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## Introducing an Intercultural Approach

The year was 1978. I was among the first dozen women ordained in the Presbyterian Church in Canada when I began ministry in two rural Presbyterian congregations in Ontario. Being petite and shy, I looked younger than my twenty-four years. My theological education at McGill University had been academically rigorous but less effective in the arts of ministry. What saved me was my passion for stories and my love of literature. Raised within a family of stoical introverts, I was intensely curious about the emotional inner workings of relationships and families. The first adult novel I read as a teenager—*The Good Earth* by Pearl S. Buck—seemed to infuse vivid emotional colors into the black and white of my emotionally suppressed Germanic American family upbringing. Vicariously experiencing the drama of human life through literature was safe and deeply engrossing. During theological studies my favorite author was Iris Murdoch. Her novels vividly portrayed how people with the best intentions became tragically entangled in each other's lives because of limited self-knowledge and unconscious needs. Murdoch's novels helped me listen for the dramas beneath the seemingly placid surface of my parishioners' lives.

I began my ministry with a commitment to visit each family, with regular follow-up visits to those in need. I'm guessing that it was my keen interest in

their stories that led many of them to trust me. Though I was anxious about these visits, I soon began to trust the process of stepping into their narrative worlds and following their lead in ways similar to how I followed the storyline of a novel.

I soon discovered that pastoral care was not just a matter of listening to these unfolding stories. It was also about creating meaning. Three months into my ministry, a young father in my congregation escaped from a locked psychiatric ward, returned home, and ended his life. His parents and widow told me stories of their helplessness in the face of his intractable depression. Out of these stories, we began to craft a metaphor of his despair as a terrible illness, a sort of recurring cancer that took over his soul. When he was in the depths of this seemingly inescapable despair, suicide presented itself as the only way out.

In recalling how I functioned in the early days of my ministry, I see how my love of novels formed me as a spiritual caregiver. I entered into the stories people told me about the tragic dimensions of their lives. Storytelling was like a vessel that carried us through turbulent waters. I trusted the process of storytelling and sharing. The process of piecing together stories helped people author their lives. For example, this family and I found a metaphor that helped them externalize the shame associated with mental illness and suicide, releasing them from fears of being judged and shunned and empowering them with a sense of agency in reaching out to parents like themselves.

This metaphor of intractable depression as an illness became the basis for my funeral address. This metaphor shaped a public theology of his death that helped his family talk openly about feeling like they had not done enough. This public theology centered on God's compassion toward those afflicted with mental illness and the compassionate ways this family could experience and live with their loss. They drew upon this public theology to tell their story and help others. It is easy to imagine the private theology of shame that could have easily shaped their memories of this young man. The public theology of compassion emerged out of my pastoral conversations with them and was articulated and communally experienced in the funeral address and service. Pastoral care, then, was not only about listening; it was also about cocreating meanings arising from their experience of God's compassion.

## STORYTELLING AS THE HEART OF PASTORAL CARE

My early experience of pastoral care engaged the arts of listening, storytelling, and story crafting. Just as drama, literature, and film use images, metaphors, and symbols artistically to convey what is unique yet also universal about life and death, storytelling in pastoral care often searches for ways to connect with God, humanity, and creation amidst pain, suffering, and the everyday trials of life. There are stories, for example, about a loved one's last breath, the betrayal of infidelity, or battles with addiction. Stories allow people to lament with each

other—express anger and question all they know about life—without imposing meanings prematurely. In the process of telling stories, people become authors, instinctively finding a story's beginning and climax and imagining various endings. When pastoral care is experienced as narrative it becomes more relational and communal.

A narrative approach is first and foremost about trust. The more people trust pastoral caregivers, the more they will entrust them with the bits and pieces of their stories, especially the undigested emotional reiterations of trauma. They will invite us into the chaos of trauma or the narrative loops of obsessive ruminations. They will ask us to play with the narratives and immerse ourselves in their sea of stories. This trust allows us, together, to begin to find meanings that keep their heads above the water, floating instead of struggling and sinking.

A narrative approach is, second, about finding meanings and practices formed in the crucible of stress, suffering, and joy, as well as the ordinary tedium and goodness of life. Relational trust opens up a space for cocreating meanings that make emotional and spiritual sense within the narrative context of personal and communal life. Being oriented to narrative, pastoral caregivers are more likely to follow the meanings that emerge as the story unfolds. Theological reflection becomes collaborative and inductive. This inductive approach to meaning-making can be contrasted with deductive approaches that apply abstract theological doctrines to the practice of care. Sometimes well-meaning pastoral caregivers move prematurely to making sense of a care seeker's story by deductively applying theological themes that are important to them. An inductive approach makes room for theological meanings to emerge from the care seeker's story. Narrative pastoral care is about contextual, provisional meanings grounded in the particularity of personal, family, and communal stories.

