Master's		x	x	x	x	
Doctoral	x					x

Sections four through eight give a brief understanding of counseling from a psychological perspective using five psychological theories: psychoanalytical, cognitive, behavioral, person centered, and family system. This is not intended to be a class in psychology but an introduction to the language and intervention styles of five schools of psychological counseling. In Section nine, training is given on how to use the Bible as a diagnostic tool in counseling. This part of the training is designed to have the participants learn how to use their rich biblical heritage during counseling using Scriptures to reconnect troubled parishioners to Christ as their true source of strength. Finally, a fictitious vignette and a presentation evaluation are given in Section ten. During the training the vignette is used to help the participants practice the different psychological approaches and the use of the GAF Scale to determine the client's level of functioning.

All six pastors had some difficulty placing the vignette character, Jeannine, on the five *DSM-IV* axes. That was gratifying to me. Their difficulties add support to my belief that: (1) pastors who are not adequately trained in the science of psychology should not do psychological counseling; (2) pastors should use psychological terminologies guardedly and sparingly in counseling; and (3) pastors should function within their discipline of theology and use the language of the Scripture when counseling parishioners.

CHAPTER 9

REFLECTION ON THE OUTCOME OF THE TRAINING PROGRAM

This chapter discusses the pre-test findings in section two of the questionnaire. What I learned from my interactions with the pastors and their questions is also discussed here. The responses from the pre- and post-test are compared and addressed. Finally, I will talk about whether or not the training was helpful to the pastors in their counseling.

Parish Counseling as a Part of Ministry

All six pastors indicated that they are doing counseling as part of their parish ministry (see table 4). While this is encouraging, some conference administrators encourage pastors not to do counseling because of the sharp rise in litigation. All six pastors are counseling between one and three times per month (see table 4). The pastors do not counsel much, but they are doing so on a regular basis. While the need for pastoral counseling is great in the congregation, pastors are expected to do less counseling and more pastoral care and church administration. As a result, pastors are not acquiring the level of skills necessary to meet this counseling need in parish ministry.

TABLE 4

PASTORAL RESPONSES AND NATURE OF COUNSELING

Response	P1	P2	P3	P4	P5	P6
Question 1: Do you do any counseling in your parish?						
Yes	x	x	x	x	x	x
No						
How often do you counsel?						
1 to 3 times per month	x	x	x	x	x	x
Question 2: What is the average number of sessions?						
3-5 sessions		x	x	x	x	
5-7 sessions	x					x

The average number of counseling sessions is three to five for four of the pastors. Both pastors with doctoral degrees indicated that the average number of counseling sessions they do is five to seven. Of the two pastors with doctoral degrees, one has a degree in a field related to counseling, the other does not. This is not something I foresaw and therefore did not ask any question on the questionnaire to draw any conclusion between their doctoral degree and length of counseling. It is possible that they average more

sessions because of their advanced academic training. If this is so, it is a faulty premise on which to do pastoral counseling. None are doing brief counseling, (one to two sessions,) before referral. Some church leaders may be concerned that they are spending too much time with a few parishioners instead of fewer sessions with more persons (see table 4).

Referral as a Part of Counseling

All six pastors believe that referrals are appropriate and do make them (see table 5). This area of responses raised some questions. Although my pre-questionnaire interview with the pastors assured them anonymity along with the option to discontinue being part of the program, my questionnaire was not worded in such a way as to allow them to identify areas of vulnerability. In hindsight, it might have been better to have phrased the questions differently. For example, had I asked the question "When is it appropriate to make referrals?" the answer would likely have been different.

All six pastors gave "beyond expertise" as a reason for referrals. Their other reasons for referrals included "time constraints" and "when client is being seductive." The fact that all six pastors did not give "Seduction," "Sexual attraction," or "Emotionally over-identifying" as a reason for referral raised some concerns for me. While some pastors may have unhealthy sexual issues, all pastors should recognize that a seductive counselee—a person who is sexually provocative or emotional captivating presents particular challenges in counseling, and should therefore be referred.

In reference to the findings, my conclusion is that one of the following may apply:

TABLE 5

MAKING REFERRALS AND THE REASONS FOR DOING SO

Responses	P1	P2	P3	P4	P5	P6
Question 3: Is it ever appropriate to make referrals?						
Yes	x	x	x	x	x	x
No						
Question 4: Do you make referrals?						
Yes	x	x	x	x	x	x
No						
Question 5: For what reasons do you make referrals?						
Time constraints	x	x			x	
Beyond expertise	x	x	x	x	x	x
Seductive client		x			x	
Emotionally over-identifying					x	
Sexual attraction		x			x	
Aggressive client		x			x	
Other				x		

(1) the question was not worded correctly, (2) the other four pastors never experienced such an encounter, (3) they did not want to make themselves vulnerable, or (4) they were being naive about a very clear and present danger in the therapeutic relationship. Two of the six pastors gave "their sexual attraction to the client" and "when client is being aggressive" as a reason for referral. Only one of the pastors gave all six categories as reasons for his referral. Some of the pastors may have felt that it was better to answer the questions based on what is expected of a pastor than what was true for them.

Collecting the Client's History

Regarding history taking, all six pastors indicated that they do gather individual, family, and spiritual information from their clients (see table 6). This finding was inconsistent with the pastors' verbalization during the training phase of this study. Part of the training program is learning how to do an intake interview, and how to record the information. Although the pastors said that they gather the parishioners' history, none of the pastors used an intake instrument. As part of the training I provided a suggested intake form for their use. None of them had a working understanding of how the person's history could help them diagnostically. All six pastors felt that the intake was a welcome tool in their counseling arsenal. Some of them had helpful suggestions as to how the intake form could be more helpful in identifying the needs of the people they serve. All were encouraged to adjust the form to their particular information-gathering needs.

TABLE 6

ASSESSMENT, TYPES OF, AND PERSPECTIVES IN COUNSELING

Responses	P1	P2	P3	P4	P5	P6
Questions 6 to 8: Do you ask clients about their history?						
Individual history	x	x	x	x	x	x
Family history	x	x	x	x	x	x
Spiritual history	x	x	x	x	x	x
Question 9: What type(s) of counseling do you do?						
Premarital	x	x	x	x	x	x
Marital		x		x	x	x
Family					x	x
Domestic violence				x		x
Teen		x	x	x		x
Grief			x	x		
Questions 10 to 11: Do you counsel from a psychological and or spiritual perspective?						
Psychological		x		x	x	x
Spiritual	x	x	x	x	x	x

Types of Counseling the Pastors Are Engaged In

Pre-marital counseling was done by all six pastors, more so than any of the other types of counseling. During the training all six affirmed their belief that pre-marital counseling was required before they perform a wedding. Two of the six said that they would not perform the wedding if the couple refused to participate in pre-marital counseling with them. We did not discuss what constitutes pre-marital counseling. No conclusion was drawn concerning the success rate of marriages they performed with pre-marital counseling versus those without pre-marital counseling. From the fervor of the conversation of the two pastors who would not marry couples who did not do pre-marital counseling, I conclude that their resolutions are prompted by current conservative societal trends regarding marriage and the family. Four of the six pastors do marital counseling, and only two do family, grief, and domestic-violence counseling. Teen counseling is being done by four of the six pastors.

While all seven categories of counseling can be too lengthy and complicated for a pastor in parish ministry, I believe that the pastor should at least be involved in the early stages of each of these counseling areas. Referral should be made when necessary. Even then, the pastor, with the parishioner's written consent, should play some ongoing collaborative and supportive roles. Marital and family issues are prevalent in our churches. Domestic violence directly or indirectly affects a growing number of American households. School and playground violence are on the rise. There is a myriad of problems facing the youth of today, even those in churches. These include: Teen pregnancy, drugs and alcohol abuse, eating disorders, youth violence, parental

neglect and abuse, and self-esteem issues. Pastors must be prepared to counsel those affected by societal ills through their emotional turbulence or their "dark night of the soul," using the Bible as a diagnostic instrument. Writing about the pastor's preparedness for counseling, Miller and Jackson write:

> Most [pastors] find their training insufficient in preparing them to deal with the rich diversity of problems that people actually bring to the pastor's office: anxieties and guilt, depression in all shapes and sizes, sexual concerns, alcohol and other drug problems, marital and family difficulties, delusion, difficult decisions, physical abuse, chronic stress, life transitions and thoughts, threats and acts of suicide. The pastor who communicates an openness to counseling with human problems finds all these and more among the people who make their way to the private study or counseling room.[1]

One of the pastors with a doctoral degree only does pre-marital counseling; the other does all kinds except grief counseling. The pastor who does only pre-marital counseling felt that he was not adequately trained to do the other kinds of counseling. Although his answer was honest, it posed a challenge for me. His (P1) years in ministry were reported as six to ten years. In that time I would believe that there would be at least some occasions where the parishioner would come to the pastor for counseling due to some significant losses. I also believe that family issues would caused a hurting member to call on the pastor. It seems clear to me that this pastor was not doing counseling in the areas of ministry which are most common in parish work.

There were notable similarities and differences in the types of counseling performed by the two un- ordained pastors, P2 and P3, who had the longest and shortest

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[1]William R. Miller and Kathleen A. Jackson, *Practical Psychology for Pastors* (Englewood Cliffs, NJ: Prentice Hall, 1985), 4.

tenure in ministry (see table 6). The pastor with the longest tenure, P2, does pre-marriage, marriage, and teen counseling. He does not do family, domestic violence, and grief counseling. It is surprising that he is not doing family and grief counseling, in spite of his rather long service record in ministry. Family problems and grief are as commonplace in society as sand on the beach. One does not have to go far to encounter them. Family problems such as physical, verbal, and substance abuse, death, separation, failing health, individuals leaving home for school or otherwise, the empty nest, and adverse change in fortunes, are prevalent in society and the congregation. It is unimaginable that a pastor can avoid having to deal with them.

The pastor with the shortest time in ministry, P3, also did no marital, family, or domestic-violence counseling. The fact that he and three of his colleagues do not do these types of family counseling is surprising and of concern. Although the Bible uses the metaphor of the body to describe the members in the church, family is the term more often employed by pastors and lay people. The family is the foundation of a stable society. The challenges facing the family today are enormous. They range from in-effective communication to financial hardships; from sexual intimacy to reproduction; from child rearing to medical setbacks and abuse. In many cases, when problems arise in the home not all parties involved are willing to come to counseling. And in most cases the unwilling party is the male. Pastors should be prepared to do family counseling with those willing to participate.

Statistics on Domestic Violence

The statistics on domestic violence are alarming. Note the reports from the Family Violence Prevention Fund in five areas:

1. Domestic Violence:

   Estimates range from 960,000 incidents of violence against a current or former spouse, boyfriend, or girlfriend per year to three million women who are physically abused by their husband or boyfriend per year. In the year 2001, more than half a million American women (588,490 women) were victims of nonfatal violence committed by an intimate partner. Intimate partner violence is primarily a crime against women. In 2001, women accounted for 85 percent of the victims of intimate partner violence (588,490 totals) and men accounted for approximately 15 percent of the victims (103,220 totals). While women are less likely than men to be victims of violent crimes overall, women are five to eight times more likely than men to be victimized by an intimate partner

2. Domestic Homicide:

   On average, more than three women are murdered by their husbands or boyfriends in this country every day. In 2000, 1,247 women were killed by an intimate partner. The same year, 440 men were killed by an intimate partner. Women are much more likely than men to be killed by an intimate partner. In 2000, intimate partner homicides accounted for 33.5 percent of the murders of women and less than four percent of the murders of men. Pregnant and recently pregnant women are more likely to be victims of homicide than to die of any other cause, and evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners. Research suggests that injury related deaths, including homicide and suicide, account for approximately one-third of all maternal mortality cases, while medical reasons make up the rest. But, homicide is the leading cause of death overall for pregnant women, followed by cancer, acute and chronic respiratory conditions, motor vehicle collisions and drug overdose, peripartum and postpartum cardiomyopathy, and suicide.

3. Domestic Violence and Youth:

   Approximately one in five female high school students reports being physically and/or sexually abused by a dating partner. Eight percent of high school age girls said "yes" when asked if "a boyfriend or date has ever forced sex against your will." Forty percent of girls age 14 to17 report knowing someone their age who has been hit or beaten by a boyfriend. During the 1996-1997 school year, there were an estimated

4,000 incidents of rape or other types of sexual assault in public schools across the country.

4. Domestic Violence and Children:

In a national survey of more than 6,000 American families, 50 percent of the men who frequently assaulted their wives also frequently abused their children. Slightly more than half of female victims of intimate violence live in households with children under age 12. Studies suggest that between 3.3 -10 million children witness some form of domestic violence annually.

5. Rape:

Three in four women (76 percent) who reported they had been raped and/or physically assaulted since age 18 said that a current or former husband, cohabiting partner, or date committed the assault. One in five (21 percent) women reported she had been raped or physically or sexually assaulted in her lifetime. Nearly one-fifth of women (18 percent) reported experiencing a completed or attempted rape at some time in their lives; one in 33 men (three percent) reported experiencing a completed or attempted rape at some time in their lives. In 2000, 48 percent of the rapes/sexual assaults committed against people age 12 and over were reported to the police. In 2001, 41,740 women were victims of rape/sexual assault committed by an intimate partner. Rapes/sexual assaults committed by strangers are more likely to be reported to the police than rapes/sexual assaults committed by "nonstrangers," including intimate partners, other relatives and friends or acquaintances. Between 1992 and 2000, 41 percent of the rapes/sexual assaults committed by strangers were reported to the police. During the same time period, 24 percent of the rapes/sexual assaults committed by an intimate were reported.[1]

Domestic violence requires a very specialized type of counseling. Pastors may do harm by not helping the victims gain the ego strength needed to end the violence. Pastors can even make the victim feel guilty for wanting to get out of the relationship. Pastors are required by state laws to report domestic violence. This can cause a role conflict in some pastors who feel governed by cultural mores to look at domestic violence as

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[1]Family Violence Prevention Fund, *Get the Facts: Prevalence of Domestic Violence* (2004, accessed 6 August 2004); available from http://endabuse.org/resources/facts/ (6 August 2004).

something between a husband and wife or parents and children. Or worse, the pastor might believe that the husband or parent has the right to take this type of action. Some pastors may just not want to get involved, preferring to look the other way altogether. At such traumatic times the pastor can be a great resource person even if only to network the needed services for the victim(s), ensuring a stable and safe transition at a time of great confusion.

The pastors' responses confirmed my belief that pastors are counseling from a psychological perspective (see table 6). During the training all but one of the pastors claimed to have taken counseling classes in college in addition to the basic Pastoral Counseling course in their M. Div. program. Yet for most of them, the five psychological theories I presented were new. They were familiar with some of the terminologies but did not know how to use them. They could not articulate which theory informed their counseling and why. Sigmund Freud was the most recognized name and some of his teachings were remembered. Carl Rogers's ideas were also recalled but they could not articulate or synthesize his teaching enough to effectively employ his client-centered approach in their counseling. Pastors trained only or primarily in the disciplines of theology and philosophy are not adequately trained to do counseling from a psychological perspective and therefore should not do so. Four of the six pastors indicated they counsel from a psychological point of reference, two said they do not.

All six pastors indicated that they counseled from a spiritual perspective (see table 6). Comparing tables 4 and 6, three of the four pastors who do psychological counseling have between three and five sessions with their clients. The other pastor who reported

doing psychological counseling has between five and seven sessions with his client. Depending on the nature of the problem, even as many as seven sessions may be insufficient to meet the needs of the client. When such situations arise, referral to the appropriate competent professional source is strongly advised.

The Role of Prayer in Pastoral Counseling

It was gratifying to note that pastors do counsel from a spiritual basis and that they do pray with clients. There were inconsistencies in that while all six reported that they prayed with their clients, four of the six said that they give their clients a choice as to whether or not they should pray. And five of the six pastors said they prayed based on their judgment of the client's need for prayer, and one did not do so (see table 7). The one pastor who did not pray out of his sense of a need for prayer also indicated that he always prays, and that he gives the clients a choice for prayer. William Hume writes that "the use of prayer as a resource in pastoral care and counseling is in harmony with the pastor's role in the ministry of the church. He or she is, in a sense, a mediator, articulator, intercessor, between a world limited to sense and time and a world of faith where 'with God all things are possible' (Matt 19:26).[1] The first question was designed to find out the frequency with which the pastors prayed with clients in counseling. It states "Do you always pray with clients as part of the counseling process?" They all said that they always pray with their clients. The second question on prayer dealt with whether or not the pastors were giving their clients a choice regarding prayer.

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[1]Hulme, 136.

TABLE 7

PRAYER AS PART OF COUNSELING AND THE USE OF THE TERM DIAGNOSIS

Responses	P1	P2	P3	P4	P5	P6
Questions 12 to 14: How do you incorporate prayer in counseling?						
Always pray	x	x	x	x	x	x
Give client a choice	x		x	x		x
Sense need for prayer	x	x	x		x	x
Question 15: What do you think of when you hear the term "diagnosis"?						
Medical doctor	x	x		x	x	x
Computer analyst			x			
Other		x				
Question 16: What do you think of when you hear the term "pastoral diagnosis"?						
A troubled parishioner	x	x			x	
A spiritually troubled parishioner		x	x	x	x	x
An addicted parishioner		x				

It reads "Do you offer the clients a choice regarding prayers in counseling?" The third question on prayer asks, "Do you pray with the client based on your sense of his/her need for prayer?" Two of the pastors indicated that: (1) they always pray; (2) they do not give the client a choice; and (3) that they pray when they sense a need for prayer in the client. I believe that pastors not having Clinical Pastoral Education (CPE) training would likely use prayers inappropriately in counseling. One objective of CPE training is to help recipients become aware of their inner needs and drives and learn how to avoid letting them distort the quality of care they provide. Clinical Pastoral Education is about empowerment and pastors may learn how to empower their parishioner during the delivery of care. Rather than doing what the pastor thinks is best for the parishioner without seeking permission, the pastor should get the person's consent when providing care. To do otherwise is to impose the will of the pastor onto the counselee.

Prayers offered by a pastor during pastoral care visits have a different impact from that offered during counseling. Pastoral care work tends to be less intense than that of pastoral counseling. Charles Gerkin notes:

> Important as this twentieth-century focus on pastoral counseling as ministry to troubled persons has been, it has unfortunately meant at times a concomitant lack of focus on nurturing the development of more ordinary, relatively healthy people. Pastoral care needs to have as its primary focus the care of all God's people through the ups and downs of everyday life, the engendering of caring environments within which all people can grow and develop to their fullest potential. Not all of God's people will need pastoral *counseling*; all people, however, need the nurture and support of a *caring* environment.[1]

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[1]Gerkin, 88.

To the believer, "prayer is the breath of the soul."[1] Therefore, invoking the name of God in a counseling setting at an ill-timed moment can in fact do more harm than good. Prayers can be used to help or hinder the process. It can cause the counselee discomfort. Therefore, the role of prayers should be discussed at the initial visit. How the client feels about God and prayers must be established. Prayer in counseling should be an invitation to a shared journey in which the pastor acts as guide and host. Pastors should make their position on prayer in counseling known as well. The client should also be made to feel that it is okay to not want to pray if it causes discomfort. But the parishioner must also know that while the pastor is willing to respect such a decision, the pastor believes that God is at the center of pastoral counseling and that prayer is an important part of his/her counseling ministry. At that point and during the whole counseling process, the pastor can pray covertly, asking God for guidance, patience, wisdom, and sensitivity as to how best to journey with the client.

Pastors are not without values. They bring to the counseling their set of beliefs that should not be ignored or overlooked. While those beliefs or values should not impede the client's journey into counseling, they should not be suppressed for the sake of the journey either. To do so is disingenuous, and it will make it difficult for the pastor to be truly empathically and therapeutically present with the counselee. When and if any of those beliefs are in conflict with that of the client's, it should be made known and the client given a choice of continuing counseling. If pastors do not give the clients a choice

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[1]Ellen G. White, *Gospel Workers* (Hagerstown, MD: Review and Herald Pub. Assoc., 1915), 254.

about having prayer; then the clients should be given a choice regarding continued counseling or referral. At the very least, it should be discussed and their feelings solicited. Hulme notes that:

> In pastoral care and counseling, the consensus is that prayer is a resource that belongs organically to the profession. This role identification with prayer has been abused by both pastors and those to whom they minister. Some people seem to believe that the pastor has not really functioned as a pastor unless he or she prays with them, regardless of how personally significant their dialogue may otherwise be. Some pastors believe likewise. This rigidity or stereotyping, of the pastoral encounter has the effect of downplaying the importance of the dialogue that takes place. In fact, some may ask the pastor to pray in order to keep from engaging in any significant dialogue, and some pastors may look to prayer to redeem an otherwise sterile encounter. When this happens, prayer becomes a means for keeping the two worlds separate, and the religion involved remains unincarnated. The pastor achieves a special status that removes him or her from this world—a professional image that is apart from the common dialogue. The pastor's function then is one of division rather than mediation, and his or her praying, a mark of the separated worlds.[1]

The third question on prayer, already stated above, looked at the level of pastoral intuition in the decision to offer prayer. Five of the six pastors responded yes to the question "Do you pray with the client based on your sense of his/her need for prayer." Only one pastor answered no. Prayer can be said to avoid discomforts by both the pastor and the counselee. Prayer can shut a person down emotionally. "Let us pray about it," can be another way of saying "Let us not talk about it." Hermeneutically, prayer is theological in nature. It is god-talk using the biblical narratives intercessionally and admonishingly as well as in praise to God. In pastoral counseling, prayer must be therapeutic. It must be phrased in such a way as to avoid putting the counselee in a place of guilt, shame, or hopelessness. Prayer can also put the pastor in a place of superiority

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[1]Hulme, 137-138.

where he/she does not share a common humanity with the client. In counseling, prayer should not be used in a judgmental or condemning manner. In order to make sure that prayer in counseling is therapeutic and mediatorial the pastor must put the needs of the person ahead of his/her own principle. Hulme states that:

> The decision regarding the use of prayer should be based on this principle. Is prayer a resource that is applicable at this time with this person? Has the movement of the dialogue indicated a need for it? Although a person is religiously-oriented, he or she may not desire the pastor's assistance in prayer. . . . If the pastor has any doubt about where the counslee is in regards to these questions, he or she should ask. In fact, I believe it is wise to ask even when one has decided that prayer is in order. . . . To lead a person reluctantly into prayer is ill-advised.[1]

In the Old Testament the prophet is referred to as *nabi,* God's mouthpiece. He spoke to the people on behalf of God. The priest spoke to God on behalf of the people. In pastoral counseling pastors are both prophet and priest. There are times when they speak to the counselee on behalf of God using scripture skillfully and appropriately to refresh the person's relationship with God as his/her "present help in time of need." There are also times in pastoral counseling when pastors take on the role of priest. They use prayer and the scriptural narrative in the genre of prayer to help the counselee know God as the "Father of mercies and God of all comfort" (2 Cor 1:3).

