Pastoral care in troubled times: Experiences of clergy during the COVID-19 pandemic

by

Dikagiso Modise

20810033

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Study leader: Prof Yolanda Dreyer
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ABSTRACT

Keywords: COVID-19, Care seekers, Pastoral Care, Pandemic

The coronavirus disease 2019 (COVID-19) impacted and affected the social, religious, and economic life across the globe in a negative way. Most countries were obligated to implement lockdown rules which led to churches having to be shut down and effectively affecting pastoral care. In general, pastoral care takes place through social contact, where either the caregiver visits the person or is approached by the person for help and guidance. The lockdown and social distancing had devastating consequences for the traditional way in which clergy perform their pastoral ministry. It is on the basis that this study was undertaken, to explore how the clergy were able to respond to these changed circumstances.

CHAPTER 1

INTRODUCTION

1.1 Background

The COVID-19 pandemic and the restrictions regarding social contact, specifically physical gatherings, presented unforeseen challenges for religious congregations and leaders (see Johnston et al. 2021). Social distancing protocols associated with the pandemic had severe consequences for conventional approaches to pastoral ministry. Some qualitative data that provide insight into these trends and that describe the lived realities of religious leaders in the pastoral ministry are becoming available. Several studies have described the impact of COVID-19 on congregations. The focus of this study is to explore the impact of COVID-19 on pastoral care. A significant skill of pastors is to play the role of a non-anxious presence during periods of anxiety. Thus, within the pandemic, pastors must be well-differentiated so that they can work with the church system and help it to understand emergent patterns of relating brought on by social restrictions and respond directly to the concomitant stresses and tensions. The theory suggests that well-differentiated pastors can build relationships and foster an environment within which people in the system can explore their issues in a healthy way.

1.2 Problem statement

The COVID-19 pandemic, which emerged at the end of 2019, necessitated public health officials to place limits on social gatherings. This included religious gatherings. The worship services of church congregations had to be moved to online platforms. The public health mandates caused disruption also to other fundamental activities of churches. One of these was pastoral care. Pastoral care constitutes a relationship and encounter that occur within a religious setting. Pastoral care consists of practices and rituals such as, among others, active listening and talking, anointing and embracing. Listening and talking to one another, in particular, is an integral part of the pastoral relationship between pastoral caregivers and those who receive care. Ideally, the social and physical space that is shared between a pastor and counselee during pastoral care should be uninterrupted (Liegeois 2016). The relationship is highly social in nature.

Pastoral care is invariably rooted in embodied experience. Pastors utilise personal conversations to connect and engage with persons on a profound human level (Byrne and

Nuzum 2020). In these conversations, body language and rituals are of importance. The pandemic required alternative ways of providing pastoral care. These alternative ways were devoid of social contact. It raises the question as to the impact of COVID-19 on pastoral ministry. This requires investigation. Some studies in this regard have emerged. This study will peruse the existing studies in its investigation of the impact of COVID-19 on the provision of pastoral care.

1.3 Literature overview

Pastoral care is rooted in the Judaeo-Christian tradition (Ağılkaya-Şahin 2015). In the Hebrew and Christian Bibles, pastoral care is understood in terms of shepherding (Klessmann 2010). Isiah 40:11 refers to God's care as follows: "God tends the flock like a shepherd: God gathers the lambs in God's arms and carries them close to God's heart; he gently leads those that have young." In Psalm 23:3, reference is made to dispirited sheep who are in need of shepherding in order to be restored. In the Hebrew Bible, the metaphor of the shepherd tending the sheep refers to God's care. In the New Testament of the Christian Bible, the metaphor is extended to the mutual care of believers for one another. Post-Pauline literature refers to the apostle Paul appointing "shepherds" in the towns where he planted a church (see Titus 1:5, 3:9). The element of "discipling" was deemed part of the pastoral relationship, according to Acts 20:22-31 (see Hawkins 2001).

In the early church, the term pastoral care was linked with the metaphor of shepherding. Pastoral work was understood in terms of services to the community (Ağılkaya-Şahin 2015). Understandings of pastoral care have generally oscillated between the ideas of soul care and service to the community. During the Middle Ages, the idea of *cura animarum* or soul care, was integrated into church law. Pastoral care was seen as acts in the name of God that support or facilitate the salvation of the soul (see Johnson 2007; Cole 2010; Louw 2010). Soul care can be understood more generally as a specific service provided by the clergy to individual members of the community (Ağılkaya-Şahin 2015). Pastoral care as *cura animarum specialis* has a narrower meaning. It concerns the care and counselling that individuals receive on their personal journey of faith, particularly when they experience trials, tribulations and crises. In the Roman Catholic Church, the idea of *cura animarum generalis* prevailed. Pastoral care and counselling were understood in terms of all the duties of the clergy. In the Protestant tradition, the idea of pastoral care as *cura animarum specialis* focused more on direct personal intervention as an individual service to soul care (Ağılkaya-Şahin 2015).

Pastoral care has become inextricably linked with therapy since the 19th and 20th centuries. As Louw (2010:69) notes, this linkage emerged against the backdrop of changing research paradigms:

> With the advent of the human sciences and the emphasis on empirical research and an interdisciplinary approach, pastoral care became more and more exposed to the paradigm of psychology in theory formation. It often leads to what one can call a paradigmatic reduction in pastoral care. The implication in the 19th and 20th centuries, i.e. the reduction of healing to the realm of the self-culture, was a paradigm shift from the spiritual realm to the realm of behaviour with an emphasis on research on the living human document.