Third, a narrative approach is about assessment: comparing theological meanings that emerge from care conversations with historical, biblical/sacred textual, and global theologies. There is a timely role for connecting personal meanings with historical theologies and worldviews that have withstood the test of time or influential contemporary theologies/worldviews that incorporate emergent ways of understanding self, culture, creation, and God/the sacred or transcendent. Referenced prematurely or deductively, historical and contemporary theologies will close down emotional and spiritual struggles at the boundaries of the known and unknown. Such struggles often de-center care seekers because their suffering calls into question ultimate beliefs and sacred values. A compassionate and respectful care relationship can provide a trustworthy space for exploring new meanings. Pastoral caregivers need to be able to draw upon their theological education and training to think biblically, historically, and comparatively about these contextual theologies. In making connections between emergent meanings and public theologies they might consider the pros and cons of referencing public theologies of suffering that have been tested over various historical and cultural contexts. For example, a morally oriented biblical or historical theology focused on individual responsibility might be life-giving when care seekers

are ready to take responsibility for suffering they caused by abusing addictive substances. This same moral theology might, on the other hand, be more life-limiting for care seekers who believe that suffering results wholly from their own failings. For these people, a theology for the “sinned against” might be more life-giving (Park & Nelson, 2001). Pastoral caregivers bring theological, cultural, and psychological expertise to evaluating personal and public theologies in order to account for suffering in complex systemic and interdisciplinary ways.

## THE COMPASSIONATE ART OF INTERCULTURAL CARE

The process of care begins when caregivers enter into the care seeker’s story-making with a sense of wonder, awe, and humility, opening themselves up to the mystery of life narratives. Narratives, like religious symbols, communicate mystery by pointing beyond themselves to ineffable dimensions of human life that cannot be fully apprehended or articulated. Mystery is a term that is easily misunderstood for obscure, secret, or divinely revealed meanings or for puzzles that can be neatly solved. Mystery in a religious or spiritual sense encompasses the territory of the sacred—a broad term for ultimate beliefs and core values, along with personal and communal spiritual practices like prayer and meditation.

Compassion plays a vital role in the process of pastoral care. Care seekers often bring narratives of pain. Entering into the mystery of another’s pain requires compassion. In a literal sense—compassion as *cum passio*—caregivers *suffer with* care seekers. “Compassion, which requires the capacities for emotional intelligence and empathy, entails the discipline of being able to surrender to and be moved by the emotional experiences and needs of the other” (LaMothe, 2012a, p. 461). Compassion also requires ongoing spiritual practices that connect caregivers emotionally and spiritually with the goodness of life. Regular spiritual practices foster compassion toward self and others, changing how caregivers react to vicarious experiences of another’s pain. They are less likely to get stuck in empathic distress, in which emotions like fear and anger become life-limiting, making caregivers want to withdraw (Klimecki, Leiberg, Lamm, & Singer, 2013). Spiritual practices make the web of compassion holding all humanity emotionally real. The embodied experience of self-compassion predisposes caregivers to respond to another’s pain with life-giving feelings—like love and concern—and desires to help (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). The embodied experience of compassion reveals the healing power of compassion. Beliefs about compassion and values about interconnected caring can in turn foster a theology of compassion as “a persisting way of interpreting and responding to the world” (Farley, 1990, p. 73).

Caregivers embody the kindness and compassion of humanity and God (in theistic religious traditions) when they show through their body language, emotional and spiritual presence, and words that they both suffer with and want to help those in pain. Compassion that “suffers *with*” and reaches out is relational.

Theologically, compassion can be understood as a life force throughout interconnected relational webs that sustains those in pain—persons, families, communities, and all of creation. Both caregiver and care seeker are held within these caring networks that spread out far beyond them. Compassion opens people up to the mystery of suffering and helps them integrate suffering into their life narratives in sustaining and creative ways.

Compassion has a long history in many religions of the world. In the Abrahamic traditions, the covenant between God and humanity is the deep grammar of a compassionate web of life. This covenant is enacted in promises Jewish and Christian people make in baptisms, confirmations, bar and bat mitzvahs, weddings, and ordinations. The study of compassion throughout the history of one's tradition can nurture the religious faith of caregivers, making compassionate love a tangible emotional and spiritual experience. Pastoral theologian Ryan LaMothe, for example, explores a parable found in the Gospel of Thomas to argue for pastoral leaders who are *radically* compassionate in that they have the courage to be emotionally and spiritually open to the pain of strangers and enemies (LaMothe, 2009) who “may hold truths and values that seem foreign and even threatening” (LaMothe, 2012a, pp. 461-62). Ongoing theological study can reveal new ways for caregivers to experience, understand, and embody what compassion means in their religious tradition. Integrating emotionally felt beliefs about compassion into one's spiritual practices will make one more likely to experience a sense of solidarity when one reaches out to help those in pain (Kok et al., 2013).

