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De-escalating Depressors in Disciples: A Post-COVID-19 Spiritual Care Drive

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Abstract

When the church doors reopened after the pandemic, congregating may have sparked some loss reminders since some individuals lost their significant others. This poses some questions that need consideration by the pastors. Which identifiable loss reminders are present in the church? What do such members think about God? How is the church prepared to reintegrate such parishioners? To what extent will the existence of depressors be? In this article, the term "depressors" is used to mean all factors that impact the members' mental well-being. This article aims at providing ways of de-escalating these depressors among members. It seeks to create awareness of identifiable loss reminders and how they can be reduced. The impact of ambiguous loss on the church members is explored. The caregiver's negative responses to personal wounds and how they may impede care provision are given some attention. A four-dimensional approach to the provision of spiritual care, pastoral care, and counselling is developed and suggested as a tool to enhance the provision of care to church members. The article adds a voice to the ongoing dialogue on having a needs-based ministry and provides practical solutions and a spiritual care drive that facilitates the healing of those who lost their loved ones during the pandemic. It also stirs further research on the impact of the absence of rituals of burial on mental well-being.

Keywords: Pastoral Care, Spiritual Care, Counselling, Post-COVID-19 Era

Introduction

The COVID-19 pandemic left about 12 million bereaved individuals.[1] These deaths are not just statistics; they were souls precious to God. Several studies[2] have documented the emotional and mental pain that the surviving family members went through: monetary constraints of meeting the high hospital bills; living in anticipatory loss; not seeing their loved one towards the end of life; and limited or no physical bereavement support. To compound the problem, "many bodies were buried without the proper religious rituals and without giving the family a chance to say their goodbyes,"[3] thus creating a new form of mourning that may inhibit the release of pent-up emotion and closure.

It is an unimaginable and a painful thing that in some families, few members remain alive. Congregating may also spark reminders of loss among individuals who lost their significant others. This poses some questions that need consideration by the pastors: Is there some grief work that is not yet finished for surviving Church members? What identifiable reminders of loss are present in the Church? What do such members think about God? To what extent will there be depressors and depression? How is the Church prepared to reintegrate

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1 Suqin Tang and Zhendong Xiang, "Who Suffered Most after Deaths Due to COVID-19? Prevalence and Correlates of Prolonged Grief Disorder in COVID-19 Related Bereaved Adults," *Global Health* 17, no. 19 (2021), accessed July 15, 2022, https://doi.org/10.1186/s12992-021-00669-5.

2 Jeffrey R. Hanna et al., "A Qualitative Study of Bereaved Relatives' End of Life Experiences during the COVID-19 Pandemic," *Palliative Medicine,* 35, no. 5, (2021): 843-851; Emily Harrop et al., "What Elements of a Systems' Approach to Bereavement are Most Effective in Times of Mass Bereavement? A Narrative Systematic Review with Lessons for COVID-19," *Palliative Medicine,* 34, no. 9, (2020): 1165–1181, accessed July 15, 2022, https://doi.org/10.1177/0269216320946273; Margaret Stroebe and Henk Schut, "Bereavement in Times of COVID-19: A Review and Theoretical Framework," *OMEGA-Journal of Death and Dying,* 82, no. 3, (2021): 500–522, accessed July 15, 2022, https://doi.org/10.1177/0030222820966928; Caroline Pearce et al., "'A Silent Epidemic of Grief': A Survey of Bereavement Care Provision in the UK and Ireland During the COVID-19 Pandemic," *BMJ Open,* 11, no.3, (2021): 1-10.

3 Zohreh Bayatrizi, Hajar Ghorbani, and Reza Taslimi Tehrani, "Risk, Mourning, Politics: Toward a Transnational Critical Conception of Grief for COVID-19 Deaths in Iran," *Current Sociology* 69, no. 4 (2021): 516.

such parishioners? In this article, the term "depressors" is used to mean all factors that impact a member's mental well-being.

Grief Work in the Post-COVID-19 Era

Grief work is necessary for the healing of those who lost their loved ones. While "there is no shortcut in grief"—caregivers need to assist the mourners to make it easier.[4] Long-term chronic illness affords sufferers an opportunity for anticipatory grief work. If they manage to do it, they have less pain and unprotracted grief when death strikes than in the event of an unexpected loss.[5] The pandemic did not allow for such grief work. To compound the problem, there was a conflict between personal mourning needs and international public health interests.[6]

In the absence of burial rituals,[7] finding closure was especially difficult. Individuals and communities are now challenged to process death and grief in the post-COVID-19 era.[8] Workplaces are equally impacted by the absence of significant others.[9] The Church is not spared from the re-experiencing of pain. Members will likely re-live the traumatic experiences. If their losses were not recognized, they

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4 H. Norman Wright, *The Complete Guide to Crisis and Trauma Counseling* (Grand Rapids: Bethany House, 2011), 107.

5 Howard Clinebell, *Basic Types Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth,* 3rd ed. (Nashville: Abingdon, 2011), 185.