The linking of pastoral care with psychotherapy was referred to by Sperry (2002:2) as the "psychologization of spirituality". Other scholars have documented the rise of pastoral psychology during this period to capture these trends (see Cole 2010; Capps 2001; Pavesi 2010; Snodgrass 2007). Current understandings of pastoral care, which are rooted in the pastoral care movement that started in the United States during the 20th century, integrate ideas of *cura animarum specialis* with psychological concepts (Ağılkaya-Şahin 2015). This notion of pastoral care has an interdisciplinary character that is rooted in the human and social sciences (Ağılkaya-Şahin 2015). Clebsch and Jaeckle (1996) note that pastoral care is a ministry of curing souls which involves helping acts performed by Christian representatives to heal and guide people who are troubled. Gerkin (1997) understands pastoral care in the context of the shepherding model. This shepherding model entails the trialogical structure of prophets, priests and wise men or women who took responsibility for shepherding God's people. The shepherding model of pastoral care noted by Gerkin (1997) emphasises community, individual and family needs. Pastoral care hence involves caring for the Christian community and caring for Christian persons at the individual level and in families (Gerkin, 1997). This caring approach to pastoral care has also been advanced by Nicolaides (2005), who notes that it facilitates communal healing. Emphasising the role played by pastors within communities, Gerkin (1997: 80) states that "the depiction of Jesus as the good shepherd who knows his sheep and is known by his sheep has painted a meaningful, normative portrait of the pastor of God's people." Hulme (1981) offers a different definition of pastoral care which is understood as a supporting ministry of the church-to-

church members who are experiencing challenges and trials including illness and bereavement. Hulme (1981) states that pastoral care is best encapsulated by the biblical story of Job. Hopson and Rice (2008:87) state that:

> The dialogue between Job and his friends illustrates how spiritual distress challenges the theological assumptions of both sufferer and caregiver. In an effort to maintain one's own spiritual equilibrium, and no doubt out of good faith efforts to comfort the afflicted, the pastoral caregiver may be tempted to cling to theological formulas and religious perspectives which disallow the sufferer's experience of anger and despair. The story of Job affirms the value of authenticity over piety, speaks of the transformative power of suffering, and provides the counselor/pastoral caregiver insights into the pitfalls and promise of caring for persons in spiritual pain.

Sifo (2014) understood pastoral care as a healing ministry. Pastoral care heals those who are wounded in their everyday lives and is compared to the protection offered by shepherds in relation to a flock. In the existing literature, pastoral care is linked to four main pastoral functions, which include: guiding, healing, reconciling, and sustaining (Clebsch and Jaeckle 1996).

The healing function involves a pastor assisting debilitated people to be restored to conditions of wholeness. Through this restoration of wholeness, it is assumed that the receiver of care also attains new spiritual insight and improves his or her spiritual welfare. This is in line with ideas of healing from a theological point of view, whereby healing involves the curing of the soul (Jibiliza and Kumalo 2021). As has been noted, “pastoral healing, therefore, is to separate a person from illness that means a healing of totality that includes mind, soul, and body. Furthermore, pastoral healing may proceed with the solicitation of curing that brings a person looking for the healing to a point of wellness” (Jibiliza and Kumalo 2021: 3). Scholars such as Louw (2011) propose that the pastoral care function of healing is important for transforming the lives of Christian believers and helps to shed light on the gaps between their way of life and how they should be living based on Christian tenets. Thus, pastoral care encourages Christian believers to make responsible decisions. The second function of pastoral care that is noted in the literature concerns the function of sustaining. This involves sustaining Christian believers who have experienced trials and tribulations via compassion so that, eventually, they are restored and also grow spiritually.

This pillar of pastoral care is often practised in relation to bereavement (Jibiliza and Kumalo 2021).

Pastoral care also involves the provision of guidance, which consists of assisting people in making correct decisions at the right time and under pressure, placing emphasis on how decisions have implications for the present and future condition of one's soul. With regard to the guidance dimension of pastoral care, Clebsch and Jaeckle (1996) have proposed two models known as educative and inductive guidance. Educative guidance relies on the care receiver's experiences as a resource for decision-making, while inductive guidance focuses on a prior set of values as a framework for decision-making. Educative guidance draws on empirical experiences, while inductive guidance is theory-driven (Jibiliza and Kumalo 2021). Another dimension of the pastoral care function is reconciliation which involves re-establishing broken relationships between Christian believers and God and between people. This pastoral care function uses forgiveness and discipline to restore relationships and cure souls: “Reconciliation takes place through forgiveness which can be a proclamation and re-uniting of persons or groups. Moreover, discipline is a mode that is concerned with confession and the amendment of one’s life” (Jibiliza and Kumalo 2021:3).

