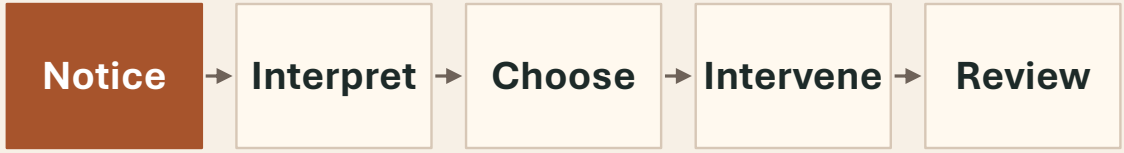
Pastoral Care & Counseling Models

Why models matter

A model is not a script; it is a disciplined way of seeing, choosing, and evaluating care.

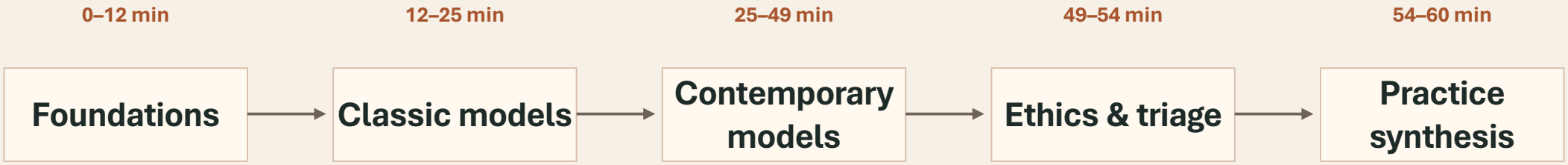
Framing claim for this session



By the end, students should be able to:

- Differentiate care, counseling, psychotherapy, and spiritual direction
- Compare major models across theology, psychology, context, and ethics
- Build a short pastoral formulation from a case vignette
- Name referral thresholds and boundaries of competence

A Practice Arc



The lecture moves from conceptual distinctions to model families, then to ethical decision-making and case formulation.

Pedagogical design: brief input → visual compare → case application → reflective judgment.

PART I

Foundations

Defining the field before comparing models.

What counts as pastoral care?

Pastoral care is a spiritually attentive, relational practice of healing, sustaining, guiding, reconciling, and liberating persons and communities.

Healing	Sustaining	Guiding	Reconciling	Liberating
reducing harm; repairing wounds	accompanying when cure is unavailable	discernment, wisdom, and moral agency	restoring relationship with self, others, God, and community	naming oppressive forces and expanding agency