6 Chao Fang and Alastair Comery, "Understanding Grief in a Time of COVID-19: A Hypothetical Approach to Challenges and Support," (Preprint, submitted in 2020), 5, accessed July 15, 2022, https://discovery.ucl.ac.uk/id/eprint/10134095/8/Fang_Preprint_Fang%20and%20Comery.pdf.

7 Peter D. Kramer, "Burials without Funerals, Grief without Hugs: Coronavirus is Changing How We Say Goodbye," *USA Today* (2020), accessed July 15, 2022, https://www.usatoday.com/story/news /nation/2020/04/02/funerals-during-coronavirus-pandemic-no-hugs-big-gatherings/5102855002/

8 Fang and Comery, "Understanding Grief in a Time of COVID-19."

9 Martha Chomyn, "Working Through It: Reimagining Grief and Bereavement in the Workplace Post COVID-19," (2022): 15, accessed July 15, 2022, http://openresearch.ocadu.ca/id/eprint/3769

may have disenfranchised grief.[10] In concurrence, Long et al. pointed out that the risk of disenfranchised and prolonged grief is high because of the COVID-19 funerary controls that inhibited mourning rituals. In their study, they revealed the pain that parishioners experienced when a member died under level 4 restrictions.[11] The widespread nature of these concerns calls for a deliberate plan to de-escalate all depressors.

De-escalating Depressors

The existence of depressors may exacerbate the pain that comes with losing loved ones. Pastors must create Church environments that facilitate grief work. They should be turned into safe havens for bereaved Church members. Churches should be places where those who feel like grieving can do so without a feeling of guilt or fear of being labelled as weak in faith.

Change and Loss Reminders

In a Church setting, some events will be reminders of the good times that the pandemic survivors shared with their deceased loved ones. Edwards explained that family-oriented events are likely triggers.[12] These may range from a child doing a poem, seeing couples together, or a memorial service, to announcements about those who are not well. Children with traumatic grief may have dreams of how the death occurred. Cohen and Mannarino[13] pointed out that such children may not desire to remember the great times

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10 Jeremy Corley, Salvador Ryan, and Neil O'Donoghue, eds., *Maynooth College Reflects on COVID 19* (Dublin: Messenger Publications, 2021).

11 Nicholas J. Long et al., "'The Most Difficult Time of My Life' or 'COVID's Gift to Me'? Differential Experiences of COVID-19 Funerary Restrictions in Aotearoa, New Zealand," *Mortality* (2022): 483.

12 Christina M. Edwards, "Family-Centered Events and Bereaved College Students: An Exploration of How Colleges Can Create an Inclusive Environment for Bereaved Students," (PhD diss., Ohio University, 2015), 65.

13 Judith A. Cohen and Anthony P. Mannarino, "Supporting Children with Traumatic Grief: What Educators Need to Know," *School Psychology International* 32, no. 2 (2011): 119.

they had with the deceased because of intrusive memories and fears. In other moments, normalcy may be there. However, in the presence of change or loss reminders, trauma bouts of anger or physical illness may be experienced. For some members who are not going through the grieving process, such incidents may be deemed insignificant. In the case of persistent complex bereavement disorder (PCBD), being in a Church may rekindle traumatic experiences.[14] If no proper attention is directed toward the grieving parishioners, their pain may escalate with each instance of Church attendance.

A four-pronged solution is suggested in addressing this case. First, providing personalized therapeutic intervention to heartbroken members is important. Second, creating awareness about the impact of loss reminders may help in establishing a grieving-friendly Church. Third, Meller and Albers[15] suggested that it is critical to make the care seeker fully conscious of their grief and to speak about it. Furthermore, a debriefing session[16] with other Church members is invaluable in aiding them to come to terms with the reality of worshipping without their deceased fellow parishioners.

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14 Michael Duffy and Jennifer Wild, "A Cognitive Approach to Persistent Complex Bereavement Disorder (PCBD)," *The Cognitive Behaviour Therapist* 10 (2017): 6.

15 William H. Meller and Robert H. Albers, "Depression," in *Ministry with Persons with Mental Illnesses and their Families*, ed. Robert H. Albers, William H. Meller, and Steven D. Thuber (Minneapolis, MN: Fortress, 2012), 2.

16 H. Norman Wright, *The Complete Guide to Crisis and Trauma Counseling* (Grand Rapids: Bethany House, 2011), 226, 231, 323.

What the Bereaved Think about God

In moments of adversity, care seekers may be angry at God. Understanding their purview is critical in addressing their search for meaning. The spiritual caregiver must allow them to vent these feelings by talking about them.[17] The danger is in attempting to respond to their theodicy questions.[18] Madegu cautions, however, that when clinical intervention is superseded by complete reliance on the Church for mental well-being, there will be insufficient treatment and management. A psychological breakdown can be caused by spiritual causes that trigger resentment against God.[19]

Allowing members to vent is only possible when the caregiver allows them to be experts in their stories. This is what Doering calls the receptive power which enables the care seeker to have directing power—the authority to lead in the storying of their pain. In this way, the caregiver may not fall into an "expert trap" that is motivated by empathetic distress but co-create meaning with the care seeker.[20]

Depression

Depression may set in among the surviving family members. Meller and Albers pointed out that in most cases of clinical depression, "grief is not always named as the culprit, but it can be the underlying dynamic that subverts and even sabotages the whole household."[21] Creating an environment that will allow parishioners

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17 Sikhumbuzo Dube, "Therapeutic Silence: Lessons from Eli and Job's Friends," *Asia-Africa Journal of Mission and Ministry* 19 (2019): 55.