Pastoral care is understood as both an encounter and relationship that occurs within the church and consists of religious content (Ağılkaya-Şahin 2015). In this relationship, the counsellor is a clergy member or pastor who represents the church (Moran et al. 2005). The ultimate concern in the relationship is religion in character. The goal of the pastor is to provide guidance for the person to establish a relationship with God. This is done through religious experience and through prayer. Pastoral care aims to reinforce the religious experience of individuals. This understanding of pastoral care has its roots in Matthew 22:37-39: “Jesus replied: ‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbour as yourself’”. The starting point of pastoral care is Christian love. Its practice is about help for life (Hawkins 2001). The realities of life cause some people to not experience or to be deprived of authentic love. This leads to conflict in their lives and has a psychological impact. When individuals experience pain and rejection, some choose to consult a counsellor or a pastor. Within the overarching theme of love, pastoral care plays a role in helping people to cope with their burdens. It also helps people to manage the burden of responsibility in their lives, assisting them in developing personal possibilities by

enhancing their relationship with God (Ağılkaya-Şahin 2015). Regarding the provision of help for life, according to Ağılkaya-Şahin (2015:68), pastoral care “releases people from false relationships and help[s] them to reorder their relations”. The author further states that "the pastoral relationship takes place as a discrete conversation; it is limited in time with a focus on solving a problem by concentrating on the whole individual (emotions, behaviour, nonverbal reactions, etc.) and addressing conscious and unconscious processes. It strengthens personal potentials and skills” (Ağılkaya-Şahin 2015:68).

Christian pastoral care is rooted in the belief in the triune God: the Creator, the Redeemer and the Holy Spirit (Woldemichael et al. 2013). God's love is expressed in its highest form through the incarnation of the Son of God, who became man and died for the sake of man because of His love for humankind. Pastoral care praxis is borne out of this love and is performed in the name of faith in Jesus Christ (Woldemichael et al. 2013). Churches have a mission and responsibility to spread the news about the love of God via their caring praxis, and the source of performing pastoral care is the love of God through which the love of all humankind flows (Woldemichael et al. 2013). References from both Hebrew and Christian scriptures show that Christian love is multidimensional in nature. It consists of loving God, one’s neighbour, oneself and nature. These dimensions of love are interconnected, and in pastoral care, complete healing is believed to be achieved when all these dimensions of love are fulfilled (Woldemichael et al. 2013). Love is integral to the provision of pastoral care because, in the Christian faith, God is recognised as love, and it is through love that God cares for people, protects and heals them during difficult times, and consoles them during times of sadness (Ziemer 2000). Love also guides communication in pastoral care (Miller-Mclure 2012; Streets 2014; Doehring 2014; Pembroke 2016).

Pastoral care is also linked to the Judeo-Christian conceptualisation of the human person as *imago Dei* (Woldemichael et al. 2013). This implies that all humans have natural and fundamental equality, and this idea of equality has implications for the practice of pastoral care. Both caregivers and receivers of care have the same level of dignity (Woldemichael et al. 2013).

The Bible portrays God as one who is present and oversees all of creation, caring and showing concern for all. As part of God’s care, God protects, helps, and heals. God's provision of care as a helper is the subject of Isaiah 41: 10: "So do not fear, for I am with

you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand." In 1 Peter 5: 7, believers are encouraged to “cast all your anxiety on him because he cares for you.” Pastoral care is therefore seen as helping and providing care and spiritual guidance. Pastoral care should reflect Jesus, the greatest shepherd who healed, strengthened, taught, and consoled his flock (Ağılkaya-Şahin 2015). Pastoral care provides a platform for people to commit themselves to God through a relationship with the pastor, predicated on love and care. Since God is eternal, the ultimate purpose of human life transcends the present. Eschatology in Christian theology concerns itself with the transcendental aspects of human life. The end of earthly life is not seen as the end. This view shapes pastoral care and expands its scope from one that is rooted in the present also to the future, even where death is imminent for the one who receives the care (Woldemichael et al. 2013).

The task of pastoral care is to encourage people through everyday engagement. This engagement enables persons to gain an external perspective of the self. It facilitates them to free themselves from the things that have captured the self. In this way, “the person learns to respect, control, and renew oneself” (Ağılkaya-Şahin 2015:69). Through pastoral care, individuals can discover their worth and value as human beings created in the image of God and achieve self-actualisation.

Pastoral care provides guidance for coping with problems and addressing challenges that prevent people from sustaining satisfactory relations. Through pastoral care, they can work toward realising their personal possibilities. All human beings struggle from time to time in their lives. These struggles are invariably rooted in human experiences, human limitations, relationships, and unfulfilled aspirations, all of which can be a source of frustration. Streets (2014:5) puts it as follows:

> Any number of things can interrupt and/or obstruct our efforts to live a meaningful life. Making meaning of our lives and discerning our own essence and value, and coping with the reality of death is a part of our ongoing human agenda that we cannot attend to alone. We are always selves-in-relationship with other people and nature itself. We become who we are as a result of our relationships with others. In this sense, we are made and healed in relationships just as we can also be destroyed by relationships.

All human beings need other people to speak to and who will listen to them. Listening and talking to one another is a crucial part of healing. The space that is shared through pastoral care between a pastor and counselee should be uninterrupted. It is a helping relationship characterised by listening love (Tillich 1963).