The process of stepping respectfully and compassionately into another's narrative world can be described with the metaphor of hospitality. We must embody compassionate respect as we step over the threshold and enter into another's religious or spiritual world, not knowing when we will encounter sacred images, meanings, and places within the narrative worlds of care seekers. The term “religious world” was coined by William Paden in his comparative study of religion. It describes the ongoing relational process that uses “language and practice [to organize] the world in terms of what is deemed sacred” (Paden, 1994, p. 10). When care seekers trust caregivers to respect the mystery of what is sacred for them, then new ways of seeing and experiencing the sacred may emerge. The experience of hospitality changes both care seekers and caregivers, as together they begin to cocreate new meanings and wisdom out of the intermingling and braiding of the care seeker's and caregiver's stories—spoken and unspoken (Cooper-White, 2004, p. vii). While values and beliefs related to hospitality have a long history within many religious traditions, I am using the metaphor of hospitality in a more reciprocal way to describe how the roles of host and guest alternate and all parties are inevitably changed through experiences of hospitality.

The mingling of the care seeker's and caregiver's narrative worlds generates an intersubjective space for meaning-making. Intersubjectivity is an abstract term whose dryness belies the wonder of this *inherently relational* process of making meaning. Religion itself can be understood as “a web not of meanings

but of relationships between heaven and earth” (Orsi, 2005, p. 5). For example, when we read a novel or watch a film we enter into an intersubjective space with the work of art. Our stories commune with the elements of a film or novel. We may become temporarily lost as though in a hall of mirrors where we see ourselves reflected in the twists and turns of the plots. A memorable film or novel becomes part of our story.

This intersubjective intermingling of stories is illustrated in a recent conversation I had with a young man about the pleasures of listening to audio books. The other day, he told me, he drove through the Park Hill neighborhood of Denver where he had delivered pizzas while in college. The best part of the job was listening to the latest Harry Potter novel while driving. “I couldn’t wait to hand over the pizza and get back to my car for the next installment,” he recalled. He now associates certain areas of Park Hill with climactic moments in Harry Potter’s battles with Lord Voldemort. At one intersection in particular he thinks, “That’s where Harry was almost killed.” The novel was woven into the young man’s life chapter of delivering pizzas. The high points of his listening are indelibly associated with geographic cues. Now certain sights, sounds, and smells trigger parts of Harry Potter’s story that have merged into his own story.

Listening to him, I was reminded of the novels I read as a teenager. Those books opened up a quality of life I knew was there but didn’t directly experience in my family, school, or social life. Many of my peers in the late 1960s got high on drugs, but I felt too anxious to seek out such mind-altering experiences. As with this young man, my highs came from novels, some of which I remember better than my daily routines. I recalled my teenage experience of novels as I wondered whether this young man experienced a high in listening to Harry Potter’s adventures. Perhaps the novel heightened and satisfied a latent longing for ultimate meanings in his mundane but necessary job. We both experienced the craft of novelists (and in his case the artistry of the actor dramatizing the story) because these fictional worlds brought out ultimate—perhaps spiritual—dimensions of our ordinary lives. In turn, we made them our own, using their artistry to embroider our lives, like the dramatic storyline in the Harry Potter novel recalled at a particular street corner.

When we enter into care seekers’ stories we may experience a similar interweaving of their story with ours. Together we elaborate and embroider the care seeker’s story and, to a certain extent, our own stories, which become a resource for care. Reflect on an enlightening conversation you had with someone who helped you in the midst of a crisis. It might seem as though the insights you gained came from one of you—from either you or your conversation partner. I am suggesting that *both* of you contributed to these insights; they were cocreated out of a trusting and respectful caregiving relationship. As caregivers we are not only cocreators of portions of care seekers’ stories; we also influence and shape aspects of their religious world, such as their core values, ultimate beliefs, and spiritual practices. Our formative role in care seekers’ meaning-making and spiritual lives make us responsible for our “stuff”—aspects of our stories/religious

worlds that become engaged with their story-making as well as other horizons of meaning that frame our understanding.