18 Howard Clinebell, *Basic Types Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth,* 3rd ed. (Nashville: Abingdon, 2011), 206.

19 John Mudegu, "Assessing the Preparedness of the Church in Handling Mental Health Cases in Society in the Post-COVID-19 Period," in *The African Church and COVID-19: Human Security, the Church, and Society in Kenya*, ed. Martin Munyao, Joseph Muutuki, Patrick Musembi, Daniel Kaunga (Lanham: Lexington Books, 2022), 122.

20 Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2015), 57, 65, 63.

21 William H. Meller and Robert H. Albers, "Depression," in *Ministry with Persons with Mental Illnesses and their Families*, ed. Robert H. Albers, William H. Meller, and Steven D. Thuber (Minneapolis, MN: Fortress, 2012), 25.

to grieve without being censured by others is vital in de-escalating depression.

Members generally prefer to get counseling from their pastors when they need help, even in cases of psychological well-being. Unfortunately, most pastors are not equipped to do psychological triage.[22] Seminary education does not focus on that. Consequently, they may miss the fact that members are experiencing depression. Ensuring that pastors are familiar with the diagnostic criteria for depression would be advantageous. While they may not provide psychological therapy, they could contribute to risk-lessening intervention by doing more informed spiritual assessments that could facilitate a referral to a mental health specialist.

Impact of Ambiguous Loss

An ambiguous loss is characterized by indefiniteness,[23] which is related to how the loss occurred. Clinton and Trent explain that losses that were not adequately mourned for may reappear in the advent of similar ones.[24] The coronavirus illness brought anticipatory loss to those remaining at home. The family members were not able to visit their infected loved ones. Furthermore, the manner of death and burial may have resulted in such inconclusiveness that grieving spirals endlessly and is triggered by other similar losses. In some circles, the manner of burying people whose death was through COVID-19 excludes the rituals which facilitate mourning. This includes the absence of viewing the body, communal mourning that involves large numbers of people, and a "proper" burial. The inconclusiveness that accompanies such interment may lead to ambiguous loss.

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22 Larry Yeagley, "Pastoral Counseling: The Art of Referral," *Ministry: International Journal for Pastors* 74, no. 9 (2002): 10.

23 Pauline Boss and Janet R. Yeats, "Ambiguous Loss: A Complicated Type of Grief When Loved Ones Disappear," *Bereavement Care* 33, no. 2 (2014): 63.

24 Tim Clinton and Trent, *Marriage and Family Counseling,* (Grand Rapids: Baker, 2009), 175.

The work of Boss[25] presents the pastor with a six-tier template to facilitate the de-escalation of ambiguous loss.

1. *Finding meaning* – Boss explains that helping the care seeker to name the actual problem causing the ambiguous loss and see pain as part of life is a good starting point.[26] In this case, the cleric will aid the one seeking help to accept the present reality and make sense of life.

2. *Tempering mastery* – Mastery is the ability to be in control of the situation. Tempering mastery is the acceptance that one is not always in control.[27] Boss describes this as a process that either strengthens the care seeker's ability to cope with the strange loss or reduces the need for disentangling oneself from the presenting drawback.[28] In other words, tempering mastery enhances one's ability to cope with an ambiguous loss.

3. *Reconstructing identity* – This takes the reinvention of who the family is and who plays what roles.[29] The pastor must consider two factors: First, the grieving process facilitates the reconstruction of this new identity. Second, the Church family must be accommodative to the member going through inconclusiveness in the loss.

4. *Normalizing ambivalence* – This is the acceptance of the tension of conflicting emotions and feelings.[30] The pastor needs to create a non-judgmental environment to facilitate the care seeker's expression of conflicting feelings of hate and love, frustration, satisfaction, and so on.

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25 Pauline Boss, "Families of the Missing: Psychosocial Effects and Therapeutic Approaches," *International Review of the Red Cross* 99, no. 905 (2017): 519-534.

26 Boss, "Families of the Missing: Psychosocial Effects and Therapeutic Approaches,", 530.

27 Pauline Boss, "Family Stress," in *Handbook of Marriage and the Family* (Boston: Springer, 1987), 695-723.

28 Pauline Boss, "The Trauma and Complicated Grief of Ambiguous Loss," *Pastoral Psychology* 59 (2010): 142.

29 Pauline Boss, "Families of the Missing: Psychosocial Effects and Therapeutic Approaches," *International Review of the Red Cross* 99, no. 905 (2017): 532.