Prayer can take on the role of a spiritual soother for an aching heart of an emotionally distraught person. Sensing the person's need for prayer and not validating the accuracy of that feeling with the individual before proceeding might keep that person from experiencing catharsis. Therefore, until the client is ready, the pastor should sense

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[1]Ibid., 138.

his/her own need for prayer and do it internally. The public ministry should be an extension of pastors' private devotional life. Speaking about the private prayer life of Jesus and how it is a model for pastors, Gilbert and Brock state:

> The implications, of course, are patent as we consider what happens in the life of any individual who follows Jesus' example of private prayer. It means to be armed with a confidence generated by recent communion with the Chief Counselor. Such communion will also provide insights into counselees' concerns and will permit the counselor to offer hope and healing to the anxious and despairing. Honestly being able to tell people immersed in trouble that you have prayed for them that their faith would be quickened in their crises will almost always bring new hope.[1]

According to Gilbert and Brock, it is the pastor's informing the client of his/her private prayer for them, not the imposed prayer with them that gives new hope. Prayer does have a place in pastoral counseling. But that place must be negotiated and agreed upon by the pastor and the person in counseling. "We need to be emancipated from compulsions either to pray or not to pray so that we can be alert to the Spirit's guidance in the existential moment."[2]

Diagnosis and Pastoral Counseling

The questions on diagnosis were divided into two parts. The first part asked question about diagnosis as a generally used term. The pastors were instructed to check all the boxes applicable to them. Four of the six pastors said when they hear the term "diagnosis" they attribute it to the work of a medical doctor. In my judgment this is consistent with a generally held perception. Historically, the term "diagnosis" is

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[1]Gilbert and Brock, 61.

[2]Hulme, 138.

attributed to the medical profession. The wider usage of the word in our post-industrial society has not become part of the pastoral counseling language. According to Pruyser,

> Diagnosis and diagnosing are applicable to a variety of disciplines, including jurisprudence, ethics, sociology, economics and pointedly, to all the so called helping professions. One might say, that whenever we are presented with a condition, especially one that entails stress, suffering, or unhappiness, which in turn elicits a desire for relief or melioration, the first thing to do is to diagnose that condition. Any would-be helper must know what he is dealing with; otherwise his moves are only shots in the dark. Thus regarded, diagnosis is very much a pastoral task also. It should be a substantial part of any pastor's daily activities. Who would deny that pastors need to approach their charges with a discerning knowledge of their condition, their situation, or their plight, and with discriminating ideas about desirable aid or intervention?[1]

One of the pastors attributes the term to a computer analyst and one to a medical doctor and "other" (psychological) (see table 7).

The second part of the question regarding diagnosis used a qualifier, "pastoral" diagnosis. Again the pastors were instructed to fill in all the boxes that reflected their thinking. Three of the six pastors attributed the term Pastoral Diagnosis to a troubled parishioner, while five of the six to a spiritually troubled parishioner, and one of the six to an addicted parishioner. Only one pastor indicated that all three were applicable to his perception of pastoral diagnosis (see Table 7). The meaning of all three terms, "troubled parishioner," "spiritually troubled parishioner," and "addicted parishioner" were explained by me to the pastors during the workshop. It is not clear to me why they did not apply the term pastoral diagnosis to all three categories in the post-test. This also raises my suspicion as to whether pastors are academically prepared to do counseling in

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[1]Pruyser, 30-31.

the framework of psychology.

Spiritual Language in Pastoral Diagnosis

Nine commonly used biblical terms were selected to ascertain whether or not pastors are using the language of Scripture in counseling. The answers were ranked: (1) not very appropriate; (2) appropriate, and (3) very appropriate. The pastors were asked to check the box that best reflects their convictions, see table 8. The questions on Baptism, Communion, and the Second Coming were the most problematic for the pastors to ask in counseling. Four of the six pastors said the role of God the Father is "very appropriate" to ask in counseling, and two indicated that it was only "appropriate" to ask. Four of the six pastors believed the role of God the Son is "very appropriate" to ask in counseling, and two believed it was only "appropriate" to ask. Four of the six pastors agreed that the role of God the Holy Spirit is "very appropriate" to ask in counseling, and two agreed that it was only "appropriate" to ask. Four of the six pastors indicated that the role of grace is "very appropriate" to ask in counseling, and two indicated that it was only "appropriate". Four of the six pastors said the role of love is "very appropriate" in counseling and two said it was only "appropriate". Four of the six pastors said the role of forgiveness is "very appropriate" in counseling and two said only "appropriate". One of the six pastors indicated baptism is "very appropriate" to discuss in counseling. One indicated that it was "appropriate" to talk about baptism in counseling, and four indicated that it is "not very appropriate" to talk about it in counseling. One of the six pastors believed the role of communion is "very appropriate" in counseling, one believed it is

TABLE 8

THE PASTORS' USE OF SPIRITUAL LANGUAGE IN COUNSELING, PRE-TEST

Responses	P1		P2		P3		P4		P5		P6	
Question 17: Should the following be discussed in pastoral counseling?												
	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate
Father		x		x			x			x			x		
Son		x		x			x			x			x		
Holy Spirit		x		x			x			x			x		
Grace		x		x			x			x			x		
Love		x		x			x			x			x		
Forgiveness		x		x			x			x			x		
Baptism			x			x	x		x		x				x
Communion			x			x	x		x		x				x
Second Coming		x			x		x			x					x

only "appropriate", and four believed that it is "not very appropriate." Two of the six pastors indicated the role of the Second Coming is "very appropriate" in counseling, Three indicated that it is only "appropriate", and one indicated that it is "not very appropriate" (see Table 8). According to the responses, baptism and communion were the two most inappropriate topics to ask in pastoral counseling. The crux of pastoral counseling is to help parishioners deal with any distortions they may have of God.

The nine commonly used biblical terms were selected based on the following: Father, Son, and Holy Spirit are chosen to determine one's attitude and understanding of the Godhead and their individual roles in salvation and redemption. Grace, love, and forgiveness are to examine how these salvific gifts of God are fleshed out in the person's daily life. Baptism and communion look at how the client became connected to Christ and one of the ways the connection can be maintained. Finally, how is the present life helped or stressed by the knowledge of the Second Coming? Part of the pastor's responsibility is to help remove any distortions the client may have of God by using the Bible and the traditions of the parishioner's faith, thus facilitating the opportunity for reconciliation. It might be helpful for clients who are having anxieties about their relationship with God to understand the significance of being baptized into Christ according to the traditions of their church. They may have ambivalence about their former method of baptism and during the counseling process desire to revisit their former experience. Pastors serving as teachers can help them understand the Biblical method of baptism and thereby relieving them of their anxieties.

In time of family counseling the communion service can be a means of

strengthening family bonds and restoring trust and reconciliation in a marriage. In the Seventh-day Adventist tradition, the ordinance of humility or foot-washing, which is part of the communion service, can also serve to help a person with a spirit of pride. One of the pastors indicated that questions on the Second Coming are inappropriate in counseling. Persons with concerns about the Second Coming may be having anxieties about their eternal salvation. Life's events that they were involved in may lead them to believe that they are beyond salvation. Or they may be involved in current behavior that according to scriptures precludes them from entrance into heaven at the Second Coming. Once that has been diagnosed, it is the role of the counselor to use the authority of Scriptures to reveal Christ and His saving grace to them. If the person is involved in sinful behavior the pastor must strongly encourage that the person discontinue the behavior while in counseling so that they can profitably process feelings and issues that are motivating the practice. In any event, the counselor should enter into counseling with an open mind as to what might be discussed. One never knows what life or spiritual event may cripple a person's relationship with God and his/her fellow human beings. The therapeutic goals of pastoral counseling are: (1) to remove any distortions about God, self, and others; (2) to heal spiritual brokenness; (3) to help the individual use the resources of the scriptures and other appropriate non-canonical materials for aid, growth, and comfort; (4) to talk about sin and salvation as it addresses one's spiritual functioning; (5) to address the issues of guilt and shame when present; (6) to experience the gift of grace; and (7) to experience reconciliation to God through the working of Scripture and the rites of the church according to one's faith. In biblical counseling the pastor

functions: (1) as a companion (Eccl 4: 9-10); (2) as a comforter (2 Cor 1:3-4); (3) as a moral guide (1 Tim 3:1-7); (4) as a servant (Matt 20: 25-28); (5) as a Biblical teacher (Matt 28:20; Acts 5:42); (6) as diagnostician (Matt 9:1-6 cf. Luke 5:17-24; John 3:1-8, 4:7-18); and (7) as a reconciler (2 Cor 5:18-20).

Recognizing Disorders in Clients

The next question focused on the pastors' ability to recognize disorders in their clients. They were asked "Would you recognize whether a client was suffering from one of the following disorders?" Most of the pastors indicated they would recognize anxiety and mood disorders. Three of the six pastors believed they would recognize substance abuse. Only two of the six pastors said they would recognize schizophrenia. All six pastors indicated that they would not recognize organic brain damage disorders. Both pastors with a post graduate degree indicated that they would recognize someone suffering from schizophrenia. Respondent P 6 has a doctoral degree in a related field. The survey did not ask them how they might recognize any of the five disorders in a parishioner (see Table 9). Without the training from the schools of psychology and psychiatry, pastors are not adequately trained to diagnose any of the above disorders. The depth of training necessary to diagnose these disorders is not reflected in five of the six pastors' training. The first three—anxiety disorder, mood disorder, and substance abuse—are more commonplace and therefore may be easier to be recognized. Pastors have a biblical frame of reference for anxiety and mood disorder. Jesus, in the Sermon on the Mount, spoke about anxiety (Matt 6:25-34). The Apostle Paul also writing to the

TABLE 9

RECOGNITION OF PSYCHOLOGICAL DISORDERS IN COUNSELING

Responses	P1	P2	P3	P4	P5	P6
Question 18: Would you recognize any of these disorders in a client?						
Anxiety		x	x	x	x	x
Mood		x	x	x	x	x
Substance abuse	x		x			x
Schizophrenia				x		x
Organic brain damage						

church at Philippi said, "Be anxious about nothing, but in all things let your request be known to God with thanksgiving" (Phil 4:6). King Saul, Israel's first king, may have suffered with some type of mood disorder brought on by an evil spirit (1 Sam 16:14ff.) The writings of the prophet Jeremiah, especially the book of Lam 3, suggest that he also had bouts of depression. Using the biblical narratives on the life of the above-mentioned characters and others, pastors can help their clients with their afflictions. When it is apparent to the pastor that the person is experiencing a mood disorder and that medication might be needed, it is advisable that the person be encouraged to seek help from a mental health professional.

Understanding *the Diagnostic and Statistical Manual* Fourth Edition (*DSM-IV*)

The final question was to test the pastors' understanding of the *DSM-IV*. They were asked to "Please indicate your level of knowledge of the following *DSM-IV* concepts, by checking the column that best suits your answer" (see Table 10). Their options ranged through "adequate knowledge," "little knowledge," "no knowledge." Based on their responses, the pastors would need more training in this area of psychopathology with an emphasis on *DSM-IV* diagnosis in order to be more competent in the use of it. Litigation remains a huge concern in our current society. More than half of the pastors in the survey had no knowledge of "diagnostic codes." Yet a number of pastors in the study use a psychological approach along with *DSM-IV* language in their counseling. Only two of the six pastors had adequate knowledge of "diagnostic codes."

The questionnaire was not designed to determine what adequate knowledge might be. It was designed with the hypothesis that pastors who may only have a cursory knowledge are using psychological language in their counseling. The training that followed the questionnaire helped prove that hypothesis to be true. The pastors did not have a clinical working knowledge of the terminologies they had grown accustomed to using. One of the six pastors had adequate knowledge of "multiaxial assessment." Two of the six pastors had adequate knowledge of "diagnosis and prognosis." Half of the pastors in the survey had little knowledge of "global assessment of functioning scale (GAF Scale)." When the topic was introduced and suggested that we use it to determine Jeannine in the vignette's psychological, social, and occupational functioning, none of

TABLE 10

PASTORS' UNDERSTANDING OF DIAGNOSTIC AND STATISTICAL MANUAL CONCEPTS, PRE TEST

Responses	P1			P2			P3			P4			P5			P6		
Question 19: Testing the pastor's level of knowledge of DSM IV Concepts																		
	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge
Diagnostic Codes			x			x			x		x		x			x		
Multiaxial Assessment			x			x			x		x			x		x		
Diagnosis & Prognosis			x		x			x			x		x			x		
Global Assessment of Functional Scale			x			x		x				x		x			x	
Differential Diagnosis			x			x			x		x			x			x	
Differences among signs symptoms and issues		x			x			x			x			x			x	
Etiology/Pathogenesis			x			x		x			x			x			x	
Clinical Presentation			x			x		x			x		x				x	
Personality Disorders			x		x			x			x		x			x		
Cognitive Disorders		x			x			x			x		x			x		

Table 10-- *Continued.*

Responses	P1			P2			P3			P4			P5			P6		
	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge
Question 19: Testing the pastor's level of knowledge of DSM IV Concepts																		
Substance Related Disorders			x		x			x			x		x			x		
Schizophrenia & Related Disorders			x			x		x			x		x			x		
Anxiety Disorders			x		x		x				x			x		x		
Somatoform Disorders			x			x		x			x			x			x	
Factitious Disorders			x			x		x				x		x			x	
Dissociative Disorders			x			x	x				x			x			x	
Sexual & Gender Identity		x			x		x				x			x			x	
Eating Disorders		x			x		x				x		x				x	
Sleep Disorders		x			x		x				x		x				x	

them was able to do so with competence. Each of the pastors had to be shown and taught how to use and interpret the scale. Half of them indicated little knowledge of "differential diagnosis."

All six pastors indicated they have little knowledge of "differences among symptoms, signs and issues." Yet that claim could not be substantiated during the workshop that ensued. Most of the pastors indicated little knowledge of "etiology and pathogenesis." Again, it is a claim that remains suspect for the pastors do not have the training necessary to determine the origination and development of a disease. Only one of the six pastors had adequate knowledge of "clinical presentation," and that pastor has a post-graduate degree in a related field and, therefore, his claim has some validity. Two of the pastors indicated that they have an adequate knowledge of "personality disorders." Though the questionnaire did not ask, the pastors may be confusing maladjustment or other types of unacceptable behaviors with disorders. Two of the pastors indicated they have adequate knowledge of "cognitive disorders." Two of the six pastors reported adequate knowledge of "substance-related disorders." Two of the six pastors reported adequate knowledge of "schizophrenia and related disorders." Two of the six pastors reported adequate knowledge of "anxiety disorders." Five of the six pastors reported little knowledge of "somatoform disorders." Three of the six pastors reported little knowledge of "factitious disorders." One of them reported adequate knowledge of "dissociative disorders." One of the six pastors reported adequate knowledge of "sexual and gender identity disorders." Two of the six pastors reported adequate knowledge of "eating disorders." Two of the six pastors reported adequate knowledge of "sleep

disorders" (see table 10). Three of the four pastors indicated that they have adequate knowledge in 14 of the 19 *DSM-IV* concepts presented on the questionnaire. The pastors' level of participation during the *DSM-IV* workshop presentation indicated that their knowledge for the most part was very limited and lacked depth.

Due to the complexity of the *DSM-IV* and the training necessary to be proficient in its application, a brief historical overview is presented below. In addition to this information that appears in the appendix, the purposes for having it here are: (1) to make the *DSM-IV* language and information available to the reader in the context of chapter 9, (2) to support my hypothesis regarding the pastors' knowledge of the *DSM-IV*, (3) to give the reader a cursory knowledge of the development of the *DSM-IV* in proximity to table 10, and (4) to provide the average reader with a sense of the complexity of the DSM-IV language.

What Is *The Diagnostic and Statistical Manual-IV (DSM-IV)*?

The *Diagnostic and Statistical Manual-IV (DSM-IV)* is a diagnostic tool that was designed by the American Psychiatric Association for the purpose of guiding clinicians, researchers, and other professionals in the diagnosis and treatment of mental disorders. The *DSM-IV* was designed to be the official terminology which would be used under a vastly diverse context.

Its final form was the result of 13 work groups from various orientations that included psychologists, psychiatrists, physicians, clinicians, social workers, researchers, and many others. This team effort included professionals from various cultures and

countries as well. This international venture was especially designed to increase and enhance the level of communication and cooperation amongst the professionals and experts in their respective fields and to ensure that the diagnostic manual would be as comprehensive as possible and would be suitable for use in other cultures.

As early as 1840 there were attempts in the United States to classify mental disorders. What evolved over the years were various nomenclatures that identified psychiatric and neurological disorders. The International Classification of Diseases (ICD) was very instrumental in the developing of the *DSM.* The American Psychiatric Association Committee on Nomenclature and Statistics developed the first edition of the *DSM* in 1952 utilizing the information found in the ICD-6. As research continued, the *DSM-IV* was developed based on empirical research studies. This empirical process included "1) comprehensive and systematic reviews of the published literature, 2) re-analyses of already-collected data sets, and 3) extensive issue-focused field trials."[1]

Definition

The term "mental disorder" implies that there is a distinction between physical disorder and mental disorder. However, a vast array of research has demonstrated that there is a correlation between physical and mental health. Ellen G. White also discussed these relationships in her non-empirical, Holy Spirit-led writings. The definition that is included is based on a variety of concepts that incorporates an individual's level of distress, loss of control, disadvantage, disability, inflexibility, and irrationality, the

[1]American Psychiatric Association, xvi-xvii.

pattern of the syndrome, etiology, and statistical deviation.

> Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event. . . . Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.[1]

It is important to note that deviant behaviors and conflicts between the individual and society are not considered to be mental disorders. However, if the deviancy or conflict is a symptom of dysfunction in the person as detailed above, then a mental disorder diagnosis may apply. It is also important to note that classification of a mental disorder is only identifying the disorder of an individual, not labeling that person.

Use of the Manual

The International Classification of Diseases is a diagnostic tool that identifies and list diseases and disorders based on a specialized coding system. Many of the disorders found in the *DSM-IV* are numerically coded based upon the ICD. These codes are located in specific places in the text: "1) preceding the name of the disorder in the classification, 2) at the beginning of the text section for each disorder, and 3) accompanying the criteria set for each disorder."[2] There are certain disorders which require more details for the appropriate code to be applied, and other disorders have

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[1]Ibid., xxi-xxiii.

[2]Ibid., 1.

alternative terms enclosed in parentheses. A systematic description of each disorder utilizing headings is listed below:

1. Diagnostic features
2. Subtypes and/or Specifiers
3. Recording Procedures
4. Associated Features and Disorders
5. Specific Culture, Age and Gender Features
6. Prevalence
7. Course
8. Familial Pattern
9. Differential Diagnosis.

A discussion of these headings is important; however, for the purpose of this dissertation, they will not be addressed in this paper. What is important to know is the basic utilization of the *DSM-IV* manual. The disorders found in the *DSM-IV* are grouped into 16 major diagnostic classes.

The first section deals with disorders usually diagnosed in infancy, childhood, or adolescence. The following three sections were originally grouped together in the *DSM-III-R* entitled "Organic Mental Syndromes and Disorders" implying that the other disorders in the manual were without an organic base.

The remaining twelve sections are grouped together based upon their presenting features and symptoms. The last section is entitled "Other Conditions That May Be a Focus of Clinical Attention." Ten appendixes are also included for the reader.

DSM-IV Classifications/ Multi-axial Assessment

1. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
2. Delirium, Dementia, and Amnestic and Other Cognitive Disorders
3. Mental Disorders Due to a General Medical Condition Not Elsewhere classified
4. Substance Related Disorders
5. Schizophrenia and Other Psychotic Disorders
6. Mood Disorders
7. Anxiety Disorders
8. Somatoform Disorders
9. Factitious Disorders
10. Dissociative Disorders
11. Sexual and Gender Identity Disorders
12. Eating Disorders
13. Sleep Disorders
14. Impulse Control Disorders Not Elsewhere Classified
15. Adjustment Disorders
16. Personality Disorders
17. Other Conditions That May Be a Focus of Clinical Attention

The term "Axis" is defined as a line around which a turning body rotates or is supposed to rotate. It is a real or imaginary central line about which things or parts are symmetrically arranged. It may also be used to describe an affiliation or coalition of two

or more nations to promote mutual interest, cooperation, etc. In utilizing this term in the *DSM-IV*, the axis is a category of information where a body of knowledge has been assimilated under specific domains. The *DSM-IV* uses a multiaxial system in order to enhance comprehension and to systematically evaluate mental disorders while identifying personality disorders, general medical conditions, psychosocial and environmental problems, and individual level of functioning. This format provides "a convenient method for organizing and communicating clinical information, for capturing the complexity of clinical situations, and describing the heterogeneity of individuals presenting the same diagnosis"[1] Furthermore, this system supports the utilization of the bio-psychosocial model in the clinical, educational, and research settings.

Axis I: Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention

This axis is used for reporting all the diverse disorders or conditions that do not include Personality Disorders and Mental Retardation. Those disorders are identified on axis II. More than one disorder can be reported; however, the leading diagnosis that initiated the contact should be identified and listed first. "If an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the reason for the visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase (Principal Diagnosis) or (Reason for Visit). If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of

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[1]Ibid., 25.

additional information, this should be coded as 799.9"[1] . The two above-mentioned codes and terms are used in both the ICD-9 and ICD-10.

Axis II: Personality Disorders, Mental Retardation

Identifying personality disorders and mental retardation on a different axis allows for these disorders to be considered and not overlooked when there is a focus on the obvious symptoms of the Axis I disorder. Nevertheless, it would be a mistake to think that this format implies that personality disorders and mental retardation symptoms and treatment have fundamental differences. Also, when an individual presents with more than one Axis II diagnosis, all should be identified. When the Axis II diagnosis is the major reason for the clinical visit, there should be a qualifying statement noted (Principal Diagnosis). If there is no disorder present, V71.09 should be the code used. If there is an Axis II diagnosis that is deferred, pending the gathering of further information, this should be coded as 799.9. In the case where there is a prominent maladaptive personality symptom that does not meet the criteria for a Personality Disorder, no code number should be recorded but a brief statement indicating the maladaptive symptoms observed. When there is the habitual use of defense mechanisms, Axis II can be used to identify this problem.

The disorders on Axis II are designated as Personality Disorders/Mental Retardation and are listed as:

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[1]Ibid., 26.

1. Paranoid Personality Disorder
2. Schizoid Personality Disorder
3. Schizotypal Personality Disorder
4. Antisocial Personality Disorder
5. Borderline Personality Disorder
6. Histrionic Personality Disorder
7. Narcissistic Personality Disorder
8. Avoidant Personality Disorder
9. Dependant Personality Disorder
10. Obsessive-Compulsive Personality Disorder
11. Personality Disorder Not Otherwise Specified
12. Mental Retardation.