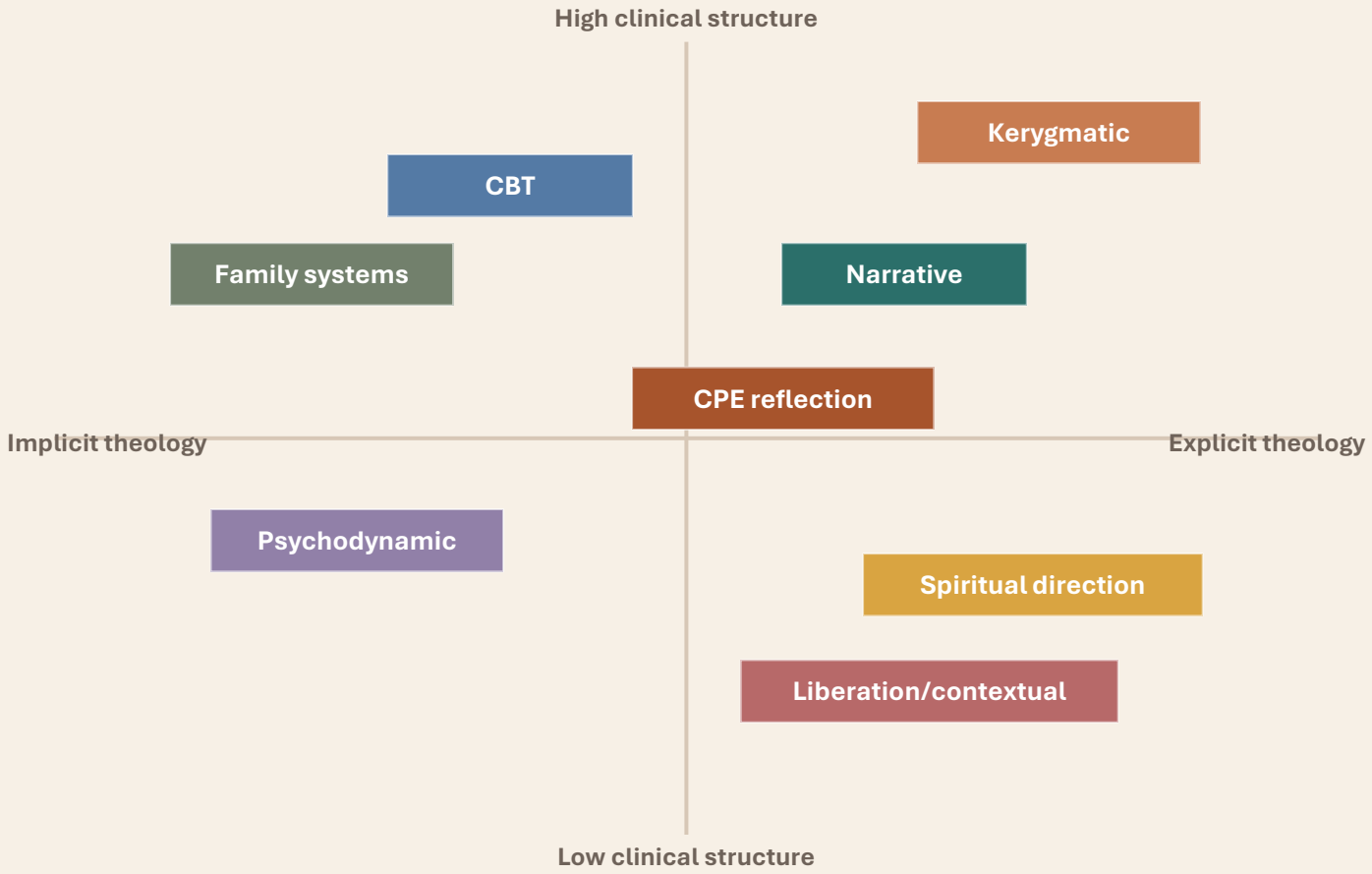
Model question: Which dimension of care is most needed right now, and what kind of authority does the caregiver appropriately exercise?

Care, counseling, psychotherapy, direction

Pastoral care	Pastoral counseling	Psychotherapy	Spiritual direction
broad, relational, often informal	**short-term, structured care with pastoral identity**	**licensed clinical treatment of mental disorders**	**discernment of sacred presence and vocation**
presence • ritual • meaning • community	assessment • goals • interventions • referral	diagnosis • treatment plan • evidence-based protocols	prayer • contemplation • spiritual practices

Boundary principle: pastoral identity deepens care; it does not automatically authorize clinical treatment.

The “model map”: two axes



No model is “neutral.” Each carries assumptions about suffering, agency, sin, systems, healing, revelation, and power.

- Locate the model’s center of gravity
- Ask what the model tends to miss
- Use supervision to test your own default posture

PART II

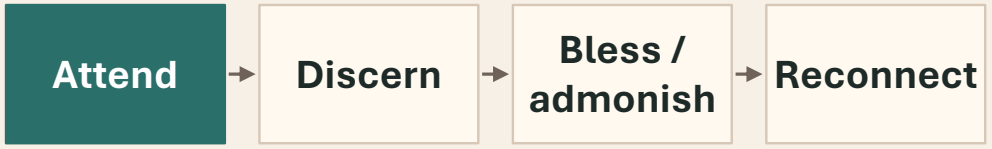
Classic models

Older frameworks still shape the instincts of contemporary care.

