

Intensive Care Community: A Model Between Hospitalization and Traditional Counseling

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American Association of Christian Counselors

March 8-9, 1996
Washington D.C.



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Intensive Care Community

Introduction

One of the emerging issues in Christian counseling today is providing the kind of intensive, loving care which huge numbers of people in the church need in order to receive healing for their broken lives. To enable persons to come to 'maturity in Christ' and develop to the fullness of personality we call the "image of Christ" represents an enormous challenge to the body of Christ. It has always been so, but it seems even more imperative in today's world that the church develop ways to provide nurture. ("Fellowship" and discipleship are not enough.) It seems that far more people in today's churches have experienced significant blows which hamper development - destructive families, violence, addictions and so on - than a few decades ago. (Possibly we are just more aware of how people's growth is stunted or fostered.)

The same need exists in the church world wide. Imagine the needs for nurturance, as well as teaching, for millions of Russians coming to Christ after suffering lifelong oppression, violence and a skyrocketing rate of alcoholism. One mental health expert considers the whole population to be suffering from depression. Imagine the millions in Africa displaced from tribal ties and rushing to cities in search of a better life.ⁱ And imagine the millions trapped in terrorism and war in dozens of other countries. Who can possibly assist these millions to understand and dream of reaching towards the wholeness which holiness implies? The church of Christ worldwide has the greatest gifts and resources to bring healing - not just through evangelism, but through in-depth loving which fosters healing and reshapes lives, not by the millions, but one by one.

Virginia Satir, one of the foremost family therapists of our time, says her "best estimate" about people growing up in North America is that perhaps four percent of us grow up in truly nurturing families -- she says one percent may be a more realistic figure. By nurturing she means that the basic needs of emotional and spiritual sustenance, as well as physical and educational requirements of children are optimally met.

We can hope that within the church we might see a higher percentage of nurturing families, but I don't believe that is necessarily so, since the people in the pew are products of the larger society. What this means is that the vast majority of people within churches, as well as outside of them, suffer some degree of deprivation as well as some life traumas. To enable people to trust God (emotional reliance) and not just "believe" (a cognitive process) means that they must experience love, acceptance and nurture-what we might call substitute parenting or re-parenting-in order to grow to maturity.

Historically at times the church has known and experienced the power which comes by living in community-as the family of God, as the body of Christ. Hundreds of Christian communities down through the ages bear witness to that. Yet in our age, most Christians live less and less in community of any kind, let alone Christian community. Most of us, especially in urban churches, live fragmented lives, only one fragment of which is "church", "spiritual life" or

ⁱ "The Coming Chaos" *Atlantic Monthly*, March 1994

“fellowship.” To receive healing and move towards wholeness requires much more than an hour or two a week in a church to which we commute. The integration of life which community best offers is foundational for personal wholeness for the vast majority of people. In my doctoral research on exceptional Christians, I found that commitment to and participation in the body of Christ (though not necessarily the organized, formal church) was a critical element in formation (Dodds, 1992).

The Biblical Model of Healing: The Living Organism

It is not by accident that the model of relationship that Jesus gives the church is that of His own body – “the body of Christ.” The body, the living organism, exemplifies living together interdependently, all of us being both needed and needy. The “body” means family at its finest, true community drawn together in a web of relationship, committed to each other for the common good.

We are all born into some kind of family. In “family” we are all shaped, for good or for ill. In family too we can best re-learn, be re-shaped, re-influenced, experience healing, become whole. We don’t learn and develop in a vacuum, devoid of close relationships. We learn better ways of thinking, behaving, relating through interactions with others. Today’s unprecedented loss of extended family and community at various levels increases the need for the church to create caring, loving groups which nurture people, especially through their very difficult times of wounding. The church is uniquely gifted and empowered to become the “secure” family - the functional one which provides re-birth and growth toward the optimum of the “image of Christ.” The small group movement has succeeded to the extent that it fulfills this role.