Axis III: General Medical Conditions

The purpose of including general medical conditions is to enhance the evaluation process and to encourage and improve the level of communication among health-care professionals. The identification of the prevailing general medical condition can be significant to the understanding and treatment of a person's mental health diagnosis. As research has found, general medical conditions can be related to mental disorders in numerous ways, either directly by the "development or worsening of mental symptoms and that the mechanism for this effect is physiological." Furthermore, "when a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed

on Axis I and the general medical condition should be recorded on both Axis I and Axis III." All known Axis III diagnoses which are clinically relevant should be reported. General Medical Conditions are listed below along with the ICD-9-CM codes.

1. Infectious and Parasitic Diseases (001-139)
2. Neoplasms (140-239)
3. Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (240-279)
4. Diseases of the Blood and Blood-Forming Organs (280-289)
5. Diseases of the Nervous System and Sense Organs (320-389)
6. Diseases of the Circulatory System (390-459)
7. Diseases of the Respiratory System (460-519)
8. Diseases of the Digestive System (520-579)
9. Diseases of the Genitourinary System (580-629)
10. Complications of Pregnancy, Childbirth and the Puerperium (630-676)
11. Diseases of the Skin and Subcutaneous Tissue (680-709)
12. Diseases of the Musculoskeletal System and Connective Tissue (710-739)
13. Congenital Anomalies (740-759)
14. Certain Conditions Originating in the Perinatal Period (760-779)
15. Symptoms, Signs, and Ill-Defined Conditions (780-799)
16. Injury and Poisoning (800-999).

Axis IV: Psychosocial and Environmental Problems

Axis IV is for reporting any psychosocial and/or environmental problem that may affect the diagnosis, treatment, and prognosis of mental disorders found on Axes I and II. They include any negative life event, an environmental problem or deficiency, interpersonal or family stress, inadequate social support system, limited personal resources, or any other problem relating to the original diagnosis. Psychosocial problems may develop as a result of an individual's psychopathology. They are important in the formation or intensification of a mental disorder, or they may compound problems that should be addressed in the treatment plan. Several problems may be noted that are considered to be relevant to the initial diagnosis. However, only those problems which have been present during the year prior to the current evaluation should be documented. Nevertheless, if a problem from previous years contributes to the mental disorder, it should be documented. When a psychosocial and/or environmental problem is the main focus of clinical attention it is to be recorded on Axis I under the heading, "Other Conditions That May Be a Focus of Clinical Attention." A list of problems is identified below:

1. Problems with primary support group
2. Problems related to the social environment
3. Educational problems
4. Occupational problems
5. Housing problems

6. Economic problems
7. Problems with access to health care services
8. Problems related to interaction with the legal system/crime
9. Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning

Axis V is used for the purpose of reporting the clinical judgment of a person's overall level of functioning. The Global Assessment of Functioning scale is utilized for this evaluation. The GAF has been found to benefit the clinician by aiding in the treatment plan development, measuring, and following clinical progress. This scale is not to be used for impairment in physical abilities, but only for psychological, social, and occupational functioning. Clinicians should rate the individual based only on the current functioning level, and then at various designated time periods to assess treatment effectiveness and clinical progress.

Global Assessment of Functioning (GAF) Scale

The Global Assessment of Functioning (GAF) Scale considers psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code **(Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good**

| **functioning in all areas, interested and involved in a wide range of activities,**
| **socially effective, generally satisfied with life, no more than everyday**
81 **problems or concerns** (e.g., an occasional argument with family members).

80 **If symptoms are present, they are transient and expectable reactions to**
| **psychosocial stressors** (e.g. difficulty concentrating after family argument); **no**
| **more slight impairment in social, occupational, or school functioning** (e.g.
71 temporarily falling behind in schoolwork).

70 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some**
| **difficulty in social, occupational or school functioning** (e.g., occasional truancy
| or theft within the household), **but generally functioning pretty well, has some**
61 **meaningful interpersonal relationships.**

60 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic
| attacks) **OR moderate difficulty in social, occupational, or school functioning**
51 (e.g., few friends, conflicts with peers or co-workers).

50 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent
| shoplifting) **OR any serious impairment in social, occupational, or school**
41 **functioning** (e.g., few friends, conflicts with peers or co-workers).

40 **Some impairment in reality testing or communication** (e.g., speech is at times
| illogical, obscure, or irrelevant) **OR major impairment in several areas, such as**
| **work or school, family relations, judgment, thinking, or mood** (e.g., depressed
| man avoids friends, neglects family, and is unable to work; child frequently beats
31 up younger children, is defiant at home, and is failing at school).

30 **Behavior is considerably influenced by delusions or hallucinations OR**
| **serious impairment in communication or judgment** (e.g., sometimes
| incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability**
| **to function in almost all areas** (e.g., stays in bed all day; no job, home, or
21 friends).
20 **Some danger of hurting self or others** (e.g., suicide attempts without clear
| expectation of death; frequently violent; manic excitement) **OR occasionally fails**
| **to maintain minimal personal hygiene** (e.g., smears feces) **OR gross**
11 **impairment in communication** (e.g., largely incoherent or mute).

10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence)
| **OR persistent inability to maintain minimal personal hygiene OR serious**
1 **suicidal act with clear expectation of death.**

0 Inadequate information.

Vignette

Below is a vignette designed to show how a person may be diagnosed using the five axes according to the *DSM-IV.*

"Mary has been living in this country for the past 10 years. She is a native of Turkey. She is the wife of Franko and they have four children. She is not employed. He works at the foundry in town, and has been employed for 8 of those 10 years. They received word that Mary's family was killed as a result of terrorist bombings. Mary had a good relationship with her three siblings and her parents. She was obviously distraught over the news. However, that was six months ago and Mary continues to grieve over the loss. No amount of prayer relieves her worry, fears, and anxiety. She does the minimal amount of household chores. There is no laughter in the home. It seems that even the children try to avoid contact with her. She has stopped attending church in order to stay home and be alone. She sits and stares at pictures of her family for hours." [Included in workshops discussions but not included in the vignette was exploration of symptomatology that would typically be required for a diagnosis of major depressive disorder.]

Diagnosing Mary's Case

Axis I	296.23	Major depressive disorder
Axis II	V71.09	Showing symptoms of avoidant personality disorder
Axis III		None
Axis IV		Problems with primary support group
Axis V	GAF = 50	(current)

Comparison of the Pastors' Pre-and Post-Questionnaire Responses

Specific questions from the first questionnaire were asked again at the end of the training period for a comparative analysis of what the pastors may have learned. Nine questions were chosen for the comparative study. The pastors' answers on the pre-test informed the selection of the post-test questions.

Counseling Perspectives

In the pre-questionnaire the pastors were asked: "Do you counsel from a psychological perspective, for example, using the counseling theories of noted psychologists?" Four of them said yes. However, during the training only two of the six pastors had psychological courses and training beyond the basic requirements for a Bachelor of Arts degree in religion and the one pastoral counseling course at the seminary level. One of the two pastors with additional training has a doctorate in religious education. He also has a master's in education degree. As part of his teacher training program, he took several courses in psychology and related classes. The other pastor has a minor in psychology, but has not used his psychological training professionally.

In the post-test, three of the six pastors said they counsel from a psychological perspective. However, two of the original four maintained their perspectives while the other two changed (see table 11). What was surprising is that one who did not hold that view in the pre-test indicated that he now does. The reason for this cannot be explained by the researcher. The psychological part of the training manual is prepared to give

pastors a cursory understanding of psychological terminologies in counseling with reference to five well known schools of psychology. The assumption is that since pastors are using psychological approaches in their pastoral counseling, they might become more familiar with some of the schools of counseling. Throughout the training, emphasis was placed on how unprepared pastors are to do counseling from a psychological perspective when they are equipped with only the training gained in the Seminary and the basic course they received as part of the Bachelor of Arts degree.

The Role of Prayer in Counseling

Question 3 asked the pastors, "Do you always pray with clients as part of the counseling process?" All six responded in the affirmative in both the pre- and post-test. The next question asked, "Do you offer the clients a choice regarding prayers in counseling?" Four of them indicated that they gave their clients a choice in the pre-test. All six of them said that the clients are given a choice for prayer. They were then asked: "Do you pray with clients based on your sense of his/her need for prayer?" The same five who indicated they do in the pre-test responded similarly. Their answers, however, created a dilemma. It is inconsistent to always pray and give the clients a choice in prayer being said. The questionnaire did not ask the pastors on what do they base their sensing of the client's need for prayer. The pastors may be using their pastoral authority in ways that may not be helpful to their clients' clinical needs.

TABLE 11

PRE- AND POST-TEST RESULTS FOR ASSESSMENTS, TYPES OF, AND PERSPECTIVES IN COUNSELING

Responses	P1	P2	P3	P4	P5	P6
Question 1 to 2: Do you counsel from a psychological and/or spiritual perspective?						
Psychological						
Pre-		x		x	x	x
Post-			x	x	x	
Spiritual						
Pre-	x	x	x	x	x	x
Post-	x	x	x	x	x	x
Question 3 to 5: How do you incorporate prayer in counseling?						
Always Pray						
Pre-	x	x	x	x	x	x
Post-	x	x	x	x	x	x
Give client a choice						
Pre-	x		x	x		x
Post-	x	x	x	x	x	x
Sensing a client's need for prayer						
Pre-	x	x	x		x	x
Post-	x	x	x		x	x

Table 11--*Continued.*

Responses	P1	P2	P3	P4	P5	P6
Question 6: What do you think of when you hear the term "pastoral diagnosis"?						
A troubled parishioner						
Pre-	x	x			x	
Post-						
A spiritually troubled parishioner						
Pre-		x	x	x	x	x
Post-		x	x			x
An addicted parishioner						
Pre-		x				
Post-						
Other						
Pre-						
Post-	x			x	x	

The Use of the Term Pastoral Diagnosis

The final question inquired into the pastors' understanding of the term pastoral diagnosis (see Table 11). The pastors were asked, "When you hear the term pastoral diagnosis, do you think of, (check the boxes that best suits your answer) a troubled parishioner; a spiritually troubled parishioner; an addicted parishioner; other; not familiar with the term." Half of the pastor in the pre-test checked *a troubled parishioner.* The majority checked *a spiritually troubled parishioner.* Only one checked *an addicted parishioner.* However, in the post-test none of them checked *a troubled parishioner* or *an addicted parishioner.* Three of them checked a *spiritually troubled parishioner* and three checked *other,* and put in their own wording as to what the term fits. One pastor indicated that the term make him think of "counseling from a spiritual perspective." Another said "it is understanding the Bible." The third pastor said that the term "has a threefold meaning" to him: "physical, spiritual, and emotional." None of the pastors indicated that the term was unfamiliar to them.

Spiritual Language in Counseling

The next set of questions dealt with the use of spiritual language in counseling. They were asked: "How appropriate are the following questions in counseling? (Check the column that best suits your answer.) The role of the Father, the role of the Son, the role of the Holy Spirit, the role of grace, the role of love, the role of forgiveness, the role of baptism, the role of communion, and the Second coming. The nine commonly used biblical terms in the pre-test were asked again. Their responses from both questionnaires

are shown and compared in Table 11. As in the pre-test, the pastors were asked to check the column that best reflected their answer. Two of the nine terminologies in the questionnaire posed problems for some of the participants as to whether or not they should be discussed in counseling. They are (1) baptism, and (2) communion. One participant had a problem discussing the Second Coming in counseling. Another of the participant's responses in this area on the post-test had to be thrown out because it was spoiled. He checked multiple boxes for the role of the Father, the Son, love, communion, and the Second Coming, making his responses invalid.

In the pre-test, baptism and communion were scored as *not very appropriate* to discuss in counseling by four of the six pastors. After the training, four of the participants ranked baptism and the communion as *appropriate* topics to discuss in counseling. The participant who felt it was *not very appropriate* to talk about the Second Coming in counseling in the pre-test ranked it as *appropriate* in the post-test. The participants' responses in the post-test indicated marked changed. What was ranked as "not appropriate" in the pre-test was up rated to "appropriate." Some of the terminologies that were rated as "appropriate" on the pre-test were changed in the ratings to "very appropriate" on the post-test (see Table 12).

TABLE 12

PASTORS' USE OF SPIRITUAL LANGUAGE IN COUNSELING, POST TEST

Responses	P1		P2		P3		P4		P5		P6	
Question 17: Should the following be discussed in pastoral counseling?												
	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate	Very Appropriate	Appropriate	Not very Appropriate
Father		x		x			x			x			x		
Son		x		x			x			x			x		
Holy Spirit		x		x			x			x			x		
Grace		x		x			x			x			x		
Love		x		x			x			x			x		
Forgiveness		x		x			x			x			x		
Baptism			x			x	x		x		x				x
Communion			x			x	x		x		x				x
Second Coming		x			x		x			x					x

Recognition of Disorders

In the third section of the questionnaire the participants were asked: "Would you recognize whether a client was suffering from one of the following disorders?" The five disorders are: anxiety, mood disorder, substance disorder, schizophrenia, and organic brain damage. See table 13. The participants were not asked whether they could diagnose these disorders. Neither were they asked what criteria they would use to ascertain these diagnoses in the people they serve. They were asked only if they would recognize whether a client was suffering from any of these disorders. Five of the six participants indicated that they would be able to recognize anxiety and mood disorders in their parishioners. All of them also said that they would not recognize organic brain disorder in their clients. One participant said that he would not recognize any of the five disorders. Two of them changed their responses from not being able to recognize a disorder before the training to being able to after the training. For one it was substance-abuse. For the other it was schizophrenia.

The pastors in the field need more training in these five areas. They should not be diagnosing and treating their parishioners with these problems without professional training. However, the pastors should develop the skills to recognize or evaluate for these disorders in their clients for the purpose of referral. Pastors should attend professional seminars, workshops and conferences to enhance their knowledge and skills in some areas of the mental health field. Their ongoing learning should earn them continuing education credits and should be tied to their employee evaluation.

TABLE 13

PRE AND POST TEST RESULTS OF THE PASTORS' RECOGNITION OF PSYCHOLOGICAL DISORDERS IN COUNSELING

Responses	P1		P2		P3		P4		P5		P6	
Question 8: Would you recognize any of these disorders in a client?												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Anxiety												
Pre-		x	x		x		x		x		x	
Post-		x	x		x		x		x		x	
Mood												
Pre-		x	x		x		x		x		x	
Post-		x	x		x		x		x		x	
Substance Abuse												
Pre-		x		x	x			x		x	x	
Post-		x	x		x			x		x	x	
Schizophrenia												
Pre-		x		x		x	x			x	x	
Post-		x		x		x	x		x			x
Organic Brain Disorder												
Pre-		x		x		x		x		x		x
Post-		x		x		x		x		x		x

Diagnostic Concepts

The pastors were asked to rate their knowledge of *DSM- IV* concepts. They were asked to "please indicate your level of knowledge about the following *DSM-IV* concepts by checking the column that best suits your answer." I wanted to know how well they understood this language and its application to mental disorders. Their answers are grouped in Table 14. The categories for this question were: "no knowledge," "little knowledge," "adequate knowledge," and "thorough knowledge." In the pre-test, none of the respondents checked the box for thorough knowledge.

There were nineteen items from the *DSM-IV*. They are: diagnostic codes; multiaxial assessment; diagnosis and prognosis; global assessment of functioning scale; differential diagnosis; differences among symptoms, signs & issues; etiology & pathogenesis; clinical presentation; personality disorders; cognitive disorders; substance-related disorders; schizophrenia and related disorders; anxiety disorders; somatoform disorders; factitious disorders; sexual and gender identity disorders; eating disorders; and sleep disorders. My belief was that pastors are counseling from a psychological perspective without the necessary training to be considered qualified to do so. For that reason the *DSM-IV* concepts were given on the questionnaire as well as introduced and discussed along with five psychological theories as part of the training program.

One of the pastors indicated that he had a thorough knowledge of personality disorders, cognitive disorders and substance-related disorders. His response in these three areas was change from "adequate knowledge" in the pre-test. Because he was the only one to so indicate, Table 14 does not show his response in the three aforementioned

TABLE 14

PASTORS' UNDERSTANDING *DIAGNOSTIC AND STATISTICAL MANUAL* CONCEPTS, POST-TEST

Responses	P1			P2			P3			P4			P5			*P6		
	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Thorough Knowledge	Adequate Knowledge	No/Little Knowledge
Question 19: Testing the pastor's level of knowledge of DSM IV Concepts																		
Diagnostic Codes			u		a	b		a	b	a	b		u				u	
Multiaxial Assessment			u		a	b		a	b	a	b		a	b			b	a
Diagnosis & Prognosis		a	b		u			u		a	b		u				u	
Global Assessment of Functional Scale			u		a	b		u			a	b	a	b				u
Differential Diagnosis		a	b		a	b		a	b		u		a	b				u
Differences among signs symptoms and issues		u			u		a	b		a	b		a	b				u
Etiology/Pathogenesis			u		a	b		u		a	b		a	b				u
Clinical Presentation			u		a	b	a	b		a	b		u					u
Personality Disorders		a	b		u		a	b		a	b		u			a		
Cognitive Disorders		u			u		a	b		a	b		u			a		

Table 14--*Continued*

Responses	P1			P2			P3			P4			P5			*P6		
	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge	Thorough Knowledge	Adequate Knowledge	No/Little Knowledge
Question 19: Testing the pastor's level of knowledge of DSM IV Concepts																		
Substance Related Disorders	a		b		u		a	b		a	b		u			a		
Schizophrenia & Related Disorders		a	b		a	b		u		a	b		u				b	a
Anxiety Disorders			u		u		u			a	b		a	b			u	
Somatoform Disorders			u		a	b		b	a	a	b		a	b				u
Factitious Disorders			u		a	b		b	a		u		a	b				u
Dissociative Disorders			u		a	b	b	a		a	b		a	b				u
Sexual & Gender Identity	a	b			u		u			a	b		a	b			a	b
Eating Disorders	a	b			u		u			a	b		u				a	b
Sleep Disorders		u			u		u			a	b		u					u

Note: a = post-test; b = pre-test; u = unchanged (same in both tests).

*None of the pastors checked Thorough Knowledge in the pre-test. P6 checked Thorough Knowledge in three categories in the post-test. As a result, No Knowledge and Little Knowledge has been collapsed and category Thorough Knowledge added for P6 only, to reflect his responses.

areas. In some of the terms, the pastors' responses were unchanged from the pre-test. Over-all, the pastors showed marked improvement on the post-test in their level of knowledge of the *DSM-IV* concepts presented. One pastor changed his answer from "adequate knowledge" to "little knowledge" regarding the multiaxial assessment. He made the same changes for *schizophrenia and related disorders.*

Summary

The questionnaires were unwittingly designed to cause a social desirability in the responses of the pastors. They may have answered the questions not as a true reflection of themselves but from a projected perception. Their answers may be in part what they believe people would want them to be. For example, how pastors incorporate prayer in counseling may be based on the belief that those who come to them expect them to pray. That sort of thinking would cause the pastors to impose their spiritual fervor into the session at the wrong time or ill-advisably. The pastors seemed uncomfortable using some of the rites of the Christian faith and the essence of Christianity (baptism) in counseling. This was troubling because more than anyone else, pastors in counseling had the training, and thus the authority to use the narratives and language of Scriptures.

Mrs. Tipper Gore, wife of former Vice-President Al Gore, and other high-profile personalities have brought many physical as well as psychological illnesses and other mood disorders to the forefront. Many of them have had personal experience with these physical and emotional challenges. Others have championed the cause of a particular charity in hope of finding a cure. Because of their public efforts in these areas, the media

has become a curriculum guide, educating the masses and thereby putting pressure on legislatures and the pharmaceutical industry to find cures or relief for sufferers. Infomercials, situational comedies, talk shows, and dramas on television as well as the proliferation of self-help books are helping the average astute person to recognize four of the five disorders listed above (see Table 13) in a person. Even if the average astute person could not diagnosis or articulate with accuracy what the specific problem might be, they would, at the very least, be able to recognize that the behavior in person or themselves is wrong or different and encourage the individual to get help from a mental health professional. Neither common knowledge nor the training program was able to bring all the pastors to the place where they felt confident enough to recognize at least four of the five disorders presented.

The five theories and the *DSM-IV* materials were part of the training because the pastors need to have, at the very least, a cursory knowledge of the concepts and psychological jargon they utilize in their clinical work. This however, was not intended to make the pastors adequately trained or prepared to work in these areas of counseling. The focus of the seminar was (1) to train the pastors to become more proficient in counseling from a biblical perspective; (2) to develop their diagnostic skills; (3) to learn to do an intake interview as part of counseling; (4) to learn how to make referrals; (5) to better understand transference and counter-transference in counseling; and (6) to learn how to maintain appropriate ethical boundaries. All six pastors indicated they have little knowledge of *differences among symptoms.*

CHAPTER 10

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS FOR FURTHER STUDY

Summary

Based on the analysis of the survey instrument and on the findings from the literature review, the following issues emerged as relevant to pastoral diagnosis.

1. The average pastor currently in parish ministry is not adequately trained to do general counseling or pastoral diagnosis based on the Bible and his/her theological heritage. Pastors are abandoning their rich theological heritage for psychological language and approaches in counseling. Pruyser observed that when pastors were asked to conceptualize their observations of the people they were counseling in their own theological concepts and symbols, they abandoned their theological language in favor of psychological language.[1]

From my observation with the pastors in the pilot program, that behavior has not changed. The pastors were more at ease with psychological conversation as an area of familiarity than with biblical diagnosis. When they counseled from their own discipline they did so without a clearly defined rubric. Their counseling styles were more of a

[1]Pruyser, 27.

blanket approach. They accepted as matter-of-fact that they would have to counsel members of their congregations from time to time, but beyond the reason that the people came to them because they were their pastors they did not have any other coherent reason. They were not clear as to what was being asked of them in counseling, nor did they have any guiding values other than not to be inappropriate with the clients. At the time of the training, none of the pastors had ever faced any major bias in counseling and, therefore, could not say what, if any bias they would have to abandon or work through in order to help the "problem-laden" person before them. Generally speaking, they did not have a clearly developed model in their approaches for intervention and melioration in the lives of those who came to them and said, "Pastor I have a problem." Parishioners who seek the pastor's help in times of crisis are looking to understand and solve their problems through their faith. They are seeking to be sustained not by a psychological understanding of their predicament but from a moral theological premise. The query of their soul is, "Is what I believe about God consistent with what I am experiencing and if not what must I now believe?"

