STYLES OF CARING

Peter L. VanKatwyk

In the literature of pastoral care and counseling a variety of roles of caring have been identified ranging from the classic and poetic images of shepherd and wounded healer to contemporary helping roles of companion and consultant to more playful pictures of the wise fool and the clown. These different styles of spiritual care do not just reflect idiosyncratic peculiarities between particular caregivers but represent a variety of styles of caring that conjointly shape a well-rounded, integrated practice of spiritual care.

A Case Example

Mark, a 38-year-old elementary school teacher, has been on sick leave from work due to “mental exhaustion.” For six weeks he has been in for counseling to deal with depression. At this point he faces the approaching end of his leave of absence. He comes in for his weekly counseling session, drawn and tense, saying:

I really don’t know what to do…whether to go back to teaching school. Ah---I can hardly stand the damn thought… but, you know, a stable job -- a decent salary…Or else make a clean break, likely go back to university and find something I can get excited about...

At this point the counselor also faces the question of how to respond. Hearing this cry of despondency and confusion, care providers will feel within themselves some confusion of what to say and, hopefully, some caution about their first impulse of what to say. The following sample of responses is not to be rated as to what is wrong or right, nor to be ranked according to personal preference. Rather, these specific responses demonstrate a variety of caring styles:

1. I think this may well be a bigger issue. You are at a critical juncture in your life. You are at a midpoint and may feel this is your last call. It may be helpful to give yourself more time to get a better sense of where you are with all of this.

2. When I listen to you I hear two persons arguing about what decision Mark has to make. My concern is that you get caught between these two adversarial voices. Perhaps we can begin to listen to what each has to say – make it a dialogue rather than a fight.

3. That’s a really tough decision. It sounds like you are under a lot of stress right now. I admire your courage to acknowledge how frightening it is just thinking to go back to the classroom… the place that nearly did you in.

4. I think that all this inward fighting, trying to be being brave, is a way of not accepting your depression. You know, Mark, you have good reason to be depressed and perhaps you need to just allow yourself to feel the depth of it.
For Reflection and Conversation
- What response do you feel most comfortable with? Why?
- What response do you feel most uncomfortable with? Why?

The four responses illustrate examples of different styles of caring. The following Helping Style Inventory (HSI) describes these four styles of caring responses

THE HELPING STYLE INVENTORY

The Helping Style Inventory utilizes a double-axis model of two dimensions that define helping interactions. The horizontal axis is the focus of attention dimension HSI map. This continuum stretches from one extreme, the task-orientation’s focus on the presenting problem, to the other extreme, the person-orientation’s focus on the person's life as affected and defined by the problem situation.

Figure 1: The Horizontal HSI Axis

FOCUS OF ATTENTION

TASK-ORIENTED ← PERSON-ORIENTED

This horizontal scale draws a continuum from the perspective of the helper’s “use of self”. At the task-orientation end of the continuum, the helper identifies primarily with the presenting problem and the perception of it by the client. At the opposite end of the continuum, the helper identifies primarily with the client as encountered and understood in the problem situation.

This focus of attention dimension is subject to polarization into potentially opposing and mutually excluding positions. In the 1950s the prominent sociologist Talcott Parsons distinguished helping functions in the nuclear family through gender specific roles: the bread-winner husband/father provided the family resources, while the homemaker wife/mother maintained supportive and integrative relations between family members. While the modern nuclear family has been largely replaced by more complex and fluid postmodern family structures, helping roles are still seen influenced in the gender specific ways of the past, men majoring in task-oriented and women in person-oriented helping relations. Taking a sociolinguistic approach, Deborah Tannen argues that women and men come from essentially different cultures apparent in gender differences in conversational and helping styles. While men tend to concentrate on problem solving, women tend to focus on understanding the person with the problem.

Spiritual care approaches to helping have traditionally emphasised that, rather than caring about the problem, care focuses on the soul: cura animarum. In common with existential and analytical psychotherapies, spiritual care and counselling has often been person-oriented in its problem-focus: rather than fixing problems or removing symptoms, the troubles of life are engaged and utilised as opportunities in examining one's life or saving one's soul. Pastoral counsellor John
Patton raises the uniquely spiritual care question "how can a person's problem be a context of care rather than the focus of care?" At the same time it needs to be stressed that spiritual care is not limited to a person-orientation. Spiritual care and counselling is about life and, consequently, addresses a broad scope of situations spanning both ends of the continuum.

The vertical axis is the use of power dimension in the helping relationship on the HSI map with a continuum stretching from the directive use of self to the facilitative use of self.