30 Ibid.

5. *Revising attachment* – This entails the care seeker's psychological release of the missing loved one while at the same time clinging to them. This is clouded with ambivalence. While the resistance to ambiguity may be detrimental to the care seeker, its acceptance will facilitate the development of a revised attachment. Boss emphasizes building new human connections,[31] which the pastor can facilitate. The Church can have post-COVID-19 victims' support groups that will help in revising attachments.

6. *Discovering new hope* – Several ways can be used in discovering new hope. Boss, however, stresses the need for human community's assistance in reimagining it.[32] The pastoral counselor will help the care seeker imagine options, laugh at the absurdity, and enhance the acceptance of ambiguity.[33]

Members whose loved ones were buried in their absence in foreign countries because of the pandemic may be helped by the above six-tier intervention. It can be adopted or adapted to the context of care.

The Future of Spiritual Care

The pandemic has changed the global landscape of ministry. It could be described through Ann Swidler's analytical framework as an "unsettled cultural period." Her ideology accentuates COVID-19's likelihood of changing gospel ministry and parish culture by compelling Church leaders to be innovative and to re-engineer worship, ministry, or the Church.[34] The migration to

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31 Ibid, 533.

32 Pauline Boss, "The Trauma and Complicated Grief of Ambiguous Loss," *Pastoral Psychology* 59 (2010): 144.

33 Pauline Boss, "Myth of Closure: What is Normal Grief after Loss, Clear or Ambiguous," in the annual conference of the National Council of Family Relations, San Antonio, TX, 2013, accessed July 15, 2022, https://www.ncfr.org/sites/default/files/317_ncfr_myth_of_closure_final_11.8.13.pdf

34 Erin F. Johnston et al., "Pastoral Ministry in Unsettled Times: A Qualitative Study of the Experiences of Clergy during the COVID-19 Pandemic," *Review of Religious Research* 64, no. 2 (2022): 378.

online platforms for worship, pastoral care and counselling, and giving offerings was a huge shift for the Church that forever altered how ministry is perceived and done.

The pandemic has left a lesson that crises can break upon people at any time. The Spiritual care provision must prepare Church members for difficult times. The frequency of tragedies is increasing. Floyd[35] opines that it is unavoidable that persons doing pastoral work will always meet people during crises. Some clerics may be feeling overwhelmed or feel like they are transitioning from one catastrophe to the other.

Spiritual care will be effective only as it takes into consideration the fact that the pandemic has left a trail of mental health challenges. Mudegu is disappointed that in some circles the "Church has covertly perpetuated the stigma toward mental health patients using unbalanced biblical interpretations."[36] In a society where social stigma has made psychological breakdown equal "to a silent epidemic,"[37] there must be a paradigm shift if the Church will respond to whatever needs arise.

A look at what sustained the Church members during the pandemic may be informative to the kind of spiritual care and pastoral care that should be provided in the post-COVID era. Members found alternative ways of worshipping in small groups, in families, or as individuals without contravening the lockdown regulations.[38] While this provided a similar worship experience to the congregational one, Baker et al. predicted that it was going to lead to the privatization of religiosity and the creeping in of secularization that will ultimately

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35 Floyd, *Crisis Counseling: A Guide for Pastors and Professionals* (Grand Rapids: Kregel, 2008), 17.

36 John Mudegu, "Assessing the Preparedness of the Church," 115.

37 Mary Amuyunzu-Nyamongo, "The Social and Cultural Aspects of Mental Health in African Societies," *Commonwealth Health Partnerships*, ed. *Andrew Robertson, Rupert Jones-Parry and Marvin Kuzamba (London, The Commonwealth,* 2013), 59.

38 Rodgers Manungo and Tinashe Rukuni, "Impact of Coronavirus Lockdown among the Seventh-day Adventist Community Members in Masvingo Urban, Zimbabwe," *East African Journal of Education and Social Sciences (EAJESS)* 2, no. 2 (2020): 110.

result in declining religiosity.[39] If this is the case, there is an urgent need for spiritual care that will appeal to the Church members as individuals thus reaching them in their private spaces.

Another element that sustained the disciples' spiritual connection was virtual worship services. The clergy had to quickly adjust to this form of ministry to nourish their membership. Afolaranmi proposed the use of social media to reach out to the younger generation.[40] While Church doors have again been opened for services, they are still in love with "cyber-worship." In a hospital setting, the chaplains used technology to support the staff, and this yielded excellent results.[41]

A Four-dimensional Approach to Spiritual Care

The four-dimensional approach to spiritual care presented here is a response developed to meet the need for a re-engineered drive for spiritual care. It aims to approach spiritual care wholistically—where the spiritual caregiver, the post-COVID-19 environment that he or she finds his or her care seeker in, the care seeker's state of being, and the process of care provision are interlinked. It entails the four Ps of spiritual care, pastoral care, and counselling: the professional, the place, the patient, and the process.