The church must offer far more than the emotional support the lucky few gain from paid professionals or an hour a week in a “cell group.” We can never hope to meet the nurturance needs of millions if we rely on these alone. Even if professional counseling was the best option, there would never be enough professionals to meet the need. We know that in times past the church community fulfilled multiple roles in the life of a person. The church was the center of living, of participation in the sacraments and confession, discipleship, fellowship, teaching, comfort, celebrating birth and mourning death. Today’s church functions in a secular society where many of these crucial life elements have been given over to other institution or agents. For instance, the priestly and pastoral roles once fulfilled within church are now more likely filled by psychologists and counselors. I would like to see the church reclaim these roles as functional elements in the life of its people.

The 3-M Model for Change I propose shows how the church can foster growth using a profound but simple approach (Dodds, 1992). This model defines what God gives to us through His Word and other resources.

1. Motivation – a desire for something better than what we currently experience
2. Model – the new ideas, persons, or ways of behaving which offers us an alternative
3. Means – the energy of the Holy Spirit available to us and within us which empowers our efforts at change.

This model can be taught simply to even small children with three statements:

1. I can behave differently and as a result my life will be different.
2. I can do something (such as apply God’s Word) to make it happen
3. God will help me through His Spirit in me.

Limitations of Counseling and Hospitalization

Even at its best, counseling and hospitalization for the severely wounded involve certain barriers or limitations. Neither, though valuable, are endowed with the kind of “family” resources

the church can provide. Traditional counseling offers an hour a week during which a wounded person can share hurts and find some help and understanding. But, after that hour, he or she must return to the same set of relationships and daily routine. To put new insights and other learning into action is difficult. He or she may or may not find support to make the important changes needed to bring about a healthier life. Without the supportive net of relationships and a “holding” environment full of love and care, many persons are not able to take steps of growth. With daily support, such as one finds in a closely knit community, much greater change is possible. This is one reason community based programs such as “half-way houses” have worked as places for persons to find healthier ways of living when recovering from addictions and so on.

Today a churchgoer in crisis is more likely to be confined to a hospital than ministered to by the body of Christ. Admission to a psychiatric unit creates several barriers to the wounded person who may not need confinement (not being at an extreme of harming the self or someone else). Consider some barriers which would be avoided in a church community setting:

1. Finances: The daily cost in a psychiatric unit runs about \$1,200 per day.ⁱⁱ A “partial hospitalization” program or “day care” can be \$600 or \$800. This is beyond the reach of most people. Even if paid by insurance, such care only serves the identified patient rather than the family in which he or she is enmeshed. There is no connection back to the people in the daily life of the patient.
2. The “hospital shock” of being treated as a psychiatric patient, having personal items taken away, being confined with a group of people who may have bizarre and terrible experiences feels demeaning to many people. Such exposure can make the wounded person more depressed before any positive changes can be fostered. One client of mine told of her hospital roommate sharing (uninvited) her many suicidal attempts and all the ways they could trick the staff and find a way to kill themselves in spite of all the rules.

Another client shared how demeaned she felt in a “Christian” psychiatric unit which robbed her of dignity by treating her as an irresponsible child or crazy person. Being treated this way, her depression became worse.

3. Hospitalization may focus on environmental safety and dispensing of medications, and may not provide immediate counseling or the support of a warm and encouraging staff who impart hope or teach a new life style. Without supportive relationships recovery is likely delayed.
4. Due to their complexity as institutions, hospitals may not be able to provide an atmosphere of support such as one could experience in a small group of caring fellow Christians.

I believe the church can be a vital force and set an example in taking initiative to provide alternative modes of care for the wounded, just as the hospice movement represents a healthy alternative to dying in a hospital. The church’s communities of care could similarly model an alternative way of offering “crisis of soul” care. The model we practice and propose here is one way to practice the love of Christ in ways which foster growth, especially in crisis or deep need. We seek to do what Olthuis admonishes the community of faith. He calls for a variety of modes of support to enable people to become whole and to flourish within the family of faith (Olthuis, 1985b,

ⁱⁱ *Newsweek* offered this figure as the price of daily care at Christian psychological in-hospital programs such as Rapha and Minirth-Meier, Sept. 14, 1992, page 60

1989).

