Church Effectiveness Nuggets: Volume 9

How to Develop a Congregational "Care Team"

Why are we gifting you this volume? Because the mission statement of our primary publication—*The Parish Paper: New Ideas for Active Congregations*—is to help the largest possible number of congregations achieve maximum effectiveness in their various ministries. *The Parish Paper* is a monthly newsletter whose subscribers receive copyright permission to distribute to their constituents—more than two million readers in 28 denominations. Go to www.TheParishPaper.com for subscription information.

Purpose of this Volume: Provides in-depth answers to questions that readers of *The Parish Paper* ask regarding principles and procedures that help to create, train, and lead a lay group that expresses concern for members and attendees during times of illness, grief, and life stress.

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I. Why Does Our Church Need a Care Team?

Will Durant wrote that one of the lessons of history is that *nothing* is often a good thing to do and always a clever thing to say.

Most people wish their overly-talkative acquaintances more often used that wisdom about *saying* nothing. On many occasions, however, *doing* nothing is quite destructive. Examples: when church members and attendees are hospitalized, recovering from serious surgery or critical illness, terminally ill, suffering grief, or experiencing acute life stress.

For at least ten reasons, congregations of every size need a care team:

1. In healthy, effective churches, laypersons express concern and care for one another during times of illness, grief, and other stress.
2. Medical research has proved that caring, especially when coupled with prayer, aids physical, emotional, and spiritual healing. Caring lifts depressive moods, reduces nervous tension, speeds up the healing process, decreases the incidence of fatal outcomes following surgery, and promotes overall health and longevity in older adults.
3. Without an organized care-team system, some parishioners slip through the cracks of leaders' good intentions and receive no expressions of care and concern. Other people receive unequal dosages of care, delivered at less than optimal times.
4. Expressions of caring from lay people meet a need that clergy contacts cannot address. Hurting people who do not receive caring attention from other laypersons become painfully aware that a major ingredient is missing in their congregation—love. Later, when these people report their feelings of neglect to friends, the collateral damage to congregational climate is difficult to repair.
5. In 1950, clergy made most of the hospital, grief, and life-stress visits, while many laypersons said, "The preacher needs to do that, not me!" Laypersons in organized care teams now make a larger percentage of the caring contacts. High on the long list of reasons for that change: application of the "priesthood of all believers" concept, first espoused in the Protestant reformation of the early 1500s. A few of the other reasons: increased numbers of people in larger congregations (which changes the pastor-to-member ratio), decreased household sizes (which creates more households per 100 worship attendees), and increased demand for clergy and staff to spend time in specialized programming (which leaves less time for one-on-one contacts).
6. When congregations exceed 150 in average worship attendance, pastors reach the limits of available hours for pastoral care. Most pastors are highly motivated to use their caring skills, but in midsize and large churches, time constraints force clergy to focus more and more of their limited time on critically ill hospital patients, funeral services, and other extreme life crises.
7. Care teams meet a need not met in the other systems, such as "Stephen Ministries," whose excellent fifty-hours of training equips people for and delivers high-quality lay pastoral counseling. Often, however, many people trained with that or similar systems report that "nobody ever asks me to use my skills." A survey of causes behind that frequent comment uncovers three facts:
    a. Many people who need counseling feel uneasy with the idea of "*lay* pastoral counseling," inaccurately assessing it as substandard to counseling by a pastor.
    b. Many people who need counseling think they should solve their own personal problems rather than asking someone to help them.
    c. Ninety percent of hurting people who navigate through the rough waters of stressful adjustment to life trauma do not want counseling as much as they crave simple expressions of caring and concern.

8. Care teams involve several church members in meaningful ministry roles through which they often report experiencing a great deal of emotional and spiritual growth.
9. Care teams reduce the possibility of clergy burnout when their caring inclinations exceed the limits of their available time.
10. Caring is the essential character of Jesus' church and disciples. On Greek coins, the symbol that specifies the coin's value (denomination) was called the "character." The defining character of a church of Jesus Christ is love. If some other "ology," goal, or driving force defines a church's character, it may be a fine organization that does many good things, but it cannot claim to be engaged in the mission and ministry of the Master. A care team ensures that people who attend or observe a church's behavior do not declare it counterfeit.

II. Principles and Procedures: Developing and Leading a Care Team

The following list is gleaned from care-team systems in countless congregations. *Warning: When you read the phrase "do not do it this way," count on its accuracy.* Doing it "this way" has produced dysfunction in many congregations' care teams. While experience is the best teacher, someone else's experience is often less painful and more quickly gets you to productive results.

1. Do not call your system a "Shepherding Program!" Approximately 80 percent of the shepherding programs established during the last three decades disappeared into the Bermuda Triangle of ideas that did not work, within eight months. Among the one-year survivors, another 15 percent of shepherding programs died within three years. "Care Team" is a more neutral term that carries no negative historical connotations in members' mental list of "we tried that and it did not work." The term, Care Team, also communicates well with age-twenty-five-to-forty-four young adults in our culture.

Exceptions: In a few congregations, the word "care" would create confusion because the church used that term in the title of another kind of program—such as a fund-raising effort, a denominational push, or a commercially packaged endeavor. If Care Team would not communicate clearly in your church, pick a different, neutral term such as "Friends Ministry."

2. Do not organize your care team geographically! If your congregation contains several thousand members that drive in from a giant metropolitan area such as New York or Atlanta, you may want to have map quadrants in mind when selecting care-team members. But in 95 percent of congregations, *do not* structure the care team around map sectors. Effective care teams use natural lines of relationships, not geography, as an organizing principle. Neighborhoods have not been natural relationship-constructs for at least fifty years. How do you pick *your* friends? By getting out a city map? Likewise, the most effective care teams use natural-relationship groupings such as Sunday school classes, acquaintanceships, and age ranges—not geography—as the organizing principle for selecting and deploying care-team members.