However, Streets (2014) points out that people, communities, and states can be impacted by traumatic events such as disease, which challenge the existential human condition and bring with it a new set of norms. This also has an impact on pastoral care and the ways in which it has traditionally been practised. In the context of a pandemic, such as COVID-19, for example, the usual ways of communication and the benefits they have, are affected. Benefits include being able to talk to someone who shows care and can create an atmosphere of safety and support. This gives some relief from the burdens people carry. The sense of relief enables them to deal more effectively with the challenges they face. It constitutes a source of empowerment (Streets 2014). Pastoral care does not only focus on individualist narratives but emphasises mutual care as an asset that can serve as a crucial source of support during difficult times. Streets (2014:3) puts it as follows: “Our failures and disappointments can blur our self-value, detracting from the creation of a healthy self-image and making it difficult for us to remember that we are created by God whose image we as human beings reflect”. Against this backdrop, pastoral care and its foundations of love play an important role in providing counselling and guidance. Tillich (1963:65) describes it as follows:

> Pastoral care transcends the limits of its techniques. It is certainly understandable that this aim is not always conscious to those who have the burden of daily work. It may be of inspiration to us to think that we contribute to the ultimate aim of being itself in our small way - and every individual's way is small ... In helping every individual to find the place where he can consider himself as necessary, you help to fulfil the ultimate aim of man and his world, namely, the universal community of all beings in which any individual aim is taken into the universal aim of being itself.

Most of the recent studies on the impact of the pandemic on religious communities focus on aspects such as worship services. This study focuses specifically on the implications for pastoral care. Existing research on this aspect includes the work of scholars such as Byrne and Nuzum (2020), Hall (2020), and Sylvester (2020). Byrne and Nuzum (2020) suggest

alternative ways of providing pastoral care during the pandemic. They explore the possibilities of virtual platforms and tools, such as virtual video-call technology via mobile devices and tablets. They show how these technologies supported the provision of pastoral care in the context of the pandemic and demonstrate how they addressed the issue of physical distance. The study by Sylvester (2020) found that the pandemic did not significantly impact the provision of pastoral care since pastors can still comfort others through prayer. The study by Hall (2020) focused on the provision of pastoral care in the hospital setting and argued that pastoral visits should be categorised as essential care. Hall (2020) is of the opinion that hospital administrators should develop policies and strategies that categorise members of the clergy as essential personnel while at the same time ensuring that they have adequate protection against health risks.

1.4 Research gap

Pastoral care is of a social nature. It relies on communication in the form of speaking, listening and gestures. In the context of a pandemic and its social distancing protocols, pastoral care was affected. The contribution of this study concerns the nature of the impact of the pandemic on pastoral care. The study explores the impact of the pandemic on pastoral care through an extensive analysis of the existing literature, drawing out the available and emergent data concerning the research question of how COVID-19 has impacted the nature and practice of pastoral care. The aim is to identify strategies for when changes in the usual ways of doing pastoral care are needed in the event of social restrictions such as those that have accompanied the pandemic. The results of the study can stimulate new knowledge about adapting pastoral care during unprecedented social disruptions.

1.5 Methodology

This is a qualitative literature study. The paradigm of the study is postmodern. For pastoral care scholar Carrie Doehring (2014), postmodern approaches to pastoral care adopt a trifocal lens that encapsulates all three approaches to knowledge: premodern, modern, and postmodern. The premodern lens is predicated on the view that God can be accessed via religious traditions, rituals and spiritual experiences. The modern prism emphasises the importance of empirical and rational knowledge, including knowledge gained from psychology, biblical critical methods and the medical field. The postmodern lens emphasises the provisional nature of knowledge (Doehring 2014). Within this framework of pastoral care, the first step is to listen to the story with empathy, “imaginatively stepping into the shoes of another person and seeing the world from his or her perspective” (Doehring 2014:18). To do so, pastors must concurrently adopt two opposite relational skills: connecting with

individuals with empathy, while maintaining separation from their experiences by being aware of the caregivers' own thoughts and feelings (Doehring 2014).

Epistemology pertains to how researchers understand knowledge or truth acquisition (Crotty 1998). Epistemology concerns the worldview held by researchers (Crotty 1998). According to Petty et al. (2012:3), epistemology can be defined as "a theory of knowledge of what can be known and what criteria it uses to justify it being knowledge". While epistemology concerns worldviews, ontology focuses on the researcher's perceptions of the nature of reality (Petty et al. 2012). Epistemology focuses on the nature of knowledge, but ontology focuses on the nature of reality. To address the research question, this study adopts a social constructivist epistemological position that, on the ontological level, is rooted in subjectivism. The point of departure of this study is that reality is socially constructed. According to Owen (1992:386), social constructivism can be understood as "the claim and viewpoint that the content of our consciousness, and the mode of relating we have to others, is taught by our culture and society; all the metaphysical quantities we take for granted are learned from others around us". This framework has an interpretivist character whereby emphasis is placed on meaning-making in specific contexts.

The study investigates the new views and norms regarding pastoral care that emerged because of changed circumstances brought about by the COVID-19 pandemic. Proponents of social constructivism as an epistemological framework, focus on not only the creation of meaning but how meaning is modified, negotiated, or sustained (Creswell 1998). This framework is, therefore, suitable for the study because the aim is to understand how the meaning of pastoral care has been modified, negotiated, or sustained during the pandemic. Social constructivism is also an appropriate epistemological framework for this study because, according to this epistemology, meaning is not understood to be universal, but rather context-specific. This will allow various views and experiences to be in order to critically unpack how the pandemic and its aftermath are shaping the nature and practice of pastoral care. Social constructivism is thus antithetical to the positivist framework, which relies on deduction and scientific enquiry. Its emphasis on cultural specificity, context and meaning lends itself to qualitative research. Patton (1985:1) explains the contextual and hermeneutical aspects of qualitative research as follows:

> An effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so

> it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting---what it means for participants to be in that setting, what their lives are like, what's going on for them, what their meanings are, what the world looks like in that particular setting … The analysis strives for depth of understanding.