I use the term intercultural to describe pastoral and spiritual care as a cocreative process of intermingling stories and lives. This generative process changes care seekers and caregivers, as well as their relationships, families, communities, cultures and even, as I believe, God. As these interconnected systems change, the ripple effects continue, moving back and forth. In other words, change is not unidirectional, from our inner worlds out to relationships, families, communities, and beyond. The preposition “inter” in the term intercultural conveys the intermingling effects of change that move back and forth across relational webs, when caregivers respect care seekers and care seekers in turn trust caregivers. I would like to suggest that this process of change begins with the essential ingredients of compassionate respect and trust: this combination has a leavening effect, making possible intersubjective spaces for meaning-making and life-giving ways of connecting with each other, God, and the sacred dimensions of life.

## THE GOALS OF PASTORAL AND SPIRITUAL CARE

The goals of pastoral and spiritual care depend on the context of care. As historical overviews of pastoral care illustrate, goals are varied and shaped by many cultural, historical, and religious factors (Clebsch & Jaekle, 1964; Patton, 1993). Such goals also reflect systems of social privilege and advantage, and what counts for knowledge—religious, psychological, and medical. For example, the goal of healing has been at the heart of the clinical paradigm of pastoral care that evolved in the twentieth century when theologically liberal pastoral caregivers and theologians embraced existential psychology and psychotherapies. The goal of individual healing is appealing in part because it puts into practice many modern middle-class Euro-American values: personal autonomy, individual freedom, and a belief in progress, along with a non-moralistic use of religion that focuses on self-actualization and personal growth (Holifield, 1983; B. McClure, 2010; Myers-Shirk, 2009).

During the 1960s more theologically conservative Protestant pastoral caregivers retrieved a long-standing historical classical/clerical paradigm of pastoral care whose goal of guiding focused on the authority of the Bible, a personal commitment to Jesus Christ, and belief in fundamental creedal statements. Challenges to the goal of healing also emerged from theologically progressive pastoral caregivers beginning in the 1980s. Moving beyond the liberal moral sensibility that gave rise to the goal of healing, these voices pushed the practice of pastoral care in new directions. African American pastoral theologians (Smith, 1982; Wimberly, 1979) questioned the ways in which the goal of healing reflected Euro-American middle-class perspectives on personal development and growth that depended upon long-term, one-on-one counseling relationships. Wimberly proposed the goal of sustaining as more contextually meaningful for black congregations

offering communal care that supported people whose healing could not be fully realized in racist social systems. In similar ways feminist pastoral theologians and caregivers valued the ways in which women's experiences as both caregivers and care receivers challenged traditional male-oriented approaches to human development and practices of care (Glaz & Moessner, 1991; E. Graham, 2012). They offered contextual goals that valued women's experiences and approaches to care. Womanist pastoral caregivers proposed goals like survival as more congruent with African American women's experiences of intersecting gender, class, and racial oppression (Watkins Ali, 1999). The need for contextual goals that take into account social systems of privilege became even more important within a global horizon where the varieties of pastoral and spiritual care, with their indigenous practices and contextual theologies, were valued as distinctively unique. Such contextual theologies were often suppressed when Western models of care were imposed (Lartey, 2004).

While acknowledging the need for contextually appropriate goals that promote social justice, I would like to propose that such goals be considered in tandem with a goal of liberative integration or integrative liberation, when such pairings fit the context of care. As I will elaborate, the intertwined goals of liberation and integration are closely tied with distinctive features of a narrative and embodied approach to intercultural care: namely, its focus on compassionately entering into the stories of care seekers and listening for how these stories are shaped by family and cultural narratives that afford or deny privileges. Compassion-based spiritual care helps care seekers tenderly understand how their emotional reactions of shame, fear, guilt, and anger—formed in childhood by family and social systems—have accompanying embodied theologies—values, beliefs, and ways of coping constellated and held together by these emotions. Integrative liberation becomes embodied when compassion envelops life-limiting theologies of fear and shame automatically triggered under stress for persons, families, and communities. Liberative integration is sustained by ongoing spiritual practices—personal and communal—along with theological awareness of when personal and cultural values, beliefs, and coping practices are life-limiting. Under stress, many care seekers are influenced by and act upon embedded formative values, beliefs, and ways of coping that may no longer be spiritually life-giving and may generate chronic spiritual struggle. Exploring and aligning values, beliefs, and spiritual practices will make room for a more complex integration of religious or spiritual worlds that can compassionately respond to suffering—one's own and the world's. Such integration is liberative in that it holds persons, families, and communities accountable for living out their values and beliefs as well as practicing their faith in ways that reach out to those in pain and seek justice (Ramsay, 2012). I am using the term liberative to refer broadly to theological reflexivity (see the definition in the glossary on p. 192) and praxis focused on social oppression and justice from any religious tradition. This systemic understanding of liberative integration and justice means that “at its core pastoral care is political. . . . [T]he link between the

personal and the political is in the DNA of caregiving” (L. K. Graham, 2013b, pp. 471–72).