This four-dimensional approach aims at equipping the pastor to deal with the four depressors in this article, namely, change and loss reminders, what the bereaved think of God, depression, and ambiguous loss. While there are other identifiable depressors that need to be de-escalated, these four have been chosen because of their impact on the Church members' emotional well-being in the post-COVID era. An attempt to respond to them may enhance the

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39 Joseph O. Baker et al., "Religion in the Age of Social Distancing: How COVID-19 Presents New Directions for Research," *Sociology of Religion* 81, no. 4 (2020): 363.

40 Adebayo Ola Afolaranmi, "Towards Understanding the Nexus between Pastoral Care, Social Media, and Sustainable Development in the Post-COVID-19 Era," (Preprint, submitted in 2022), 6, accessed July 15, 2022, https://orcid.org/0000-0001-8057-137X

41 Beba Tata et al., "Staff-care by Chaplains during COVID-19," *Journal of Pastoral Care and Counseling* 75, no. 1_suppl (2021): 27.

spiritual care provided to bereaved members. Figure One below shows the model of care provision.

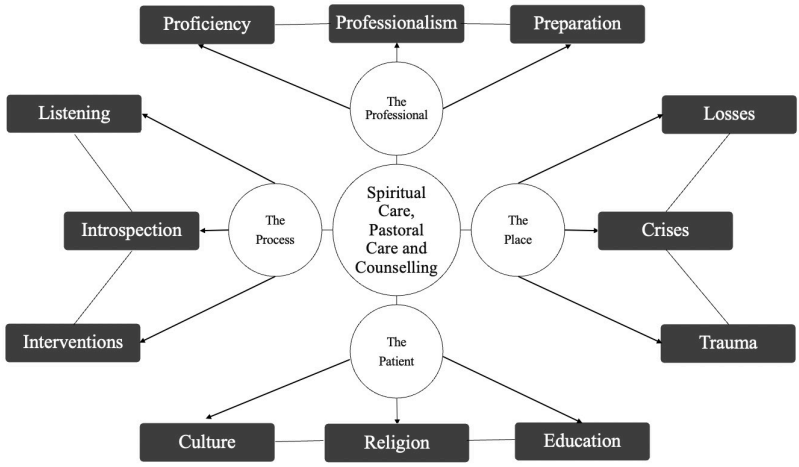

Figure 1. The 4 Ps of Spiritual Care, Pastoral Care, and Counselling

The Professional

The professional is the one who directs the plan of spiritual care. In a parish-based ministry or multi-Church district, it is the pastor; in other settings, it is the chaplain. Three elements need attention for spiritual care to be viable. First, it is *preparation* for providing spiritual care. Ministers can do this by taking a unit in Clinical Pastoral Education (CPE). Anderson suggested an integration of CPE with seminary education to foster ministry formation.[42] Pastors may also spend time getting acquainted with psychological issues that affect their members. Mental health is no longer supposed to be

[42] Robert G. Anderson, "The Integration of Clinical Pastoral Education with Seminary Learning: Fostering the Student's Ministry Formation," *Journal of Pastoral Care* 50, no. 1 (1996): 13-21.

divorced from pastoral work.[43] In preparing for ministry, the clergy will benefit from understanding the impact of the depressors that inhibit the sustenance of emotional well-being.

The second element is *professionalism*. There are professional boundaries that are to be respected when providing care. In the successful execution of the work, the principles of autonomy, beneficence, non-maleficence, and justice must be at the core of care provision.[44] Bereaved members must neither be further harmed nor be denied what is good. The cleric must ask him/herself the following questions: Is the member adapting positively or negatively to change or loss reminders? What is the bereaved parishioner thinking about God? Is there any existence of depression or the member may be heading towards it? Is the member's loss enshrouded with ambiguity? Professionalism ensures that the prescribed interventions are helpful and not hurtful.

Ministers need to rise to a level of professional etiquette[45] that is higher than that of other professionals if they are to make a meaningful impact. "Unlike so many other professions, the pastoral office is one in which the philosophy and performance of the vocation is so intimately entwined with the commitments, values, and behavior of

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43 Several studies indicate a correlation between spirituality/religiosity and mental health. While they may not be diagnosticians, pastors need to appraise themselves with psychological disorders. See T. Scott Bledsoe et al., "Addressing Pastoral Knowledge and Attitudes about Clergy/Mental Health Practitioner Collaboration," *Social Work & Christianity* 40, no. 1 (2013); Andrew J. Weaver, "Has There Been a Failure to Prepare and Support Parish-based Clergy in Their Role as Frontline Community Mental Health Workers: A Review," *Journal of Pastoral Care* 49, no. 2 (1995): 129-147; Andrew J. Weaver and Harold G. Koenig, "Elderly Suicide, Mental Health Professionals, and the Clergy: A Need for Clinical Collaboration, Training, and Research," *Death Studies* 20, no. 5 (1996): 495-508; Andrew J. Weaver, Harold G. Koenig and David B. Larson, "Marriage and Family Therapists and the Clergy: A Need for Clinical Collaboration, Training, and Research," *Journal of Marital and Family Therapy* 23, no. 1 (1997): 13-25.