In this study, pastoral care is understood from the *cura animarum specialis* perspective. This narrower meaning concerns the care and counselling that individuals receive on their personal journey of faith, particularly when they experience trials, tribulations, and crises. This form of care depends on personal communication, which includes non-verbal communication and body language. Restrictions in this regard because of the COVID-19 pandemic can therefore cause disruption of the quality of pastoral care and communication.

Bowen's (1966) Family Systems Theory will be utilised as the primary theoretical framework in the study. According to Matthews (2005), this theory is particularly useful for studies in the field of pastoral care and counselling because it "serves as a personal resource for the minister seeking to assume the non-reactive stance necessary for any attempt to understand more clearly the dynamics involved in a ministry situation. Closely related to this is the capacity of the theory's conceptual framework to provide an accurate and in-depth understanding of the often unrecognised but always determinative emotional process present in a situation" (Matthews 2005:436). This theory has been used in a wealth of studies that analyse Christian relationships, including those related to the practice of pastoral care in a congregational context.

This study reviews recent studies that have been emerging since the COVID-19 pandemic. In this sense, the study makes use of secondary data. No first-hand empirical data will be collected. Studies will be selected for analysis based on the following inclusion criteria:

- Studies must be published from 2019 and must relate to the COVID-19 pandemic and pastoral care or dimensions of pastoral care such as healing, the cure of souls cure, and the care of souls, among others.
- Studies must be published in peer-reviewed academic journals.
- Studies should be published in English.
- Studies must have their abstracts and full texts available.

- No geographical restrictions are delineated due to the limited availability of such studies.

Insights from literary sources will be analysed using narrative synthesis. The tools of narrative synthesis, as identified by Popay et al. (2006:5) as follows:

FIG.1 NARRATIVE SYNTHESIS TOOLS

The first tool, textual analysis, is the basic component or starting point of narrative synthesis. It will be utilised to articulate the results of the investigation of existing studies on the topic. Textual analysis will be conducted systematically by means of the second tool, namely groupings and clusters. This will enable patterns in the dataset to become more apparent. The patterns will be organised as themes and discussed.

1.6 Chapter outline

Chapter 2 presents an overview of the relevant literature and results of empirical studies. Appropriate pastoral care theories are selected and discussed briefly. The *cura animarum specialis* perspective on pastoral care is worked out in greater detail.

Chapter 3 explores the results of empirical studies that have emerged in the wake of the pandemic thus far. This chapter utilises Bowen's family system theory, which is particularly useful for the study of pastoral care. The chapter illustrates how this theory has been applied in pastoral care studies in general and then focuses on how it can be applied specifically to pastoral caregiving during a pandemic.

Chapter 4 integrates the insights from the previous chapters in conversation with the study objectives. The results of the existing studies are interpreted by means of the theoretical framework of this study. The chapter describes and explains the nature of the impact of the pandemic on pastoral care.

Chapter 5 presents the findings and recommendations of the study.

CHAPTER 2

PASTORAL CARE, TRAUMA AND DISRUPTION

2.1 Conceptualising pastoral care

This chapter focuses on pastoral care, especially in situations of trauma and disruption. Historically, Judaeo-Christian traditions have conceptualised pastoral care as more general support for people in the eventualities of life and, more specifically, also as crisis care. This care is provided by both ordained pastors and members of religious communities (Doehring 2015). The image of care provided by a shepherd to the flock, which embodies the love of God, has been used both historically and biblically to illustrate how Christian and Jewish leaders provide spiritual care for members of faith communities and others (Gerkin 1997).

The Bible portrays God as one who is omnipresent and oversees all of creation, caring, loving and showing concern for all. God's provision of care as a helper is the subject of Isaiah 41: 10: "So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand." In 1 Peter 5: 7, believers are encouraged to "cast all your anxiety on him because he cares for you." Pastoral care is consequently the provision of care and spiritual guidance.

The concept of pastoral care is specific to the Judeo-Christian tradition, though the term is sometimes used to also describe spiritual care in other religious traditions. However, Carrie Doehring (2015) draws distinctions between pastoral care and spiritual care. Pastoral care has the capacity to make use of specific religious rituals, symbols and traditions during times of crisis. Pastoral care draws upon the image of the shepherd depicted in the Judea-Christian tradition and its sacred texts (Klessmann 2010). In the Christian tradition, Jesus is seen as the great shepherd who healed, strengthened, taught, and consoled his flock (Ağılkaya-Şahin 2015). Christian pastoral care draws on a Trinitarian understanding of God as Creator, Redeemer and Holy Spirit (Woldemichael et al. 2013). The incarnation of Jesus, the Redeemer, constitutes the highest expression of God’s love. Jesus shared people’s humanity and gave himself for the sake of humanity and out of love for humanity. Pastoral care praxis is rooted in this Christ-like love and is performed in the name of faith in Jesus Christ (Woldemichael et al. 2013). Through their caring praxis, pastors demonstrate Christ-like behaviour and, in this way, spread the good news of God’s love (Woldemichael et al., 2013).