Reasons for Life and Healing in Community

I define community as a shared, common life based on voluntary commitment to agreed upon purpose, goals, and values. It is a network of significant others knit together by covenants which connect persons, nourish health and enable healing. In the context of this model it also includes small groups within the larger community, serving each other in “life together” workshops or retreats. Biblical community, or the body of Christ, is founded in God’s essential being.

1. In the Trinity, God’s essence and nature as a relational being are reflected. The Trinity is a model of loving relationship. Being made in God’s image, we too are made for loving relationship; in pursuing relationship with Him and with each other we find both the challenge and the support needed for our highest development as persons.

2. Love, springing from and centered in God, is the greatest healer. Relationship is essential for love to be enacted and experienced. Personal encounter changes people.

3. We are developmental beings created by God for growth. Community provides for that developmental process so that we may become like Christ in all dimensions.

4. Community is the optimal environment in which to foster loving personal relationships, to nurture growth and to experience restoration and healing. It provides a foundation for healthy service through affording both individuality and interdependence, the mutual valuing of persons and their gifts.

5. The word “restoration” implies that something has gone wrong. Things are not as they should be or not as God intended for us. We have sinned. We have been sinned against. We are entangled, stuck, bogged down, bound and broken. We need to be released, healed, mended, set free from old patterns and generational chains of sin. Community provides for the integration of relational, social, emotional and spiritual aspects of our lives, which living in a fragmented and tortured society does not do for us.

6. When there is deprivation of loving relationship in our original community (especially that of the family), gaps in the self occur. We experience these as inadequate development, wounds or losses. When a person is surrounded by healthy, positive community, well-being is promoted; healing, restoration, growth and wholeness can occur.

Values which a Christian community of care might share are: interpersonal communication centered in honesty, immediacy and openness; a high degree of interaction, implying time together, mutual availability; trust and understanding and an appropriate definition of boundaries; acceptance and affirmation; sense of family (place of belonging); valuing of each person as essential, as gifted and unique; mutuality and reciprocity; accountability; nurturance; creativity.

The Spiritual Foundation for Caring for Others

Our foundation for service in the body of Christ is a spiritual one, based in God as creator, restorer and healer, as modeled for us by Jesus, the Servant Leader. Therefore our service to one another depends upon applying divine resources. These include the gifts of the Spirit, the healing Word, and prayer. 2 Peter 1:3 says God has already given us everything we need for life and godliness. Our challenge is to put these resources to work and apply them in our own and others’ lives. Our perspectives must include the awareness that none of us Christians are exempt from the effects of sin and its impact and infringements on our lives. Sin can disrupt our total being --

emotional, spiritual, physical, intellectual, relational. It can also skew godly patterns of life, relationship and ministry. Christians, especially those who care for others, are the target of God's enemy who is out to devour us (I Peter 5:8). Those who serve the body of Christ as agents of Christ's healing need to be mature enough to understand these truths, and sufficiently strong to withstand the pressures which ministering to others creates.

In addition to the ordinary, personal ravages of sin, the stresses of living in a sinful world, and the extraordinary dangers of life in Satan-bound cultures, some Christians in ministry may suffer extreme forms of spiritual warfare due to their dedication to Christ and their efforts to release those held captive by or stunted by Satan. Such battles may harm their ability to grow in godly maturity and may limit their effectiveness in ministry. Attacks may take the form of illness, relational difficulties, spiritual oppression. They may at times lead them to despair, to staggering wounds, and even to death.

In spite of these forces of evil, we know that Christians, including the care givers themselves, can be restored, renewed, released and healed in a caring Christian community committed to prayer, support, and nurturance.