Shepherding / cura animarum

Core image: caregiver as shepherd of souls within a covenant community.

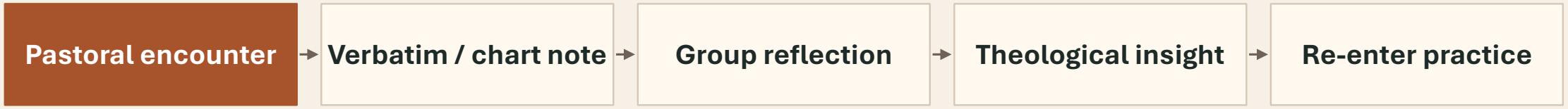
- Strengths: moral clarity, communal accountability, ritual depth
- Risks: authoritarianism, moralism, under-recognition of trauma or mental illness
- Best use: sacraments/rituals, life transitions, spiritual struggle, communal repair



Guiding question

What form of spiritual accompaniment helps this person live truthfully before God and neighbor?

CPE/action-reflection model



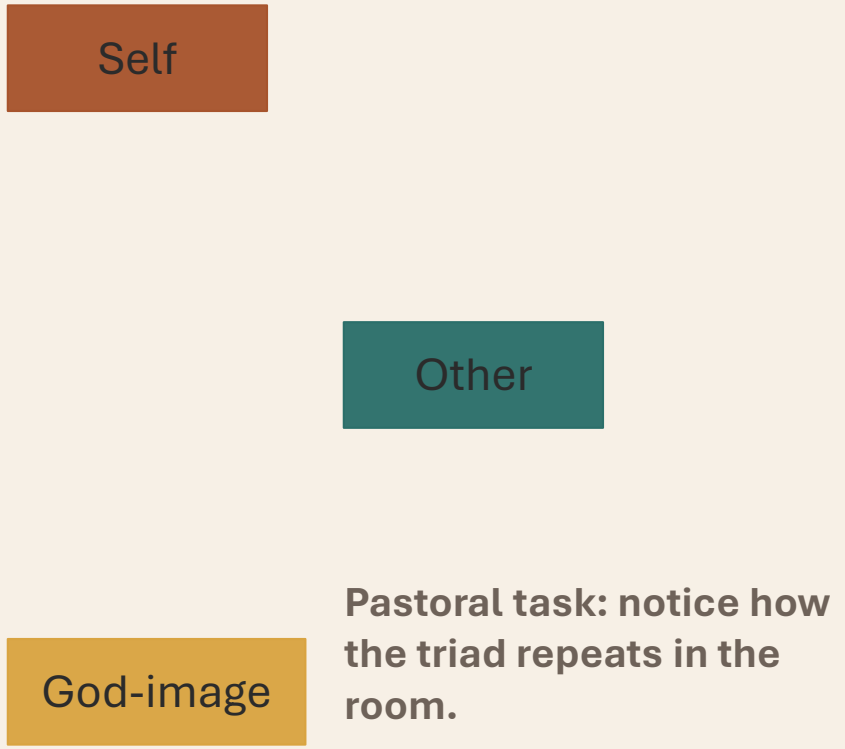
Clinical Pastoral Education trains caregivers through supervised reflection on actual encounters, not just abstract theory.

Experience	Self-awareness	Theology
What happened in the room?	What did I bring?	What meanings and images of God were active?

Psychodynamic/object relations model

Listen beneath content for patterns of attachment, transference, shame, defense, and internalized images of God.