Caregivers bring their theological formation, education, and training to the collaborative work of exploring the religious and spiritual worlds of persons, families, and organizations. In paying attention to how formative stories point to core values, ultimate beliefs, and spiritual practices, pastoral caregivers balance their narrative knowledge of care seekers with theological knowledge about when beliefs, values, and coping are most likely to be life-giving or life-limiting. Such theological assessment, used alongside psychological, family systems, and organizational knowledge of religious coping and social oppression, is what makes this narrative intercultural approach to spiritual care distinct from psychological and medical care.

Collaboratively exploring embedded beliefs, values, and ways of coping/connecting with the sacred can feel like venturing into places in care seekers’ religious or spiritual homes that are historically in the past but still exerting an influence, especially under stress. Stress-related feelings of fear, shame, and guilt pull together values, beliefs, and ways of coping that are embodied life-limiting theologies formed by systems of social oppression. Compassion brings these embedded beliefs, values, and coping practices out of the shadows, fostering spiritual integration as these life-limiting body theologies are tenderly acknowledged and understood. Such explorations of bodily felt theologies may enhance an appreciation for the mystery of life and the world—both the immanent mystery of particular stories and an overarching transcendent sense of mystery about life itself. Spiritual integration of beliefs, values, and practices goes hand in hand with the integration of “walking the talk” within persons, relationships, and organizations.

Pairing the goal of liberative integration with other contextually meaningful goals will bring spiritual caregivers alongside significant research and models of care that interface the health sciences with religion and spirituality. For example, psychologist of religion Ken Pargament proposes a model of spiritually integrated therapy that can be used in tandem with various counseling approaches and goals. Pargament’s definition of spiritual integration works for an intercultural approach to spiritual care. He describes spiritual integration as

broad and deep, responsive to life’s situations, nurtured by the larger social context, capable of flexibility and continuity, and oriented toward a [spirituality] that is large enough to encompass the full range of human potential and luminous enough to provide the individual with a powerful guiding vision. (2007, p. 136)

In medical care, integration has often been linked with a nuanced understanding of individual healing, as distinguished from cure (Dunlap, 2012; Kleinman, 1988). Cure suggests that one’s painful life-altering experiences are left behind, while a nuanced understanding of healing appreciates how such life experiences

are integrated into one's ongoing narrative, and indeed, one's entire life. When suffering is profound for persons, families, and organizations, integration may be initially episodic, becoming more continuous over time, especially with ongoing care and support. Healing, along with transformation, is a long-term goal of care for persons and communities: sometimes not fully realized when trauma is extreme. Integration and healing are personal, relational, and communal goals of pastoral and spiritual care that are oriented to justice across these interconnected webs of life. Care of persons must encompass care of worlds (L. K. Graham, 1992). In order to retain a more nuanced understanding of systemic healing, I will usually refer to the goals of intercultural care in several ways: integration, justice, liberative integration, and integrative liberation. Having sketched the broad outlines of a narrative approach to persons, families, and organizations in this introduction, I turn now to several key definitions.

## DEFINING PASTORAL AND SPIRITUAL CARE

Historically pastoral care in Christian and Jewish communities has referred to supportive and crisis care offered by lay and ordained members of these religious communities. The adjective "pastoral" refers to the image of the shepherd found in biblical texts and Christian traditions. The shepherd's care of the flock has been used biblically and historically to depict how Jewish and Christian leaders and laity spiritually care for members of their religious communities by embodying the love of God.

Pastoral care takes many forms depending upon the historical and global context in which it is offered. In a North American context, it often takes the form of *crisis intervention* in response to a sudden loss or experience of violence, followed by *supportive care*. Crisis intervention is a form of care offered to persons, families, and communities who, because of complicating factors, have difficulty moving through a crisis or transition using their usual support systems and resources. When the acute phase of the crisis starts to subside, care becomes more supportive as care seekers cope with any long-term effects of the crisis.