Examples of The Need for Care in Community

Let's look at some actual examples which come from our experience in caring for members of the body of Christ. Our experience covers about 30 years in cross-cultural, international work. We have devoted our lives to attending to the medical and emotional needs of foreign workers, as well as to their spiritual and educational/intellectual needs. We learned quickly that a person's difficulties, especially in crisis situations, seldom encompass just one dimension of life. A person's problem may begin with a physical illness, for instance, but effects of the illness usually spread into the emotional, the spiritual and other dimensions of his or her life, as well as into the lives of the whole family and the work roles. The longer the first need is unresolved or unmet, the more intense the need becomes and the more it affects all other aspects of the person and his/her roles within the organization. If problems and needs are identified within the community of care and addressed promptly, the damage is minimized. If not, however, the problem is compounded, affecting more areas of the person's life and more persons within the family or community.

Often the church community invests little in its members who are hurting. Such neglect may cost the person and church tremendously when measured in the devastation or suffering. It may lead to other consequences, such as cynicism and distrust or loss of faith.

These examples from our own work with the wounded in missions illustrate the varied dimensions of need.¹ Though these life stories are more extreme in some details, they are not significantly different in magnitude or scope from 'ordinary' Christians sitting in the pew with you on any Sunday.

Mary was thrilled to receive a grant from a prestigious international foundation to fund her doctoral research in anthropology. Twenty-four hours after departing her Ivy League university she sat on a mud bench in a rural village in the Andes Mountains. She attempted to establish relationships with the villagers and to begin the arduous task of learning their language and collecting research data. The people mocked her, misled her, and sometimes threatened her with stones. She became ill with dysentery, laying in her hut for days before a villager dared to help her. She suffered periodic terrors, feeling something clutching her in embraces so hard they

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squeezed away her breath. She feared she would die of suffocation. Finally well enough to sit again in the square and record notes, she was overwhelmed with loneliness and rejection. After one more round of jeering and ridicule she ran sobbing from the village, caught the first truck passing on the rutted road, and returned to the homeland. She dropped out of her study program.

Caroline sought treatment for continuous headaches, even leaving her field assignment for CAT scans and other sophisticated tests. Two and a half years later her headaches were still undiagnosed, and she and her family left the field in total discouragement, having been told that she was a “psychosomatic case.” Her self-esteem plummeted, her head still hurt, no diagnosis was forthcoming. She and her family planned to leave missions - until at Wycliffe’s Quest (where they came in desperation hoping for some renewal) God led to the correct diagnosis of the medical root of the problem.

Gerald experienced excruciating pain, changes in visual perception and on-going disequilibrium. He became deeply depressed because of the continual pain. He and his family left the field after a year of anguish, still seeking relief from the pain, which became so severe that he contemplated suicide. The life of the whole family was thoroughly distorted. Again, through the ministry at Quest, the root of the problem was identified and the man experienced release from demonic oppression.

James stepped out of the ivory halls of a Christian college into a camp with 20,000 refugees and a ten million dollar budget. He and his fellow workers, all in their early twenties, worked feverishly to deal with the myriad problems of caring for the refugees. There were no mature leaders on hand, and no place for R&R. In anguish over the suffering and his own inordinate responsibility, the young leader turned to alcohol for some relief - within a year he was having several drinks a day to make life bearable. Some of his fellows became so cynical about Christian leaders and people-helping that ten years later they have not recovered their faith or their desire to serve in cross-cultural work.

Nancy, a translator, left the field after prolonged illness and resulting depression. Her partnership had broken up through bouts of rage, after she and her co-worker rented a house all the villagers rejected because they believed it was haunted. Four years later neither her illness nor her depression had been treated successfully even though she was shunted from one “care-giver” to another for four years. Through the multi-modal care at Quest and PEEQ she finally recovered.

John and Cindy were accepted for mission service in a third world country where they were to live on two hundred dollars a month as a way of relating to the nationals whom they would serve. Their training consisted of three days in New York city. Cindy left the funeral of her mother, dead by suicide, to catch the overseas flight. Her field leaders labeled her a trouble-maker and a poor adjuster, difficult to work with and slow to learn the language. Cindy and John suffered deep rejection and severe depression. They were sent home as unsuitable; their home church considered them failures.

