

TASK-FOCUSED CARING

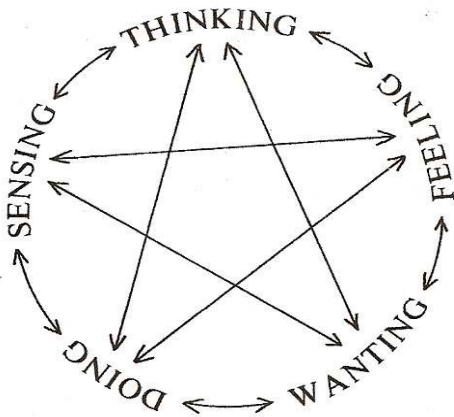
Introduction

At the core of CPE is a person-centered theology and practice of caring. CPE students are often reminded that caring is a matter of “being with” rather than “doing for.” However, starting in the 1970’s, action-oriented approaches began to impact and expand the practice of pastoral care and counselling. Traditionally CPE centered on feelings, attitudes and self-perceptions, but increasingly the behavioral and cognitive aspects of human functioning are seen as equally essential focus areas in spiritual care.

A systems approach helps by integrating person-centered and task-focused caring. Systems-thinking sees all the different aspects of psychological functioning and human experience – sensing, thinking, feeling, wanting, acting – as one interdependent whole. Each part interacts with and organizes all the other parts and together they constitute something different and larger than the sum of the individual parts.

From this systems perspective there is no essential contrast between person-centered and task-focused caring since both connect with the overall dynamic in the person. The difference between a person-centered and a task-focused approach is the focus of attention: on the person’s feelings and sense of self or on the person’s immediate concern or issue that presses for resolution. Or conversely, whether one collaborates for the solution of the concern (task-focused) or attends to how the concern impacts the person emotionally (person-centered).

Figure 1



THE AWARENESS WHEEL¹

This diagram of a wheel presupposes a hub – signifying that all the aspects of human awareness revolve around an issue, a hurt, a crisis or problem situation.

In the practice of care the point of entry can vary – starting with the feelings, thoughts, behavior, wishes, or the sensory experience – but in the end the person as a whole gets addressed.

A PERSONAL AND/OR GROUP EXERCISE

(see the Appendix for the “awareness wheel” exercise sheet)

- Choose a current concern or issue and place it as the hub in the center of the wheel. Take some time to organize your awareness as you go around the five functions: what do you think, feel, want, do and get from your sense experience regarding the issue in the centre.
- Share in a small group what awareness dimensions come more directly or easily to you than others. Are you more of a thinker than a feeler, a doer than a wisher, etc.?

I. Behavior/Cognitive Action-Therapies

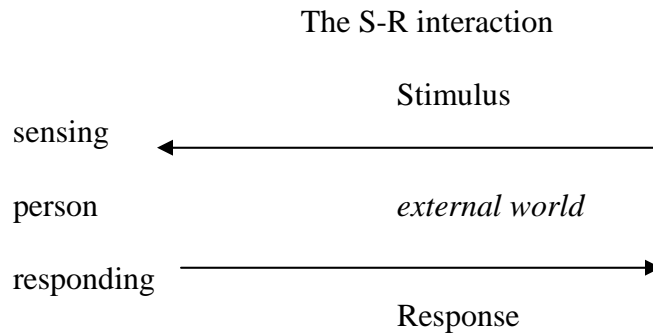
Beginning in the early 1970's behavioral methods were introduced in the field of pastoral care and counseling. . The standard and popular seminary text of Howard Clinebell, *Basic Types of Pastoral Care & Counseling*, debuting in 1966, included behavior therapy as a resource. His student and prominent voice in the pastoral care literature, Howard Stone, wrote an introduction to crisis intervention methods (1976) and a succinct guide in *Using Behavioral Methods in Pastoral Counselling*. (1979).