Supportive care is spiritual presence that comes alongside people in an ongoing way (such as visitation) or at strategic moments (such as baptismal or premarital counseling). Supportive care sustains people through the losses and gains of life transitions, especially as they begin new chapters in their life stories (leaving home, becoming married, entering parenthood, retiring). Ongoing supportive care helps people learn to live with life-altering events, like raising a child with disabilities or living with chronic health problems. Pastoral care offered to people who are frail and elderly, for instance, is often supportive care that helps to sustain them in the midst of multiple losses. Supportive care for people in chronic experiences of suffering is informed by sociocultural understandings of the suffering that occurs in contexts of social oppression. For example, elderly people who lack financial resources may have limited options when it comes

to long-term care. In being supportive of elderly persons with few financial resources, caregivers need to widen their perspectives to include the sociopolitical context of the caregiving and strategies for seeking justice.

Within health care, military, occupational, educational, and correctional settings the term “spiritual care” is used to describe care that respects and actively engages religious differences. Intercultural spiritual care goes beyond an acknowledgment of religious difference (religious plurality) to creating respectful relationships for working with differences in values, beliefs, and practices (religious particularity) (Greider, 2012). In order for spiritual care to engage religious differences respectfully, caregivers need theological expertise that goes beyond knowledge of their own tradition and includes comparative studies of religion. In listening, for example, to how Muslim parents mourn the loss of a child, a chaplain respects how such parents draw upon their religious faith. In this instance of intercultural spiritual care, chaplains need to be cautious about what kinds of care they can offer. They need to know when and how to connect parents to care and resources within their own tradition. Since the term pastoral has historically been used to describe Christian or Jewish care, it is more appropriate to use terms like Buddhist or Muslim care to refer to spiritually oriented care within specific traditions that have not historically adopted the term pastoral care. In order to compare and contrast these two different contexts of care—one’s own community of faith and religiously diverse contexts—I will use the term pastoral care for care offered within Christian communities and traditions and spiritual care within other religious traditions, as well as religiously diverse contexts. I will also be mindful of how terms like theology are meaningful in theistic traditions, while the term worldview is more relevant in non-theistic traditions like Buddhism.

In distinguishing between pastoral and spiritual care I am especially interested in the role of one’s cornerstone beliefs and values within these different contexts of care. I use the term cornerstone beliefs metaphorically to describe beliefs that are foundational or essential to one’s religious identity. For Christian pastoral caregivers, examples of cornerstone beliefs concern Jesus Christ and how the Bible is interpreted. Many people in North American contexts have religious identities that are less conformist and more plural and particular, as sociological research by the Pew Foundation has demonstrated (Lugo, Green, & Smith, 2008). For example, the religious identity of a person who was raised and is still within a Christian tradition may be based on Christian beliefs and practices but have additions from other religious traditions, like beliefs in reincarnation. Visually, that person’s religious identity might well look like postmodern architecture that includes contrasting architectural styles within one edifice. Religious leaders in many religious traditions may, however, still retain more conformist religious identities, especially given their role in representing their religious tradition. Thus, the role of cornerstone beliefs is likely more important for religious leaders than for the general population in North America.

What happens to cornerstone religious beliefs and values when spiritual caregivers shift from caregiving within their own community of faith to a religiously

diverse context? It is tempting to make simplistic distinctions between those who hold their cornerstone beliefs to be exclusively true (such as, in order to be saved, all people must claim Jesus as Lord and Savior) and those who respect the contextual truth of each person's religious identity. Rather than using simple categories based on exclusivist versus contextual religious truth, I find it more helpful to acknowledge that most caregivers, to a certain extent, act as if their cornerstone religious beliefs are exclusively true when functioning within their own communities of faith. Often they implicitly shift to acting as if religious truth is contextual in diverse or secular contexts like health care or military chaplaincy.

Most caregivers gain the cognitive, spiritual, and emotional capacity to make this shift from universal to contextual beliefs with integrity and authenticity through their theological education, formation, and/or clinical training. When this shift is problematic for religious reasons for individuals or religious organizations, then these caregivers may need to focus on pastoring within their communities of faith. Holding onto and seeking to convert others to their exclusivist religious truth gets in the way of respectful spiritual care to those outside of their tradition, especially in secular contexts that ethically require them to respect each person's religious beliefs and not proselytize or try to convert "nonbelievers." Those focused on tradition-specific pastoral care within their own communities of faith may find confessional approaches to pastoral care more relevant than intercultural approaches to spiritual care.

Given the ways in which religious identity is becoming increasingly plural and less conformist, we can no longer make assumptions that those within our communities of faith have similar cornerstone beliefs and religious identities. Shared experiences of community life, worship, and education may well be interpreted in different ways from one participant to the next. An intercultural approach that respects what is unique about each person's religious identity will be helpful in both spiritual care in religiously diverse contexts and pastoral care within Christian communities of faith that allow for variations in beliefs.