Brad and Angie submerged their marital difficulties in religious zeal. Feeling God called them to serve in an overseas assignment, they worked hard to pass through the orientation and training program without letting their problems show. Once in the new culture and in school to learn the new language, they found the stresses unbearable. Brad began abusing Angie, at times hitting her, demanding she satisfy his sexual needs twice a day, “as a good Christian wife ought to do.” She was terrified to let anyone know; to be sent home would be humiliating and lead to their loss of candidate status. Their church would throw them out as bad examples. An astute counselor saw abnormalities in the children’s behavior, but field leaders could not accept that there was a problem. Two years later the wife filed for divorce. The husband joined another mission and was immediately sent on another overseas assignment.

Just out of college, Sarah and Toni were idealistic and highly motivated. They accepted an overseas assignment as house parents for 23 children, ages 5 to 18. This included supervising nationals who worked as household employees. With their own toddler and infant, and the additional roles of buyer for the organization and keeping round-the-clock radio contact with workers in the interior, they began to find the stresses unbearable, but were afraid to let on lest they be labeled as complainers and perceived as uncommitted. Toni developed prolonged gastrointestinal illness. Sarah found she could no longer breast feed and began to experience frequent anxiety attacks. The baby developed colic from cow's milk; no alternatives for infant formula were available.

Ruby, a young teacher in a foreign land, suffered several traumatic episodes, having her home robbed and invaded, and being threatened at knife point on various occasions.. Her field team minimized the serious implications of her experiences. She became increasingly withdrawn and depressed. The field situation was compounded by unresolved issues from her family of origin and childhood abuses. After being sent back to her homeland, she was shunted from care giver to care giver without anyone of them attending to the complex matrix of her needs. Impatient with her inability to work due to prolonged illness, her organization and her church cut off her financial support. Her recovery during our PEEQ experience (see Pilot Program) was dramatic.

Kristi and Bob moved twenty-three times in thirty months, with three little children, during their training phase with an international mission. This period included two new countries, learning two new languages, many geographic settings and climactic changes. Once in their field assignments they were shocked at the dismal and hopeless outlook at many of their colleagues. They worked twice the "normal" hours to meet the devastating needs of the nationals and their colleagues. By the end of their first term they had each lost twenty pounds, and staggered through several illnesses, some with lasting consequences.

Robert traveled the world continually, as an International director for his multi-national company. He was seldom home, often only staying long enough to sleep and to refill his suitcase with clean clothes. Due to his constant travel he found it nearly impossible to sustain relationships. His marriage began to crumble. In the Orient he suffered an acute illness which left him incapacitated. He became allergic to his whole environment and to food itself. After six months the company "let him go" because he was unproductive. He was left with no medical coverage. His finances melted away; he fell into debt. His wife divorced him. Expensive specialists he consulted never spoke to one another. Finally a relative flew him across the country to care for him. His errant teenager was murdered; he suffered terrible guilt knowing he had been too busy, and then too ill, to attend to his child's needs. He was left with permanent disabilities.

In all these cases, the persons and families would have suffered far less if early interventions had been made to support them in caring community. Though the examples are of people serving in Christian ministry, the needs are representative of the throngs of Christians who need the loving ministry of the body of Christ. When appropriate care and support are lacking, and people are faced with on-going, overwhelming stresses and burdens, exhaustion, illness and other forms of depletion, crisis or tragedy result.

One Form of the Model: Intensive Care Community

Intensive Care Community provides an intensive, residential support and care community for cross-cultural workers who are suffering exhaustion, depletion, depression, burnout or other
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crisis as a result of overseas and cross-cultural ministry. In this community context staff and guests live together with a high degree of interaction for two weeks or more. The needs of the whole person are attended. Small groups provide an ideal setting for maximizing healing.

We are located in Liverpool, a hamlet in central, rural Pennsylvania, overlooking the Susquehanna River. This is a scenic, relaxed setting for our groups. Our home offers a comfortable family experience, including meals and group activities.