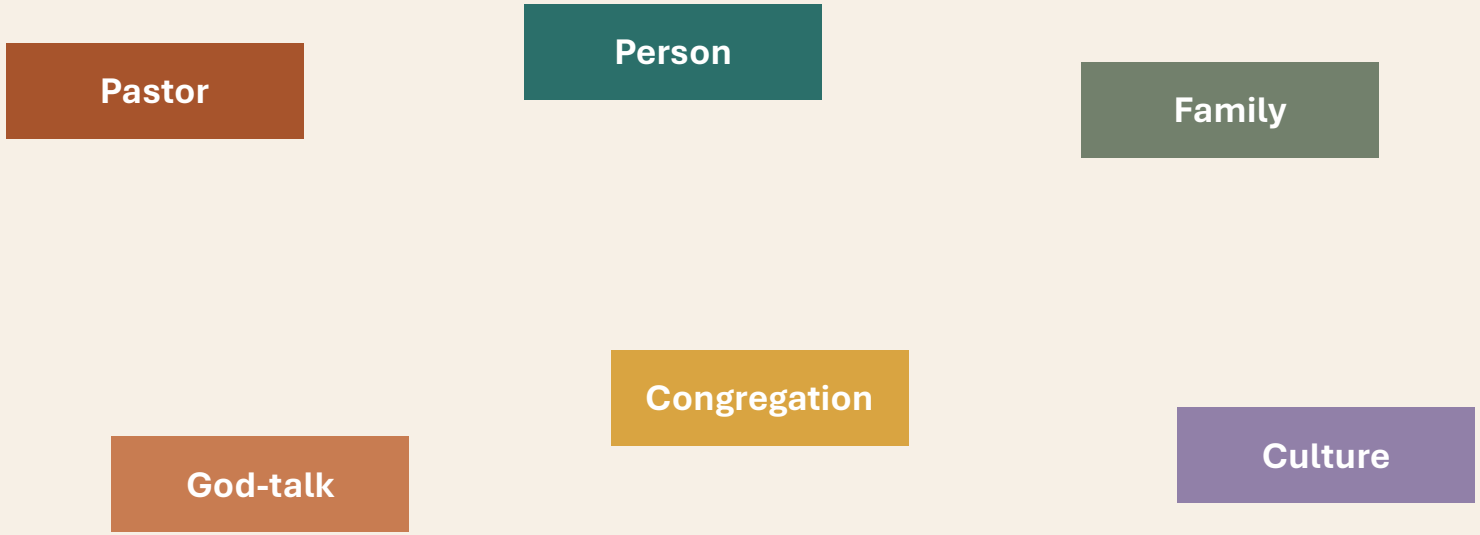
- Suffering: unresolved loss, relational wounds, conflicted self-images
- Caregiver stance: reflective, non-anxious, curious about depth
- Pastoral contribution: explores how God, community, and authority are emotionally represented



Pastoral task: notice how the triad repeats in the room.

Family systems model

The unit of care expands: the problem is not only inside an individual but in patterns of relationship.



Key concepts: differentiation, triangles, homeostasis, boundaries, genograms, multigenerational transmission.

Clinebell’s growth-oriented typology

A classic pastoral counseling contribution: care should promote wholeness across life dimensions, not only symptom relief.

Mind	Body	Relations
meaning & thought	health & embodiment	intimacy & community

Work	Play	Spirit
vocation & agency	delight & creativity	faith & ultimate concern

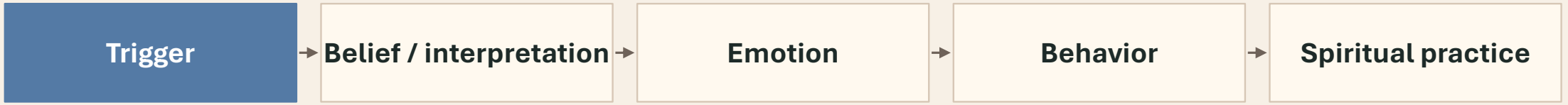
Pastoral formulation asks: Where is growth blocked, wounded, or newly possible?

PART III

Contemporary models

Humanistic, behavioral, contextual, and trauma-informed approaches.