Pastoral care has several meanings depending on the historical and global context within which it is understood (Doehring 2015). Although in the early church, pastoral care was understood in terms of shepherding, during the Middle Ages, the idea of *cura animarum* or soul care became integrated into church law, and pastoral care was understood as acts in the name of God that support or encourage the salvation of the soul (see Johnson, 2007; Cole 2010; Louw 2010). Soul care is perceived as a general form of service but also as a specific type of service by the clergy to individual members of the religious community (Ağılkaya-Şahin 2015). The term *cura animarum specialis* pertains to the care and counselling that individuals receive on their personal journey of faith during experiences of trials, tribulation and crisis. In the Roman Catholic Church, *cura animarum generalis* has generally been understood as all the duties performed by the clergy. In the Protestant tradition, pastoral care as *cura animarum specialis* pertains to direct personal intervention as an individual service to soul care (Ağılkaya-Şahin 2015). In the North American context, pastoral care has been understood in terms of crisis intervention in response to traumatic experiences such as a sudden loss, followed by supportive care (Doehring 2015). Pastoral care as a form of crisis intervention is typically offered to families, communities and individuals who experience difficulties or crises or go through a difficult transition. In such challenging circumstances, they need all the support systems and resources that are usually available to them. During the acute phase of the crisis or transition, pastoral care takes the form of crisis intervention. When this phase subsides, it is reconfigured into supportive care.

Supportive care or "sustaining" assists individuals in coping with the long-term impact associated with a crisis. According to Doehring (2015:xxii), "supportive care is a spiritual presence that comes alongside people in an ongoing way (such as visitation) or at strategic moments (such as baptismal or premarital counselling". Supportive care, therefore, sustains individuals as they move through life transitions. Pastoral care that is specially offered to the frail and elderly is typically supportive care that helps to sustain them during the experience of multiple losses. This interpretation of pastoral care aligns with Hulme's (1981) definition, where pastoral care is conceptualised in terms of supportive care for church members who are experiencing challenges and trials including illness and bereavement. Hulme (1981) refers to the biblical story of Job as an illustration of what supportive pastoral care entails. Pastoral care supports and encourages Christian believers as they proceed with their everyday engagements. In this way, pastoral care also provides them with an external perspective on the self which is vital for renewal during times of crisis (Ağılkaya-Şahin 2015). Pastoral care entails guidance for coping with life's challenges. Through this guidance,

people can (re)discover their worth and value as human beings created in the image of God (Baumgartner and Muller 1990). Pastoral care encourages self-realisation and self-actualisation.

Pastoral care is also understood in terms of a *healing ministry* for individuals who have been wounded in their everyday lives (Sifo and Masango 2014). The aim of a healing ministry is the restoration of weak and emotionally wounded people to wholeness (Clebsch and Jaeckle 1996). In this process of healing, religious symbols and rituals can contribute to believers attaining new spiritual insight and improving their spiritual welfare (Clebsch and Jaeckle 1996). This relates to the theological idea of healing "the cure of the soul" (Jibiliza and Kumalo and Kumalo 2021; see Louw 2011a, 2011b; Louw et al. 2012; Louw 2020). Pastoral healing plays a transformative role in the lives of Christian believers as it highlights the disconnect between their present lives and how their lives should and could be in light of their faith. Consequently, pastoral care encourages Christian believers to make wholesome and responsible choices.

Aside from the pastoral care functions of sustaining and healing people who experience crises, pastoral care also involves *guidance*. The role of guidance is to facilitate people to make effective decisions, even under pressure, taking the implications of their decisions into account. These decisions have an impact on the future path of the soul. Guidance in pastoral care can take two forms: educative and inductive (Clebsch and Jaeckle 1996:9). For educative guidance, pastors draw upon the experiences of the person as a decision-making tool (Clebsch and Jaeckle 1996:9). Inductive guidance draws upon existing frameworks for decision-making and is consequently theory-driven (Jibiliza and Kumalo and Kumalo 2021). Pastoral care also has the function of *reconciliation*, whereby pastors play a role in the mending of broken relationships. This can be broken relationships between Christian believers and God or between human persons. Pastoral care encourages forgiveness to restore souls. From a psychological perspective, forgiveness should not be rushed or coerced because that could be more damaging than healing (see Schnabl Schweitzer 2010:829-842). When facilitated appropriately, Jibiliza and Kumalo and Kumalo (2021:3) explain that "reconciliation takes place through forgiveness which can be a proclamation and re-uniting of persons or groups. Moreover, discipline is a mode that is concerned with confession and the amendment of one's life".