44 Elizabeth Sager, "Components of Successful Spiritual Care," *Journal of Religion and Health* 61, no. 2 (2022): 1139-1154.

45 Dube, "Mental Health and Sustainable Development Goals: A Study of Zimbabwean Chaplains," in *Rethinking Sustainable Development Goals in Africa: Emerging Trends and Issues,* ed. Josephine Ganu, Musa Nyakora, Mary A. Razafiarivony, (Nairobi, Kenya: The Catholic University of Eastern Africa, 2020), 51.

one's private life and one's public life."[46] Professionalism includes how a pastor carries himself or herself around. This either reduces or enhances his/her connection to the Church members in need of care.

Third, although spiritual care is worthless without the Holy Spirit, the ministry must be attended to with *proficiency*.[47] Proficiency entails being skilled in the provision of care. While professionalism concerns meeting the standards that matter[48] in an organization, vocational proficiency as a pastor is a demonstration of expertise in handling brokenness among care seekers. It means doing the work as someone who has been schooled in the area.

The Place

The place is the environment or situation that necessitates spiritual care. It is characterized by three elements: first, the *losses*. The post-COVID-19 environment is littered with losses. Besides the loss of loved ones, the surviving Church members may have had other losses. It is crucial to understand the other past and present losses to fully appreciate the presenting one. Wright[49] emphasized that when one is ministering to grieving individuals, knowledge about their past is an invaluable resource that will aid the cleric in helping them. The treatment and prevention of traumatic grief resulting from loss require a collaborative network of friends, family, rituals, spiritual care, psychological health, and palliative care. Since losses are interconnected, it is important to help the care seeker create what Layne called the "Loss Reminders Inventory"[50]—which is a list of things that evoke painful loss memories. This will help the one in need of care to either increase tolerance to, or avoidance of triggers.

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46 P. Lessing, and A. Chua, "The Life of a Pastor," (Preprint, submitted in n.d.), n.p.

47 Dube, "'The Spirit of the Lord is Upon Me' (Luke 4: 18): The Place of the Holy Spirit in Spiritual Care." *Asia-Africa Journal of Mission and Ministry 20*, 75.

48 Mind Tools, "Professionalism: Meeting the Standards that Matter," *Mind Tools,* (n.d), accessed July 15, 2022, http://www.mindtools.com/pages/article/professionalism.htm

49 Wright, *The Complete Guide*, 128.

50 Christopher M. Layne, "Clinical Perspectives on Bereavement and Grief: Past, Present, and Future," (Webinar Online), Keynote Address at the Eating Recovery and Pathlight Foundation Annual Conference, (August 25, 2021).

The second element is the *crises*—which "are turning points where counselees can move toward growth, enrichment, and improvement; or they can move toward dissatisfaction, pain, and in some cases, dissolution." The pandemic presented a global crisis that overwhelmed many Church members—this saw some parishioners having questions about God. Feelings ranged from being angry with God[51] to disappointed with Him[52] as they saw themselves without their loved ones. Some failed to cope. However, among some health workers, faith became how they became resilient.[53] Those who failed to utilize their faith as a tool for coping were led into the third element—*trauma.*

Trauma includes negative external stimuli that paralyze the internal defence system.[54] Spiritual caregivers need to be reminded that care seekers may encounter trauma reminders, that bring to memory the traumatic nature of death. Loss reminders may be evoked by just contemplating, through recollections, or even seeing individuals that are connected to the deceased. Change reminders bring to memory the new circumstances that have been brought about by death.[55] When the *professional* carefully steps into the *"place"* of the person *(patient)* going through pain, de-escalating depressors becomes easier.

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51 Gianmarco Biancalani et al., "Spirituality for Coping with the Trauma of a Loved One's Death during the COVID-19 Pandemic: An Italian Qualitative Study," *Pastoral Psychology* 71, no. 2 (2022): 173-185.

52 Diana Cecilia Tapia-Pancardo et al., "Emotions and Stressing Situations Adaptation of Nursing Students in the New Normality," *Health* 14, no. 7 (2022): 766-774.

53 Zaid Ahmad Wani et al., "'Faith versus Fear'–A Study in Medical Professionals in the Light of COVID-19 Pandemic," *Journal of Medical Sciences and Health*, 6, no. 3, (Sep-Dec 2020), 25.

54 Scott Floyd, *Crisis Counseling*, 42.

55 Robyn Howarth, "Concepts and Controversies in Grief and Loss," *Journal of Mental Health Counseling* 33, no. 1 (2011): 7.