Cognitive-behavioral pastoral counseling



CBT-informed pastoral care examines how interpretations shape distress and action, while honoring theological meanings.

- Useful for anxiety, rumination, guilt, and behavioral stuckness
- Pastoral adaptation: examine distorted God-images, scrupulosity, and hope practices
- Risk: reducing spiritual suffering to faulty cognition

MICRO-INTERVENTION

"When you say, 'God must be punishing me,' what evidence supports that? What alternative interpretations fit your tradition and your story?"

Person-centered pastoral counseling

The central intervention is not advice; it is a relational climate in which the person can hear themselves truthfully before God, self, and community.

Empathy	Congruence	Unconditional regard
accurate, disciplined understanding	non-defensive, real presence	dignity without moral collapse

Pastoral adaptation: presence becomes sacramental only when it is consent-based, non-coercive, and honest about power.

Motivational interviewing in pastoral care

MI is especially useful when a person is ambivalent: wanting change, fearing change, and needing to hear their own reasons for faithful action.

O Open questions

A Affirmations

R Reflections

S Summaries

PASTORAL MICRO-SKILL

“On one hand, staying silent feels safer. On the other hand, you keep saying truth matters. What do you make of that tension?”

ACT-informed pastoral counseling

ACT does not begin by eliminating pain. It builds psychological and spiritual flexibility: making room for suffering while moving toward values-shaped action.

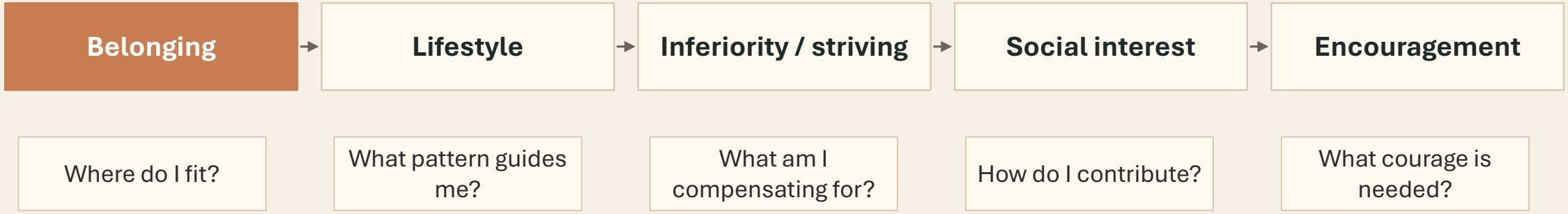
Acceptance	Defusion	Present moment
make room for pain	hold thoughts lightly	return to now

Self-as-context	Values	Committed action
more than the struggle	chosen direction	embodied next step

Pastoral translation: “What faithful action is possible even while fear, grief, or doubt is still present?”

Adlerian pastoral counseling

Adlerian care asks how a person seeks belonging, significance, courage, and contribution—and what mistaken strategies are shaping distress.



- Useful with discouragement, perfectionism, family-of-origin themes, and vocational stuckness
- Pastoral contribution: connects courage and belonging to vocation, community, and neighbor-love
- Risk: overemphasizing responsibility when oppression or trauma constrains choice

Solution-focused brief pastoral counseling

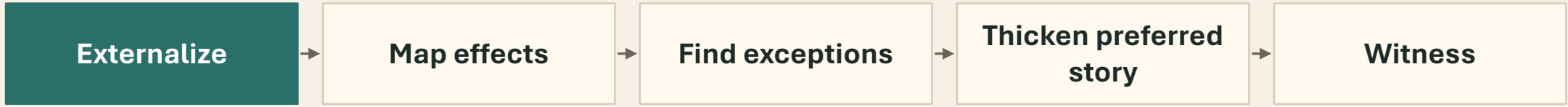
Instead of analyzing the problem's origin first, begin by locating exceptions, resources, preferred futures, and next steps.