3. For your initial care-team, recruit people who feel a sense of spiritual call to this particular ministry and are willing to serve for one year to get it started. Do not ask an official church group, such as the deacons, the elders, or the nurture committee to comprise the care-team membership. Not everyone elected or appointed to a specific office or role has the personality gifts and inclinations that make them effective care-team members.

Tell the people you invite to serve on the initial care team that they will receive in-service training in monthly meetings with the pastor(s). Stress that the monthly meetings are an essential part of the care-team process. People who attend monthly care-team meetings maintain a high level of commitment to their original response of "Yes, I'll be glad to serve as a care-team

member." People who do not attend monthly meetings usually (a) get little satisfaction from their service and (b) exhibit a lack of follow-through dependability in their care-team role.

If your church has fewer than 100 people in average worship attendance, select and personally invite members of the initial care team. Churches with 100 to 300 in average worship attendance usually put together the initial care team with a combination of (a) asking for volunteers and (b) personal recruitment. One large congregation of 3,000 members sends a letter of invitation to potential care-team members who are recommended by staff and others. The letter invites these prospective care-team members to sign up for an equipping seminar, after which they can decide whether to commit themselves to care-team service. The invitation letters suggest that people are qualified for care-team service through qualities they already possess, such as the following:

- Being a good listener
- Expressing feelings of warmth and understanding
- Enjoying opportunities to perform acts of kindness and thoughtfulness
- Looking for potential in others and providing encouragement
- Willing to take training that enhances natural skills
- Believing that spiritual growth comes through caring service
- Feeling God's call to use the spiritual gift of compassion

In its publicity brochure, one church summarizes the ministry of care-team members with this acronym:

Prayer (James 5:16)
Availability (Galatians 6:2)
Contact (Acts 15:36)
Encouragement (1 Thessalonians 5:11)

Generally speaking, the more you stress the biblical basis for and the spiritual nature of care-team service, the more effectively your care team performs. By contract, if you emphasize the need to "fill X number of slots in this care group," its members are less enthusiastic and effective.

4. Your congregation's size and its number of natural groups determine the appropriate size of your care team. In churches that average fewer than 100 people in worship, eight care-team members may suffice. In churches with an average worship attendance of 100 to 300, a group of twelve-to-eighteen people works best. Churches that average more than 400 in worship may require more than eighteen care-team members.

If your church has twelve adult Sunday school classes, you need a care-team member from each class, plus a care-team member from every other natural grouping in the church, such as the choir, the men's prayer breakfast, and each woman's organization circle. If the natural grouping such as an adult Sunday school class or group contains more than fifteen households, select two or more care-team members from that class or group.

Looking at the care-team size from a "total church membership" perspective, some large churches strive for a ratio of one care-team member for every fifty people on their church membership roles (including inactive members). Looking at the care-team size from a "total church households" perspective, other congregations strive for a ratio of one care-team member for every fifteen households.

In addition to one care-team member from each adult class or other church group, you need additional "at large" care-team members, since a large percentage of members in every church do not relate to an adult Sunday school class or another adult group. The care-team selection process is also determined by historic patterns in your congregation and denomination. For example, the percentage of adult Lutheran members involved in church-school classes is usually quite small, often less than 10 percent of the congregation's members. By contrast, the percentage of adult Southern Baptists in Sunday school classes usually exceeds 80 percent of the congregation's average worship attendance. Construct your care team accordingly.

5. Do not recruit care-team representatives from within and to serve members of your governing board and committees. Those appointed and elected groups lack the strong fellowship bonds of adult classes and other groups, which are structured around study, service, or spiritual growth goals. Thus, representatives selected from governing boards and committees seldom function as well in caring for their board or their committee constituents as do care-team representatives selected from adult Sunday school classes and other such groups.

6. Prepare for your care team's organizational meeting by typing the names of all church-member and worship-attendee households on three-by-five-inch cards—one household per card. Exclude from this procedure all households in which one or more of the adults relate to an adult Sunday school class or other natural fellowship group. A care-team member from within each adult class or group should handle those households.

At an orientation/organizational meeting for the care team, lay the three-by-five-inch cards on a big table, alphabetically by last name. Ask each care- team member to take turns walking around the table to select one card. Repeat this process until each care-team member has ten-to-fifteen cards. In the early "rounds," care-team members always pick up cards of households with whom they are acquainted. In later rounds, care-team members pick up the cards of inactive members they do not know. This feels fair, since every care-team member automatically gets a few inactive members. This personal selection procedure ensures far greater ownership of the care-team process than any other method.

By contrast, *care teams fail* when they use one of the following procedures: (a) when they hand each care-team member a list of randomly selected names; or (b) when they assign the names in alphabetical order from the church's membership list, or (c) when they determine the names each-care-team member receives with geographical, "neighborhood clusters."

7. After completing the selection process, obtain a master list of each care-team member's household names for use by the pastor and church secretary (plus the pastoral-care staff member in extremely large churches). Do not publish in the church newsletter, or distribute in any other manner, the lists of the households for which each care-team member is responsible. In most small communities and small-to-midsize churches, that kind of list-distribution makes the caring process seem formal, synthetic, and institutional. Then, too, what if one of your care-team members does not function effectively? His or her household members can feel neglected, sometimes rejected. The objective of the care-team process is "organized spontaneity," not institutional mechanics.

Large congregations in metropolitan areas are sometimes the exception to the suggestion above. They may find benefit from publicizing to each household its care-team member's name. Why? In large churches, care-team members (especially those who are "at large" and not from an adult class or fellowship group) make a high percentage of caring contacts to people with whom they are not personally acquainted. In such situations, "knowing my care-team member's name" can add credibility to the contact, limit misunderstandings, and increase interaction quality.