**Figure 2: The Vertical HSI Axis**

**DIRECTIVE**

- U: expert knowledge
- S: clinical competence
- E: symbolic role

**FACILITATIVE**

- O: client resources
- F: client capability
- P: client affirmation

In contrasting the one with the other end of the continuum, two distinct styles in the use of power become apparent. The HSI uses the traditional psychotherapy terms "directive" and "facilitative" to distinguish between the two. The continuum is visualised going from one extreme where the power to help is totally located in the helper, to the other extreme where the power to help is totally located in the person seeking help. A directive use of power emphasises the strengths of the professional helper in terms of expert knowledge, clinical experience, and/or in terms of charismatic or symbolic roles through which the helper represents a larger reality than his or her own personal presence. The disconcerting aspect of this helping scenario is that its script implies the complementarity of the "strong" helping the "weak." Public consciousness of the "weak" centres on those vulnerable to abuse: children, women, and the elderly. The awareness that all who receive care are at personal risk, contributes to a "hermeneutics of suspicion" in which directive use of power is feared as the potential abuse of power.

In contrast, the "facilitative" use of power emphasises the strengths of the persons seeking help in terms of their own personal agency and inner wisdom as well as available resources through their life experience and social supports. The
disconcerting aspect of this helping scenario may be a perceived competitive script that requires the helper to restrain the exercise of her or his own power to help so as not to interfere with the other person's strengths. Contrary to Rogerian ideals about the equal reciprocity of the therapeutic relationship, current professional codes of ethics rightly see helping relationships as unequal on account of the inherent power differential. Paradoxically, the potential of "abuse of power" often fits more the "facilitative" than the "directive" use of power. It is in the "facilitative" context that the power of the helper is not openly acknowledged, even at times concealed by believing, or make-believing, that it is not in use.

From this perspective, the two ends of the power continuum do not represent the relative presence or absence of the helper's use of power. The issue is not whether or not but how this power is being exercised: overtly or covertly, explicitly or implicitly. In the history of helping relationships these two styles in the use of power have often been experienced as contrary in value orientation and mutually exclusive in clinical practice.

The HSI is constructed along two main dimensions that define the context of helping interactions. Both dimensions are visualised going from one extreme to another. It is understood that these two extreme ends reflect not so much real as hypothetical helping situations discussed for didactic purposes in visualising the “focus of attention” and the "use of power" continuums.

**Putting it all together: The HSI Map**

The HSI map as a double-axis model produces four quadrants, which identify four helping styles and four helping images (going clockwise from the top):

*Figure 3: Four Styles and Four Images*

<table>
<thead>
<tr>
<th>Helping Style</th>
<th>Helping Image</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Directively person-oriented (dp)</td>
<td>The Guide</td>
</tr>
<tr>
<td>2. Facilitatively person-oriented (fp)</td>
<td>The Celebrant</td>
</tr>
<tr>
<td>3. Facilitatively task-oriented (ft)</td>
<td>The Consultant</td>
</tr>
<tr>
<td>4. Directively task-oriented (dt)</td>
<td>The Manager</td>
</tr>
</tbody>
</table>

The four types of helping styles emphasise that care is informed by multiple perspectives and that the competent caregiver is characterised by a differential use of self. The HSI proposes an integrative approach to spiritual care and counselling. In order to operationalize the HSI map as a teaching and supervision tool, specific helping behaviours are incorporated to define the practice of each helping style. This identification of specific behaviours in the HSI map does not pretend to provide a comprehensive classification of helping behaviours. The HSI descriptions of helping behaviours illustrate the distinctive features of each of the four helping styles.
Each of the helping behaviours is placed on a scale of three levels of intensity. For instance, the guide helping behaviours range from informing to coaching to directing. The less intense helping behaviours are arranged at the core while the next two levels of increasing intensity move toward the outside. The core area constitutes a closer and less shaded environment on the HSI map, signifying that core-area helping behaviours are less separated and differentiated (informing-connecting-conversing-suggesting), allowing the helper to shift easily from one to another helping style. The movement from the core to the outer rim, toward more shaded areas, leads to more pronounced and separated helping style behaviours. Such behaviours, as they become more extreme, increasingly confine the helper in terms of one inflexible helping style with the exclusion of other options.

Figure 4: The Helping Style Inventory
The HSI map assumes that basic students in clinical education do best by concentrating on core-level helping behaviours. Students who enter clinical education programs with pronounced helping styles, such as found in directing/guiding or confirming/celebrating, tend to be more stuck in their specialised helping posture and less likely to expand their helper identity and skill repertoire as a caregiver. Advanced students, those more mature in contextual sensitivity and skill competence, can profitably use the midrange and, at times, even venture into more extreme helping responses as situationally appropriate, without necessarily locking themselves into a limited and rigid role in counselling.