Miracle question	Exception question	Scaling question	Coping question
"Suppose relief came overnight…"	"When is this less intense?"	"Where are you from 0–10?"	"How have you kept going?"

Pastoral strength: it resists deficit narratives and makes hope concrete without denying pain.

Narrative pastoral counseling

People are not problems. People live within stories—some inherited, some imposed, some sacred, some oppressive.



Problem-saturated story
“I am a failure. God is done with me.”

→

Re-authored story
“I am wounded, responsible, and still called into repair.”

Existential and spiritual direction-informed care

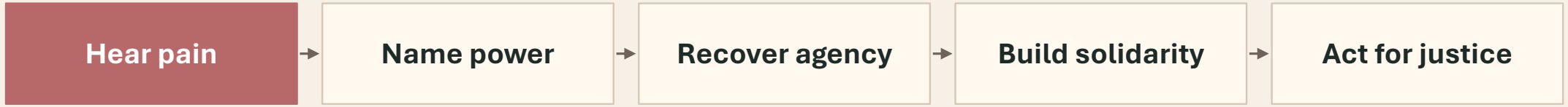
Some suffering is not a problem to solve but a summons to attend: finitude, guilt, freedom, meaning, vocation, silence.

Meaning	Freedom	Mortality	Mystery
What is worth living for now?	What choices remain?	What must be faced?	What cannot be mastered?

Caregiver stance: reverent patience, careful questions, prayerful silence, and discernment of spiritual practices.

Liberation, contextual, and feminist models

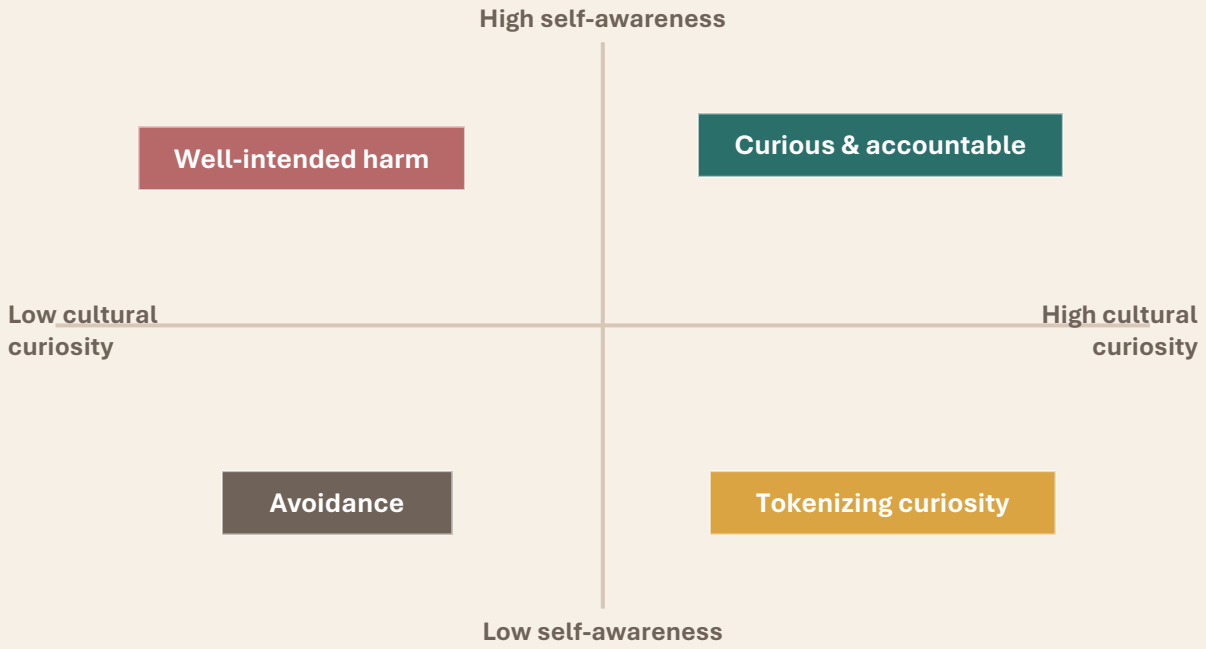
Care becomes distorted when it treats suffering as private while ignoring power, culture, gender, race, class, and institutional harm.