Either way, however, recognize your care-team members in some formal way, to make the congregation aware of this important ministry. The larger the church, the more likely it will, and should, formally commission its care-team members in a worship service. The commissioning service also reminds the church of the biblical principles on which its care-team ministry is built:

- God told Moses to choose qualified leaders to assist with people's needs (Exodus 18:13-27).
- Jesus sent the disciples to minister in his name, not just twelve disciples but on some occasions seventy disciples (Luke 10:1).
- Peter said, "Tend the flock of God that is in your charge" (1 Peter 5:2-4).
- Paul urged pastors to "Equip the saints for the work of ministry" (Ephesians 4:12).

In some churches, the commissioning service provides an opportunity to spotlight the care-team's mission statement, which might be something like the following: "To strengthen, encourage, and care for one another through the calling forth and equipping of lay people who through the Holy Spirit have received the spiritual gift of compassion. Our care team supplements and compliments the clergy's on-going pastoral care."

8. The church secretary automatically notifies the appropriate care-team member when church members or attendees are hospitalized, bereaved, or experiencing a major life stress. Obvious exceptions to this rule would include confidential matters about which the member or the pastor feels that sharing the information with a care-team member is inappropriate. In 99 percent of the above situations, however, this information is already publicly known and therefore appropriate to share with a care-team member.

When notified, the care-team member understands that she or he is to visit those people and extend concern and caring. These contacts do not substitute for contacts by the pastor. He or she continues normal pastoral roles. Care-team contacts supplement the pastor's role, thereby enormously multiplying the volume of caring and increasing the climate of congregational warmth and concern.

9. Do not ask care-team members to organize monthly or quarterly group meetings of the households on their lists! This inappropriate mixing of two totally different paradigms not only fails to achieve its goal of getting people together; it also demoralizes the care-team members. They feel like failures because they cannot get the people in their group to do what many of those people find little benefit in doing. Many church members feel that "flock" meetings are interpersonally synthetic and therefore a waste of time. Most people who want to participate in a small group prefer to select it in other ways; they do not want to be arbitrarily assigned to a group. This is one of the principle reasons why so many of the 1970s and 1980s shepherding models crashed and burned three months to one year beyond the end of the runway. The idea looked good on a wall chart but did not meet the fellowship needs, study needs, or spiritual-growth needs of most church members.

Nor should church officers or committee chairpersons succumb to the temptation of asking care-team members to become a telephone committee to promote attendance at church events or to serve as stewardship campaign callers for households under their care. When the care-team members are pressured to use the caring bond with their households for purposes such as fundraising, both the care-team member and the church member can feel used and manipulated. Keep the care team focused totally on its one goal—caring.

10. A monthly meeting of the pastor (plus associate pastors in large churches) and the care team is essential. Teams that do not meet monthly soon evaporate. When care-team leaders focus on doing a job rather than doing the job as a team, the fellowship and joy go away; commitment to job and family crowds out commitment to caring; and only a hand-full of care-team members find sufficient meaning in the activity to continue their efforts.

Each monthly care-team meeting with the pastor(s) unfolds in three parts.

To open the meeting, team members take turns "reporting in" to the group on their ministry experiences during the previous month—sharing only public information, not confidential information. In these monthly sessions, pastors inevitably learn things they would not have otherwise known. Likewise, information that care-team members learn from the pastor(s) can strengthen their caring abilities (clergy are always sensitive to the need to avoid breaching confidentialities). At the first team meeting, which is also the orientation/training session, ask each team member to pledge confidentiality regarding sensitive information. The World War II adage, "Loose lips sink ships." also applies to the reputation of a care team's ministry.

The system of care-team members reporting in to their peers is far more motivational and meaningful than asking team members to accept an assignment from and report in to an associate pastor. Do not go down that primrose path. It looks like it should work, but it does not. Reporting in to peers makes the team a team rather than a collection of individuals who are helping the pastor do his or her job. Care teams whose members do not meet together and report in to one another lose their cohesiveness, focus, accountability, and results.

Following the report session in their monthly meetings, which may take twenty or thirty minutes, the pastor leads care-team members in a thirty-minute study/discussion designed to strengthen their listening and caring skills. The following material, *studied in this sequence*, provides care-team members with the breadth and depth of instruction they need for every kind of situation they will encounter:

- The next section in this volume of *Nuggets*, titled "III. Care-Team Training," provides foundational listening skills for every kind of caring conversation.
- To build on that basic training, study the chapters in *Tools for Active Christians* by Herb Miller (St. Louis: CBP/Chalice Press) that address how to visit hospital patients, how to relate to grief sufferers, how to talk with terminally-ill patients, and how to deal with angry church members.
- Next, study *The Caring Church* by Howard W. Stone (Minneapolis: Augsburg Fortress), which adds other helpful dimensions to care-team training.
- Then, study *A Ministry of Caring* (contains a leader's guide and participant's workbook) by Duane A. Ewers (Nashville: InterActive Resources) for additional insights.

Your church office should order whatever number of the books listed above is needed so that each care-team member can have his or her own copy. However, ask each care-team member to pay for his or her own copy. People place greater value on what they pay for. Since individuals are not asked to purchase more than one study book a year, this cost is not an unreasonable burden.

These monthly, thirty-minute study/discussion sessions provide the best kind of in-service training. People learn skills while practicing the skills that they are learning. Use the above-listed materials and other such books in three-to-four-year cycles. Continuous training gives new care-team members the basics and veterans a refresher course, preventing the inevitable "institutional drift" away from the original purpose of care teams.