The Patient

The patient is the person in need of spiritual care. The word "patient" is chosen here to illustrate the brokenness that could be existing either emotionally, cognitively, socially, physically, or spiritually. The term is used to describe any individual whose management of depressors is compromised by negative external or internal stimuli. While it can be used to mean someone who is physically not well, it is not restricted to that meaning. When death strikes, it has a systemic effect—it sabotages the whole system. Three elements are determinants of the patient's decision-making process. First, it is his or her *culture*—which becomes the lens through which the patient perceives life's situations. In some cases, the cause of COVID-19 losses may either be seen as biomedical or witchcraft. In the African culture, nothing happens without a cause. Mbiti pointed out that in sickness, sufferers use both biomedical therapies and folk healers without any feeling of guilt. He emphasized that they either go secretly or openly use the medicine man's treatments publicly.[56]

Culture may impact the way loss or change of status is interpreted. For instance, some viewed the pandemic protocols as damaging the cherished long-held cultural practices,[57] thus inhibiting the grieving process. In de-escalating depressors, the pastor must not ignore the impact of culture.

The second element is the patient's *religion*. This controls the patient's reception of the plan of care and the level of willingness to be helped. If help-seeking behavior is affected by one's culture and religion,[58] then the pastor needs to understand the patient's religious persuasions and convictions. The questions that will be helpful in de-escalating depressors in the light of religion are: to what extent is the patient's religion influential in interpreting the reality of the loss, loss reminders, and change reminders? Does the

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[56] John S. Mbiti, *African Religions and Philosophy* (London: Heineman, 1969), 107.

[57] Frederick Iraki, "Covid-19 Protocols Damaging our Culture, Humanity and Mental Health," *Journal of Language, Technology and Entrepreneurship in Africa* 13, no. 1 (2022): 260.

[58] A. Akangbe Tomisin, "Culture, Religion and Help-seeking for Intimate Partner Violence Victims in Nigeria: A Narrative Review," *Culture* 3, no. 2 (2020): 58.

patient have maladaptive religious coping mechanisms that can lead to depression? What is the patient's view of God during a loss?

The third element is *education*. Exposure to education may positively or negatively affect personal decision-making in a crisis. While culture has a huge bearing, education is an undeniable factor. For instance, in Muslim countries, where mental health issues are made complex by religious and cultural beliefs, it has moderated them.[59]

Care seekers should be helped to avoid negative coping mechanisms. "Some of the most common unhelpful strategies that appear to maintain prolonged grief include rumination, avoidance of reminders, time-consuming rituals that keep [the] focus of attention on loss, social withdrawal or excessive social contact with bereavement networks that maintain [the] focus of attention on loss."[60] The patient should be prepared to accept the process of grieving the loss if they are to be helped.

Many members were denied the privilege of burying their loved ones during the pandemic. They were left as patients in need of care. It should be noted that depending on the culture, religion, and education of the bereaved member, the rites of burial are key to psychological maturation. They aid the survivors to confront their losses and initiate grief work publicly.[61]

The Process

Process refers to the execution of the plan of spiritual care. It is the means through which the cleric de-escalates depressors in the Church. When a pastor has polished his/her professional work,

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[59] Anisah Bagasra, "Muslim Worldviews: Implications for Helping Professionals Providing Culturally Competent Care," in *Working With Muslim Clients in the Helping Professions*, pp. 1-22. IGI Global, 2020.

[60] Michael Duffy and Jennifer Wild, "A Cognitive Approach to Persistent Complex Bereavement Disorder (PCBD)," *The Cognitive Behaviour Therapist* 10 (2017): 11.

[61] Christiane Pantoja de Souza and Airle Miranda de Souza, "Funeral Rituals in the Process of Mourning: Meaning and Functions/Rituais Funebres no Processo'do Luto: Significados e Funcoes," *Psicologia: Teoria e Pesquisa* 35 (2019): NA-NA.

he or she will be better prepared to enter the place of the patient and initiate a therapeutic process. The first thing is listening. No spiritual care occurs when one is not listening. Kidd outlined foundational listening and responding skills that will be helpful to every pastor. He encourages ministers to abandon the domination of therapeutic dialogues if they are to render spiritually supportive listening.[62] Listening communicates that the spiritual caregiver is a "respectful guest who steps into the lived and intentional theologies of the care seeker's stories."[63] The pastor needs to listen to the ambiguity presented by the care seeker's narrative, what he or she thinks about God, the inclination towards depression, and his or her processing of loss or change reminders. This will facilitate the creation of an evidence-based empowerment program for the de-escalation of depressors.

The second element is introspection. Taking an introspective look into one's life reveals ignored deficiencies.[64] This entails looking into the internal rant that may hinder the work of care. The professional's negative responses to personal wounds may badly impact the provision of care. The pandemic affected every individual in one way or the other. Its advent ushered in new hurts that need healing. Pastors were not spared from such wounds, however, they are expected to be strong and care for others who are needy.[65] One study indicated that many pastors are leaving the ministry because of the demands that they are not able to meet, burnout, and emotional woundedness.[66] Consequently, they may be victims of denial, and brooding over septic wounds. Their response to personal injuries

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62 Robert A. Kidd, R. A. "Foundational Listening Skills," in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed., Stephen B. Roberts (Woodstock, VT: Skylight Paths, 2014), 93.

63 Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2015), 5.