Three streams of behavior therapies can be distinguished in historical sequence:

A. Classical Conditioning

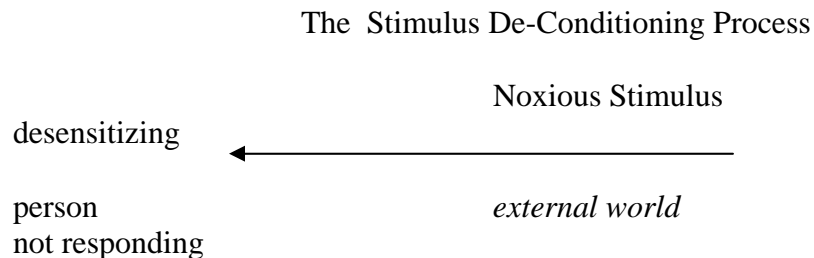
- Pavlov's experiments in conditioning animals in the early 1900's established the stimulus-response model, the mediational S-R sequence with the intervening variables of anxiety and trauma.
- As diagrammed in figure 2, the focus is on the S-R interaction – what is objectively observable in the external world: the physical stimulus event and the ensuing behavioral response. No attention is given to the person's internal, experiential world as represented in the awareness wheel.

Figure 2



- In the 1950's Joseph Wolpe developed the counter-conditioning method of *systematic desensitization* that eliminated anxiety disorders in many instances and did so in a relatively brief period of treatment.

Figure 3



- applications of desensitization/relaxation methods target mainly anxiety disorders, phobias and sexual dysfunctions (Masters & Johnson).

B. Operant Conditioning

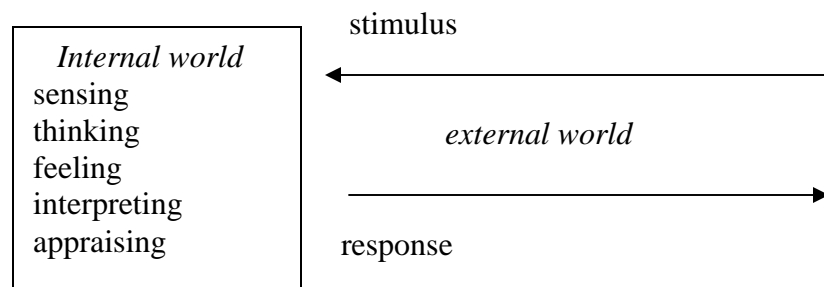
- In the mid 1950's Skinner developed methods in shaping new behaviors through *positive reinforcement*, focusing on what comes immediately after (consequences). The use of rewarding preferred behaviors has been prominent in mental health centres, schools and family life education, and, not to forget, dog obedience classes ("token economy").
- Therapy practice proceeds from stimulus discrimination to the use of four kinds of behavior responses:
 - positive and negative reinforcers (rewards)
 - punishment and "time-out" responses
- Applications are prominent in couple & family therapies and group process as relationships constitute mutual influence systems that respond to:
 - social learning theory and behavior exchange contracts
 - cost benefit analysis and reinforcement of preferred behaviors

C. Cognitive Behavioral

- While the early behavior therapies stuck to the observable, factual, external world, cognitive behavior therapies expanded the range to include the internal world diagrammed in the awareness wheel: the subjective experience of beliefs, assumptions, expectations, and feelings.
- The S-R formula is stretched by inserting cognitive appraisal (A) as the primary intervening variable (S-A-R). Therapy addresses both the external and the internal world with a focus on how the sensory information coming from the outside is processed and interpreted by the person.

Figure 4

The S-A-R model



- In the practice of pastoral care and counselling several models in cognitive behavior therapy have become prevalent in its ministry of care:

□ RATIONAL-EMOTIVE THERAPY

Starting in 1955 Albert Ellis extended behavior therapy into the person's internal world of experience. Rational-Emotive Therapy (RET) describes how the four interdependent processes of perceiving, feeling, acting, and thinking can either sabotage or promote human well-being. Ellis highlighted the determinative role of cognition and became a popular presenter by listing in provocative fashion irrational beliefs such as:

- *The idea that it is a dire necessity for an adult human being to be loved or approved by virtually every significant other person in his community, and*
- *The idea that one should be thoroughly competent, adequate and achieving in all possible respects if one is to consider oneself worthwhile.*ⁱⁱ

RET outlines a three step (A.B.C.) process:

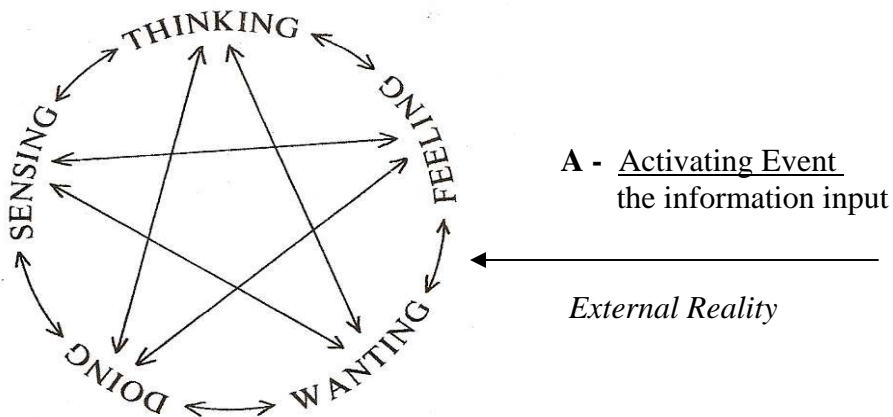
- A. *Activating event* (I sense somebody to be critical of me)
- B. *Belief system* (if not approved of by all, I fall short)
- C. *Consequent emotion*. (depressed, angry, upset)

RET intervenes by disputing (D) the irrational belief. The outrageous wording employed by Ellis sets up the irrational idea for disbelief if not ridicule, a process that can be further pursued by rational arguments. With cognitive correctives the meaning of the activating event can be more realistically assessed and constructive feelings and behavior will follow.

Figure 5: The RET process: aligning beliefs with rational reality.

B – Belief System

the “awareness wheel” dynamic of information processing



C – Consequent Emotion

determined by level of rational correctness of basic beliefs

- Other catalogs of cognitive errors list dichotomous (e.g. all-or-nothing, good-or-bad) thinking, overgeneralization, arbitrary inference, selective abstraction, mental filter, disqualifying the positive, jumping to conclusions, magnification or minimization, should statements, labeling, and personalization.ⁱⁱⁱ
- Ellis was enamored by philosophy and outspoken in his atheistic and existentialistic values. Yet RET fits well with spiritual care in its emphasis on an inclusive, ethical humanism and its therapy stand of “condemning the sin but accepting the sinner”. It does not oppose religion if not dogmatic in its requirements or irrational in its truth claims. Religious counselling can benefit from the RET process in a shared faith context as illustrated in the following:^{iv}

The idea that it is a dire necessity for an adult human being to be loved and approved of by virtually every significant other person in his community.

- There are so many different types of people that it is impossible to be loved by all nor advisable to seek approval from all of them.
- Sometimes to be disapproved of can mean we are actually doing something of worth and integrity: “blessed are you when people hate you, and when they exclude you.” Luke 6:22.
- Rather than the approval of others what counts is a larger reality that cannot be seen: “beware of practicing your piety before others in order to be seen by them; for then you have no reward from your father in heaven.” Matthew 6:1

□ COGNITIVE THERAPIES

The key theorist-therapist here is Aaron Beck known for the classic work, *Cognitive Therapy of Depression* (1979). The core concept is that emotional disturbance results from mistaken and oppressive beliefs people maintain about themselves and about their place and future in the world around them. With his associates Beck has successfully applied cognitive theory to the therapy of anxiety disorders, phobias and depression. Cognitive therapists direct clients through the stages of identifying and analyzing their automatic thoughts, followed by restructuring the erroneous beliefs. This process is pursued in the work sheet of *daily record of dysfunctional thoughts* that outlines the client’s homework assignment (Beck, 1979).

In contrast with the RET model, cognitive therapy is not rationalistic or philosophical in its approach. Rather than abstract categories of rationality, cognitive therapy identifies basic beliefs in concrete and personalistic ways based on early traumatic experiences and memories. For instance, the childhood drama of seeing father leave mother permanently after a fight may

engender the present fear that “others will leave if I am assertive,” with the underlying belief “if I make others angry they will leave me.”

Traditional pastoral care and counselling has utilized cognitive approaches mainly on account of its practical benefits: it is generally a brief therapy that is task – focused and situated in the here-and-now. In addition the cognitive dimension holds special significance for spiritual care. Irrational ideas can stem from negative religious experiences that have generated beliefs that function in oppressive and restrictive ways. More fundamentally, a person’s self-concept and view of life often come referenced with the person’s image of God. The way people think and talk about God can accommodate irrational processes such as magical thinking, emotional reasoning, and personalization of specific events such as accidents. Spiritual care and pastoral conversations encounter all sorts of God-talk, some that frame, what can be termed, theological thought distortions. In such instances, spiritual care can adopt a cognitive restructuring process of identifying and addressing dysfunctional religious constructs or God-representations that can lead to personal impairment and social injustice.