Our intensive program attends to the needs of the whole person, by providing:

1. **Spiritual care**, including daily worship and healing prayer, pastoral counseling and sharing of Biblical insights helpful in setting out issues relating to God, self and mission ministry. A pastor-counselor ministers to the spiritual/religious needs of persons by being a visible and human spiritual advocate who hears confession (of sin, needs, wounds, etc), assures forgiveness, encourages trust in God, administer the Word, and fights the “spiritual battle.”
2. **Physical assessment** of health status, nutritional needs and stress management related to physical health, and recommendations or referrals as needed. As part of an overall plan of health (restorative and preventive), our physician recommends appropriate diets and fitness programs for each person.
3. **Individual and group counseling** daily, assisting individuals, couples and families to deal with issues arising from and related to ministry. Group sessions give opportunity for processing common experiences, stressors and issues and includes healing prayer.
4. **Daily instruction for education and prevention** relating to stressors of field life, symptoms of stress, coping strategies; communication and conflict skills and other topics related to field and organizational life. Journal writing, life history narration and a variety of tools are used for enhancing personal effectiveness. Classes allow participants to gain greater personal awareness and knowledge and to develop new skills (e.g., interpersonal communication, stress management, etc.), and more healthful attitudes.
5. **Recreation and rest**, with daily exercise.
6. **Attention to needs of school-aged children**, if staff is available.

We know that a two-week intensive program is less than what missionaries need, though it does provide an excellent start in working through field issues, etc. As God provides funds for facilities, we plan to offer six-week programs which allow more time for rest and change.

Our staff for Intensive Care Community has decades of overseas, cross-cultural, mission experience in more than two dozen countries. Our full time staff includes Larry Dodds, M.D., Board Certified in Preventive Medicine and trained in family practice and tropical medicine, Lois Dodds, Ph.D. a counselor and educator. Additional staff with extensive mission field experience contribute a variety of gifts and training.

We have a large library for both staff and guests. As we increase staff and facilities, we envision adding several other components to a greater degree:

1. **Art, music and other creative therapies.** Staff incorporate the creative arts into worship and other daily activities and work with individuals to foster their creativity in the arts as part of their restoration to wholeness.
2. **A sports counselor/coordinator** to work with individuals and groups for physical renewal and fitness. Recreational activities help to foster healing.

3. A personal appearance counselor to assist each individual in the restoration of self esteem and confidence through color analysis and suggestions for choosing most appropriate clothing and hair styles.

4. A career development counselor to assist persons in reviewing and assessing their job and professional roles, taking into account personality type and various factors in their foreign assignments.

These various elements of a program would be feasible for a church community, as all these roles are usually fulfilled by members of a congregation. Instruction could be geared to the life issues of the participants.

Earlier Trials of Our Model

During our years abroad we had opportunity to discover the healing power of community. Our best example is Yarinacocha, a small community with a unique group of Christians located in the Amazon at the center for literacy, linguistics and Bible translation. In this face-to-face, year round community we experienced enormous growth through the interaction with about 250 others. This was a permanent community, with periodic change of participants. It taught us many of the powerful dynamics of growth through living in community. We also discovered this in other field settings.

Quest, a month-long candidate program of Wycliffe Bible Translators, was a wonderful arena for developing learning and growth through community. In about two dozen sessions we guided nearly a thousand persons in their growth. For eleven years we have traveled each summer to three or more overseas sites to teach courses for missionaries and national church leaders. Each experience has been a wonderful example of the healing power of concentrated time together dedicated to growth and learning. Though our formal task is academic, the outcomes in the lives of these persons are long lasting, providing mutual love, support, and progress in life struggles—all leading to professional and personal growth. We know from interacting with these same persons that Christian groups do not automatically function with such positive outcomes! Many people are wounded because life together is harmful instead of helpful.