2. Pastoral diagnosis is a necessary process in counseling for pastors doing parish ministry. It is part of the process in counseling that allows pastors to name the problem for the purpose of applying the right cure. The pastor uses his/her theological, theoretical, and practical knowledge honed over time and bequeathed as a sacred legacy, to help the sufferer sort out and clarify the issues within a moral and theological context. It is having a comprehensive understanding of human nature, suffering, the sin problem and its damaging effects on society as a whole, and the Incarnation as the vehicle to

reconciliation.

Pastoral diagnosis provides a set of filters through which the pastor and parishioner move towards a worldview that is grounded in Scriptures and the shared beliefs of their faith community. It functions as a set of filters that helps the pastors to determine the parameters for what, if anything, should be done. Diagnosis is subjective because the pastor is a person with values that are a part of the prism through which he/she sees life and makes moral judgments and anthropological assumptions. Intake assessments can assist the pastors to understand the types of people with whom they are working. Pastoral diagnosis also helps the pastors look at the possibilities for fulfillment and change in the clients, and to determine where their freedom ends and accountability to God and society begins or if they are mutually exclusive. Pastors must become aware of what is being asked of them in counseling both by the parishioners and what is required of them by God and the larger community. They must strive to be ethical, relevant, consistent, and sensitive.

Ethically, pastors are duty bound to provide the best care possible. They must not knowingly act towards their parishioners nor put them in an environment that will compromise the counseling process or do harm. The cure must fit the ailment. The pastor must use Scriptures and other non-canonical material that would do the most good. Each circumstance is different, even though it may be similar by presenting problems. Suffering is highly individualistic and each of us is a product of our sub-culture. Siblings reared in the same home interpret life experiences differently. Since diagnosis helps determine the kind of cure needed, the pastor's dialogue must be carefully crafted so as to

avoid questioning unnecessarily to satisfy any morbidity he/she might have.

The pastor must be relevant in the choice of care. When a diagnosis is determined, the pastor must choose his/her mode of intervention carefully so as to speak to the discoveries made during the dialogue as part of the assessment and history gathering. The pastor has limited time, so the goals of counseling should be established and agreed upon by both the pastor and the counselee. Similarly, any tests used or assignments given should be selected for their effectiveness and time efficiency.

The pastor must be consistent though somewhat fluid in his/her diagnostic and intervention. The evidences in the survey showed a bias by the pastors towards using psychological language and interventions in counseling. Therefore the pastors must be sure that their use of psychology does not diminish the importance of Scripture, which remains central to what they do. Aden and Ellens state:

> Whatever use is made of psychological and psychotherapeutic theories and techniques in pastoral care and counseling, this use should be consistent with the disclosive power of the Bible. It is not that the Bible is conformed to psychotherapeutic goals, but that the use of psychological theories and methods is to be consistent with the disclosive possibilities of the biblical form being employed in shaping the care or counseling process.[1]

The pastor must be sensitive to the person's limitations when applying the remedy. Part of the pastor's role in counseling is that of guide for the purpose of helping the individual remove any distortions he/she might have of God. If the pastor's role is perceived as judge or evangelist, the purpose might be defeated. The pastor may be leading the parishioner when he/she needs to follow or at least come alongside the one in

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[1]Aden and Ellens, 54.

care. If the pastor is not clear of his/her own therapeutic (healing) role in counseling, he/she might alienate the person from, rather than reconcile to, God.

3. Diagnosis as an art for pastors doing counseling is still evolving. In 1993 Robert J. Wicks and Richard D. Parsons devoted a chapter entitled "Re-Visioning Pastoral Diagnosis" in the book they edited, *Clinical Handbook of Pastoral Counseling.*[1] In it they called for a vision of pastoral diagnosis that is consistent with the interdisciplinary nature of pastoral clinical care. Such a re-visioning would allow those doing pastoral diagnosis and counseling to incorporate the full range of resources available to us in ways that are authentic, consistent, and coherent and would provide for validity and reliability. At the heart of Wicks and Parsons' call to revisit and redefine how pastoral diagnosis is done is a call for pastors to develop the art of "knowing apart." Knowing apart is grasping what the sufferer is going through apart from and in context of the person's overall presentation.

4. Although all my pastors were African-American, they are exposed to cultural diversity in their congregations and church community. They should therefore, be sensitive to cultural diversity in their counseling. I will be including a section on cultural diversity in counseling in future workshops. A recommended reading in that area is a book by David W. Augsburger.[2]

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[1]Wicks and Parsons, 51-101.

[2]David W. Augsburger, *Pastoral Counseling Across Cultures* (Philadelphia, PA: The Westminster Press, 1986).

Conclusion

Seventh-day Adventist pastors are facing an ever-increasing number of members from dysfunctional homes and backgrounds. One of the negative effects of our Western society's never-ending quest for "more" is the breakdown of families. The electronic era has also served to isolate people more, even in the same home, turning each room in the home into a private island. With the breakdown of family values comes a correlated demise of the traditional nuclear family. If the church is to use Jesus' model of evangelism,[1] ministry must have a psychosocial context. As society continues to be more open about abuse issues, mental health issues, and issues of the physically challenged, the church can no longer ignore them and remain relevant. Pastors must develop the ability to deal with the varying needs of the congregation. Among those needs is the ability to counsel from their theological perspectives while paying attention to the interdisciplinary nature of their counseling services.

The current Western societal climate is a highly litigious one. Lawyers are all too eager to seek judgments where they believe wrong or harm has been done. The pastor must, therefore, choose to be guided by a set of ethics and disciplines that do not put the church as an organization in jeopardy. The pastor can lessen the likelihood of litigation by: (1) working in his/her own theological discipline, (2) becoming aware of his/her own brokenness and deal with it appropriately in private counseling, (3) understanding the nature of Transference and Countertransference and how they affect counseling, (4)

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[1]White, *The Ministry of Healing*, 142.

having someone to whom they make themselves accountable, (5) knowing their limitation and human frailties in all things, (6) being true to themselves, and when in doubt seeking help, (7) working collaboratively with other helping professionals in the community in providing care for the people in their charge, and (8) making referrals as much as possible.

The pastors were given an opportunity to learn to recognize mental disorders as described in the *DSM-IV* and other clinical literature. However, their primary role within their pastoral functioning contacts is to diagnose spiritual problems which are described in Scripture and other non-canonical literature. The pastors in the study were using both psychological and spiritual perspectives in their counseling. They were praying with clients but not giving them a choice as to whether or not prayer should be a part of their counseling. They were not comfortable using spiritual, religious, and theological language in their assessment of the parishioner for the purpose of diagnosing in the pre-test. However, to their credit they indicated that they were more apt to use them in the post-test. A majority of the pastors indicated they would be able to recognize three of the five disorders given on the questionnaire. Most of them indicated a positive change in their responses on the *DMS-IV* post-questionnaire. This showed that these pastors were so accustomed to psychological approaches in counseling that they felt the brief introduction to the *DSM-IV* material improved their knowledge sufficiently to claim better understanding and application of it. They all made referrals, although some of the circumstances under which they did not indicate that they would refer, is of concern. They may not be recognizing situations which may lead to inappropriate or unwarranted

behavior in the counseling process.

One of the compelling issues facing pastors in the postmodern world is cultural diversity. In hind sight I should have addressed it during the training. Pastors should be aware of the implications of the reality of diversity and seek to become culturally sensitive at all times.

Recommendations

Several recommendations are now put forward to the Seventh-day Adventist Theological Seminary, conference presidents, and pastors already in parish ministries.

Improve the preparation of seminarians to meet the counseling demands of the parish. Future pastors need to learn how to do assessments and diagnosis from a biblical perspective.

Study ways of developing a counseling curriculum that includes Clinical Pastoral Education (CPE) on site. This could initially be included as an elective and in time become a core course.

Do a comparative study of pastors already in parish ministry with and without the clinical training. The study could be done to determine the relevance of clinical/counseling courses and the preparedness of the seminary graduates to meet the needs of the parishioners from a theological perspective.

Conference presidents and other church leaders need to support the Seminary in making some curriculum enhancements to adequately train pastors to meet the counseling demands of parish ministry in an increasingly litigious society.

Presidents can encourage and support pastors by giving them the time and financial assistance to obtain basic Clinical Pastoral Education (CPE) training.

Workshops on pastoral diagnosis and biblical counseling could be done at some of the Workers' Meetings. This would provide opportunities for pastors to improve their skills as diagnosticians. This should also provide for continuing education credits which could be tied to advancements in ministry as the needs warrant.

Pastors who do not have basic Clinical Pastoral Education (CPE) training should endeavor to acquire it.

They should develop the skills of using their own theological language in diagnosing and counseling, thus greatly reducing the possibility of lawsuits.

The pastor's time is one of his/her most valuable assets and should be managed wisely. Therefore, pastors must become proficient at assessments, diagnosis, referrals, and working in a multidisciplinary environment.

Pastors must discipline themselves and commit to their own personal growth and development, theologically and clinically, through workshops, refresher summer courses, and seminars.

APPENDIX A

INFORMED CONSENT

ANDREWS UNIVERSITY
School of Theology/D.Min Program

"Informed Consent"
Pre-Session and Post-Questionnaires on the Role of Pastoral Diagnosis in Parish Ministry

I have been told that my participation in this study is voluntary and that I could choose to withdraw.

I have been told that there is no foreseeable risk to me or my ministry in participating in this survey.

I have been told that the benefits to me will be: (1) to have a better understanding of what happens in therapy between the pastor and client, (2) to have a better understanding of the diagnostic process, (3) to diagnose using the pastoral dialogue, and (4) to diagnose from a biblical perspective.

I have been told that my identity and that of my district will not be a part of any published document including the dissertation of which this study is a part. My identity will not be known by anyone other than the researcher and or his advisor and that strict confidentiality will be upheld.

I have been told that there will not be any financial cost or benefit to me in participating in this study.

The purpose of the research is to survey 6 pastors in the Lake Region Conference regarding their knowledge of pastoral diagnosis in their ministry.

The expected duration of the project will be three months.

Due to the busy schedules of the pastors, the researcher will conduct the study with them personally in their districts.

There are no foreseeable risks to the pastors.

The foreseeable benefit to the pastors will be to employ a more scripturally based model for counseling with their parishioners.

I have been told that if I wish to contact the researcher's advisor with any complaint I may have about the study, I may contact Dr. James North, at the Christian Ministries Department, Andrews University Seminary Building. (269) 471-3244.

I have read the contents of this consent form and have listened to the verbal explanation given by the investigator. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. If I have additional questions or concerns, I understand that I can raise them with pastor Sylvester, 8998 Fourth Street, Berrien Springs, MI 49103. (269) 473-5452; Cell (574) 276-5005.

Maintaining of Confidentiality:

The researcher will be traveling to the pastors districts to meet with them once a month for six months. Most of our interviews and teaching will be done face to face. There will be occasions when phone conversations will take place.

The instrument will be seen by the researcher and his advisor. The researcher will assign a number to each of the pastor's name that will be known to him alone. In discussions with my advisor the pastors will be known as: P1, P2, P3, P4, P5, and P6. The instruments will be so marked at the headings.

The names (signatures) of the pastors on the "Informed Consent" sheet will be kept by me the researcher alone in a locked file at home for a period of time to be agreed upon with my advisor. This action will be told to the pastors at the beginning of the study and agreed to by them before implementation.

Signature of Participant Date

APPENDIX B

PRE-AND POST-WORKSHOP QUESTIONNARES ON THE ROLE OF PASTORAL DIAGNOSIS IN PARISH MINISTRY

PRE-SESSION QUESTIONNAIRE ON THE ROLE OF PASTORAL DIAGNOSIS IN PARISH MINISTRY

Questionnaire for Adventist Ministers (Please do not write your name)

Under each question, please check the items that are applicable to you

I. BACKGROUND INFORMATION:

1. Gender

❒ male ❒ female

2. Age group

❒ 21-30 years ❒ 31-40 years ❒ 41-50 years ❒ 51-60 years ❒ 61 years and over

3. How long have you been an active minister in the Seventh-day Adventist Church?

❒ Less than1 year ❒ 1-5 years ❒ 6-10 years
❒ 11-15 years ❒ 16-20 years ❒ 21-25 years
❒ 26-30 years ❒ 31 years and over

4. Are you an ordained minister? If yes, how long? ❒ yes ❒ no

❒ Less than1 year ❒ 1-5 years ❒ 6-10 years
❒ 11-15 years ❒ 16-20 years ❒ 21-25 years
❒ 26-30 years ❒ 31 years and over

5. Highest level of education completed:

❒ High school ❒ Associate degree ❒ Bachelor's degree
❒ Master's degree ❒ Doctoral degree ❒ Other:

II. PROFESSIONAL EXPERIENCE IN PASTORAL COUNSELING:

1. Do you do any pastoral counseling in your parish? ❒ yes ❒ no

If yes, how often? ❒ 1-3 times per month ❒ 4 or more times per month

2. **Average number of counseling sessions you have with the clients from the initial interview to termination?**

   ❒ 1-2 ❒ 3-5 ❒ 5-7 ❒ More than 7

3. **Do you believe it is ever appropriate to make referrals?**

   ❒ yes ❒ no

4. **Do you make referrals?**

   ❒ yes ❒ no

5. **For what reasons do you make referrals?** (Check all that apply)

   ❒ Time constraints ❒ When client's needs are beyond my level of expertise
   ❒ When the client is being seductive ❒ When I am emotionally over-identified with the client
   ❒ When I am sexually attracted to the client ❒ When the client is being aggressive
   ❒ Other:

6. **Do you ask the client about his/her individual history?**

   ❒ yes ❒ no

7. **Do you ask the client about his/her family history?**

   ❒ yes ❒ no

8. **Do you ask the client about his/her spiritual life?**

   ❒ yes ❒ no

9. **What type(s) of counseling do you do?** (Check all that apply)

   ❒ Premarital ❒ Marital ❒ Family
   ❒ Domestic violence ❒ Substance abuse ❒ Career
   ❒ Teen ❒ Grief ❒ Other:

10. Do you counsel from a psychological perspective, for example, using the counseling theories of noted psychologists?

❒ yes ❒ no ❒ I do not know

11. Do you counsel from a scriptural perspective, for example, using scriptural passages?

❒ yes ❒ no ❒ I do not know

12. Do you always pray with clients as part of the counseling process?

❒ yes ❒ no

13. Do you offer the client a choice regarding prayers in counseling?

❒ yes ❒ no

14. Do you pray with the client based on your sense of his/her need for prayer?

❒ yes ❒ no

15. When you hear the term *diagnosis*, do you think of: (Check the boxes that best suits your answer)

❒ Medical doctor ❒ Auto mechanic ❒ Computer analyses

❒Other:_____ ❒ Not familiar with the term

16. When you hear the term *pastoral diagnosis*, do you think of:

❒ A troubled parishioner ❒ A spiritually troubled parishioner ❒ An addicted parishioner

❒ Other:_____ ❒ Not familiar with the term

17. How appropriate are the following questions in counseling? (Check the column that best suits your answer.)

	Very appropriate	Appropriate	Not very appropriate	Inappropriate
The role of the Father				
The role of the Son				
The role of the Holy Spirit				
The role of grace				
The role of love				
The role of forgiveness				
The role of baptism				
The role of communion				
The Second Coming				

18. Would you recognize whether a client was suffering from one of the following disorders?

Anxiety disorders ❒ yes ❒ no

Mood disorders ❒ yes ❒ no

Substance abuse ❒ yes ❒ no

Schizophrenia ❒ yes ❒ no

Organic brain damage ❒ yes ❒ no

19. Please indicate your level of knowledge about the following DSM-IV concepts by checking the column that best suits your answer.

	Thorough Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge
Diagnostic Codes				
Multiaxial Assessment				
Diagnosis and Prognosis				
Global Assessment of Functioning Scale				
Differential Diagnosis				
Differences Among Symptoms, Signs, & Issues				
Etiology & Pathogenesis				
Clinical Presentation				
Personality Disorders				
Cognitive Disorders				
Substance-Related Disorders				
Schizophrenia and Related Disorders				
Anxiety Disorders				
Somatoform Disorders				
Factitious Disorders				
Dissociative Disorders				
Sexual and Gender Identity				
Eating Disorders				
Sleep Disorders				

POST-SESSION QUESTIONNAIRE ON THE ROLE OF PASTORAL DIAGNOSIS IN PARISH MINISTRY

Questionnaire for Adventist Ministers (Please do not write your name)

Under each question, please check the items that are applicable to you

1. Do you counsel from a psychological perspective, for example, using the counseling theories of noted psychologists?

❒ yes ❒ no ❒ I do not know

2. Do you counsel from a scriptural perspective, for example, using scriptural passages?

❒ yes ❒ no ❒ I do not know

3. Do you always pray with clients as part of the counseling process?

❒ yes ❒ no

4. Do you offer the client a choice regarding prayer in counseling?

❒ yes ❒ no

5. Do you pray with the client based on your sense of his/her need for prayer?

❒ yes ❒ no

6. When you hear the term *pastoral diagnosis*, do you think of:

❒ A troubled parishioner ❒ A spiritually troubled parishioner ❒ An addicted parishioner

❒ Other:_____ ❒ Not familiar with the term

7. How appropriate are the following questions in counseling? (Check the column that best suits your answer.)

	Very appropriate	Appropriate	Not very appropriate	Inappropriate
The role of the Father				
The role of the Son				
The role of the Holy Spirit				
The role of grace				
The role of love				
The role of forgiveness				
The role of baptism				
The role of communion				
The Second Coming				

8. Would you recognize whether a client was suffering from one of the following disorders?

Anxiety disorders ❒ yes ❒ no

Mood disorders ❒ yes ❒ no

Substance abuse ❒ yes ❒ no

Schizophrenia ❒ yes ❒ no

Organic brain damage ❒ yes ❒ no

9. Please indicate your level of knowledge about the following DSM-IV concepts by checking the column that best suits your answer.

	Thorough Knowledge	Adequate Knowledge	Little Knowledge	No Knowledge
Diagnostic Codes				
Multiaxial Assessment				
Diagnosis and Prognosis				
Global Assessment of Functioning Scale				
Differential Diagnosis				
Differences Among Symptoms, Signs, & Issues				
Etiology & Pathogenesis				
Clinical Presentation				
Personality Disorders				
Cognitive Disorders				
Substance-Related Disorders				
Schizophrenia and Related Disorders				
Anxiety Disorders				
Somatoform Disorders				
Factitious Disorders				
Dissociative Disorders				
Sexual and Gender Identity				
Eating Disorders				
Sleep Disorders				

APPENDIX C

PRUYSER'S GUIDELINES FOR

PASTORAL DIAGNOSIS

PRUYSER'S GUIDELINES FOR PASTORAL DIAGNOSIS

A. Awareness of the Holy

1. What, if anything, is sacred, revered
2. Any experiences of awe or bliss, when, in what situation
3. Any sense of mystery, of anything transcendent
4. Any idolatry, reverence displaced to improper symbols

B. Providence

1. What is God's intention toward me?
2. What has God promised me?
3. Belief in cosmic benevolence
4. Related to capacity for trust
5. Extent of hoping versus wishing

C. Faith

1. Affirming versus negating stance in life
2. Able to commit self, to engage
3. Open to world or constricted

D. Grace or Gratefulness

1. Kindness, generosity, the beauty of giving and receiving
2. No felt need for grace or gratefulness
3. Forced gratitude under any circumstances
4. Desire for versus resistance to blessing

E. Repentance

1. The process of change from crookedness to rectitude

2. A sense of agency in one's own problems or one's response to them versus being a victim versus being too sorry for debatable sins

3. Feelings of contrition, remorse, regret

4. Willingness to do penance

F. Communion

1. Feelings of kinship with the whole chain of being

2. Feelings embedded or estranged, united or separated in the world, in relations with one's faith group, one's church

G. Sense of Vocation

1. Willingness to be a cheerful participant in creation

2. Signs of zest, vigor, liveliness, dedication

3. Aligned with divine benevolence or malevolence

4. Humorous and inventive involvement in life versus grim and dogmatic

APPENDIX D

CODE OF ETHICS FOR PASTORS

CODE OF ETHICS

Taken from the American Association of Pastoral counselors

To develop and maintain a high level of integrity in our relationships we (as pastors) should:

1. Seek out and engage in collegial relationships, recognizing that isolation can lead to a loss of perspectives and judgment.

2. Manage our personal lives in a healthful fashion and seek appropriate assistance for our own personal problems or conflict.

3. Diagnose or provide treatment only for those problems or issues that are within the reasonable boundaries of our competence.

4. Establish and maintain appropriate professional relationship boundaries.

5. Use our knowledge and professional associations for the benefit of the people we serve and not to secure unfair personal advantage.

6. Be prepared to render service to individuals and communities in crisis without regard to financial remuneration when necessary.

7. Neither receives nor pays a commission for referral of a client.

8. Not abandon or neglect clients. If we are unable, or unwilling for appropriate reasons, to provide professional help or continue a professional relationship, every reasonable effort is then made to arrange for continuation of treatment with another professional.

9. Make only realistic statements regarding the pastoral counseling process and its outcome.

10. Show sensitive regard for the moral, social, and religious standards of clients and communities. We avoid imposing our beliefs on others, although we may express them when appropriate in the pastoral counseling process.

11. Continue the counseling relationship only so long as it is reasonably clear that the clients are benefiting from the relationship.

12. Recognize the trust placed in and unique power of the therapeutic relationship. While acknowledging the complexity of some pastoral relationship, we avoid exploiting the trust and dependence of clients. We avoid those dual relationships with clients (e.g., business or close personal relationships) which could impair our professional judgment, compromise the integrity of the treatment, and/or use the relationship for our own gain.

13. Not engage in harassment, abusive words or actions, or exploitative coercion of clients or former clients.

14. Recognize that all forms of sexual behavior or harassment with clients are unethical, even when a client invites or consents to such behavior or involvement. Sexual behavior is defined as, but not limited to, all forms of overt and covert seductive speech, gestures, and behavior as well as physical contacts of a sexual nature; harassment is defined as, but not limited to, repeated comments, gestures or physical contacts of a sexual nature.

15. Recognize that the therapist/client relationship involves a power imbalance, the residual effects of which are operative following the termination of the therapy relationship. Therefore, all sexual behavior or harassment as defined above with former clients is unethical.

16. Store or dispose all records on clients in a manner that assures security and confidentiality.

17. Treat all communications from clients with professional confidence.

18. Not disclose client confidences to anyone, except: as mandated by law; to prevent a clear and immediate danger to someone; in the course of a civic, criminal or disciplinary action arising from the counseling where the pastoral counselor is a defendant; for purpose of supervision or consultation; or by previously obtained written permission. In cases involving more than one person (as client) written permission must be obtained from all legally accountable persons who have been present during the counseling before any disclosure can be made.

19 Obtain informed written consent of clients before audio/video tape recording or permitting third party observation of their sessions.

20. Not use the standards of confidentiality to avoid intervention when it is necessary, e.g., when there is evidence of abuse of minors, the elderly, the disabled, the physically or mentally incompetent.