Since the late 19th century and throughout the 20th century, pastoral care became inextricably linked with psychology and psychotherapy, especially in the North American

context. Sperry (2002:2; see Sperry 2012, 2013) refers to this as the “psychologization of spirituality”. The rise of the academic field of pastoral psychology in the US has been reported by scholars in theology such as Capps (2001), Cole (2001), Pavesi (2010) and Snodgrass (2007). Pastoral psychology entails the application of modern psychology to pastoral care within Christian churches (see Marteau 2018). This approach to pastoral care integrates techniques and insights from three primary sources: theological sources of Judeo-Christian heritage, therapeutic methods from the field of psychology, and contemporary knowledge about interpersonal relationships and human personalities derived from the human sciences (Marteau 2018). Contemporary understandings of pastoral care, which were formed during the 20th-century pastoral care movement in the United States, integrate ideas of *cura animarum specialis* with psychological concepts (Ağılkaya-Şahin 2015). This notion of pastoral care has an interdisciplinary character that is rooted in the human and social sciences (Ağılkaya-Şahin 2015). In contemporary approaches to pastoral care, the Greek word *therapeuo* is of significance. In the New International Dictionary of New Testament Theology (Reeves and Brown 1971), this word is linked to the concept of recovery, although, in the New Testament itself, it is used primarily in the context of healing and a willingness to serve or give. *Therapeuo* encapsulates the process of healing, renewal and restoration, not only in the context of individuals’ relationship with God but also in their relationship with others.

Growth constitutes an important objective of pastoral care (Clinebell 1984; Krogsrud 2021). The aspect of pastoral care does not only focus on growth at the level of the self but also in society at large. This aligns with the concerns of practical theology, which emphasise how meaning is generated in relationships as part of broader discourses concerning the role of theology in human contexts (Mouton 2014; see Louw 1999; Pattison and Woodward 2005; McClure 2012). Against this backdrop, pastoral care, with its roots in practical theology, "appears to be about change, transformation, relationships, lived reality, praxis-theory interaction, reflection, interpretation, meaning-generation and care” (Mouton, 2014:102). Pastoral care is about a reflective awareness of the “praxis of God as related to the praxis of faith within a vivid social, cultural and contextual encounter between God and human beings” (Louw 2008:17).

Pastoral care is also a relationship and an encounter that takes place within faith communities. It is a religious and spiritual event. The pastor as counsellor represents the faith community as a whole (Moran et al. 2005). The counselling relationship draws on

religious rituals, understandings of faith and symbols such as prayer. Pastors aim to support and guide members of the Christian faith community to draw closer to God. Pastoral care finds roots in Judeo-Christian views of the human person as *imago Dei* (Woldemichael et al. 2013). This influences pastoral practice and the caregiving relationship. The point of departure is that all human beings are fundamentally equal before God and function on the same level of human dignity (Woldemichael et al. 2013), even though there is a power difference between pastors and counselees. Pastors, from their professional position, provide care and listen to the members of the faith community. They, therefore, have privileged information about the personal lives of individuals. Pastoral care necessitates active and empathic listening. The space shared by a pastor and counselee is "sacred ground", which requires listening love (Tillich 1963). Pastoral care is about understanding the concerns of others from their perspective. While verbal communication constitutes a central part of the provision of pastoral care, words do not always suffice for expressing the breadth of religious and human commitment towards others, particularly those in distress (Liegeois 2016). Often when people are in severe distress, they lack the capacity to talk about their challenges. Non-verbal communication, both on the part of the pastor and the individual, can be a different way of expressing and coming to an understanding of the depth of what is communicated. Physical proximity, body language and physical touch can be signals of hope and comfort in the practice of pastoral care (Liegeois 2016).

Although Christian pastoral care is predicated on beliefs concerning Jesus Christ and biblical interpretations, some individuals develop a religious identity that is not strictly conformist. They often draw on other religious traditions and influences. Doehring (2015) points out that since religious identity is becoming increasingly pluralistic, pastors can no longer assume that members of their faith communities share similar cornerstone beliefs and must therefore adopt an intercultural or postmodern approach.

2.2 Paradigms of pastoral care

This is a qualitative study, and it draws from a postmodern paradigm. The premodern lens is predicated on the view that God can be accessed via religious traditions, rituals and spiritual experiences. The modern prism emphasises the importance of empirical and rational knowledge, including knowledge gained from psychology, biblical critical methods and the medical field, while the postmodern lens emphasises the provisional nature of knowledge (Doehring 2014).

According to Doehring (2014), pastoral caregivers draw upon all three approaches to knowledge. Pastors effectively draw upon a premodern lens when they focus on the care seeker's religious and spiritual experiences of feeling a connection to God. Through a premodern lens, pastors can explore the way in which care seekers experience their connection to God. Further, they can determine the extent to which religious and spiritual practices effectively induce God's presence in their lives. A premodern lens enables pastors to determine whether moments of feeling a connection to God arise in the midst of worship, during participation in rituals or sacraments, via the singing of hymns, or "in the contemplation of an icon or statue in the sanctuary of their community of faith" (Doehring 2014:2). Ultimately, the aim of religious and spiritual practices is to facilitate experiences of the divine or sacred; thus, pastors can use a premodern approach to focus on such practices. Through a premodern lens, pastors can be aware of moments during their interactions with care seekers when they are able to connect with God. These moments may arise during prayer or by talking about their feelings and experiences. Pastors, alongside care seekers, can also explore which spiritual practices may be helpful for enhancing the latter's connection to God in the midst of trials and tribulations. In other words, a premodern lens supports coping mechanisms to be determined, whether this is through religious hymns that offer comfort or meaning derived from reading the book of Psalms, amongst others.