The idea of creating a place and programs for the restoration of persons through life in caring community grew out of our experiences. We formed Heartstream as a result of many long conversations with colleagues about our own struggles and crises and our longings to find support, especially in a place where we could openly share without fear of “losing face” or losing financial supporters.

Long before we conducted our pilot program as Heartstream Resources, our experience in numerous mission field settings and educational workshops taught us. Two pilot programs of PEEQ (Personal Effectiveness Enhancement Quest), a month long workshop accredited by Azusa Pacific University, served as excellent examples of the gains in a residential community, even in a short time. Though PEEQ was not designed to be a therapeutic program, it proved to be highly therapeutic and beneficial for those who attended. Participants included cross-cultural workers who came to the U. S. from various foreign locations, as well as pre-field mission candidates identified as gifted in growth facilitation.

PEEQ workshop was designed for growth facilitators, formal and informal, who work in cross-cultural ministries, to foster their knowledge and understanding of human development and Heartstream Resources Dodds

counseling, and to provide skill development. The design of the workshop allowed for ample pursuit of both cognitive and experiential learning, and involved a high degree of interaction between resident staff, students of all ages and more than a dozen specialists in the area of human development who were in residence for one to five days. We anticipate offering PEEQ as a graduate level program once or twice a year.

About Heartstream Resources

Heartstream Resources is one of several budding ministries in the movement to provide mental health care in missions. In the last decade God has drawn together mental health and mission professionals for ongoing and crisis care.

Heartstream Resources exists to provide care for cross-cultural workers. We are planning a residential community to foster healthy living and restoration and healing of Christians in full-time service. We especially minister to those who suffer crises, burnout and other serious forms of depletion. At our center we desire to model and foster the growth and building up which can take place in a loving community in which each person contributes his or her gifts, talents and training for the nurturance of others. Interaction and therapeutic relationship are not limited to the professional, such as counseling, but include such activities as daily community worship, corporate prayer, shared work projects and recreation.

Our purpose is fulfilled four ways:

1. Therapeutic community for restoration and personal growth.
2. Educational programs emphasizing health, personal wholeness, problem prevention, life skills.
3. Consultation with mission leaders about caring for people and maximizing their development.
4. Applied research in mental health, pastoral care, physical health and human resources in cross-cultural settings.

How The Local Church Could Use This Model

Appropriate care and support for all Christians, including those in ministry, involves nurturing the whole person, attending to the emotional, relational, spiritual, intellectual and physical aspects of the self. It also involves healing of wounds and restoration of losses. In Ephesians 4:16 we read that the whole Christian community can build itself up in love "as each part does its work." The body together can do far more than any of us acting alone!

In a local congregation the pastoral staff might begin by identifying individuals who need intense love and nurture, such as those suffering divorce, recovering from abuse or addiction, those who are or were deprived of adequate parental love and nurture. These persons and their families could be brought together with mature, loving church members at a camp or retreat center, or even a large home. They could live together for a week or two, devoting time to activities fostering healing and growth. The pastoral staff, along with deacons and elders capable of nurture and healing could head up such a community.

Trained lay or peer counselors could assist in various roles, such as encouragement, teaching, attending to physical needs. A professional counselor might volunteer to direct the experience. Dr. Siang-Yang Tan of Fuller Seminary researched the effectiveness of lay counseling programs and found them to be highly effective (Tan 1990, 1991, 1992). Such a week or period could be called "crisis prevention," "spiritual formation," "restoration" or "spiritual healing."

If the church relies solely on professional “healers” it seems it will be impossible for all the needy to receive help -- one by one. My desire is that the church at large accept the obligation and the opportunity to care for its wounded and to nurture them to health, to develop the beauty and maturity of Christ. If we are ever to speed the healing of the masses of persons who fill the pews, I believe that small group “intensive care’ communities such as we describe must be created. Being loved, comforted, accepted, guided and taught within a group, by a group, is the most effective way to bring about healing.

Our efforts for even the most wounded and broken will never be wasted, for as Jesus Himself said, ‘I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me’ (Matt. 25:40).