In the closing five-to-ten minutes of each monthly meeting, the care team engages in prayer, with participation by individuals who feel comfortable praying aloud. Some care teams divide the larger group into groups of three or four people who huddle together for five minutes, share a bit about their personal lives, and pray together. In conjunction with that, those three or four individuals covenant to pray daily, by name, for one another and their pastor(s) between now and the next meeting. Reshuffling these huddles of three or four care-team members each month (a) allows team members to pray for one another on a rotating basis, (b) strengthens personal prayer life, (c) improves the fellowship climate, and (d) builds team spirit. Some groups use the card titled *The Secret to Abundant Living: Learning How to Ask* to facilitate daily prayer among team members, available as a free download at the www.TheParishPaper.com Web site.

11. At the end of each year give care-team members the option of continuing for another year. Many people will wish to reenlist, saying that they derive significant meaning and satisfaction from their participation. Others, due to increased time demands at this stage of their personal lives or involvement in other ministries, prefer not to continue. Giving people a genuine opportunity to say yes or no each year keeps personal commitment high.

12. Large churches with many hundreds or thousands of members should create care-team subdivisions that provide specialized ministries. People with the spiritual gift of compassion often find that they have unique gifts for a specific kind of caring ministry. For example, some care-team members with strong listening- and hospital-visitation skills feel emotionally uncomfortable in nursing homes. Other care-team members may feel especially suited for and "called" to a ministry with homebound people and nursing-home residents.

One large congregation has several specialized subsections in its care team:

- One group of care-team members visits in the local hospital each day of the week, including Saturday and Sunday. Using a procedure that operates through the church secretaries and the minister of pastoral care, every "known" hospital patient is visited every day of his or her hospitalization by a member of the specialized hospital-calling unit of that church's care team. People who require hospitalization have a great deal of time to think. One thing they want and need to think at those times is "My pastor cares about me." They also want and need to think that "My church friends care about me." Nothing communicates that message as well as physical presence. If we care enough to send the very best, we send a person, not just cards.
- Another group of care-team members in that church is a one-to-one ministry. That group makes friendship contacts with elderly, homebound, and nursing-home residents. Each of these care-team members take one-year responsibility for one individual, expressing concern in these four ways: making a monthly contact, visiting on birthdays, remembering them during special times such as the Christmas season, and notifying the pastor of any unusual need or life stress. Because people in nursing homes have lost a major personal identity and esteem factor—meaningful work—relationships are all they have left. Yes, people need care and concern from a pastor, but they also need it from other people in the church. A specialized division of the church's care team can guarantee that a ministry which is everyone's responsibility does not become nobody's responsibility. Thus, people who have loved and served the church for a lifetime do not fall through the compassion cracks in their sunset years.
- Another group of care-team members in that church makes follow-up telephone contact with and home-visits to people who are recovering from grief due to loss of a spouse or close relative.
- Another care-team group in that congregation has received *Stephen Ministries* training. They are on call to provide lay pastoral counseling in special situations where that is requested by a church member, either directly or through a staff member.

Another church has a care-team sub-group consisting of people who have experienced divorce and are gifted in and willing to relate to people going through that ordeal.

Another church has a care-team sub-group that specializes in relating to people who are passing through the emotional desert of unemployment.

In other words, the list of care-team subdivision possibilities is almost endless. The number, nature, and titles of specialized subdivision groups will depend on church size, local circumstances, and the compassionate imagination of care-team leaders.

Remember Your Goal! Many congregations have a display rack in their entryway area containing *Care Notes.* These excellent pamphlets cover the gamut of pastoral-counseling needs. They aim at helping those who hurt in mind, body, or spirit, and offer a blend of information and inspiration, psychology, and Christian faith. (Obtain from the **www.onecaringplace.com** Web site.) Care on paper has value. People pick up, take home, read, and receive help from those little pamphlets.

Despite the obvious value of printed information tools for people experiencing various kinds of life stress, caring information on paper never completely substitutes for the presence of a caring person. When God wanted to change the world, he sent a person, not just the paper of the Old Testament. When churches want to change people's lives for the better, they send cards and letters. But they also send a caring person.

III. Care-Team Training

This section provides foundational listening skills for every kind of caring conversation. The pastor may want to particularize this material with additional guidelines from his or her experience in your community. For example, care teams in Florida or Arizona retirement communities encounter situations unique to that type of culture, as do care teams in the rural Midwest or the metropolitan Northeast.

A. How to Help People Cope with Life Stresses: In one of his most often quoted statements, Jesus said, "You shall love your neighbor as yourself" (Matthew 19:19). A young lawyer pressed Jesus for a definition of neighbor. Jesus told the story of The Good Samaritan, which defined "neighbor" to include people we do not know, not just the people who live next door and the people with whom we are closely acquainted (Luke 10:30-36).

How can Jesus' contemporary disciples live out those teachings about loving your neighbor? Church people are a long way down that road of application when they develop skill in four actions—caring, relating, listening, and talking.

1. Caring. People sometimes call this quality sympathy, empathy, compassion, concern, or the willingness to take time to listen. Whatever we call it, *caring* people create a natural environment in which other people often make positive changes in their life situations—or change their emotional feelings about those life situations.

In the medical field, health outcomes improve when people see their physician as a *caring* person. When people see a physician as merely *knowledgeable* and capable of providing medical information, devoid of caring, patient health outcomes are not as positive. This aspect of health care is called "bedside manner." In the average layperson, this quality is called *caring*.

Stated in contemporary psychiatric jargon, *caring* people communicate the feeling of "psychological acceptance." In other words people who care come across as friends, not just as people who are willing to help or to give advice. This quality of caring, and this quality alone, without providing people with any new information, often lays a foundation on which people decide to change their life situation—or change the way they feel about that situation.

This does not mean, however, that a caring person practices "runaway sympathy" and becomes emotionally entangled with the other person's feelings and his or her life-situation outcome; that can be as counterproductive as showing no caring at all. "Runaway sympathy" is dangerous for both the caring person and the person to whom she or he relates. It is dangerous for the caring person because she or he starts doing defective listening. It is dangerous for the person cared about because she or he is less likely to make positive and permanent changes.