The therapist’s gentle but direct efforts to enable people to reevaluate and revise their pathogenic beliefs may help them gradually relax their defensive hold on growth-restricting beliefs. Such “theotherapy” usually takes considerable time, but it can be crucial in liberating the potentials of individuals and family systems to grow spiritually and otherwise.
Howard Clinebell – Contemporary Growth Therapies, p.144.

A THEOLOGICAL DISCERNMENT/REFLECTION EXERCISE

There are no ready lists of religious cognitive errors or theological thought disorders. Stepping into this void, group members can individually draw up a personal target list of what they consider pathogenic religious beliefs and share these in the group for exploration – to argue and dispute *à la* Albert Ellis the respective *cognitive sins*, i.e. viewing sin not so much as moralistic (what we do) as dispositional (how we think).

More recently a new spiritual dimension has been added to the cognitive therapies by integrating the discipline of meditation in a practice that has been shown to be clinically effective. *Mindfulness-Based Cognitive Therapy* (MBCT) incorporates a particular awareness and meditative experience known as *mindfulness* – a practice originating in the wisdom traditions and Buddhist culture in Asia. Mindfulness can also be called *heartfulness* or *soulfulness* – a compassionate awareness. As shown in programs of

mindfulness-based stress reduction, the effects go beyond the subjective experience of feelings and thoughts to the actual physical patterns of brain activity that underlie negative emotions.^v

II. Constructivist Therapies

The practice of pastoral care can be seen through the three lenses of premodern, modern and postmodern perspectives.^{vi} Premodernity portrays religious experience and knowledge that is immediate, intuitive and unquestionable. Modernity utilizes the critical study of historical and literary sources in the interpretation of sacred scripture and religious experience, with a practice of care informed by the social sciences. Constructivist therapies are based on the premises of postmodernism relativising the objective validity of the grand theories of scientific knowledge. The focus is on the subjective process of constructing the internal maps of world and life views. The constructivist lens disputes the decisive role of sensory experience in favor of self-generated, idiosyncratic processes of continually emerging constructions and reconstructions of meaning

In constructivist terms human beings are foremost meaning-makers. People are not passive recipients of general knowledge that reflects external, final realities, but active agents in generating inner maps of highly particularized values by which to live their lives. This constructivist process, however, is not a solitary one of separate minds but recruits cooperation from other meaning-systems. Meaning-making-constructs exist on many levels (individual, family, social, cultural, religious), which jointly co-author evolving life scripts. The theory of *social constructionism* emphasizes the commanding role of social systems involvement in shaping people's beliefs and lifestyle. Social Constructivism emphasizes social justice concerns based on the fact that individuals readily incorporate the dominant values and beliefs of such destructive cultural traditions as those that champion patriarchy, heterosexism, racism, and consumerism.

In constructivist practice, therapy is essentially a special sort of conversation that elicits a person's strengths and choices. While the traditional behavioral cognitive therapies are directive and tied to an authoritative theory, reconstructive communication is joining others in the meaning-making process of understanding, based on the belief that there are many possibilities in viewing the world and in living our lives. The hermeneutic approach in Biblical exegetical studies has been applied to the collaborative style of constructivist conversations. Constructivist conversations explore various lines of interpretation of a life situation, selectively organizing its meaning-making processes while seeking to deconstruct and reconstruct restrictive life patterns. Rigid personal constructs often hamper a person's social integration or constrict his or her range of responses to new situations. Reconstructive conversations seek to clear these obstacles by enhancing the person's or family's adaptive, creative abilities to live a life.

Constructivism constitutes the common ground for two prominent current action-therapies: the *solution-focused* and *narrative* schools of therapy. The first one presses action for new solutions, the other action for new meanings. Both approaches are actively applied in the practice of spiritual care, their respective use being determined by the particular context of ministry. In the classical tradition of spiritual care, the emphasis has been on *soul curing* rather than *problem solving*. However, in constructivist terms, presenting problems are not about problems but about solutions: new, creative ways of seeing and living life. Solution-focused and Narrative styles of caring connect when presenting problems are listened to as life stories that are open-ended, inviting further interpretation and revision.