APPENDIX E

INTAKE FORM

INTAKE FORM: (Sample)

Name_____ Phone_____

Address: _____

Occupation _____Day Time Phone_____

Sex_____ Birth Date_____

Marital Status: Single_____ Dating_____ Married_____
Separated_____ Divorced_____ Widowed_____

Education (last year completed): _____ (Grade) _____ College:_____

Vocational (list type and years completed)_____

Referred by_____Relationship_____

HEALTH INFORMATION:

Rate your health (Check): Very Good_____ Good _____ Average_____
Declining_____ Other_____

List major illnesses:_____

Date of last medical examination:_____

Are you presently taking medication? Yes_____ No_____

What?_____

Have you ever had a nervous breakdown? Yes_____ No_____

Have you recently suffered the loss of someone who was close to you?

Yes____ No ____Explain_____

Have you recently suffered loss for serious social, business, or other reversals?

Yes____ No ____Explain_____

How do you rate your coping skills? Very Good____ Good ____ Average ___Poor _____

RELIGIOUS BACKGROUND:

Denominational affiliation:_____ Member of_____

Church attendance per month (Circle): 1 2 3 4 5 6 7 8 9 10 or more

Church attended in childhood?_____

Baptized? Yes_____ No_____

Religious background of spouse (if married) _____

Do you consider yourself a religious person? Yes_____ No_____ Uncertain _____

Do you consider yourself a spiritual person? Yes____ No _____ Uncertain _____

Do you believe in God? Yes_____ No_____ Uncertain _____

Do you pray to God? Never_____ Occasionally_____ Often_____

Do you have a relationship with Christ? Yes____ No _____ Uncertain _____

Are you saved? Yes____ No _____ Uncertain _____

How often do you read the Bible? Never_____ Occasionally_____ Often_____

Do you have regular family devotions? Yes____ No _____

Explain any recent change in your religious life_____

_____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. What do you perceive to be your problem? _____

2. What have you done about it so far? _____

3. What are your expectations in coming here? _____

4. How would you describe yourself? _____

5. What concerns you the most right now? _____

6. What do I need to know that I did not ask? _____

PSYCHOLOGICAL INFORMATION:

On a scale of 1-5 with 1 being *"no problem"*, and 5 being *"a serious problem"*, please rate the following:

I have feelings of sadness, crying, being "down"	1	2	3	4	5
I find it difficult to focus my thoughts	1	2	3	4	5
I have unwanted thoughts in my mind	1	2	3	4	5
I feel out of control sometimes	1	2	3	4	5
I have problems sleeping	1	2	3	4	5
I have feelings of worthlessness	1	2	3	4	5
I problems with anger/temper	1	2	3	4	5
I have problems with my eating	1	2	3	4	5
I have thoughts and feelings too painful to talk about	1	2	3	4	5
I have concerns about my sexuality	1	2	3	4	5
I have been using alcohol and/or drugs	1	2	3	4	5
I am doing things over and over	1	2	3	4	5
I am being more forgetful lately	1	2	3	4	5
I'm seeing or hearing things that others don't	1	2	3	4	5
I feel anxious or nervous at times	1	2	3	4	5
I am preoccupied with spiritual concerns lately	1	2	3	4	5
I have anxiety about the Second Coming	1	2	3	4	5
I have pain and/or health concerns	1	2	3	4	5

MARRIAGE AND FAMILY INFORMATION:

Name of spouse_____ Phone_____

Address_____

Occupation_____ Day Time Phone_____

Your spouse's age_____ Education (in years) _____

Religious orientation_____

Is spouse willing to come for counseling? Yes____ No _____ Uncertain _____

Have you ever been separated? Yes____ No _____ When _____

Years of Marriage?_____ Number of children?_____

Ages: 0-5_____ 6-10_____ 11-15_____ 16-20_____ 21-30_____ 30+_____

APPENDIX F

TRAINING WORKSHOP MANUAL FOR PASTORS

ON HOW TO DIAGNOSE IN PARISH MINISTRY

SEMINAR FORMAT

MINISTERS TRAINING PROGRAM

Title: The Role of Pastoral Diagnosis in Parish Ministry

Duration: Two Times a Month for Three Months

Target Audience: Six Pastors in the Lake Region Conference

Prerequisite Knowledge: No prerequisite knowledge is needed

I Instructional Objectives:

1. To develop basic skills in intake and record keeping procedures.
2. To comprehend how the DSM IV is used in the diagnosis and treatment of mental disorders
3. To examine and evaluate assumptions, etiologies, diagnoses, and treatment options of psychoanalytic, cognitive, behavioral, person-centered, and family therapies.
4. To discover the significance of Holy Scriptures as a therapeutic tool.
5. To increase levels of competency in utilizing diagnostic and referral factors in parish ministry.

II Course Content:

1. Intake and Record keeping
   - A. Gathering the Parishioner's history
   - B. The Pastoral Dialogue
   - C. Securing the Information
   - D. Written Consent
2. Diagnostic and Statistical Manual IV
   - A. Introduction to the DSM IV
   - B. Use of the DSM IV Manual
   - C. DSM-IV Classifications
   - D. Multi-Axial Assessment

3. Counseling Theories

A. Psychoanalytic Theory and Therapy

1) Key Proponent

2) Key Concepts

a) View of Human Nature

b) Structure of Personality

c) Conscious and the Unconscious

d) Anxiety

e) Ego-defense Mechanism

f) Development of Personality

3) Therapeutic Process

a) Therapeutic Goals

b) Therapist (Pastor's) Function and Role

c) Client's Experience

d) Therapeutic Relationship between the Pastor and Client

4) Therapeutic Techniques and Procedures

a) Free Associations

b) Interpretations

c) Dream Analysis

d) Resistance

e) Transference

B. Cognitive Theory and Therapy

1) Key Proponent

2) Key Concept

a) View of Human Nature

b) View of Emotional Disturbance

c) ABC Theory and Personality

3) Therapeutic Process

a) Therapeutic Goals

b) Therapist (Pastor's) Function and Role

c) Client's Experience

d) Therapeutic Relationship between the Pastor and Client

C. Behavior Theory and Therapy

1) Key Proponent

2) Key Concepts

a) View of Human Nature

b) Basic Characteristics

3) Therapeutic Process

a) Therapeutic Goals

b) Therapist (Pastor's) Function and Role

c) Client's Experience

d) Therapeutic Relationship between the Pastor and Client

D. Person Centered Theory and Therapy

1) Key Proponent

2) Key Concepts

a) View of Human Nature

b) Basic Characteristics

3) Therapeutic Process

a) Therapeutic Goals

b) Therapist (Pastor's) Function and Role

c) Client's Experience

d) Therapeutic Relationship between the Pastor and Client

E. Family Theory and Therapy

1) Introduction

a) Family Systems Perspective

b) Difference between Individual verses Systemic

2) Key Proponent

3) Key Concepts

a) Differentiation of Self

b) Triangulation

4) Therapeutic Process (Multi-generational Model)

a) Therapeutic Goals

1) Change individuals within the system

2) Decrease anxiety and symptoms

3) Increase differentiation

b) Therapist's (Pastor's) Function and Role

c) Techniques & Process of Change

d) Therapeutic Relationship between the Pastor and Client

5) Key Proponent

6) Key Concepts

a) Family Life

b) Functional

c) Defensive Stance

d) Roles and Triads

7) Therapeutic Process (Human Validation Model)

a) Therapy Goals in the Human Validation Model

1) Clear Communication

2) Expand Awareness

3) Enhance Growth Potentials

4) Improve Self-esteem

5) Improve Coping with Demands and Process of Change

b) Therapist (Pastor's) Role and Function

c) Techniques & Process of Change

d) Therapeutic Relationship between the Pastor and Client

F. Biblically Based Counseling as Therapy

1) Key Proponent

2) Key Concepts

a) The Holiness of God

b) His Acts in Human History

c) View of Human Nature

d) Biblical Counseling

3) Therapeutic Process

a) Therapeutic Goals

b) Therapist (Pastor's) Function and Role

c) Client's Experience

d) Therapeutic Relationship between the Pastor and Client

e) Compare and Contrast Biblical Counseling with Psychological

4) Pastoral Diagnosis and Referral

5) Assessment

6) Competency

7) What is being asked of me?

8) Case History

III. Assessment/Evaluation

Vignette/Post-Questionnaire/Evaluation of presentation

INTAKE AND RECORD KEEPING

In this chapter, we will discuss various elements of how to gather client/parishioner data, and how to maintain clients/parishioners records. All information discussed is based upon the research gleaned by the writer, as well as the writer's professional experience.

In the past, information that was obtained as apart of the clients records were based upon understanding the etiology of the clients problems, and obtaining a specific diagnosis. Currently, the trend is to describe the client, identify their behaviors, assess their strengths, and explore their coping skills. You are encouraged to develop a professional writing style which excludes the use of slang, jargons, acronyms, abbreviations, and clichés. The use of the local language may be appropriate as long as a reference is made to indicate so. It is important to be brief and precise, writing short paragraphs or phrases, with the focus on a single concept.

As you record information, think about how the reader or client will interpret the data. It is important to remember that we are living in an era of mass litigation for a variety of reasons. Therefore, do not use terms or phrases inappropriately or haphazardly. It has been suggested in the Clinician's Thesaurus, pg 335, "first decide on the answers to these questions:

1. To/for whom am I writing?
2. For what purpose am I making these notes?
3. What is my system for recording data?

When you are reporting facts be specific. When quoting someone, use the

appropriate quotation marks and indicate the source. Negative information and findings are equally as important to reports as are positive information and findings.

During the initial intake interview, it is crucial to inform the parishioner about the limits of confidentiality. In some instances, it may be appropriate to have a signed form which indicates that the limits of confidentiality have been discussed and the individual understands the limits and agrees to continue with the counseling session.

Provide information that is only relevant and have meaning for the focus of treatment. Make sure your statements are consistent. Do not make a judgment in one aspect of your notes then report a different conclusion. Make sure your notes are legible. For information that can be controversial, be sure to carefully phrase the information indicating its source. If you cite an authority, identify the qualifications as well as a disclaimer when necessary.

There are various formats utilized to gather information about clients/parishioner's. The method used may be based upon the requirements of the agency or the preference of the therapist or what is stipulated by managed care organizations. While it would be interesting to know the different formats, for the sake of brevity, only one will be discussed.

Gathering the Parishioner's History

There are two different methods of gathering historical information on an individual, either by the individual completing a written intake form, (a sample will be provided), or through the personal interview. There are advantages and disadvantages in

having an individual fill out a form requesting specific detailed information. As an advantage, it can leave more time for the personal interview, and it gives the clinician/pastor written information to aid in the discussion. Furthermore, it can provide you with the opportunity to arrive at a holistic picture of the individual/family – past and present situations. As a disadvantage, it can be timely, it may provide information that has nothing to do with the reason for seeking counseling, the individual may be unwilling to provide some personal information and question the need for the request.

The intake interview and subsequent interviews are an important and dynamic process that must be entered into with seriousness and professionalism. Regardless of the therapeutic intervention, the quality of the relationship between the pastor/clinician and the individual will determine the outcome of the counseling sessions.

The D.A.R. or D.A.P record taking format is recommended:

D = Data. Record the information that is presented. This could include the client's mental status (orientation to person, place, time, and situation); your observation of their affect; observation of their mood; thought processes; behavioral presentation, and current cognitive presentation. A simple checklist format would help identify and record significant data. It is important in this section to include information that is the topic of discussion or the treatment plan to be addressed.

A = Assessment/Action. In this section it is important to include information about your assessment, your interpretation of the data presented by the client. What is your impression of the client's information or presentation? Also, it is here that you include information of what you introduced to the client, the action plan.

R= Response. After you share the action plan with the client, be observant of their response and record that. Record all behavioral, cognitive, and emotional responses. Again, it is important to record that which is pertinent to the data presented.

The other recommended format is the D.A.P. Data and Assessment is the same; however, P represents the Plan that will be utilized to address the presenting problem. Be aware that this is the clients plan on how to resolve the issue.

Huber, J.T., (Report writing in psychology and psychiatry. New York: Harper, 1961) suggest this alternative format:

1. Content or behavior: What each did and said. Record these with no modifiers.
2. What the therapist thought and felt about the content and may have said to the client.
3. What the therapist thought and felt about the client, the interview, the content-and probably did not tell the client, the therapist impression or a specific "Note"
4. Anything bearing on the therapy that happened outside the interview. This could include compliance with the therapeutic program, steps taken to overcome parishioner patient's resistance and who took them, telephone calls, consultations with colleagues and the results.
5. Plans for the next interview, promises made, what to pursue, follow up questions, homework to be done by either the client or therapist, or topics for next session.

The Pastoral Dialogue

There are four phases of counseling: clarification, formulation, intervention, and

termination. This first phase, **clarification**, according to Miller and Jackson begins "at the moment that either the pastor or the client initiates contact for the purpose of counseling. This can be as simple as the request, 'do you have a few minutes?' or 'I wonder if I could talk to you sometime this week?'"[1] When the pastor begins counseling with a parishioner they enter into a dual relationship. Because of the earlier relationship that will most likely continue after the counseling is over, clarity is necessary for both of them. Open and honest discussion must take place around confidentiality. What, if anything from the sessions will be disclosed? They also need to discuss the specific time and nature of the counseling. This is especially critical if the person is active in the congregation and sees the pastor often in the exercise of his/her duties. Care must be taken to set specific time and place for counseling so that the role will not become confused.

The second phase **formulation** is where the pastor begins to listen to the person telling his/her story. Listening must be empathic and questions designed to put the clients at ease and help them tell their story (see Jeffrey Watson, 79). Here the pastor begins to diagnose the problem for the purpose of choosing the type of intervention that will be most helpful. This will also test the pastor's level of skill. The pastor must be able to:

1. Understand and define the problem.
2. Pay attention, listen and search for understanding.

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[1]Miller and Jackson, *Practical Psychology for Pastors*, 14.

3. Do some critical analysis and comparison of the presenting problem.

4. Decide on a method of intervention.

While there is a dialogue between the pastor and parishioner there must also be a conversation between the pastor and him/herself. Don Browning believes that during the pastoral dialogue with the parishioner, the pastor must process the information through what he calls "the five levels of practical moral thinking," especially when faced with a moral issue. They are:

1. The metaphorical level: What kind of world or universe constitutes the ultimate context of our action?

2. The obligational level: What are we obligated to do?

3. A tendency-need level: Which of all our human tendencies and needs are morally justified in satisfying?

4. A contextual-predictive level: What is the immediate context of our action and the various factors which condition it?

5. A role-rule level: What specific roles, rules, and processes of communication should we follow in order to accomplish our moral ends?[1]

The third phase **intervention** is where the pastor makes the decision, based on the information gathered and the level of skill and time necessary, to help the person or persons achieve wholeness and restore trust and confidence in God. At this stage it may be prudent for the pastor to talk about referring to a more competent counselor. This

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[1]Browning, 53-55.

should not be an embarrassment or an admission of failure on the part of the pastor, but being the shepherd who cares enough to make available the best resource to those under his/her care. It is wise to know and have on file the services and service providers in your parish area. Take the time to meet with them and find out their approach to different types of counseling. Know their theological beliefs if any. Form alliances with those with whom you are able to do so with a clear conscience.

If you do not refer because the parishioner's needs met your level of skills, the last stage is **termination**. Hackney and Cormier, (Counseling Strategies and Interventions. 4th ed, Boston, MA: Allyn and Bacon, 1994), point out that terminating a therapeutic relationship will evoke a host of emotions for the client and the counselor that can be intense. It has been viewed as the loss of a meaningful relationship or the symbol of success for the client. However, viewing termination as a transition can be more helpful, especially within the pastoral – congregant relationship.

Various theoretical approaches have guidelines for the termination process. Cormier and Hackney (1992) have identified the following practical considerations:

1. When clients feel that their goals have been accomplished, they may initiate termination

2. When the relationship appears not to be helpful, either to the counselor or client, termination is appropriate.

3. When contextual conditions change – for example, the client or counselor moves to a new location – termination must occur.

This writer believes that in the pastoral – parishioner counseling relationship

termination should not be discussed with the parishioner early in the counseling process, unless asked, because among other things, it can create anxiety and in some cases feelings of unworthiness by the parishioner.

It is prudent however; that the parishioners are made aware of the termination transition when counseling is no longer needed or the pastors have reached their limitations. This does not mean that individuals will have resolved all their issues, nor will it mean that they have acquired all the resources to improve the quality of their life. It does imply that they have developed the ability to be less dependent on the therapeutic relationship; they may be happier and more self-fulfilled, and able to engage in a trusting relationship with God. It also implies that pastors are caring and ethical enough to stay within their expertise. Early termination does not imply incompetence on the part of the pastors.

The pastor should **play down** the termination process because, as stated earlier, the therapeutic relationship may have been the most significant relationship for the parishioner and ending the relationship may evoke strong emotional reactions. It is important that the pastor anticipate the parishioner's reaction and provide them with assurance, emphasize their progress, recognize their emotional reactions, and affirm their reconnection in their relationship with God.

Termination can be **gradual** when necessary. This can be done by spacing the counseling sessions from weekly appointments to bi-weekly sessions, to monthly sessions, and then a six-month check up. This can give the parishioner the sense that the therapeutic relationship is on-going and they can return for support when needed. While

typical therapeutic relationships have a sense of finality, the pastoral/parishioner relationship will continue at a different level. In this stage the dialogue should be around shifting back to a regular pastoral relationship. But the relationship is not nor will it ever be a normal pastoral one again.

Counseling is fraught with risk. Authenticity on the part of the pastor meant being vulnerable. The pastor was allowed into the private, emotionally vulnerable and sensitive parts of the person's life. Sexual and emotional boundaries had to be maintained especially if counseling a member of the opposite sex. Transference and counter-transference, if present, had to be addressed and guarded so as not to cross boundaries. There was a level of intimacy that was experienced that changed the dynamics of the pastoral relationship. Now the discussion is about resources to cope and assurance of the pastoral presence for the occasional verbal check up, "how are things going with you?"

Securing the Information

A critical part of counseling is securing the pertinent information one gathers. It is not only wise but also ethical to gather only necessary information and for the purpose of providing the help that you are trained to give. The person should also know how you intend to use the data collected and the role of confidentiality. Confidentiality must be maintained to the point that Federal and state laws are not violated or when it is necessary to protect life or the wellbeing of others. The clients should know how and for how long their information will be stored. All data should be kept in a locked area and names be

identified by a coding system.

Written Consent

It is important to let the person know that any information you share about them is with their knowledge and written consent unless otherwise mandated by federal and state laws.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOUTH EDITION

Introduction

The Diagnostic and Statistical Manual of Mental Disorders-IV (*DSM-IV*)[1] is a diagnostic tool that has been designed by the American Psychiatric Association for the purpose of guiding clinicians, researchers, and other professionals in the diagnosis and treatment of mental disorders. The *DSM-IV* was designed to be the official nomenclature which would be used under a vast diverse context.

Its final product was the result of 13 work groups from various orientations including psychologists, psychiatrist, physicians, clinicians, social workers, researchers, and many others from around the world. This international venture was especially designed to: increase and enhance the level of communication and cooperation amongst the professionals and experts in their respective fields, to ensure that the diagnostic manual would be as comprehensive as possible, and it would be suitable for use in other cultures. As early as 1840 there have been attempts in the United States to classify mental disorders. What evolved over the years were various nomenclatures that identified psychiatric and neurological disorders. The International Classification of Diseases (ICD) was very instrumental in the developing of the *DSM*. The American Psychiatric Association Committee on Nomenclature and Statistics developed the first edition of the DSM in 1952 utilizing the information found in the ICD-6. As research

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[1]Association.

continued, the *DSM-IV* was developed based on empirical research studies. This empirical process included "1) comprehensive and systematic reviews of the published literature, 2) re-analyses of already-collected data sets, and 3) extensive issue-focused field trials."

Definition

As a form of a disclaimer, the term "mental disorder" implies that there is a distinction between physical disorder and mental disorder. There is a vast array of research that has demonstrated that there is a correlation between the physical and mental health, which Ellen G. White discussed in her non-empirical, Holy Spirit led writings. Due to this knowledge, there is no adequate definition for the concept of "mental disorder."

The definition that is included is based on a variety of concepts that incorporates an individual's level of distress, loss of control, disadvantage, disability, inflexibility, and irrationality, the pattern of the syndrome, etiology, and statistical deviation. ". . . Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event . . . Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual."

It is important to note that deviant behaviors and conflicts between the individual and society are not considered to be mental disorders. However, if the deviancy or conflict is a symptom of dysfunction in the person as detailed above, then a mental disorder diagnosis may apply. It is also important to note that classification of a mental disorder is only identifying the disorder of an individual. It must not be used to labeling people.

Use of the Manual

The International Classification of Diseases is a diagnostic tool that identifies and list diseases and disorders based on a specialized coding system. Many of the disorders found in the *DSM-IV* are numerically coded based upon the ICD. These codes are located in specific places in the text: "1) preceding the name of the disorder in the classification, 2) at the beginning of the text section for each disorder, and 3) accompanying the criteria set for each disorder." There are certain disorders which require more details for the appropriate code to be applied and other disorders have alternative terms enclosed in parentheses. The text of *DSM-IV* systematically describes each disorder under the following headings:

1. Diagnostic features
2. Subtypes and/or Specifiers
3. Recording Procedures
4. Associated features and Disorders
5. Specific Culture, Age and Gender Features

6. Prevalence
7. Course
8. Familial Pattern
9. Differential Diagnosis

A discussion of these headings is important, however, for the purpose of this document, it will not be addressed in this paper. What is important to know is the basic utilization of the *DSM-IV* manual.

The disorders found in the *DSM-IV* are grouped into 16 major diagnostic classes along with an additional section entitled, "Other Conditions That May Be a Focus of Clinical Attention."

Disorders Usually First Diagnosed in Infancy, childhood, or adolescence is the first section. The following three sections were originally grouped together in the *DSM-III-R* entitled "Organic Mental Syndromes and Disorders" implying that the other disorders in the manual were without an organic base.

The remaining 12 sections are grouped together based upon their presenting features and symptoms. The last section is entitled "Other conditions that may be a focus of clinical attention." 10 appendixes have also been included in the final product.