There is a big difference between showing concern for people and taking responsibility for people. The temptation to cross over that line between caring and responsibility is present in every kind of caring relationship. Yet none of us can successfully take responsibility for another person's behavior, thinking, and feelings. We can care about the positive outcome of the person's life situation, but we cannot successfully take responsibility for it.

If we go down that road, we are sure to fail. When we go down that road to failure, we start feeling guilty. After we start feeling guilty, we begin feeling either depressed or angry. If we are too sympathetic toward the other person, we become depressed. If we are too low in sympathy,

we become angry. Either of those reactions is (a) unpleasant for the person we care about and (b) unproductive for his or her mental and emotional outcome.

2. Relating. Coming across as caring can create an environment that facilitates positive life change or changes in the way people feel about their life situation. However, each of us has a choice. We decide whether to spend time relating to someone. Without that willingness, caring about them is an irrelevant emotion.

3. Listening. Few tools exceed the therapeutic power of a listening ear attached to a keen mind and a caring heart. At least a dozen kinds of psychological therapy models are in use today. Research indicates that all of them work about equally well, *providing the counselor is a good listener*. If the counselor is not a good listener, none of them work well.

An old axiom taught to people who work in emergency medical situations such as battlefields and emergency rooms says, "Do no damage." That is a good description of the power in effective listening. With a small amount of training and experience, you do no damage and virtually always help the person to some extent.

Effective listeners operate from two basic principles, of which less capable listeners seem unaware.

- *The prime objective of effective listening is not to hear enough information to offer a solution*. Rather, effective listening allows the other person to hear his or her own information clearly enough to find insights and self-direction.
- *Listening to people in a nonjudgmental way—without offering evaluations or criticisms of their thinking, words, or behaviors—does not equal giving approval of their inaccuracies, mistakes, or wrongdoings.* Rather, effective listening accepts what people are saying, without a response that gives either approval or disapproval.

Unless the listener understands and is emotionally comfortable with those two principles, training him or her in effective listening is like teaching music to the tone deaf.

Effective listeners, either by instinct or by intention, avoid these five traits of poor listeners:

- Helping people finish sentences when they pause too long
- Doing all the talking
- Stepping on sentences by starting to talk before people have finished expressing their thoughts
- Not maintaining eye contact while others are talking
- Giving more feedback than necessary by going too far beyond a simple "uh huh"

When listeners' conversational habit patterns include any of those five traits, people enjoy talking to them about as much as they enjoy hearing chalk screech on a blackboard.

The *desire* to listen and to understand is the single most important factor in accomplishing effective listening. When that desire is present, people can learn the fundamentals in a few minutes. Perfecting the skill of listening, like learning any other new behavior, takes practice, but the basics are simple.

Paraphrasing: This involves stating back to the person the meaning of what she or he just said. Good paraphrasing begins with such phrases as the following:

- "What you are saying is that …."
- "You are saying . . . ."
- "Are you saying . . . ?"
- "You feel that . . . ."
- "It seems to you that . . . ."
- "You think . . . ."

Paraphrasing tells the listener whether his or her understanding is still on track or has accidentally become derailed. Paraphrasing also tells the other person that the listener cares enough to pay close attention. Paraphrasing is somewhat like acting as a human mirror. You reflect back the facts and feelings the person expresses to you—without making a judgment about whether those facts and feelings are rational or irrational, right or wrong. A mirror does not change anything; it merely reflects the reality before it. To get the hang of how well these five paraphrasing words work, test some of them in conversations with friends or family. People soon think of you as a sparkling conversationalist.

Perception Checking: With this tool, we give back to the other person the feeling that he or she seems to be expressing.

- "You feel _____[feeling] because_____[content].
- "I hear you saying that you feel . . . ."
- "I see that you are coming from a perspective of . . . ."
- "You appear to be feeling . . . ."
- "You feel hurt."
- "It sounds as though you're very angry about that."
- "It sounds as if you're frustrated."
- "I sense that . . . ."
- "Correct me if I'm wrong, but it sounds like . . . ."
- "I'm not sure whether I'm with you; do you mean . . . ?"
- "I'm not certain I understand; you're saying . . . ."
- "I'm picking up that you . . . ."

Perception checking ensures that the listener understands the feelings and viewpoint underlying the facts and information the other person is conveying.

Creative Questioning: Good listeners use this tool to flush out missing information by giving the other person permission to share in greater depth and detail. However, use creative questioning sparingly, *only one-tenth as much as you use paraphrasing and perception checking*.

A genuinely creative question cannot be answered with a simple yes or no or a one-word fact.

"How old are you?" is not a creative question.

"How did you feel about that?" is a creative question that elicits not just facts but feelings. Nor should the creative question seem like a judgment. If so, it will induce silent withdrawal instead of additional information.

Creative questions express positive interest in receiving more information (in a nonjudgmental way) and provide a receptive sliding board down which the person can send it.

Avoid the Sand Traps: Unskilled listeners often find themselves unexpectedly off the fairway. We avoid many of these sand traps through increased awareness of the way we fall into them. The following list is especially applicable to one-on-one sessions with people, in which personal problems are most likely to come out.

Avoid thinking about something else while the other person is talking. You listen with your eyes and body language, not just with your ears. People who read your eyes and body language as distracted or preoccupied decide that you are not interested in them and reduce their inclination to communicate feelings. Leaning toward the person physically shows a determination to hear.

Normal conversation is about 80-to-120 words per minute. Most of us can hear and compute more than 500 words per minute. This means we have much discretionary time when we listen to

someone. Try to use that time to understand what the person is saying and feeling rather than using it to figure out what you will say after he or she stops talking.