A HSI Verbatim Example

In the following counselling verbatim excerpt we return to Mark who is on sick leave from his teaching job (M=Mark, C=Counsellor):

M1: I really don’t know what to do…whether to go back to teaching school. Ah- I can hardly stand the damn thought…but, you know, a stable job - a decent salary…Or else make a clean break, likely go back to university - find something I can get excited about...
C1: The closer it gets for you to return to work, the bigger this inner turmoil...
M2: I don’t know…(buries his head in his hands)
C2: You say “I don’t know” but I wonder whether you really do know what you want to do.
M3: Perhaps I am too scared to really say… (looking up) that I don’t want to go back to teaching.
C3: Pretend that you are not scared. Tell people - your dad... your wife...
   Right now tell me: “I don’t want to go back to school.”
M4: I…I.. don’t want to go back... to school. (haltingly)
C4: What is happening Mark?
M5: God – my heart is pounding...(begins to cry) I can’t even say it.
C5: Perhaps it is not just your job you are disgusted with ...
M6: What do you mean?
C6: I think I hear you berating yourself, saying that you haven’t the guts to quit.
M7: Well should I quit? .
C7: How important is it for you to know what others think what is best for you, and how concerned are you not to disappoint them?
M8: It wouldn’t be the first time that I disappoint, especially my family...
C8: I think, Mark, these are the scariest things in life - to leave, or disappoint

When the counsellor’s responses are inserted on the HSI map, a counselling profile appears as presented in figure 5: the HSI Counselling Score. The diagram illustrates that the process of counselling is not confined to any one area on the HSI map. In fact, the assumption of the HSI is that, ideally, the counsellor moves about in a flexible use of a variety of styles. The HSI encourages spiritual care-providers to become more differentiated, creative and
flexible in their use of themselves, beyond the limiting choices of ideological preference and personal comfort.

Figure 5: HSI Counselling Score
Applications for Clinical Education

The HSI tool in clinical education emphasizes the need to learn a variety of helping skills through a flexible use of self. Students can approach the task of the practice of caring with the intimidating idea that there is one “right” way of therapeutic communication, hence feeling limited in experimenting with different responses. The HSI encourages the exploration of new territory with the enhancement of professional self-awareness. A larger repertoire of helping styles will provide the student with choices of what is contextually appropriate, beyond the restraints of personal or theoretical limitations.

Research studies of the implementation of the HSI in clinical education programs seem to confirm that the HSI can be readily incorporated as a conceptual model that becomes available as a self-monitoring tool in spiritual care and counselling and in supervision. Conversational scenarios, whether in written form or performed in role-play, provide a series of options for the student to choose from. The choices of caring responses configure the student’s preferred helping style profile and mark the growing edges in the student’s personal and professional use of self.

Correlating conversational scenario questionnaires with taped counselling sessions, measures the level of congruence between the student’s espoused theory of spiritual care with the actual practice in use. The research indicates that the majority of students in theory reject the manager helping image, yet many of them do employ manager helping behaviors (suggesting, advising) in their spiritual care practice. Conversely, students who view human nature as defective and in need of corrective guidance, often adopt a non-directive and predominantly facilitative helping stance in their counselling. The interaction between theory and practice, views of reality and caring approaches, is at the core of the HSI. Helping styles are grounded in concrete communication interactions, yet inspired by the visions of health that vitalize the models of care. The various ways in which the HSI model can be applied as a conceptual tool in self-monitoring, teaching, and supervising, and as a catalyst in critical reflection on the beliefs and practices of care, illustrate the model’s inclusive and wide-ranging approach to the practice of spiritual care.

For Role Play Practice
Take an issue that a care-receiver may present such as Mark having to decide what to do with his life, or a less critical issue such as whether to read more professional literature or cultivate more social relationships. In a role play, the care-receiver states the issue and the care-giver responds by going around the HSI map while shifting his/her caring style. In the feedback session both care-receiver and care-giver share their experience of the shifts and observers share where and how they noted the shifts.
ENDNOTES


3 Deborah Tannen, *You just don’t understand, Women and Men in Conversation* (New York: Ballantine, 1990), 51,52

4 John Patton, *Pastoral Care in Context – An Introduction to Pastoral Care* (Louisville: Westminster/John Knox, 1993), 56,57

5 In the unpublished HSI research study that won the 1987 Annual Research Award from the Canadian Association for Pastoral Practice and Education, Carrie Doehring tracked student learning curves through HSI coded verbatims. Thomas O’Connor et al., in the article "Diversity in the Pastoral Relationship: An Evaluation of the Helping Styles Inventory” present an ethnographic study of practitioners’ experiences of the HSI, analyzing the data from twenty-one interviews, noting helpful and limiting aspects of the HSI, concluding that the “HSI is an effective tool in celebrating diversity “in the therapeutic relationship. *The Journal of Pastoral Care* (Vol.49, No.4, 1995), 365-374