DSM-IV Classifications

1. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
2. Delirium, Dementia, and Amnestic and other Cognitive Disorders
3. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

4. Substance Related Disorders
5. Schizophrenia and Other Psychotic Disorders
6. Mood Disorders
7. Anxiety Disorders
8. Somatoform Disorders
9. Factitious Disorders
10. Dissociative Disorders
11. Sexual and Gender Identity disorders
12. Eating Disorders
13. Sleep Disorders
14. Impulse Control Disorders Not Elsewhere Classified
15. Adjustment Disorders
16. Personality Disorders
17. Other Conditions That May Be a focus of Clinical attention

Multi-Axial Assessment

The term "Axis" is defined as a line around which a turning body rotates or may be supposed to rotate. It is a real or imaginary central line about which things or parts are symmetrically arranged. It is also an affiliation or coalition of two or more nations to promote mutual interest, cooperation, etc. In utilizing this term in the *DSM-IV*, the axis is a category of information where a body of knowledge has been assimilated under specific domains. The *DSM-IV* uses a multiaxial system in order to enhance comprehension and

to systematically evaluate mental disorders while identifying personality disorders, general medical conditions, psychosocial and environmental problems, and individual level of functioning. This format provides "a convenient method for organizing and communicating clinical information, for capturing the complexity of clinical situations, and describing the heterogeneity of individuals presenting the same diagnosis" (*DSM-IV*, p. 25). Furthermore, this system supports the utilization of the biopsychosocial model in the clinical, educational, and research settings.

Axis I: Clinical Disorders/ Other Conditions That May Be a Focus of Clinical Attention

This axis is used for reporting all the diverse disorders or conditions which would not include Personality Disorders and Mental Retardation. Those disorders are identified above. More than one disorder can be reported. However, the leading diagnosis that initiated the contact should be identified and listed first. "If an individual has both an Axis I and an Axis II disorder, the principal diagnosis or the reason for the visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal Diagnosis)" or "(Reason for Visit)". If no Axis I disorder is present, this should be coded as V71.09. If an Axis I diagnosis is deferred, pending the gathering of additional information, this should be coded as 799.9" (*DSM-IV*, p. 26). The two above mentioned codes and terms are used in both the ICD-9 and ICD 10.

Axis II: Personality Disorders, Mental Retardation

Identifying personality disorders and mental retardation on a different axis allows for these disorders to be considered and not overlooked when there is a focus on the obvious symptoms of the Axis I disorder. Nevertheless, it would be a mistake to think that this format implies that personality disorders and mental retardation symptoms and/or treatment have fundamental differences. Also, when an individual presents with more that one Axis II diagnosis, all should be identified. When the Axis II diagnosis is the major reason for the clinical visit, there should be a qualifying statement noted "Principal Diagnosis." If there is not disorder present, V71.09 should be the code used. If there is an Axis II diagnosis that is deferred, pending the gathering of further information, this should be coded as 799.9. In the case where there is a prominent maladaptive personality symptom that does not meet the criteria for a Personality disorder, no code number should be recorded but a brief statement indicating the maladaptive symptoms observed. When there is the habitual use of defense mechanisms, Axis II can be used to identify this problem.

The disorders to be listed on Axis II are listed below:

Personality Disorders
Mental Retardation

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive Compulsive Personality Disorder
Personality Disorder not otherwise Specified

Mental Retardation

Axis III: General Medical Conditions

The purpose of including general medical conditions is to enhance the evaluations process and encourage and improve the level of communication among health care professionals. The identification of the prevailing general medical condition can be significant to the understanding and the treatment of a person's mental health diagnosis. As research has found, general medical conditions can be related to mental disorders in numerous ways, either directly by the "development or worsening of mental symptoms and that the mechanism for this effect is physiological." Furthermore, "when a mental disorder is judged to be a direct physiological consequence of the general medical condition, a Mental Disorder Due to a General Medical Condition should be diagnosed on Axis I and the general medical condition should be recorded on both Axis I and Axis III." All known Axis III diagnosis which is clinically relevant should be reported. General Medical Conditions are listed below along with the ICD-9-CM codes.

Infectious and Parasitic Diseases (001-139)
Neoplasms (140-239)
Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (240-279)
Diseases of the Blood and Blood-Forming Organs (280-289)
Diseases of the Nervous System and Sense Organs (320-389)
Diseases of the Circulatory System (390-459)
Diseases of the Respiratory System (460-519)
Diseases of the Digestive System (520-579)
Diseases of the Genitourinary System (580-629)
Complications of Pregnancy, Childbirth and the Puerperium (630-676)
Diseases of the Skin and Subcutaneous Tissue (680-709)
Diseases of the Musculoskeletal System and Connective Tissue (710-739)
Congenital Abnormalities (740-759)
Certain Conditions Originating in the Perinatal Period (760-779)
Symptoms, Signs, and Ill-Defined Conditions (780-799)
Injury and Poisoning (800-999)

AXIS IV: Psychosocial and Environmental Problems

Axis IV is for reporting any psychosocial and/or environmental problem that may affect the diagnosis, treatment, and prognosis of mental disorders found on Axis I & II. They include any negative life event, an environmental problem or deficiency, interpersonal or family stress, inadequate social support system, limited personal resources, or any other problem relating to the original diagnosis. Psychosocial problems may develop as a result of an individual's psychopathology, they are important in the formation or intensification of a mental disorder, or they may compound problems that should be addressed in the treatment plan. Several problems should be noted which are considered to be relevant to the initial diagnosis. However, only those problems which have been present during the year prior to the current evaluation should be documented. Nevertheless, if a problem from previous years contributes to the mental disorder, it should be documented. When a psychosocial and/or environmental problem is the main focus of clinical attention it is to be recorded on Axis I under the heading, "Other Conditions That May Be a Focus of Clinical Attention". A list of problems is identified below:

Problems with primary support group
Problems related to the social environment
Educational problems
Occupational problems
Housing problems
Economic problems
Problems with access to health care services
Problems related to interaction with the legal system/crime
Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning

Axis V is used for the purpose of reporting the clinical judgment of a person's overall level of functioning. The Global Assessment of Functioning scale is utilized for this evaluation. The GAF has been found to benefit the clinician by aiding in the treatment plan development, measuring and following clinical progress. This scale is not to be used for impairment in physical abilities, but only for psychological, social, and occupational functioning. Clinician should only rate the individual based on the current functioning level, and then at various designated time periods to assess treatment effectiveness, and clinical progress. See attached for GAF Scale. Example:

Mary has been living in this country for the past ten years. She is a native of Turkey. She is the wife of Franko and they have four children. She is not employed. He works at the foundry in town, and has been employed for eight of those ten years. They received word that Mary's family was murdered from terrorist bombings. Mary had a good relationship with her three siblings and her parents. She was obviously distraught over the news. However, that was six months ago and Mary continues to grieve over the loss. No amount of prayer relieves her worry, fears, and anxiety. She does the minimal amount of household chores. There is no laughter in the home anymore. It seems that even the children try to avoid contact with her. She has stopped attending church in order to stay home and be alone. She sits and stares at pictures of her family for hours. [Included in workshops discussions but not included in the vignette was exploration of symptomatology that would typically be required for a diagnosis of major depressive disorder.]

Axis I	**296.23**	**Major depressive disorder**
Axis II	**V71.09**	**Showing symptoms of avoidant personality disorder**
Axis III		**None**
Axis IV		**Problems with primary support group**
Axis V	**GAF = 50**	**(current)**

Global Assessment of Functioning (GAF) Scale *

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (**Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g. difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork).

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational or school functioning** (e.g., occasional truancy or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

40 **Some impairment in reality testing or communication** (e.g., speech is at times
| illogical, obscure, or irrelevant) **OR major impairment in several areas, such as**
| **work or school, family relations, judgment, thinking, or mood** (e.g., depressed
| man avoids friends, neglects family, and is unable to work; child frequently beats
31 up younger children, is defiant at home, and is failing at school).

30 **Behavior is considerably influenced by delusions or hallucinations OR**
| **serious impairment in communication or judgment** (e.g., sometimes
| incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability**
| **to function in almost all areas** (e.g., stays in bed all day; no job, home, or
21 friends).

20 **Some danger of hurting self or others** (e.g., suicide attempts without clear
| expectation of death; frequently violent; manic excitement) **OR occasionally fails**
| **to maintain minimal personal hygiene** (e.g., smears feces) **OR gross**
11 **impairment in communication** (e.g., largely incoherent or mute).

10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence)
| **OR persistent inability to maintain minimal personal hygiene OR serious**
1 **suicidal act with clear expectation of death.**

0 Inadequate information.

PSYCHOANALYTICAL THEORY AND THERAPY

In this section you will get a basic knowledge of psychoanalytical theory as a psychological approach in counseling. Most of the following material on the five theories is excerpted form T*heory and Practice of Counseling and Psychotherapy,* Fifth Edition *by* Gerald Corey.[1] It is my primary teaching source book in conducting the workshop.

Key Proponent: Sigmund Freud

In part or in whole most of the Freud is the originator of psychoanalytical treatment and theory of personality. He developed his theory from information he learned from his patient and from years of self analysis. He was the oldest of eight siblings from Jewish parents who lived in Vienna, Austria. He earned a medical degree from the University of Vienna and became a lecturer there at age 26. In his early 40's he developed numerous mental health disorders including phobias, psychomatic symptoms, and what appeared to be anxiety disorders. During this period of self analysis and from observing his patients work through their own problems during analysis, he was able to develop his theory entitled psychoanalysis.

Psychoanalysis Key Concepts

According to Sigmund Freud, he viewed **human nature** as deterministic. He believed the following:

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[1]Corey, *Theory and Practice of Counseling and Psychotherapy*, 91-128.

1. Human behavior is determined by irrational forces, unconscious motivations, and biological and instinctual drives.

2. Humans develop through psychosexual stages of development which are driven by internal forces, drives, motivations.

3. Individuals can free themselves from past experiences through insight, as the unconscious becomes conscious, and replacing blind habit with choice.

4. Human instincts drive us to survive and are focused on growth, development, and creativity.

5. The *libido*, which was once referred to as the sexual energy, was later changed to include the energy of all the life instincts.

6. The *death instincts* were correlated to the aggressive drive.

7. The Eros (life instinct) and the Thanatos (death instinct) were in conflict.

8. Human beings were not to be the victims of aggression and self-destruction, but are to constantly strive to manage their aggressive drive.

According to Freud, **the personality** consisted of three structures: the id, the ego, and the superego, which functions as a whole.

1. The *id* is the biological structure of the personality. It is the primary source of psychic energy and the seat of the instincts. It lacks organization; it is blind, demanding, and insistent. It cannot tolerate tension and functions to discharge tension immediately. The Id is ruled by the pleasure principle which whole purpose is to reduce tension, avoid pain, and gain pleasure. The id is illogical, amoral, and driven to satisfy instinctual urges. The id never matures, only acts, and is unconscious.

2. The *ego* is rules by the reality principle. It functions to control and regulate the personality by mediating between the environment and the instincts. It engages in logical and reality based thought processes, it devises plans to gratify needs. In reference to the *id*, the *ego* reins as the seat of intelligence and rational processes, and puts the blind impulses of the id into check and under control. Furthermore, the *ego* is capable of distinguishing between mental images and things from the environment.

3. The *superego* acts as the judicial extension of the personality. It embodies the moral code of the individual. It represents the ideal, traditional values of ones culture and society, and strives for perfection. The superego functions to constrain the impulses of the id and to convince the ego to replace goals that are moral based with reality based ones. It also seeks to encourage the ego to aim for perfection. There are psychological rewards and punishments emitted by the superego such as pride, euphoria, contentment, and self love or guilt, anxiety, inferiority, fears.

Freud's contributions to the concepts of the **unconscious and conscious** state of mind are well praised. He believed that the unconscious can only be inferred from ones behavior and not studied directly. He identified specific clinical features for stating his views:

1. Dreams which he considered to be indications of the unconscious needs, wishes, and conflicts.

2. Slips of the tongue.

3. Forgetting.

4. Posthypnotic suggestions.

5. Information obtained from free association techniques.

6. Information obtained from projective assessment.

7. Psychotic symptoms and their symbolic meaning

Freud also believed that the unconscious state of mind is a storehouse of all the memories, experiences, repressed information, needs, and motivations. Therefore, the aim of psychoanalysis is to make the unconscious conscious in order to facilitate the individual's ability to choose. He also pointed out that the unconscious does influence behavior and the unconscious processes are the root of all forms of neurotic symptoms and behaviors. "A cure is based on uncovering the meaning of symptoms, the causes of behaviors, and the repressed materials that interfere with healthy functioning. . . . The client's need to cling to old patterns must be confronted by working through transference distortions."

Anxiety was believed to be the sense of tension that motivates our behavior and serves as a warning of imminent danger. The tension that develops is from the conflict that occurs between the id, the ego, and the superego as they struggle over the psychic energy.

Freud described three kinds of anxiety: realistic, neurotic, and moral.

1. "*Realistic anxiety* is the fear of danger from the external world, and the level of such anxiety is proportionate to the degree of real threat". When there is a threat to the balance of power within an individual, neurotic and moral anxiety are aroused. A signal goes to the ego that it will be overthrown if appropriate measures are not taken.

2. "*Neurotic anxiety* is the fear that the instincts will get out of hand and cause one

to do something for which one will be punished."

3. *"Moral anxiety"* is the fear of one's own conscience. Individuals with a conscience that is bound by ethics may feel guilt when they act in ways contrary to their virtues.

Ego-Defense Mechanisms are techniques that the ego utilizes when anxiety can not be controlled. These mechanisms are behaviors that are normal adaptive features that can benefit the individual if they are not used to maintain a dysfunctional lifestyle. One's developmental stage and the degree of anxiety determine what, if any, defense mechanism will be used. Defense mechanisms either deny or distort reality and they function at an unconscious level. There are at least 11 defense mechanisms:

1. *Repression* – "It is the basis of many other ego-defenses and of neurotic disorders". It is how the conscious excludes painful or threatening thoughts and/or feelings from awareness. "It is assumed that most of the painful events of the first five years of life are so excluded, yet these events do influence later behavior."

2. *Denial* – Operates at a preconscious and conscious level, and serves to distort what a person thinks, feels, or perceives about a disturbing situation.

3. *Reaction formation* – is the development and expression of an opposing thought, emotion, or reaction that is different from the threatening situation.

4. *Projection* – The attribution of one's unacceptable desire or impulses on to someone else.

5. *Displacement* – is the directing of negative impulses toward a different object or person when the original thing or person is absent.

6. *Rationalization* – How an individual makes excuses to explain for losses and/or failures.

7. *Sublimation* – the diversion of sexual energy or aggressive impulses into more socially responsible, positive behaviors.

8. *Regression* – When an individual retreats to an earlier state of development when the requirements of life were not as great.

9. *Introjections* – absorbing and adopting the values and standards of others.

10. *Identification* – Besides being a developmental process where children learn sex-roles, this defense mechanism serves to assist an individual by identifying with someone or something that is successful in an effort to be perceived as successful.

11. *Compensation* – the development of some positive traits in an effort to cover up for perceived limitations

Development of Personality

The psychosocial and psychosexual stages of development are specific stages of development from birth to adulthood that "provides the counselor with the conceptual tools for understanding trends in development, key developmental tasks characteristic of the various stages, normal and abnormal personal and social functioning, critical needs and their satisfaction or frustration, origins of faulty personality development that lead to later adjustment problems, and healthy and unhealthy uses of ego-defense mechanisms. Freud identified the following stages of development:

1. The oral stage – from birth to the 12 months. Sucking at mother's breast satisfies

need for food and pleasure. Needs to get basic nurturing or later feelings of greediness and acquisitiveness may develop. Oral fixation results from deprivation or oral gratification in infancy. Personality problems later in life include mistrust of others, rejecting others love, fear of and inability to form intimate relationships

2. The anal stage – from ages 1 – 3. The tasks to be mastered are learning independence, personal power, autonomy, and to recognize and cope with negative emotions. Methods of discipline by parents and their attitudes have significant consequences for the child later in life. The child seeks to manipulate the parent by how they control their feces. The parents who focus too much attention – positive or negative- may develop children who are anal-retentive personality. Those who experience parents as too strict in toilet training methods may develop anal-regressive personality traits.

3. The phallic stage – ages 3 – 6. The conflict that is experienced is the unconscious incestuous desires the child develops for the parent of the opposite sex which are repressed. The phallic stage is the Oedipus complex. The female phallic stage is the Electra complex. How the parents respond to the child's budding sexuality will have a great impact on the child's attitude and feelings regarding sex.

4. The Latency stage – ages 6 – 12. This is considered to be a restful stage in comparison of the previous developmental stages. The major facets of the personality, the id, the ego, the superego, are well formed. The subsystem relationships are also formed. New interest in school, friends, sports, and other activities replace sexual impulses. The child turns outward and begins to form relationships with others.

5. The genital stage – ages 12 – 18. The sexual themes of the phallic stage are

renewed. Sexual energy can be channeled into socially acceptable activities. Freud believed that the mature adult is to have the freedom to love and to work and to obtain satisfaction from doing so. Actually, this stage continues throughout adulthood.

THERAPEUTIC PROCESS

Therapy Goals

Freudian psychoanalytic therapy has two main goals:

1. To make the unconscious conscious
2. To strengthen the ego so that ones behavior is based on reality and not on instinctual cravings.

Successful analysis is believed to result in significant modification of the individual's personality and character structure. The focus is to use therapeutic methods to bring out unconscious material that can be worked through. Childhood experiences are reconstructed, discussed, interpreted, and analyzed....the problem is not limited to solving problems and learning new behaviors....there is a deeper probing into the past in order to develop the level of self-understanding that is assumed to be necessary for a change in character.

Therapist's Function and Role

1. Establish working relationship.
2. Engage in a lot of listening and interpreting. Major purpose of interpretation is to speed the process of uncovering unconscious material. Listen for gaps and

inconsistencies in client's story.

3. Draws inferences from dreams and free associations.

4. Be sensitive to clues of transference.

5. Observe and analyze client's resistance.

6. Engage in very little personal disclosure.

7. Maintain a neutral stance.

8. Foster transference relationships for clients, these projections have their origins in unfinished business and repressed situations.

9. Help client acquire the freedom to love, work, and play.

10. Aid client to achieve self awareness, honesty, and more effective personal relationships.

11. Help client deal with anxiety in more realistic manner.

12. Help client gain control over impulsive and irrational behavior

13. Teach clients how to analyze their problems, increase awareness of how to change, and gain more control over their lives.

14. Avoid pushing clients too rapidly or offering interpretations that are inappropriate.

Client's Experience in Therapy

1. Must be willing to commit to an intensive, long term therapy process.

2. Attend treatment several times a week up to 3 - 5 years.

3. Lies on couch and engages in free association - reporting their feelings,

experiences, associations, memories, fantasies, dreams. Lying on the couch encourages deep uncensored reflections and reduces external stimuli; reduces the ability to read and interpret analyst facial reactions.

4. Make commitment to stick with treatment - agree to talk.

5. Terminate treatment when they can agree with therapist that they have clarified and accepted their emotional problems, understood their historical roots, and can integrate their awareness of the past with their present relationships.

Relationship between Therapist and Client

1. Transference is the client's unconscious shifting to the analyst of feelings and fantasies that are reactions to significant others in the clients past.

2. Takes place when the client is able to resurrect from past intense unresolved conflicts and bring them into the present, re experience them and attach them to the analyst.

3. Working through the process requires exploration of unconscious repressed material and defenses. It is achieved by repeating interpretations and by exploring forms of resistance. This results in resolution of old patterns and allows the client to make new choices.

4. Counter-transference is the emotional reaction therapists have toward their clients that interfere with their ability to be objective. While in training, the therapist must undergo his/her own extensive analysis as a client to address those issues.

5. Not every feeling that clients experience toward therapist is transference. It may

be reality based.

Therapeutic Techniques and Procedures

1. **Maintaining the analytic framework**: is in reference to maintaining the procedures and styles to psychoanalysis. This consistent framework is an important therapeutic factor. (Therapist remains anonymous, regular and consistent appointments, ending and beginning sessions on time, use of couch, etc.)

2. **Free Association**: therapist explains process. Client begins free association without censorship. When resistance occurs, interpret. Therapist interprets repressed material and guides toward increased insight. Nothing that is said is taken at face value - everything is available for interpretation. What is not talked about is as important as what is said.

3. **Interpretation**: analyst points out, explains, and explains meaning of behaviors that are manifested in dreams, free associations, resistance, and transference. This allows the ego to assimilate new material and enhance the process of uncovering further repressed information. "Interpretation is grounded in the therapist's assessment of the client's personality and of what factors in the client's past contributed to his/her difficulties." Interpretations must be well timed or clients will reject them. They must be introduced when the issue is close to becoming conscious. Interpretations should start from the surface and only go as deep as the client is able or willing to go. Point out resistance or defenses before interpreting the emotion or conflict that lies beneath it.

4. **Dream Analysis**: is "the royal road to the unconscious" for in it one's unconscious

wishes, needs, and fears are expressed. Some motivations are so unacceptable that they are expressed in symbolic or disguised forms. Two levels of content:

a. Latent content consists of hidden, symbolic, and unconscious motives wishes, and fears.

b. Manifest content - these painful and threatening unconscious sexual and aggressive impulses that make up the latent content are transformed into more acceptable manifest content - the dream as it appears to the person.

Dream Work is the process by which latent content of a dream is transformed into less threatening manifest content. The therapist's task is to uncover disguised meanings by studying the symbols in the manifest content. Ask the client to engage in free association to some aspect of the manifest content of a dream in order to uncover the latent meanings. Assist the clients to explore their associations. This process helps the client unlock the repressed material and relate new understanding to their present struggles.

5. **Analysis and Interpretation of Resistance:** anything that works against the progress of therapy and prevents the client from producing previously unconscious material. It could be an idea, attitude, feeling or actions that foster the status quo and hinders change. Freud viewed resistance as an unconscious dynamic that people use to defend against intolerable anxiety and pain that would arise if they became aware of their repressed impulses and feelings. It also interferes with the client's ability to accept change that could lead to a more gratifying life. Therapists need to respect client's resistance and assist them in working therapeutically with their defenses.

6. **Analysis and Interpretation of Transference:** transference manifests itself at

the point where clients' earlier relationships contribute to their distorting the present with the therapist. This reaction is considered valuable because its manifestations provide clients with the opportunity to re-experience a variety of feelings that would otherwise be inaccessible. The client is then able to express feelings, beliefs, and desires that have been buried. It allows the clients to achieve here-and-now insight into the influence of the past on their present situations. Such interpretations enable the clients to work through old conflicts that are keeping them fixated and hindering their emotional growth.

COGNITIVE THEORY AND THERAPY

In this session you will get a basic knowledge about Cognitive Therapy as a psychological approach in counseling.