Avoid judgmental evaluations such as "That's dumb." or "You were foolish to tell your husband about your affair." Judging people defeats the purpose of listening, by causing the person to withdraw from giving further information.

Avoid scolding and shaming. Example: "Oh, cheer up! You shouldn't be talking that way!" Such statements stifle further productive conversation.

Avoid arguing about facts and ideas. You move few people in positive directions by argumentation.

Avoid using the other person's sharing of a problem as a chance to share a big problem of your own. This changes the conversational focus from his or her need to your need. Warning: Your instinct may tell you that this personal sharing strengthens rapport with the person. If so, your instinct is defective.

Most females find themselves more challenged than males at this point, because women in general tend to share their personal experiences in order to emotionally connect with each other. However, in most situations, paraphrasing is a much better way to connect with the person.

Avoid thinking you must fill every silence with words. Waiting five seconds for people to continue their thoughts often gives them the courage to say what they would not otherwise have dared to say. In personal conversations, compulsive talkers seldom help people. Try to become a compulsive listener. Telling is a teaching skill. Listening is a caring skill.

Avoid giving advice such as, "If I were you, I would . . . ." By using active-listening skills, give the person time to arrive at the right decision.

There are definitely times when you should give people information (a physician giving a patient medical advice is one of those times). However, in most one-on-one sessions when a person is talking to you about a personal problem is not the time for that—unless the person directly asks you for some kind of information that he or she knows you possess.

People who have a great deal of specialized knowledge are always tempted to substitute teaching for caring, didactic skills for compassion skills. Connecting with the person's motivation and will to change comes more from skill in "story listening" than skill in "information giving."

Avoid too many probing questions. The words, "You feel like . . . ." followed by a restatement of what the person just said gets more information than a list of prosecuting-attorney-type questions. More importantly, the information obtained from "You feel like . . . ." type responses saves time by staying on the subject of what the person is trying to share with you.

Avoid praising and agreeing as a substitute for listening. Sometimes listeners are inclined to say things such as, "You are doing great. Don't worry about a thing. You are coming along just fine." While those statements may at times be appropriate, they can sometimes block a timid person from talking about a problem he or she has hesitated to bring up.

Avoid trying to look as if you know everything. "I don't know" is an adequate answer to some direct questions about facts or circumstances.

In a few instances, where having accurate facts might clarify the person's perceptions and improve his or her feelings, the listener might add, "Do you want me to check on that and get you the information?"

Avoid interpretations such as "You are doing that because you don't like women" or "That's probably because of your mother's harsh treatment as you were growing up." This subtle attempt of the listener to appear intelligent sidetracks people's conversations so that they may stop talking about their real problem. While your evaluations may be accurate, teaching your ego to hold its breath is much more valuable in a listening conversation.

Avoid giving reassurance not based on facts. When you tell a woman, "I'm sure he will come back," you are giving an opinion based on knowledge that you do not possess. Most people view such comments as an attempt to avoid listening to their painful feelings.

Avoid platitudes such as "God helps those who help themselves." Platitudes communicate your lack of understanding that this person's problem is unique.

Avoid moralizing and preaching. Do not use listening time as an opportunity for sermonizing. Statements such as "You should . . . ." or "You ought to . . . ." or "It is your responsibility to . . . ." seldom connect with a person's motivation and will to change.

Avoid trying to be a psychiatrist with people who appear to be out of touch with reality, or deeply depressed, or suicidal. If their problem seems to be an acute mental disorder, encourage them to see a counselor or a physician.

Avoid quoting scripture or using prayer in manipulative ways. Many non-religious people feel put down by these spiritually focused actions, so use discretion when you consider asking people, "May I offer a prayer?" Most religious people find prayer helpful, but do not use it as a substitute for sensitive listening.

Avoid ordering or commanding. Examples include "You must . . . ." "You have to . . . ." and "You will want to . . . ."

Avoid warning and threatening. Examples include "If you don't, then . . . ." and "You had better, or . . . ."

Avoid diverting and withdrawal statements. Example: "Let's talk about more pleasant things."

Avoid violating confidences. When you say, "I'm sure you know that whatever you tell me will be kept in the strictest confidence," keep that promise despite all temptations to do otherwise.

Exceptions to this rule include the necessity of sharing issues with the appropriate colleague or leader in order to insure that you are following a proper and legal course of action. Share something with your supervisor if you wonder whether it has implications related to your organization's protocol or to the laws of your state.

In most states, the law requires any kind of helping professional—such as psychiatrists, clergy, or physicians—to contact authorities if they obtain information related to homicide or potential homicide and child abuse. In a few states, that law also requires helping professionals to contact a family member and/or other authorities when people make statements that sound like they are contemplating suicide.

4. Talking. This subject comes last on the list, because if you are not an effective listener people pay little attention to what you say to them.

What not to say: Avoid using shame, ridicule, blame, criticism, condemnation, sarcasm, and statements that sound judgmental. Rather than motivating people to change, that kind of talking usually increases resistance to change.

What to say: The following is not an exhaustive list but provides some basic examples. Remember that these happen less often if you have several conversations with someone who talks out his or her feelings.

What if the person goes off on a tangent of some kind, such as talking about a financial problem? Use your active-listening skills to listen to their story. People talk to you about this because they have no one else to talk with and you seem like a caring person. The problem they need to talk about may be blocking them from getting the motivation and will to address their primary problem. If a listening conversation removes the roadblock, it is worth doing.

What if the person cries? Possible response: "That is very painful. Take your time. There is nothing wrong with crying." With some people you might say, "If you didn't feel like crying, you would have to be a pretty insensitive person, wouldn't you?" or "If you didn't feel like crying about that, you wouldn't be very smart, would you?"