The intercultural approach described in this revised and expanded edition of *The Practice of Pastoral Care* is contextual and provisional: not a one-size-fits-all model of spiritual and pastoral care. Instead of assuming that theories and research findings are universally and trans-historically true in all times and places, we will assess whether they are relevant and meaningful in the contexts in which we teach and practice spiritual care. In other words, when one functions in the role of spiritual caregiver, the criteria of meaningfulness and relevance replace the criterion of universal truth, even for psychological research findings. This intercultural approach is essential within religiously diverse contexts where spiritual caregivers work with people of various religious, spiritual, and existential beliefs and practices.

### ILLUSTRATING THE CHALLENGES OF POSTMODERN APPROACHES TO CARE

Robert Johnson, an African American Baptist minister, enters the Woodside Nursing Home with a heavy heart, for he has some sad news for a resident, Emily

Watson, a member of his congregation. Her oldest son has been killed in an automobile accident. The minister has prayed for the openness of heart and wisdom he will need to enter into Mrs. Watson's religious world of grief and lament. If he can respect the mystery of her grief and gain her trust, they can consider what spiritual practices and religious meanings help her connect with God in the immediacy of this loss and in the long-term process of grieving this death. Given the time constraints of needing to make decisions about funeral arrangements, they will also begin in the next several days to cocreate a funeral service that might hold the complex meaning-making of her son's life and her relationship with him.

I have written this book for those like Robert Johnson who have been called to a particular religious vocation—pastoral and spiritual care—in a historical context when many long-standing assumptions about truth are being questioned and critically appraised (Lartey, 2002, p. 1). In such a context, pastoral caregivers like Robert Johnson face the challenge of keeping “alive in the post-modern world a religious vision created in a distinctly *premodern* cultural context, honed to a level of sophistication and lived out courageously through many centuries of premodernity” (Lakeland, 1997, p. 39). What sort of religiously based care can be offered by those who use a postmodern approach to knowledge within pastoral care and assume that knowledge about humanity, the world, and what is named as God is socially constructed in the midst of complex historical contexts?

In my approach to pastoral and spiritual care I invite caregivers to view their ministry through trifocal lenses that include precritical, modern, and postmodern approaches to knowledge. Using a *precritical* lens, ministers, rabbis, and imams assume for the moment that God or that which is sacred can be glimpsed, apprehended, and expressed in the first-order language of religious and spiritual experiences through sacred texts (the Hebrew Scriptures, the New Testament, the Qur'an, the Tripitaka, the Tibetan Book of the Dead, the Vedas, the Gita, Upanishads, and Sutras, and so on), religious rituals and traditions, and spiritual practices—the way transcendent realities seemed to be known within the ancient and medieval religious traditions prior to the use of critical approaches to knowledge introduced by Enlightenment thinkers. Using a *modern* lens, pastoral and spiritual caregivers draw upon second-order languages that reflect on experience using rational and empirical methods, like text critical methods for interpreting the Bible or Qur'an, medical knowledge, and the social sciences. A *postmodern* lens brings into focus the contextual and provisional nature of knowledge, including knowledge of God or transcendent dimensions of life, and uses third-order languages that articulate methods of knowing (Jennings, 1990).

Pastoral and spiritual caregivers who draw upon all three approaches to knowledge can listen for how care seekers often use first-order religious language to express their religious faith in prayers, devotional readings of sacred texts, creedal statements, liturgical practices, and music. Such statements often sound precritical, as though care seekers are spontaneously expressing their faith rather than thinking critically. Caregivers can listen for how care seekers use first-order language to describe a seemingly direct connection with God or the sacred and whether spiritual and religious practices induce a sense of God's presence in their

lives. Do such moments come in the midst of worship, during the singing of a hymn, through participation in a sacrament or ritual, or in the contemplation of an icon or statue in the sanctuary of their community of faith? Do care seekers experience a sense of the sacred in the beauty of nature or the arts or in the daily ritual of prayer or practice of meditation? Since one of the purposes of religious and spiritual practices is to mediate experiences of the sacred or divine, pastoral and spiritual caregivers can pay attention to first-order language to see if these seemingly direct apprehensions of the divine are possible.

Mr. Johnson, for example, can be aware of moments in his conversation with Mrs. Watson when she uses first-order language to describe her sense of connection with God. Such moments might come when they pray together or when Mrs. Watson expresses her fears about her son's suffering as he died. In looking ahead at the next several days, Mr. Johnson can explore with Mrs. Watson whether spiritual practices help her feel connected to God in the midst of her anguish over the death of her son. What has helped her cope with past experiences of suffering? If, for example, she has found meaning in reading from the book of Psalms, then she and Mr. Johnson can turn to these psalms as they sit together. Perhaps particular hymns and religious music that have offered comfort in the past can be a resource now. Attending to how she uses first-order language to express aspects of her religious faith, Mr. Johnson can focus on whether and how Mrs. Watson is experiencing a connection with God.