Key Proponent: Albert Ellis, born in 1913

Key Concept: View of Human Nature

Albert Ellis was born in 1913 in Pittsburgh, PA., and grew up in New York. He developed many health problems as a young man, but learned to care for his health in a very rigorous manner. He became a psychologist and began practicing in the area of marriage, family, and sex therapy. He practiced classical analysis and analytically oriented psychotherapy from 1947 to 1953. After becoming disillusioned with psychoanalysis, he began to experiment with other therapeutic forms. In 1955 he combined humanistic, philosophical, and behavioral therapies to form rational-emotive therapy known as REBT.[1]

Rational emotive behavior therapy (REBT) is based on the assumption that human beings are born with a potential for both rational, or straight, thinking and irrational, or crooked, thinking. People have predispositions for self-preservation, happiness, thinking and verbalizing, loving, communion with others, and growth and self-actualization. They also have the propensities for self-destruction, avoidance of thought, procrastination, endless repetition of mistakes, superstition, intolerance, perfectionism and self-blame, and avoidance of actualizing growth potentials. Taking for granted that humans are fallible, REBT attempts to help them accept themselves as

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[1]Ibid., 371-340.

creatures who will continue to make mistakes yet at the same time learn to live more at peace with themselves.

Ellis has concluded that humans are *self-talking, self-evaluating,* and *self-sustaining.* They develop emotional and behavioral difficulties when they take *simple preferences* (desires for love, approval, success) and make the mistake of thinking of them as dire needs. Ellis also affirms that humans have inborn tendencies toward growth and actualization, yet they often sabotage their movement toward growth as a result of their inborn tendency toward crooked thinking and also the self-defeating patterns they have learned.

View of Emotional Disturbance

We originally learn irrational beliefs from significant others during our childhood. We create irrational dogmas and superstitions by ourselves. We actively re-instill self-defeating beliefs by the processes of autosuggestion and self-repetition and by behaving as if they are useful. Hence, it is largely our own repetition of early-indoctrinated irrational thoughts, rather than a parent's repetition, that keeps dysfunctional attitudes alive and operative within us.

REBT insists that blame is the core of most emotional disturbances. If we are to recover from a neurosis or personality disorder, we had better stop blaming ourselves and others. It is important that we learn to accept ourselves despite our imperfections. We have strong tendencies to escalate our desires and preferences into dogmatic, absolutistic "Shoulds," "musts," "oughts," demands, and commands.

Because we largely create our own disturbed thoughts and feelings, we have the power to control our emotional destiny. When we are upset, it is a good idea to look to our hidden dogmatic "musts" and absolutistic "shoulds." Absolutistic cognitions are at the core of human misery, because most of the time these beliefs impede and obstruct people in their pursuit of their goals and purposes.

REBT contends that people do not *need* to be accepted and loved, even though it may be highly desirable. The therapist teaches clients how to feel un-depressed even when they are unaccepted and unloved by significant others. Although REBT encourages people to experience sadness over being unaccepted, it attempts to help them find ways of overcoming depression, anxiety, hurt, loss of self-worth, and hatred.

A-B-C Theory of Personality

The basic tenet of REBT is that emotional disturbances (as distinguished from feelings of sorrow, regret, and frustration) are largely the product of irrational, self-defeating thinking. Ellis believes that emotional consequences will not vanish merely because feelings have been intensified and expressed. The client and the therapist must work together to dispute the irrational beliefs that are causing disturbed emotional consequences.

The A-B-C theory of personality is central to REBT theory and practice. A is the activating event. B is the belief the person holds about that event. C is the emotional and behavioral consequence or reaction the person experiences as a result of their belief about the activating event. D is the disputing intervention that the therapists encourage in the

client. E is the new and effective rational philosophy consisting of replacing inappropriate thoughts with appropriate ones. F is the new feeling the client has about the activating event if the therapist was successful with the intervention.

The philosophical restructuring to change dysfunctional personality involves the following steps:

1. Fully acknowledging that we are largely responsible for creating our own emotional problems.
2. Accepting the notion that we have the ability to change these disturbances significantly.
3. Recognizing that our emotional problems largely stem from irrational beliefs.
4. Clearly perceiving these beliefs.
5. Seeing the value of disputing such foolish beliefs, using rigorous methods.
6. Accepting the fact that if we expect change, we had bettor work hard in emotive and behavioral ways to counteract our beliefs and the dysfunctional feelings and actions that follow.
7. Practicing REBT methods of uprooting or changing disturbed consequences for the rest of our life.

THE THERAPEUTIC PROCESS

Therapeutic Goals

The desired outcome in rational emotive behavior therapy is for clients to minimize their emotional disturbances and self-defeating behaviors by acquiring a more

realistic and workable philosophy life. Other important therapeutic goals include reducing a tendency for blaming oneself or others for what goes wrong in life and learning ways to deal with future difficulties.

REBT strives for a thorough philosophical reevaluation based on the assumption that human problems are philosophically rooted.

The specific goals toward which REBT therapists work with their clients are: self-interest, social interest, self-direction, tolerance, flexibility, acceptance, high tolerance of frustration, and self-responsibility for disturbance.

Therapist's (pastor's) Function and Roles

One of the first steps for the therapist is to show clients that they have incorporated many irrational "shoulds," "oughts," and "musts." Clients learn to separate their rational beliefs from their irrational ones. The therapist serves the function of a scientist who challenges the self-defeating idea that the client originally accepted or invented without question as truth. The therapist encourages, persuades, and at times even directs the client to engage in activities that will counter this propaganda.

A second step in the therapeutic process takes clients beyond the stage of awareness. It demonstrates that they are keeping their emotional disturbances active by continuing to think illogically and by repeating self-defeating meanings and philosophies.

The third step is for the therapist to help clients to modify their thinking and abandon their irrational ideas. REBT assumes that their self-defeating beliefs are so deeply ingrained that clients will not normally change them by themselves. The therapist

therefore assists them in understanding the vicious circle of self-blaming process.

The fourth step in the therapeutic process is to challenge the clients to develop a rational philosophy of life so that in the future they can avoid becoming the victim of other irrational beliefs.

Because REBT is essentially a cognitive and directive behavioral process, it often minimizes the intense relationship between the therapist and the client. The therapist mainly employs a persuasive methodology that emphasizes education.

REBT therapists actively *teach* clients that self-condemnation is one of the main causes of emotional disturbance; that it is possible to stop *rating* themselves on their performances; and that by hard work and by carrying out behavioral homework assignments, they can minimize irrational thinking that leads to disturbances in feeling and behaving.

Clients' Experience

Once clients begin to accept that their beliefs are the primary cause of their emotions and behaviors, they are able to participate effectively in the cognitive restructuring process. The client's role in REBT is that of a learner. The therapeutic process focuses on the client's experience in the present. REBT mainly emphasizes here-and-now experiences and clients' present ability to change the patterns of thinking and emoting that they constructed earlier. The therapist does not devote much time to exploring the client's earlier history and making connections between their past and present behavior. Instead the therapeutic process stresses that regardless of clients' basic,

irrational philosophies of life; they are presently disturbed because they still believe in their self-defeating view of themselves and their world. Questions of where, why, or how they acquired their irrational philosophy are of secondary importance.

Ellis describes three main levels of insight in REBT. The first level refers to the fact that we choose to disturb ourselves about events in our lives. We do that by accepting and inventing irrational beliefs. The second level of insight pertains to the ways in which we acquired our irrational beliefs originally and how we are choosing to maintain them. We do that by reindoctrinating ourselves with our absolutistic beliefs. The third level of insight involves the recognition that there are no magical ways for us to change our personality and our tendencies to upset ourselves. We do that by actively changing our disturbances-creating beliefs and then act against them.

Therapeutic Relationship between the Therapist (Pastor) and Client

The issue of the personal relationship between the therapist and the client takes on a different meaning in REBT than it has in most other forms of therapy. In REBT the therapist shows *full acceptance* or *tolerance*. The basic idea is to help clients avoid self-condemnation. Although they may evaluate their behavior, the goal is for them to refuse to rate themselves as persons, no matter how ineffectual some of their behavior is. Therapists show their full acceptance by refusing to evaluate their clients as persons while at the same time being willing to honestly confront clients' nonsensical thinking and self-destructive behaviors. REBT does not place a premium on personal warmth and empathic understanding, on the assumption that too much warmth and understanding can

be counterproductive by fostering a sense of dependence for approval from the therapist.

Rational emotive behavior therapists are often open and direct in disclosing their own beliefs and values. Some are willing to share their own imperfections as a way of disputing the client's realistic notion that therapists are "completely put together" persons.

Transference is not encouraged, and when it does occur the therapist is likely to attack it. The therapist wants to show that a transference relationship is based on the irrational belief that the client must be liked and loved by the therapist.

BEHAVIORAL THEORY AND THERAPY

In this session you will get a basic knowledge about Behavioral theory as a psychological approach in counseling.

A Key Proponent: Arnold A. Lazarus, born in 1932

Key Concepts: View of Human Nature

Arnold A. Lazarus, born in 1932, grew up and was educated in Johannesburg, South Africa.[1] He obtained a Master's degree in experimental psychology in 1957, and a Ph.D. in clinical psychology in1960. He began his private practice in Johannesburg in the 1960. In 1967 he was appointed a full profess at Temple University Medical School in Philadelphia where he worked with Joseph Wolpe. They parted after Lazarus criticized Wolpe for his narrow-mindedness. In 1970 he worked at Yale University as Director of Clinical Training and in 1972 he received the rank of Distinguished Professor at Rutgers University where he teaches in the Graduate School of Applied and Professional Psychology. His private practice is in Princeton, New Jersey.

Modern behavior therapy is grounded on a scientific view of human behavior that implies a systematic and structured approach to counseling. The person is the producer *and* the product of his or her environment (Bandura, 1974, 1977, 1986).

The current trend is toward developing procedures that actually give control to clients and thus increase their range of freedom. Behavior modification aims to

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[1]Ibid., 281-290.

increasing people's skills so that they have more options for responding. By overcoming debilitating behaviors that restrict choices, people are freer to select from possibilities that were not available earlier. Thus, as behavior modification is typically applied, it will increase rather than stifle individual freedom (Kazdin, 1978).

According to Thoreson and Coates, greater attention is being given to the emerging similarities among theories. There are three interrelated themes that characterize this convergence. First is the focus on therapy as an action-oriented approach. Clients are being asked to act rather than to reflect passively and introspect at length on their problems. They are being helped to take specific actions to change their life. Second is the increasing concern of behavior therapists with how stimulus events are mediated by cognitive processes and private or subjective meanings. Third is the increasing emphasis on the role of responsibility for one's behavior.

Basic Characteristics

Spiegler and Guevremont (1993) list the following six recurrent themes as characterizing behavior therapy:

1. Behavior therapy is based on the principles and procedures of the scientific method. Experimentally derived principles of learning are systematically applied to help people change their maladaptive behaviors. The distinguishing characteristic of behavioral practitioners is their systematic adherence to specification and measurement.

2. Behavior therapy deals with the client's current problems and the factors influencing them, as opposed to historical determinants. Counselors assume that a client's problems are influenced by present conditions. They then use behavioral techniques to change the relevant current factors that are influencing the client's behaviors.

3. Clients are expected to engage in specific actions to deal with their problems.

4. Behavior therapy is generally carried out in the client's natural environment, as much as possible.

5. Behavioral procedures are tailored to fit the unique needs of each client.

6. The practice of behavior therapy is based on a collaborative partnership between the therapist and client in two major respects. First, every attempt is made to inform clients about the nature and course of treatment. Second, clients are often trained to initiate, conduct, and evaluate their own treatment under the guidance of the therapist.

THERAPEUTIC PROCESS

Therapeutic Goals

Goals occupy a place of central importance in behavior therapy. The general goals are to create new conditions for learning on the assumption that learning can ameliorate problem behaviors. The client usually formulates the goals, which are specifically defined as the outset of the therapeutic process. Continual assessment throughout therapy determines the degree to which these goals are being met. Assessment and treatment occur together.

Contemporary behavior therapy stresses clients' active roles in deciding about their treatment. The therapist assists clients in formulating goals that are specific, unambiguous, and measurable. A number of characteristics of behavior therapy ensure that the rights of clients are protected. The goals of therapy must be refined to the point that they are clear, concrete, understood, and agreed on by the client and the counselor. Behavior therapists and clients alter goals throughout the therapeutic process as needed.

Once goals have been agreed on, a process of defining them begins. The counselor and client discuss the behaviors associated with the goals, the circumstances

required for change, the nature of sub-goals, and plan of action to work toward these goals. The general goals of behavioral therapy are to increase personal choice and effective living. Relieving people from behaviors that interfere with living fully is consistent with the democratic value that individuals should be able to pursue their own goals freely as long as these goals are consistent with the general social good.

Therapist's (pastor's) Function and Role

Behaviorally oriented practitioner function in some ways as other clinicians do. They pay attention to the clues given by clients, and they are willing to follow their clinical hunches. They use techniques such as summarizing, reflection, clarification, and open-ended questioning. But there are two functions that distinguish behavioral clinicians: They focus on specifics, and they systematically attempt to get information about situational antecedents, the dimensions of the problem behavior, and the consequences of the problem. The therapist, as a person, becomes a significant model. Because clients often view the therapist as worthy of emulation, they pattern their attitudes, values, beliefs, and behavior after him or her. Therapist's should be aware of the crucial role that they play.

Client's Experience

One of the unique contributions of behavior therapy is that it provides the therapist with a well-defined system of procedures to employ with the context of a well-defined role. It also provides the client with a clear role, and it stresses the importance of

client awareness and participation in the therapeutic process. Clients must be motivated to change and must be willing to cooperate in carrying out therapeutic activities, both during therapy sessions and in their life. If they are not involved in this way, the chances are slim that therapy will be successful.

Clients are encouraged to experiment for the purpose of enlarging their repertoire of adaptive behaviors. They are helped to generalize and to transfer the learning acquired within the therapeutic situation to situations outside therapy.

Therapeutic Relationship between the Pastor and the Client

A good therapeutic relationship increases the chances that the client will be receptive to therapy. The client's positive expectations about the effectiveness of therapy often contribute to successful outcomes.

PERSON-CENTERED THEORY AND THERAPY

In this section you will get a basic knowledge of Person-Centered theory as a psychological approach in counseling.

Key Proponents: Carl Rogers (1902-1987)

As a major spokesman for humanistic psychology, Carl Rogers led a life that reflected the ideas he developed for half a century.[1] He showed a questioning stance, a deep openness to change, and courage to forge into unknown territory, both as a person and as a professional. He earned recognition around the world for originating and developing the humanistic movement in psychotherapy, pioneering in research, and influencing all fields related to psychology. In writing about his early years, Rogers recalls his family atmosphere as characterized by close and warm relationships but also by strict religious standards. Play was discouraged, and the virtues of the Protestant ethic were extolled. His boyhood was a somewhat lonely one in which he pursued scholarly interests instead of social ones.

Key Concepts: View of Human Nature

The person-centered approach is based on concepts from humanistic psychology, and it can be classified as a branch of the existential perspective. Rogers' basic assumptions are: that people are essentially trustworthy, that they have a vast potential for

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[1]Ibid., 196-221.

understanding themselves and resolving their own problems without direct intervention on the therapist's part, and that they are capable of self-directed growth if they are involved in a therapeutic relationship. From the beginning, he emphasized the attitudes and personal characteristics of the therapist and the quality of the client/therapist relationship as the prime determinants of the outcome of the therapeutic process. He consistently relegated to a secondary position matters such as the therapist's knowledge of theory and techniques.

A common theme originating in Rogers's early writing and continuing to permeate all of his works is a basic sense of trust in the client's ability to move forward in a constructive manner if the appropriate conditions fostering growth are present. His professional experience taught him that if one is able to get to the core of an individual, one finds a trustworthy, positive center. He firmly maintains that people are trustworthy, resourceful, capable of self-understanding and self-direction, able to make constructive changes, and able to live effective and productive lives. When therapists are able to experience and communicate their realness, caring, and nonjudgmental understanding, significant changes in the client are most likely to occur.

Rogers expresses little sympathy for approaches based on the assumption that the individual cannot be trusted and instead needs to be directed, motivated, instructed, punished, rewarded, controlled, and managed by others who are in a superior and "expert" position. He maintains that three therapist attributes create a growth-promoting climate in which individuals can move forward and become what they are capable of becoming. These attributes are (1) congruence genuineness, or realness) (2)

unconditional positive regard (acceptance and caring), and (3) accurate empathic understanding (an ability to deeply grasp the subjective world of another person). According to Rogers, if these attitudes are communicated by the helper, those being helped will become less defensive and more open to themselves and their world, and they will behave in social and constructive ways. The basic drive to fulfillment implies that people will move toward health if the way seems open for them to do so. Thus, the goals of counseling are to set clients free and to create those conditions that will enable them to engage in meaningful self-exploration. When people are free, they will be able to find their own way.

The person-centered approach rejects the roles of the therapist as the authority who knows best and of the passive client who merely follows the dictates of the therapist. Therapy is thus rooted in the client's capacity for awareness and self-directed change in attitudes and behavior.

Seeing people in this light means that the therapist focuses on the constructive side of human nature, on what is right with the person, and on the assets that people bring with them to therapy. It focuses on how clients act in their world with others, how they can move forward in constructive directions and how they can successfully encounter obstacles (both from within themselves and outside of themselves) that are blocking their growth. The implication is that therapy is more than "adjustment to norms," and this approach does not stop with merely solving problems. Instead, practitioners with a humanistic orientation aim at challenging their clients to make changes that will lead to living fully and authentically, with the realization that this kind of existence demands a

continuing struggle. People never arrive at a final or a static state of being self-actualized; rather, at best they are continually involved in the process of actualizing themselves.

Basic Characteristics

Rogers did not present the "person-centered theory" as a fixed and completed approach to therapy. He hoped that others would view his theory as a set of tentative principles relating to how the therapy develops, not as dogma. Rogers and Wood describe the characteristics that distinguish the person-centered approach from other models. An adoption of this description follows.

The person-centered approach focuses on clients' responsibility and capacity to discover ways to more fully encounter reality. Clients, who know themselves best, are the ones to discover more appropriate behavior for themselves based on a growing self-awareness. The approach emphasizes the phenomenal world of the client. With an attempt to apprehend the client's internal frame of reference, therapists concern themselves mainly with the client's perception of self and the world.

According to the person-centered approach, psychotherapy is only one example of a constructive personal relationship. People experience psychotherapeutic growth in and through a relationship with another person who is caring, understanding, and real. It is the relationship with a counselor who is congruent (matching external behavior and expression with internal feelings and thoughts), accepting, and empathic that facilitates therapeutic change for the client. Person-centered theory holds that the therapist's

function is to be present and accessible to the client and to focus on the here-and-now experience.

This approach is perhaps best characterized as a way of being and as a shared journey in which therapist and client reveal their humanness and participate in a growth experience. The therapists can be a guide on this journey because they are usually more experienced and more psychologically mature than the client. However, it is important to realize that the therapeutic relationship involves two people, both of whom are fallible. Both of them can get better at what they are doing, yet they have limits. It is not realistic to expect that any therapist can be real, caring, understanding, and accepting all of the time with clients.

THERAPEUTIC PROCESS

Therapeutic Goals

The goals of person-centered therapy are different from those of traditional approaches. The person-centered approach aims toward a greater degree of independence and integration of the individual. Its focus is on the person, not on the person's presenting problem. In Rogers's view the aim of therapy is not merely to solve problems. Rather, it is to assist clients in their growth process, so that they can better cope with problems they are now facing and with future problems.

Rogers writes that people who enter psychotherapy are often asking: "How can I discover my real self? How can I become what I deeply wish to become? How can I get behind my facades and become myself?" The underlying aim of therapy is to provide a

climate conducive to helping the individual become a fully functioning person. Before clients are able to work toward that goal, they must first get behind the masks they wear, which they develop through the process of socialization. Clients come to recognize that they have lost contact with themselves by using these facades. In a climate of safety in the therapeutic session, they also come to realize that there are other possibilities.

When the facades are worn away during the therapeutic process, what kind of person emerges from behind the pretenses? Rogers describes people who are becoming increasingly actualized as having: 1) an openness to experience; 2) a trust in themselves; 3) an internal source of evaluation; and 4) a willingness to continue growing. Encouraging these characteristics is the basic goal of person-centered therapy.

These four characteristics provide a general framework for understanding the direction of therapeutic movement. The therapist does not choose specific goals for the client. The cornerstone of person-centered theory is the view that clients in a relationship with a facilitating therapist have the capacity to define and clarify their own goals. Many counselors, however, experience difficulty in allowing clients to decide for themselves their specific goals in therapy. Although it is easy to give lip service to the concept of clients' finding their own way, it takes considerable respect for clients and faith on the therapist's part to encourage clients to listen to themselves and follow their own directions-particularly when they make choices that are not what the therapist hoped for.

Therapist's (Pastor's) Function and Role

The role of person-centered therapists is rooted in their ways of being and

attitudes, not in techniques designed to get the client to "do something." Research on person-centered therapy seems to indicate that the attitudes of therapists, rather than their knowledge, theories, or techniques, facilitate personality change in the client. Basically, therapists use themselves as an instrument of change. When they encounter the client on a person-to-person level, their "role" is to be without roles. Their function is to establish a therapeutic climate that helps the client grows.

The person-centered therapist thus creates a helping relationship in which clients experience the necessary freedom to explore areas of their life that are either denied to awareness or distorted. They become less defensive and more open to possibilities within themselves and in the world. First and foremost, the therapist must be willing to be real in the relationship with a client. Instead of viewing clients in preconceived diagnostic categories, the therapist meets them on a moment-to-moment experiential basis and helps them by entering their world. Through the therapist's attitudes of genuine caring, respect, acceptance, and understanding, they are able to loosen their defenses and rigid perceptions and move to a higher level of personal functioning.

Client's Experience in Therapy

Therapeutic change depends on clients' perception both of their own experience in therapy and of the counselor's basic attitudes. If the counselor creates a climate conducive to self-exploration, clients have the opportunity to experience and explore the full range of their feelings. What follows is a general sketch of the experience of the client in therapy.

Clients come to the counselor in a state of incongruence; that is, a discrepancy exists between their self-perception and their experience in reality. For example, Leon, a college student, may see himself as a future physician, and yet his below-average grades might exclude him from medical school. The discrepancy between how he sees himself (self-concept) or how he would like to view himself (ideal self-concept) and the reality of his poor academic performance may result in anxiety and personal vulnerability, which can provide the necessary motivation to enter therapy. Leon must perceive that a problem exists or, at least, that he is uncomfortable enough with his present psychological adjustment to want to explore possibilities for change.

One of the reasons that clients seek therapy is a feeling of basic helplessness, powerlessness, and inability to make decisions or effectively direct their own life. They may hope to find "the way" through the guidance of the therapist. Within the person-centered framework, however, they soon learn that they can be responsible for themselves in the relationship and that they can learn to be free by using the relationship to gain greater self-understanding.