64 John W. Behnken, "An Emergency Appeal to Our Pastors," *Concordia Theological Monthly* 3, no. 1 (1932), 98.

65 Wandee Wajanathawornchai and Jon Nicholas Blauw, "The Impact of Spiritual Well-Being, Calling, and Religious Coping on Burnout, Mediated by Job Stressors, among Thai Protestant Pastors," *Scholar: Human Sciences* 10, no. 1 (2018): 128.

66 Ronald Strong, "Burnout among African American Pastors: A Biblical and Practical Solution," (Doctor of Ministry diss., Liberty University, 2017).

may be marred by unresolved issues. The provision of spiritual care, which is a vital component in de-escalating depressors, may be affected. Pastors who are dealing with personal needs should seek therapy to ensure that they neither demand the sympathy of those in need of care nor provide hurtful interventions.

The last area is the focus on interventions. After one has listened to the patient, made observations, and verified them, he or she then provides empowerment.[67] Empowerment can take the form of journaling the losses, writing a letter of grief, or enumerating the losses. What will inform the type of empowerment or referral to therapy is the richness or paucity of the period of listening. Some will not find it necessary to refer cases to mental health professionals, because they have not listened deeply to the patient.

Referrals are an important part of the interventions. Those in emotional pain sometimes prefer to seek help from pastors—who by default function as frontline mental health workers and gatekeepers to the psychological healthcare system.[68] As such, pastors need to acquaint themselves with psychological issues if they are to de-escalate depressors among disciples. They may not be experts in the area, but an appreciation of mental health issues will help them in making better referrals to psychiatric specialists.

Churches must be grief friendly to facilitate grief work among the bereaved members. Clinebell proposed a player-coach approach where the pastor becomes both the equipper and facilitator. In this approach lay members become peer counsellors under the instruction of the pastor.[69] This makes pastoral and spiritual care a congregational initiative. Teaching members to practice the art of therapeutic silence[70] and the ministry of presence will make

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67 Dube, "The LOVE Spiritual Care Model: A Chaplain's Tool in Clinical Practice," *Asia-Africa Journal of Mission and Ministry,* 21, (2020): 29.

68 William Heseltine-Carp and Mathew Hoskins, "Clergy as a Frontline Mental Health Service: A UK Survey of Medical Practitioners and Clergy," *General Psychiatry* 33, no. 6 (2020): 1-10.

69 Clinebell, *Basic Types Pastoral Care and Counseling*, 185.

70 Dube, "Therapeutic Silence," 43–62.

churches grief friendly. Such an intervention will result in a healing encounter.

An adoption of spiritually informed therapies may be crucial. These have been found to help bring emotional catharsis to those who are amid difficulties.[71] Through collaboration, pastors may work with mental health professionals to provide these therapies. They may not need to utilize such therapies as professional mental health workers would, but they may learn to apply principles that are within their pastoral competencies.

Conclusion and Recommendations

In re-engineering spiritual care in the post-COVID era, attention must be given to the losses that people have incurred. Human lives were lost, and they were connected to other losses that have compounded the grief that the members are experiencing. An understanding of the connected losses will place pastors in a better position to provide care. Churches need to be grief-friendly to facilitate the release of pain. Support groups can be established to create a community of care for the bereaved members. When the pastor talks about supporting the surviving members in public it will create a helpful environment of care.

The post-COVID era needs pastors to prepare themselves to meet the challenges of those who have lost their loved ones with a needs-based spiritual care plan. This preparation entails self-improvement in terms of knowledge and skills. An acquaintance with psychological issues that trouble members will be an added advantage. It is highly recommended that pastors be knowledgeable in mental health issues so that they will be able to make referrals to mental health professionals.

There are moments of being angry at God among the bereaved. Questions may be raised from time to time. This may not be the time

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[71] Harold G. Koenig, "Religion and Hope," in *Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers,* ed., Jeffrey S. Levin (pp. 18–51), (Thousand Oaks, CA: Sage, 1994).

to defend God. In such moments, the pastor needs to train members to exude an empathetic presence. Pastors must know the art of just being there. They should also be taught to normalize the losses without minimizing them and validate the feelings of the grieving fellow members. This will strengthen the faith of the disciples discouraged by death.

There is a need to learn to de-escalate the depressors. When the incidence of change and loss reminders is deliberately increased in the Church it may escalate the pain. Being proactive and having a debriefing service with the help of trained mental health professionals will create an environment that communicates care. Ambiguous loss can be one difficult depressor for those who did not have time to see their loved ones being buried because of public health regulations. Going through the six-tier solution described here may yield good results.

In re-engineering the future of the work, lessons learnt during the pandemic should be applied in the post-COVID-19 era. This includes the use of technology for providing spiritual care. The four-dimensional approach to the provision of care provides a rubric through which ministers can assess how they are approaching the care of the bereaved. It encourages them to look at themselves and their work *professionally* and understand the *place* where the *patient* is coming from. For this to be possible, the Church membership and leadership must work together to provide grief-friendly parishes, and pastors must learn the art of referral to mental health professionals.

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