Sit quietly and wait for them to finish crying. This is one of those times when silence communicates better than words. Do not say anything judgmental, such as, "Now, now, don't take it so hard." Everyone is entitled to his or her feelings. The listener should accept those feelings, no matter how irrational the feelings seem. Accepting painful feelings as real is the only way some people can get on the other side of those feelings.

What if the person is angry? Possible response: "It sounds like you have some strong feelings about that. Let's sit down and talk about it." If possible, get the angry person to sit down with you, apart from others. (People have much greater difficulty staying angry while sitting down than when standing up.)

Use your active-listening skills to listen to their story. After they finish, say something like, "What sounds like a good solution to that?" or "If you were in my shoes, how would you handle that?"

Other possible responses: "It sounds like you are feeling pretty angry about this. Tell me a little more."

Another possible response—"You seem like a person of real integrity, so there must be a good reason why you feel so angry about that. Tell me a little more about why you feel that way."

Another possible response: Act like a mirror to reflect their feelings with "You feel like . . . ." or "I hear you saying that . . . ." Use your active-listening skills to draw out their story.

Their emotion will drain away as they express it. Remember that angry people often practice "displacement," meaning that they are angry at someone in their family or at work and are dumping their feelings on you and your organization. If you use active-listening skills for a few minutes, they may start talking about the real person at whom they are angry. If that happens, getting it out of their system can help them tremendously and improve their feelings toward you.

What if a person says he or she is thinking about suicide? If, for example, someone says something similar to "Sometimes I feel like I should just end it all!" *always* take it seriously. You do not want to read about your oversight in the paper tomorrow morning.

Possible response: "It sounds as if you are feeling pretty hopeless about your situation. Tell me a little more about that."

After your conversation with them, notify an appropriate person, such as the closest family member or their pastor or their physician or their counselor (if you know they are seeing a psychiatrist or psychologist).

Possible referral statement, if you encourage them to see a professional counselor: "I would like you to talk with someone who is much more of an expert in this than I am." Describe that helping professional and his/or expertise. Try to make an appointment for the person as soon as possible, such as via telephone while the two of you are together. Try to avoid leaving it up to him or her to make that appointment at a later time.

What if a person describes spousal abuse? Possible response: "Have you talked with the police about that?" Then, use your active-listening skills.

Many women who suffer repeated spousal abuse secretly feel that they deserve it. Try to connect with that unconscious feeling. You might say some or all of the following, depending on the situation. "You are probably not a perfect wife. There is no such creature. However, that is no reason for your husband to treat you like that. You did not cause the problem the first time it happened, but it sounds like you are encouraging it to continue. Husbands who beat their wives seldom stop doing it until they hit a brick wall. In other words, they keep doing it until doing it becomes painful to them, which seldom happens until the authorities are involved. You have two choices. You can keep on letting this happen or you can stop it."

Remember that some women are justifiably fearful for their lives. In such situations, refer the woman to the Women's Protective Service. Offer to make a telephone call to set up an appointment with that agency, but do that while the person is present, not later.

Remember that most spousal abuse victims habitually use a "yes, but" response. When you offer them a solution, they usually say, "Yes, but …." After the "but" they give you a reason why they cannot correct the problem.

Confront such people with, "I hear you saying on the one hand that you want to fix the problem and on the other hand that you are not willing to fix the problem. I am confused. How can anything change if you keep saying, 'I want it to change, but I am not willing to do what it takes to change it'?"

What if the person reports child abuse? Most states require that you report that to the police, so follow the protocol of your organization in conjunction with the laws of your state.

What if the person seems overwhelmed by grief, such as with the recent death of a family member? Possible responses: "You feel a great sense of loss right now, and it is hard for you to find the energy to take care of yourself." Use your active-listening skills and listen to their story.

Do not tell them not to think about it. If someone just hit his finger with a hammer, telling him not to think about it will cause him to think you are not very bright. Expressing their feelings of grief to a caring person often helps people get through the process.

Remember that grief comes to people in waves—it gets better for awhile, then it comes over them again—so do not be surprised if they have similar feelings several weeks later. However, grief that does not resolve itself in twelve-to-fifteen months may have an underlying psychological problem and the person often benefits from referral to a professional counselor.

Summary: Jodie Foster, playing Anna in the movie *Anna and the King*, completed an astonishing scientific demonstration for her elementary-age students, a class consisting of the king's children. She showed them that, by using a chemical reaction inside the bottle, an egg can slip into a bottle whose neck is far too small for it (without breaking its shell). When asked a few minutes later how change could be possible in a country so steeped in tradition and resistant to outside influences, Anna replied, "One way to achieve the impossible is to change the climate."

Anna's statement summarizes the goal of an effective care-team member. In the role of standing by and being creatively and compassionately present, he or she does not change the circumstances that created the stress. Yet he or she, by changing *the climate* through skillful application of these four tools—caring, relating, listening, and talking—often accomplishes what a few minutes earlier looked impossible. Without providing people with any new information, those four tools often lay a foundation on which people decide to change their life situation—or change the way they feel about that situation.

B. How to Visit Hospital Patients. After whatever number of thirty-minute, monthly care-team study/discussions is necessary to cover the "Care-Team Training" section above, the pastor leads the group in discussing pages 29-37 of *Tools for Active Christians* by Herb Miller (St. Louis: CBP/Chalice Press). Titled "My Aunt Hattie Had That Same Thing," the chapter deals with how to visit hospital patients by providing instruction in these eighteen points:

1. Assume that the call should be made.
2. Knock before entering.
3. A light above the door indicates that a nurse has been called.
4. See yourself as the patient's guest.
5. Stand facing the patient.
6. Use caution in physical contacts with the patient.
7. Be brief.
8. Feel the patient's emotional pulse and fit your mood to his/hers.
9. Listen to the patient's feelings.
10. Don't diagnose.
11. Avoid giving advice.
12. Avoid bringing up family problems caused by his/her absence.
13. Don't talk in the presence of unconscious patients (often, people who are in a coma or seem unconscious can hear everything you say).
14. If the patient shows anger toward you or others, don't overreact or try to pry.
15. Don't prejudge the patient's religious needs.
16. Don't use hospital visits for evangelism purposes.
17. Complete isolation from visitors is often the first and best form of treatment for the emotionally ill.
18. Understand the stages through which terminally ill patients pass when facing death.