References and Recommended Reading

Bieble, David B. 1986, *To kiss the joy: moving toward wholeness with the help of God*. Doctor of Ministry Thesis Project, Gordon-Conwell Theological Seminary, South Hamilton, MS.

Dodds, Lois A, 1992. *The perception and experience of supernatural spiritual power for personality growth and change: an analysis of twelve life histories*. Doctoral dissertation. UCSB. Available through University Microfilms, International.

_____. *The role of the Holy Spirit in personality growth and change*. Presentation. II International Congress on Christian Counseling, Atlanta, Georgia, November 11-15, 1992.

_____. 1989. *The PEEQ Experience: A Residential Workshop for Growth Facilitators Based on the Philosophy and Methodology of Confluent Education*. 1989. Unpublished field project presentation for Master's Degree, UCSB, Graduate School of Education, Confluent Education program. pp. 103.

_____. *How Do I Look Front Up There? You, From God's Point of View*. Wheaton, Illinois: Scripture Press, Victor Books Division. 1981. Paperback, pp. 140. (A study for teens on the Biblical basis for self-esteem.)

Olthuis, James. 1985. "Straddling the boundaries between theology and psychology: the faith-feeling interface." *J. of Psychology and Christianity*. 4(1), Spring, pp. 6-15.

_____. 1985. "Faith development in the adult life span." *Studies in Religion*. 14(4), Fall, pp. 497-509. 1989.

_____. "The covenanting metaphor of the Christian faith and the self psychology of Heinz Kohut." *Studies in Religion/Sciences Religieuses*. 18(3), pp. 313-324.

Maton, Kenneth I. 1989. "The stress-buffering role of spiritual support: cross-sectional and prospective investigations." *J. for the Scientific Study of Religion*, 28(3), 310-323.

Rizzuto, Ana-Maria. 1979) *The birth of the living God: a psycho-analytic study*. Chicago: The U. of Chicago Press.

Roman, Mel, and Raley, Patricia E. 1980. *The Indelible Family*. New York: Rawson, Wade Pubs.

Sandford, John and Sandford, Paula. 1982. *The transformation of the inner man*. So. Plainfield, NJ: Bridge Publ., Inc.

Satir, Virginia. *People Making*.

Shengold, Leonard. 1989. *Soul murder. the effects of childhood abuse and deprivation*. New York: Fawcett Columbine.

Stein, Edward V. 1985. "The psychological roots of self and faith." *Pastoral Psychology*. 33(3), Spring 1985. pp. 189-199.

Tan, S. Y. 1990a. Explicit integration in Christian counseling (an interview). *The Christian Journal of Psychology and Counseling*. v(2), 7-13.

_____. 1990b. Lay Christian counseling: The next decade. *Journal of Psychology and Christianity*. 9(3), 59-65.

_____. 1991a. *Lay Counseling., Equipping Christians for a helping ministry*. Grand Rapids, Zondervan.

_____. 1991b. Religious values and the interventions in lay Christian counseling. *Journal of Psychology and Christianity*. 173-182.

_____. 1992. Development and supervision of paraprofessional counselors. In L. VandeCreek, S. Knapp, and T. L. Jackson (Eds). *Innovations in clinical practice: A sourcebook*. (Vol. 1 1) Sarasota, Fl: Professional Resources Exchange, Inc.

_____. 1992. The Holy Spirit and counseling ministries. *The Christian Journal of Psychology and Counseling*. VII(3), 8-11.

Tournier, Paul. 1957. *The meaning of persons*. NY: Harper and Row.

_____. 1964. *The whole person in a broken world*. NY: Harper.

Wagner, Maurice E. 1975. *The sensation of being somebody: building an adequate self-concept*. Grand Rapids: The Zondervan Corp.

Wallerstein, Judith S. 1991-92. "Children after divorce: wounds that don't heal: The nature of systems." In *Readings, Education 282*. UCSB. 1989. pp. 90-106.

Endnotes

¹ The situations and persons are real, but the names are pseudonyms.