- **Solution Focused Therapies**

A preeminently task-focused approach, prominent in “managed care” practice as well as in institutional contexts, is the solution-focused approach. It is a brief therapy that is pragmatic, located in the here-and-now and focused on the future, with a positive and cognitive emphasis. It is related to the strategic, problem-solving approaches in family therapy of the 1970’s. But rather than problem-oriented, solution-focused therapy targets the solution. This has radical implications for the helping relationship. Gone is the task-division by which the client owns the problem and the therapist the solution. Now the client is credited for having the potential to generate not only the problem but also its solution.

Solution Focused therapists major in asking questions that maximize client autonomy and choice. The two “mainstays” of the therapy are

1. the *miracle question* “Suppose one night, while you were asleep, there was a miracle and the problem was solved. How would you know? What would be different?”
2. the *exception question* explores those times when the client did not have the problem when ordinarily he or she would. How can those exceptions be repeated and expanded at this time?

Other standard questions in the therapy’s repertoire are coping questions, scaling (on a scale of zero to ten) questions, and competence or resource questions. Just as important as the questions are the therapist’s reinforcing responses – compliments preferably with surprise and exclamation!

- **Narrative Therapies**

In the present postmodern context, the *living human document* (Anton Boisen) does not reflect an objective reality recorded by past events but constitutes a subjective text, unfinished and in process. According to constructivist theories and narrative therapies, which since the 1980’s entered CPE and the pastoral counseling movement, our life story does not evolve by itself for us to discover and study. Our life stories are not passed on to us by outside forces or fate but are self-authored, though as authors we are often not

aware of our own imprint. In our life stories we selectively and subjectively organize our experiences, sorting them into chapters and titles, introductions and conclusions – meaning-making constructs by which we write up and view ourselves and our place in the world under particular headings and themes. As others listen, the story gains an audience, co-authors who situate themselves in the story by appropriating and interpreting it. From this constructivist perspective, living human documents are scripts that map and highlight what author and audience see as the determinative markers and contours in a life story, not a factual recitation of past events but a fluid, interactive and imaginative process.

Narrative therapy explores how human experience is shaped by meaning-making stories colored by larger social and cultural themes, and proposes that we are both the creators and the creations of the stories we live by. The therapy critically assesses the impact of our personal and communal stories and, through therapeutic conversation, seeks to reinterpret, sometimes rewrite, closed and oppressive stories into alternative versions that open up to life and include our creative participation.

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An acclaimed self-help book in mindfulness including a CD of guided meditations.

APPENDIX

THE AWARENESS WHEEL



This diagram of a wheel presupposes a hub – signifying that all the aspects of human awareness or experience revolve around an issue, a hurt, or a problem situation. In the practice of care the point of entry can be varied, starting at feelings, thinking, acting, wanting, or sensing, but all the other parts will ultimately be involved to make it one total human experience.

Source: *Couple Communication*. 1979. Sherod Miller, Elam Nunnally, and Daniel Wackman. Interpersonal Communication Programs, Inc.

End-Notes

ⁱ Taken from *Couple Communication*. Sherod Miller, Elam Nunnally, and Daniel Wackman. 1979. Interpersonal Communication Programs, Inc.

ⁱⁱ For an early list of irrational ideas see Ellis & Harper. 1961. *A Guide to Rational Living*. Prentice Hall; For an update see Dryden & Ellis. 1988. "Rational-Emotive Therapy" in Keith Dobson (Ed.) *Handbook of Cognitive-Behavioral Therapies*. Guilford.

ⁱⁱⁱ See Beck, Rush, Shaw, & Emery. 1979. *Cognitive therapy of depression*. Guilford; David Burns. *Feeling Good: The New Mood Therapy*. Wm. Morrow Co.

^{iv} Rebecca Propst. 1982. "Cognitive Therapy via Personal Belief Structures," in Abt & Stuart. *The Newer Therapies – A Sourcebook*. Van Nostrand Reinhold.

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^{vi} Doehring. 2006. *The Practice of Pastoral Care – a postmodern approach*. Westminster Johan Knox. See also the module *Spirituality in the practice of Care* on the three lenses of premodern, modern and postmodern approaches.