- Therapeutic goal expands from adjustment to liberation and communal repair
- Pastoral caregiver interrogates their own location and authority
- Danger: advocacy without deep listening; analysis without tenderness

Intercultural and anti-oppressive pastoral care

Competence is not mastery of "other cultures"; it is disciplined humility, repair, and accountability in relationship.



- Ask permission before sacred language or ritual
- Distinguish cultural humility from relativism
- Attend to historical trauma, religious harm, and institutional mistrust

Trauma-informed pastoral care

Trauma-informed care asks not “What is wrong with you?” but “What happened, what helped you survive, and what restores safety now?”

- Safety
- Trust
- Choice
- Collaboration
- Empowerment
- Cultural humility

Pastoral caveat: prayer, touch, confession, or sacred texts can heal—or retraumatize—depending on consent and context.

Crisis, grief, and loss care

Stabilize → **Assess risk** → **Normalize acute reactions** → **Mobilize supports** → **Plan next 24–72 hours**

In crisis, the first pastoral goal is not insight; it is safety, containment, and connection.

- Suicidal intent or plan
- Psychosis or mania
- Domestic violence / abuse
- Substance withdrawal risk
- Medical emergency

These are referral/urgent-care thresholds, not solo pastoral counseling cases.

PART IV

Ethics & triage

Model choice is never separated from power, safety, and competence.

Spiritual assessment and formulation

Assessment is not interrogation. It is a respectful map of meaning, resources, distress, risk, and relational ecology.

- Meaning
- Community
- Practices
- God / sacred images
- Moral injury
- Risks & resources

Graduate move: convert assessment into formulation: “The presenting distress is maintained by… and care should prioritize…”

Ethical guardrails

A model may be elegant and still be harmful if boundaries, confidentiality, competence, or power are mishandled.

Competence

Do I have training/supervision for this?

Confidentiality

What are the limits and mandated duties?

Boundaries

What dual roles distort freedom or consent?

Power

Whose voice is centered or silenced?

Documentation

What must be recorded and protected?

Referral

What level of care is needed now?

Referral and collaboration model

Listen → **Assess urgency** → **Name concern** → **Offer warm referral** → **Collaborate with consent**

Referral is not abandonment; it is often the most faithful pastoral intervention.

LANGUAGE THAT HELPS

"I want to stay with you pastorally, and I also think your care needs a therapist/physician/crisis team. We can make that connection together."

AVOID

"This is beyond me, so I can't help you."
"Just pray harder."
"I know exactly how to treat trauma."

Comparative matrix: choose with intention

Model	Best fit	Watch-outs
Person-centered	Shame, guardedness, identity pain	Warmth without direction
Motivational interviewing	Ambivalence about change	Persuasion disguised as care
ACT-informed	Anxiety, grief, values conflict	Pressuring “values” prematurely
Adlerian	Discouragement, belonging, vocation	Ignoring trauma/oppression
Systems	Family/congregational anxiety	Triangulation of caregiver
CBT-informed	Ruminative guilt/anxiety	Over-cognitive approach
Solution-focused	Brief encounters, stuckness	Premature positivity
Narrative	Shame, identity, oppression	Ignoring risk/stabilization
Trauma-informed	Abuse, violence, moral injury	Forcing disclosure
Liberation/contextual	Institutional/cultural harm	Analysis without accompaniment

Teaching cue: the question is not “Which model is best?” but “Which model is ethically fitting for this person, setting, and moment?”

PART V

Practice synthesis

Formulation, skills practice, and transfer to ministry settings.