Mr. Johnson can shift to using second-order religious language during his pastoral care conversation when he draws upon biblical critical methods, systematic modern theological perspectives, and psychological and medical perspectives on death and grief. Modern approaches to religious knowledge use second-order religious language gained through theological education to reflect upon first-order religious language. For example, his knowledge of how biblical-critical methods have been used to explore the many meanings of the Psalms can be relevant if Mrs. Watson finds comfort and meaning in the Psalms. In drawing upon second-order knowledge gained from modern approaches to understanding biblical texts, theological problems like suffering, and the psychological experience of acute stress, Mr. Johnson uses a modern lens.

Mr. Johnson shifts to using a postmodern lens during the conversation when he is aware of how much Mrs. Watson's response to this crisis is shaped in myriad ways by her unique history and various aspects of her social identity like her gender, race, religion, social class, sexual orientation, and age. Here he draws upon third-order religious language to step back and consider how context shapes knowledge (Jennings, 1990). He wonders what unique experiences as an African American woman of faith she will bring to grieving the sudden death of her son. In ongoing pastoral care conversations, he can draw upon her religious practices and language to engage in a process of cocreating religious ways of connecting with the sacred and making sense of this death. He might also wonder how intersecting systems of social oppression related to her gender, race, and other aspects of her identity shape her suffering and meaning-making. His sermon,

written specifically for this occasion, will reflect the contextual psychological, cultural, and theological meaning-making he has created with Mrs. Watson. A postmodern lens will help him focus on the particular religious meanings and ways of connecting with God that they cocreate, which are relevant to her in the immediate crisis and long-term process of understanding this death.

## A CONTEXTUAL THEOLOGICAL APPROACH

My approach to intercultural pastoral and spiritual care is contextual, reflecting my scholarly, pastoral, and clinical contexts, and will be most relevant to persons whose religious, educational, and professional context are similar to mine. It is not presented as an approach to intercultural care that is universally useful; it is one of a myriad of ways to offer spiritual care.

In order for readers to evaluate whether the intercultural approach I develop in *The Practice of Pastoral Care* is relevant, I will briefly describe my context. I am a Germanic-American third-generation woman raised as a Roman Catholic in a middle-class home in the United States and later Canada by parents of a mixed-religious marriage (my father is an agnostic and my mother is Roman Catholic). I was ordained in the Presbyterian Church in Canada and was the minister in two village churches in Ontario for nine years before moving to Boston, where I completed a Ph.D. in pastoral psychology at Boston University. I taught there for eleven years and was a psychologist and clinical supervisor at the Danielsen Institute, a pastoral counseling and mental health center affiliated with Boston University. I also was a part-time minister at a congregational church. Currently, I teach at Iliff School of Theology. My concern with offering a pragmatically useful description of pastoral and spiritual care reflects my pastoral and clinical experiences of providing care that draws upon the richness and complexity of precritical, modern, and postmodern approaches to knowledge.

I am continually aware of the challenges of combining a postmodern approach with modern approaches to knowledge, particularly biblical, critical, and social science studies and also more precritical kinds of religious knowledge expressed in emotionally felt first-order religious language, where it feels as if one's beliefs are literally true and one can directly experience a sense of the sacred without any need for interpretation. I want to help lifelong learners maintain their connection to their sense of the sacred (or whatever is ultimately meaningful for them) while thinking about and questioning their beliefs by using their graduate education in theological and religious studies. Here is my hope: when they value their religious journey and heritage as their unique religious home they will be more able to work reflexively with their embedded beliefs, values, and practices from childhood along with theoretical ways of interpreting religion introduced in graduate studies. All these aspects of their journey are part of the furniture and interior design of their religious homes. In other words, they need not jettison

precritical beliefs and practices during graduate studies but can reclaim these with a sense of reenchantment or second naiveté that includes critical appraisal.

## THE SHAPE OF THIS BOOK

This book poses questions about how to engage in intercultural pastoral and spiritual care and suggests a process of listening to, assessing, and coconstructing stories. For the sake of convenience these are described as a linear sequence; in actuality, a caregiver moves back and forth among these ways of listening. The following chart depicts this process.

Having introduced a narrative approach to intercultural care and mapped the way ahead, I will describe the process of intercultural care in more detail in chapter 1.

### *Diagram A: The Practice of Pastoral Care: Listening, Assessing, and Cocreating*