In the monthly study, the pastor and care-team members facilitate discussion and learning with questions such as the following: What personal experiences from your own visiting illustrate one or more of the eighteen hospital-calling principles?

C. How to Talk with Terminally Ill People. Following the hospital calling training session or sessions in the monthly care-team meetings, the pastor leads the group in discussing pages 38-40 of *Tools for Active Christians* by Herb Miller (St. Louis: CBP/Chalice Press). Titled "Emotional Stages Preceding Death," this section deals with terminally ill patient conversations by helping care-team members understand and know how to respond in appropriate ways to the typical phases through which people pass if they have several weeks or months of foreknowledge about their death:

1. Denying death
2. Anger at death
3. Bargaining with death
4. Depression
5. Acceptance and adjustment

In the monthly study, the pastor and care-team members facilitate discussion and learning with questions such as the following: Have you had personal experiences that illustrate the five emotional stages through which people go when facing their own death?

D. How to Relate to Grief Sufferers. Following the training sessions that cover hospital calling and terminally ill patients in the monthly care-team meetings, the pastor leads the group in discussing pages 19-28 of *Tools for Active Christians* by Herb Miller (St. Louis: CBP/Chalice Press). Titled "I Wouldn't Know What to Say," the chapter deals with how to relate to grief sufferers by providing instruction in these seventeen points:

1. Encourage expressions of grief.
2. Try to understand grief instead of being annoyed by it.
3. Don't try to blur the physical reality of death with homespun preachments.
4. Expect all grief to be accompanied by some degree of guilt feelings.
5. Expect grief to be accompanied by some anger, especially in early stages.
6. Do not become so upset by the grief situation that you cannot help people.
7. Do not try to buck them up; listen to what they are feeling.
8. Do not divert the conversation to other subjects.
9. Do not fear talking about the person who died.
10. Do not fear causing tears.
11. Do not isolate people with their loneliness and loss.
12. Perform some concrete act.
13. Stay alert for symptoms of physical illness.
14. After the initial shock has passed, encourage them to keep busy.
15. Loneliness is often more acute three months later than three days after the funeral.
16. Try to understand unresolved grief.
17. Organize a system of continuing contact and concern.

In the monthly study, the pastor and care-team members facilitate discussion and learning with questions such as the following: Have you observed instances in which "awkward helpers" interacted with grief sufferers in ways opposite from the seventeen principles illustrated in the "I Wouldn't Know What to Say" chapter?

E. How to Deal with Angry Church Members. Care-team members are not ordinarily deployed to intentionally focus on that kind of emotional reaction in parishioners. However, the chapter in *Tools for Active Christians* by Herb Miller (St. Louis: CBP/Chalice Press) titled "Extinguishing Church Fires," provides some helpful basics in how to react and respond. The chapter provides instruction under the following headings:

1. Isolate them.
2. Get them to sit down someplace.
3. Listen carefully.
4. Tell them that you agree with some specific part of what they have said.
5. Ask them for suggestions about how this problem should be handled.
6. Tell them you appreciate their bringing it up.

F. Continuous Training Sessions. Use the following books in subsequent monthly study sessions. The pastor and care-team members facilitate discussion and learning with questions such as the following: Have you experienced situations in which you wish you had used one of the suggestions in this chapter instead of the way you handled it?

- *The Caring Church* by Howard W. Stone (Minneapolis: Augsburg Fortress)
- A *Ministry of Caring* (contains a leader's guide and participant's workbook) by Duane A. Ewers (Nashville: InterActive Resources)

The training modules from "Stephen Ministries" and other, similar, lay pastoral counseling systems are another source of care-team training. Depending on preferences and local availability, the pastor may want to invite a "trainer" from one of those systems, either in the congregation or a neighboring congregation, to lead one or more care-team study/discussion sessions.

We cannot overstate the importance of *in-service* training, learning by studying *and* doing. This contrasts sharply with educational systems that call for studying *before* doing. Care-team members learn more, faster, when they simultaneously study *and* apply caring principles.

IV. The Bottom Line

Jesus said, "Love one another as I have loved you" (John 15:12). That means we love people in spite of their imperfections. A famous Green Bay Packers' quarterback developed an incentive program to motivate his son toward better schoolwork. For every perfect paper Bart brought home, Bart Senior gave him ten cents.

After an especially tough game in St. Louis, Bart Senior returned home weary and dejected. He had played below his best. His body had been battered. The trip home was long and tiring. But when he entered his bedroom late that night, he felt better. Attached to his pillow was this note: "Dear Dad, I thought you played a great game. Love, Bart." Taped to the note were two dimes. That is the way Jesus loved us. To love others that way is to love despite imperfections.

After Jesus says, "Love your neighbor as yourself," his story of the Good Samaritan makes it clear that his definition of the word *neighbor* includes people we do not know (Luke 10:25-37). A leading insurance company has a group of employees who claim to be "Good Hands People." The company advertisements shows agents standing with hands outstretched, palms upward, indicating that they will take care of you. When church people operate at optimum biblical Christianity standards, they are willing to extend love to people they do not yet know.

Those verses summarize a care-team's ministry. With common-sense training that builds on the God-given spiritual gift of compassion, loving people the way Jesus loves each of us, and overlooking imperfections, the care team extends love the way Jesus did—reaching out with care and concern to people on Jericho Roads of painful circumstances, many of whom live outside the boundaries of personal acquaintance.