An integrative formulation template

Presenting concern → **Spiritual meaning** → **System/context** → **Risk & resources** → **Model + next step**

One-sentence formulation

“This person is experiencing ___, shaped by ___, maintained by ___, resourced by ___; therefore pastoral care should prioritize ___ while monitoring ___.”

- This prevents “technique shopping.”
- It connects theology, psychology, social context, and ethics.
- It makes supervision more precise.

Case study A: moral injury after betrayal

VIGNETTE

A 34-year-old church staff member says: “I helped cover for a leader who harmed people. I cannot pray. I feel dirty, and I am terrified the church will collapse if I tell the truth.”

Model lenses

- Moral injury: guilt, shame, betrayal, repair
- MI/ACT: ambivalence, values, and committed action
- Narrative: re-authoring beyond “dirty” identity
- Systems/liberation: truth-telling and protection of vulnerable people

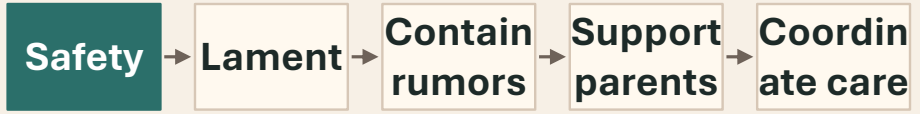
Discussion prompt: What is the first ethical priority—comfort, confession, protection, or referral?

Case study B: congregational grief after suicide

VIGNETTE

A congregation loses a beloved youth to suicide. Parents ask for a private funeral. Peers want to speak publicly. Rumors are spreading. Several teens are frightened and angry.

Care plan sequence



- Crisis/grief: stabilization and ritual
- Systems: boundaries and communication
- Trauma-informed: avoid sensationalizing details
- Referral: suicide postvention and teen mental-health support

Discussion prompt: How do you create truthful ritual without exposing vulnerable people?

Skills practice: a 12-minute encounter

Three roles: caregiver, care-seeker, observer. Rotate if used in a longer seminar.

0–3 min	3–6 min	6–9 min	9–12 min
Establish consent and concern	Listen for model cues	Offer one fitting intervention	Name next step and referral/supervision need

Observer feedback: What model did the caregiver appear to use? What did it illuminate? What did it miss?

Evaluating care: what counts as “good”?

Pastoral care outcomes are theological, relational, behavioral, and ethical—not only symptom reduction.

Attunement

The person felt heard and respected

Meaning

The person gained language for what matters

Agency

A next faithful step became possible

Connection

Support, community, or referral increased

Safety

Risks were identified and addressed

Integrity

The caregiver acted within role and competence

Designing your own pastoral model

Graduate-level integration means naming your working theology of care—and submitting it to critique.

Anthropology

What is a person?

Suffering

What wounds people?

Healing

What does care seek?

Authority

What power do I hold?

Method

What do I actually do?

Limits

When do I refer?

Assignment option: write a 750-word model statement and test it against one case vignette.

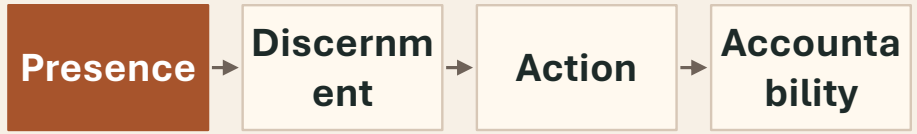
Takeaways

Pastoral models are lenses, not cages.

- Every model makes some realities visible and others easy to miss
- Ethical triage is part of model selection, not an afterthought
- Good pastoral care integrates presence, theology, psychology, context, and referral
- The most mature practitioners keep learning through supervision and reflection

The question is not only, "What technique works?" but, "What kind of faithful presence does this moment require?"

Closing question



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Use the deck as a teaching scaffold. Adapt citations, legal/ethical standards, and referral protocols to your jurisdiction and tradition.