As counseling progresses, clients are able to explore a wider range of their feelings. They can express their fears, anxiety, guilt, shame, hatred, anger, and other emotions that they had deemed too negative to accept and incorporate into their self-structure. With therapy, people constrict less, distort less, and move to a greater acceptance and integration of conflicting and confusing feelings. They increasingly discover aspects within themselves that had been kept hidden. As clients feel understood and accepted, their defensiveness is less necessary, and they become more open to their

experience. Because they are not as threatened, feel safer, and less vulnerable, they become more realistic, perceive others with greater accuracy, and become better able to understand and accept others. They come to appreciate themselves more as they are and their behavior show more flexibility and creativity. They become less oriented to meeting others' expectations, and thus they begin to behave in ways that are truer to themselves. These individuals empower themselves to direct their own lives, instead of looking outside of themselves for answers. They move in the direction of being more in contact with what they are experiencing at the present moment, less bound by the past, less determined, freer to make decisions, and increasingly trusting in themselves to manage their own lives. In short, their experience in therapy is like throwing off the self-imposed shackles that had kept them in a psychological prison. With increased freedom they tend to become more mature psychologically and more actualized.

Relationship between the Pastor and client

The basic hypothesis of person-centered therapy is summarized in this sentence: "If I can provide a certain type of relationship, the other person will discover within himself or herself the capacity to use that relationship for growth and change, and personal development will occur." Rogers hypothesizes further that "Significant positive personality change does not occur except in a relationship."

According to Rogers, there are six characteristics of the therapeutic relationship that is conducive to creating a suitable psychological climate in which the client will experience the freedom necessary to initiate personality change.

1. Two persons are in psychological contact.

2. The first, whom we shall term the client, is experiencing incongruency.

3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.

4. The therapist experiences unconditional positive regard or real caring and acceptance for the client.

5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.

6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

From Rogers's perspective the client /therapist relationship is characterized by equality, for therapists do not keep their knowledge a secret or attempt to mystify the therapeutic process. The process of change in the client depends to a large degree on the quality of this equal relationship.

As we have noted, three personal characteristics, or attitudes, of the therapist form a central part of the therapeutic relationship: (1) congruence, or genuineness, (2) unconditional positive regard and acceptance, and (3) accurate empathic understanding.

Congruence or Genuineness

Congruence implies that therapists are real; that is, they are genuine, integrated, and authentic during the therapy hour.

Unconditional Positive Regard and Acceptance

The therapists need to communicate to the client a deep and genuine caring for

him or her as a person. Therapists value and warmly accept the client without placing stipulations on the acceptance.

Accurate Emphatic Understanding

One of the main tasks of the therapist is to understand clients' experience and feelings sensitively and accurately as they are revealed in the moment-to-moment interaction during the therapy session. The therapist strives to sense clients' subjective experience, particularly in the here and now. The aim is to encourage them to get closer to themselves, to feel more deeply and intensely, and to recognize and resolve the incongruity that exists within them.

Empathic understanding implies that the therapist will sense clients' feelings as if they were his or her own without becoming lost in those feelings. By moving freely in the world as experienced by clients, the therapist can not only communicate to them an understanding of what is already known to them but can also voice meanings of experience of which they are only dimly aware. It is important to understand that accurate empathy goes beyond recognition of obvious feelings to a sense of the less clearly experienced feelings of clients.

FAMILY SYSTEMS THEORY AND THERAPY

In this session you will get a basic knowledge about Family Systems theory as a psychological approach in counseling. There are several models to choose from however, only two models will be addressed in this section, Multi-generational and Human Validation.

Introduction:

A. The Family Systems Perspective

Although Adler started working with families and systems in Vienna in the 1920s the seeds of a North American family therapy movement were not planted until the 1940s. By the 1950s, systemic family therapy began to take root, but it was still considered a revolutionary approach to treatment.[1] In the 1960s and 1970s, psychodynamic, behavioral, and humanistic approaches (called the first, second, and third force, respectively) dominated counseling and psychotherapy. Today, the various approaches to family systems represent a paradigm shift that we might even call the "fourth force." They are becoming major theoretical orientations of many practitioners. Young found that 10% of counselors and counselor educators identified with a family systems orientation. The prediction was that this figure would rise to 23% within five years.

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[1]Ibid.

The family systems perspective holds that individuals are best understood through assessing the interactions within an entire family. Symptoms are often viewed as an expression of a dysfunction within a family; these dysfunctional patterns are thought to be passed across several generations. It is revolutionary to conclude that the identified client's problem might be a symptom of how the system functions, not just a symptom of the individual's maladjustment, history, and psychosocial development. This perspective is grounded on the assumptions that a client's problematic behavior may (1) serve a function or purpose for the family, (2) be a function of the family's inability to operate productively, especially during developmental transitions, or (3) be a symptom of dysfunctional patterns handed down across generations. All these assumptions challenge the more traditional intrapsychic frameworks for conceptualizing human problems and their formation.

The one central principle agreed upon by family therapy practitioners, regardless of their particular approach, is that the client is connected to living systems and that change in one part of the unit reverberates throughout other parts. Therefore, a treatment approach that comprehensively addresses the other family members and the larger context as well as an "identified" client is required. Because a family is an interactional unit, it has its own set of unique traits. It is not possible to accurately assess an individual's concerns without observing the interaction of the other family members, as well as the broader contexts in which the person and the family live. The family therapy perspective calls for a conceptual shift, because the family is viewed as a functioning unit that is more than the sum of the roles of its various members. Actions by any individual

family member will influence all the others in the family, and their reactions will have a reciprocal effect on the individual.

Differences between individual verses systemic

There are significant differences between individual therapeutic approaches and systemic approaches. Ann, age 22, sees a counselor because she is suffering from a depression that has lasted for more than two years and has impaired her ability to maintain friendships and work productively. She wants to feel better, but she is pessimistic about her chances. How will a therapist choose to help her?

Both the individual therapist and the systemic therapist are interested in Ann's current living situation, and life experiences. Both discover that she is still living at home with her parents, who are in their 60s. They note that she has a very successful older sister, who is a prominent lawyer in the small town in which the two live. The therapists are impressed by Ann's loss of friends who have married and left town over the years while she stayed behind, often lonely and isolated. Finally, both therapists note that Ann's depression affects others as well as her. It is here, however, that the similarities tend to end:

The individual therapist may:	*The systemic therapist may:*
* focus on obtaining an accurate diagnosis, perhaps using the *DSM-IV* begin therapy with Ann immediately	* explore the system for family process and rules, perhaps using a Genogram.
* focus on the causes, purposes, and cognitive, emotional, and behavioral processes involved in Ann's depression and coping	* invite Ann's mother, father, and sister into therapy with her focus on the family relationships within which the continuation of Ann's depression "makes sense"

* be concerned with Ann's individual experiences and perspectives	* be concerned with the transgenerational meanings, rules, cultural and gender perspectives within the system, and even community and larger systems affecting the family
* intervene in ways designed to help Ann cope	* intervene in ways designed to help change the context

In contrast, the goal of most approaches to family therapy is change in the system, which is assumed to produce change in the individual members.

B. Key Proponent of Multigenerational Family Therapy - Murray Bowen

Murray Bowen was one of the original developers of mainstream family therapy. His family systems theory, which is a theoretical/clinical model that evolved from psychoanalytic principles and practices, is sometimes referred to as multigenerational (or transgenerational or intergenerational) family therapy. His approach operates on the premise that a family can best be understood when it is analyzed from at least a three-generation perspective, because a predictable pattern of interpersonal relationships connects the functioning of family members across generations. According to Bowen, the cause of an individual's problems can be understood only by viewing the role of the family as an emotional unit.

C. Key Concepts: Multigenerational Family Therapy

Bowen emphasizes the role of theory as a guide in practicing family therapy. For him a well-articulated theory is essential in remaining emotionally detached as a family therapist. Bowen believed that the absence of a clearly articulated theory had resulted in

an unstructured state of chaos in family therapy. Bowen's theory and practice of family therapy grew out of his work with schizophrenic individuals in families. He was much more interested in developing a theory of family systems therapy than in designing techniques for working with families. The major contributions of Bowen's theory are the core concepts of differentiation of the self and triangulation. In this section we also deal with the importance of self-awareness on the part of the family therapist, especially with reference to understanding how experiences in the family of origin are likely to affect clinical practice.

Differentiation of Self

The cornerstone of Bowen's theory is differentiation of the self, which involves both the psychological separation of an intellect and emotion and independence of the self from others. Differentiated individuals are able to choose between being guided by their feelings or by their thoughts. Undifferentiated people have difficulty in separating themselves from others and tend to fuse with dominant emotional patterns in the family. These people have a low degree of autonomy, they react emotionally, and they are unable to take a clear position on issues. People who are fused to their family of origin tend to marry others to whom they can become fused. Two undifferentiated individuals seek and find each other and become a couple. Unproductive family dynamics of the previous generation are transmitted from one generation to the next through such a marriage. In family systems theory, the key to being a healthy person encompasses both a sense of belonging to one's family and a sense of separateness and individuality.

Similar to psychoanalytic theory, the process of individuation involves a differentiation whereby individuals acquire a sense of self-identity. This differentiation from the family of origin allows one to accept personal responsibility for one's thoughts, feelings, perceptions, and actions. Simply leaving one's family or psychological maturity is not a fixed destination that is reached once and for all; rather, it is a lifelong developmental process that is achieved relative to the family of origin through re-examination and resolution of conflicts within the individual and relational contexts.

Triangulation

Bowen notes that anxiety can easily develop within intimate relationships. Under stressful situations, two people may recruit a third person into the relationship to reduce the anxiety and gain stability. This is called triangulation. Although triangulation may lessen the emotional tension between the two people, the underlying conflict is not addressed, and in the long run the situation worsens. If the couple have unresolved and intense conflicts, for instance, they may focus their attention on a problematic son. Instead of fighting with each other, they are temporarily distracted by riveting their attention on their son. Yet their basic conflict remains unsolved.

In his therapy, Bowen sometimes worked with both members of a conflictual dyad (the couple). He did not require that every family member be involved in the therapy sessions. Bowen tended to work from the inside out: Starting with the spousal relationship, he helped the two adults establish their own differentiation. He often worked with individuals while the rest of the family was present, coaching each person

through his or her conflictual relationships. As a therapist, he attempted to maintain a stance of neutrality. From his vantage point, if the therapist becomes emotionally entangled with any one family member, he or she loses effectiveness and becomes part of a triangulated relationship. Bowen maintains that to be effective, family therapists have a very high level of differentiation. If therapists still have unresolved family issues and are emotionally reactive, they are likely to revisit those difficulties in every family they see.

D. **THERAPEUTIC PROCESS: Multigenerational Family Therapy**

Therapy Goals

For Bowenians the goal is to change the individuals within the context of the system. That school of therapy believes that problems manifested in one's current family will not change significantly until the relationship patterns in the individual's family of origin are understood and directly challenged. People are products of their family of origin. Unless the damage is dealt with it will be transmitted from generation to generation. Multigenerational Family Therapy has two goals: (1) lessening of anxiety and symptom relief and (2) increase each family member's level of differentiation of the self. If significant change in a family system is to take place, closed family ties must be opened and the family must actively engage in a de-triangulation process.

Therapist's (pastor's) function and role

The therapist or pastor functions as a teacher or coach and neutral observer who is

responsible for creating the tone of family therapy. After learning about triangulation, the individual or couple goes back to their family of origin to emotionally separate themselves from the triangular patterns. The therapist or pastor helps the person or persons in therapy gather information and coaches or guide them into new behavior by showing them how people might change their relationships with members of their family of origin. They are taught how to better observe and how to replace emotional reactivity to better objectivity. The clients are also taught that they must take the necessary steps to self-differentiation.

Therapeutic Techniques

How individuals function within the family, how dysfunctional patterns are developed, how they can be fixed, and how family relationships can be improved is always the focus of Bowen's theory. Bowenians teaches individual and couples to understand how their family system operates generationally. Their method of intervention is to question, use tracking sequences, teaching/coaching, and directives to a family. They use genogram (a pictorial layout of the person's family over three generations). This helps the client to recognize key unresolved emotional issues and how they live on from generation to generation.

Process of Change

In the multigenerational model, questions and cognitive processes lead to differentiation and understanding of family of origin.

E. Key Proponent of Human Validation Model - Virginia Satir

Virginia Satir was a well known member of the early Mental Research Institute (M.R.I) group in Palo Alto. She emphasized communication and emotional experiences. As a social worker, she began her private practice by seeing families in 1951. She was instrumental in setting up a training program for residents at the Illinois State Psychiatric Institute in 1955. She joined the Mental Research Institute in 1959 after receiving an invitation from Don Jackson. She was the first director or training of that organization until she left in 1966 and became the director of Esalen Institute in Big Sur, CA.

F. Key Concepts: Human Validation Model

Satir's human validation process stresses enhancement and validation of self-esteem, family rules, congruence versus defensive communication patterns, sculpting, nurturing triads and family mapping, and family life-fact chronologies. It emphasizes factors such as making contact, metaphor, reframing, emotional honesty, clear communication, creating new possibilities, drama, humor, and personal touch in the therapy process. Satir believed in looking at three generations of family life. She worked to bring those patterns to life *in the present*, either by having families develop maps (her word for genograms) and life-fact chronologies or by creating a group process in which family patterns and experiences could be simulated in a reconstruction.

Family Life

Children always enter the world as part of preexisting systems, with the family being the most common and central one. Their early experience is a constant transition from what is known and familiar to what is unknown and unfamiliar, the movement from the womb to the outside world being but the first of many transitions. These transitions often leave children with feelings of fear, helplessness, and even anger as they struggle for competence and security in a challenging and often difficult new environment. Children enter families that are already loaded with rules, and as they grow, more rules are developed to help the system function and prosper. Rules can pertain to any part of human living and interaction, but the most important rules, according to Satir, are the ones that govern communication: who says what to whom under what conditions.

As children, we learn rules by observing the behavior of our parents. When rules are presented without choice and as absolutes, they typically pose problems for us. As small children, we may have decided to accept a rule and live by it for reasons of both physical and psychological survival. When we carry such a pattern into our adult interactions, it can become self-defeating and dysfunctional. In healthy families, rules are few and are consistently applied. They are humanly possible, relevant, and flexible depending on changing situations. According to Satir and Baldwin, the most important family rules are the ones that govern individuation (Being unique) and the sharing of information (communication). These rules influence the ability of a family to function openly, allowing all members the possibility to change. Satir notes that many people develop a range of styles as a means for coping with the stress that result from such

change and the inability of family rules to meet the demands of change.

Functional versus Dysfunctional Communication in Families

Satir's approach to family therapy distinguishes between functional and dysfunctional communication patterns. Bitter contrasts a functional family structure with one that is dysfunctional. In families that are functioning relatively well, each member is allowed to have a separate life as well as a shared life with the family group. Different relationships are allowed and are nurtured. Change is expected and invited, not viewed as a threat. When differences lead to disagreements, the situation is viewed as an opportunity for growth rather than an attack on the family system. The structure of this family system is characterized by freedom and flexibility and by open communication. All members within the family have a voice and can speak for themselves. In this atmosphere, the individuals feel support for taking risks and venturing into the world. A healthy family encourages the sharing of experiences; the members are secure enough to be themselves and to allow others to be who they are.

By contrast, a dysfunctional family is characterized by closed communication, by poor self-esteem of one or both parents, and by rigid patterns. This kind of family resists awareness and blunts responsiveness. There is little support for individuality, and relationships are strained. In a family that exhibits dysfunctional patterns, the members are incapable of autonomy or genuine intimacy. Rules serve the function of masking fears over differences. Rules are rigid, many, and frequently inappropriate in meeting given situations. The members are expected to think, feel, and act in the same way.

Parents attempt to control the family by using fear, punishment, guilt or dominance. Eventually, the system breaks down because the rules are no longer able to keep the family structure intact.

Defensive Stances in Coping with Stress

When stress increases, threatening a breakdown of the family system, members tend to resort to defensive stances. Satir and Baldwin identified four universal communication patterns that express these defensive postures, or stress positions: placating, blaming, being super-reasonable, and being irrelevant.

1. Family members who use *placating* behaviors as a style for dealing with stress pay the price of sacrificing themselves in their attempt to please others. They are weak, tentative, and self-effacing. Because they do not feel an inner sense of value, and because they feel helpless without others, such people say and do what they think others expect of them. Out of their fear of being rejected, they strive to be too many things to too many significant others.

2. People who adopt a *blaming* posture will sacrifice others to maintain their view of themselves. They assume a dominating style and find fault with others. As they point the finger of blame at others, they avoid responsibility for mistaken actions and the perceived loss of self-worth and meaning. They frequently say, "If it weren't for you . . ." They attribute responsibility to others for the way they are.

3. People who become *super-reasonable* tend to function much like a computer. They strive for complete control over themselves, others, and their environment by living

a life governed by principle. In their attempt to avoid humiliation and embarrassment, they keep their emotions tightly in check. Of course, the price they pay for being overly controlled and rigid is distance and isolation from others.

4. *Irrelevant Behavior* is manifested by a pattern of distractions in the mistaken hope that hurt, pain, or stress will diminish. The irrelevant person is unable to relate to what is going on. He or she appears to be in constant motion, with everything going in different directions at the same time. People who rely on this style of behavior are frightened of stress; they avoid taking a clear position, lest they offend others.

Is there an alternative to dealing with family life other than taking one of the four defensive postures described above? How does a healthy person deal with the stress of meeting family rules? Satir and Bitter describe how congruent people cope with this stress. They do not sacrifice themselves to a singular style in dealing with it. Instead, they transform it into a challenge that is met in a useful way. Such people are centered, and they avoid changing their colors like a chameleon. Their words match their inner experience, and they are able to make direct and clear statements: They are congruent. They face stress with coincidence and courage, because they know that they have the inner resources to cope effectively and to make sound choices. The congruent communicator is alert, balanced, sensitive, and real and sends clear messages.

Family Roles and Family Triads

The roles that the parents play in relation to each child are especially important, because children always see their parents as essential to their survival. Like Bowen, Satir

acknowledges that a child can be brought into the parents' relationship and that the resulting triadic process will be dysfunctional for everyone involved. Unlike Bowen, however, Satir also sees the possibility of parents forming a nurturing triad with each of the children. In such a triad, roles become flexible and open to change. Children are encouraged to make a place for themselves that fits the various situations they are in; they are supported, allowed to make mistakes, and engaged in congruent communication; most importantly, each child's self-esteem is tended and enhanced. They are heard, acknowledged, appreciated, allowed to complain, and given the information they need to handle life both within and outside of the family.

G. THERAPEUTIC PROCESS - Human Validations Model

Therapy Goals

The goals of Human Validation approach are to establish clear communication, expand awareness, enhance the individual's potentials for growth, and learn how to cope with the demands and process of change. Satir teaches that like all systems, the family tends to establish a relatively constant state called *status quo*. The tendency will be to maintain this place of emotional comfort by the family because it is the familiar. When a new element that threatens the *status quo* is introduced into the family it causes chaos while the members try to adapt. Only to the degree that the family can be helped to identify new possibilities and practice them its possible for it to change and integrate the change in a new way to engage family life. Individual members of the family must become more sensitive to one another, share their experiences, and relate to each other in

new and genuine ways. The old *status quo* with dysfunctional rules and defensive in nature must be changed. The family must open to new possibilities and learn how to integrate nurturing family-life experiences.

Therapist's (pastor's) function and role

Family members must be guided through the change process. The therapist functions as a facilitator, a resource person in charge of the therapeutic process. It is not the therapist's job to make change happen or cure the individuals. Central to the Human validation approach is the therapist's faith in the ability of family members to move toward growth and actualization.

Therapeutic Techniques

The human validation model teaches that changes occur in the session and healing in the family's relationships. Satir taught that techniques should focus on emotional honesty, congruence, and systemic understanding. She used family maps (akin to a genograms), family life–facts chronology (a listing of a family's three-generation history), family sculpturing, drama, reframing, humor, touch, *parts party*, and family reconstruction.

Process of Change

In the Human Validation model family is helped to move from status quo through chaos to new possibilities and new integration.

APPENDIX G

VIGNETTE

Vignette

Jeannine attended church very distraught. It was obvious that she had been crying as her eyes were red and swollen. She sat in the back, not in her usual seat up front. Her husband Jack, the church's Head deacon, was not in attendance. The children sat with their friends and seemed to be oblivious of their mother's emotional state. She kept leaving the sanctuary to go to the ladies room, and returning to her seat in the back. Eventually, the usher who saw her sobbing, offered to assist her and led her out of the sanctuary. Jeannine refused to tell the usher or the woman's ministry leader why she was so distressed. She stated that she would only speak to the pastor. After the sermon the pastor and his wife met with Jeannine and here is her story.

Jeannine is a 45 year old woman with four children and a husband. She has been married for 25 years. She has a son, 19 years old, a daughter, 17, a son 13, and a daughter 10 years old. All her children attended the local Adventist church school at one time or another. The oldest son is graduating and leaving for college soon. The daughter is involved in ROTC and plans to join the Navy after she graduates. The 13 year old is ADHD and has several behavior problems in his class room. The teacher wants to refer him to another school if he is not medicated. Little Abbie, the 10 year old daughter, seems to be the forgotten child and is overly attention seeking.

Jeannine was diagnosed with AIDS a few weeks ago. She was infected by Jack her husband. He admitted to her that he has had numerous adulterous affairs. Jack has decided to leave and move in with his current lover, his high school sweetheart. The high

school lover is an intravenous drug user, and passed on the dreaded disease to him. The children do not know, but she thinks that their oldest son knows about the other women because he had found some pictures in the garage a few weeks ago, of his father and another women. When he confronted his dad, the father explained that they were work friends. Jeannine does not know what to do.

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VITA

VITA

Personal Background:

Name:	Richard Dunstan Benedict Sylvester
Date and Place of Birth:	February 14th 1954, Grand Anse, Grenada
Wife:	Gale Sylvester, MSW, Master in Community Counseling

Educational Background:

1960-1969	Primary School, Grand Anse, Grenada, Laventille, Trinidad
1978- 1979	Harold Washington Junior College, Chicago, Illinois
1980-1984	Batchelor of Arts, Andrews University, Berrien Springs, MI
1984-1986	Master of Divinity, Andrews University, Berrien Springs, MI
1993-1995	Basic and Advance Clinical Pastoral Education (CPE) Edmonton, Alberta
2002-2005	Doctor of Ministry, Andrews University, Berrien Springs, MI

Professional Experience:

1980-1986	Respiratory Therapy Technician: Berrien Genera Hospital, Berrien Center MI and Mercy-Memorial Hospital, Benton Harbor-Saint Joseph, MI.
1986-1990	Church Pastor, East Saint Louis, Illinois, Illinois Conference of Seventh-day Adventists. Ordained to the Gospel Ministry
1990-1994	Church Pastor, Edmonton, Alberta Conference
1995-1997	Contract Counselor, Syncrude Oil, Fort McMurray, Alberta
1999-Present	Church Pastor, Lake Region Conference of Seventh-day Adventists, Chicago, Illinois