Pastors can enhance pastoral care even further by shifting to a modern approach to knowledge during the administering of pastoral care. A modern approach involves drawing upon biblical critical methods, modern theological perspectives, as well as medical or psychological perspectives in relation to life events such as grief and death. Pastor's knowledge of the effective use of biblical critical methods can be of relevance in responding to the problems of care seekers (Doehring 2014). Pastors' knowledge of theological perspectives regarding God's presence during experiences of suffering can offer them various ways to respond to care seeker's challenges (Baucom 1997). Through pastors' knowledge of psychological perspectives, they can respond to care seekers' shock or stress while making them aware of the psychological underpinnings of their experiences or respond to crises. Through the process of drawing knowledge acquired from modern approaches to theological problems such as suffering, understanding biblical texts, and understanding the psychological experience of life events such as grief or acute stress, pastors use a modern lens (Doehring 2014; Thorstenson 2012; Lee 2017; Louw 1998).

Pastors adopt a postmodern lens when they interact with care seekers and become aware of their responses to crisis and how this is shaped by various social factors (Thorstenson 2012). These social factors include the history of the caregiver, their religion, sex, race, sexual orientation, age and social class. A postmodern lens aligns in this way with Bowen's Family Systems Theory which adopts a systems approach to pastoral care (Bowen 1985). Pastors who adopt a postmodern approach consider how the unique experiences of care seekers influence their responses to life events. During pastoral care conversations, pastors can leverage language and religious practices to participate in the process of co-constructing religious ways of establishing a connection with God and making sense of life events (Doehring 2014). Pastors, as they engage with care seekers, draw upon the theological, cultural, and contextual psychological meanings that are co-constructed. A postmodern lens assists pastors in focusing on specific religious meanings and approaches to connecting with God that is co-constructed and that have relevance to the crises experienced by care seekers (Doehring 2014; Sims 1998).

The process of moving across premodern, modern and postmodern approaches to knowledge in pastoral care, according to Doehring (2014), typically follows a pattern which involves pastoral caregivers beginning with a premodern approach as a strategy for helping care seekers acquire a sense of God's presence during moments of crisis. Pastors also initially rely on modern approaches so that they can gain a nuanced understanding of the medical or psychological aspects of a crisis. Although pastors use a premodern approach to connect with God, they leverage modern approaches to understand what has happened in the lives of care seekers, helping them to realise how much they do not know. Further, a premodern approach enables pastors to understand how the experiences of care seekers are influenced by the context in which they live and who they are (Doehring 2014). According to Doehring (2014:4), "with this realisation comes an acknowledgement of the provisionality of knowledge and an awareness of the relevance of a postmodern approach".

According to Doehring (2014:4), pastoral caregivers who take up a trifocal lens are less likely to provide limited care rooted in premodern, modern, or postmodern approaches to knowledge. When these approaches are used independently or exclusively, the administering of care is not holistic. For example, using a premodern approach exclusively culminates in the practice of nouthetic or biblical counselling, which involves biblical texts being literally interpreted and applied in directive ways. Doehring (2014:5) states that "pastoral caregivers who only use premodern approaches to knowledge, bracketing the

critical approaches of modern and postmodern thinkers, believe the absolute truth of their religious traditions, similar to the beliefs of the church in ancient and medieval times. In an extreme form of premodern pastoral care, caregivers reject scientific knowledge altogether".

Pastoral caregivers who exclusively draw upon modern approaches to knowledge miss out on the contextual meanings that then do not form a part of their theoretical perspectives. By relying on biblical critical and other such methods, pastors can assume that questions about the underlying meanings of the biblical text can be applied in all pastoral care conversations. However, such questions may not be relevant to the circumstances of care seekers. For example for care seekers who experience grief, aspects of grief that are not conceptualised via the psychological and theological perspectives with which they are familiar, can be ignored.

Within a postmodern framework of pastoral care, the first step is to listen to the story of the care seeker with empathy and to "imaginatively stepping into the shoes of another person and seeing the world from his or her perspective" (Doehring 2014:18). This involves two simultaneous and opposite relational skills. Doehring (2014:18) suggests that the caregiver connects with the care seeker by experiencing what it is like to be them, yet maintains separation by being aware of one's own feelings and thoughts. Doehring (2014), however, advises against exclusively adopting a postmodern approach because there is the risk of neglecting care seekers during a crisis where they require the experience of a tangible connection with God. Pastoral caregivers who are cognisant of postmodern concerns about how people can acquire a sense of the sacred may be inhibited during their conversations with care seekers about how to cope with stressors from a religious or spiritual perspective. Doehring (2014:5) is of the view that "their fear of knowing how to respond when care seekers describe seemingly simplistic or naïve ways of understanding God may make it hard for caregivers to have any conversations about God or the care seeker's sense of the sacred". Further, adopting an exclusive postmodern approach in which there is a focus on ways of understanding God, ignoring the meanings that are relevant for people in crises, can cause care seekers to be deprived of immediate spiritual comfort or guidance. Thus, while this study adopts a postmodern approach to pastoral care, the importance of a trifocal lens to knowledge acquisition is understood.

2.3 Pastoral care, traumatic events and social disruption

A crisis is not limited to the emotionally turbulent or spiritual state of individuals where typical coping methods and resources fail to be effective. Scholars such as Streets (2014) have

underscored that people, communities, and states can be impacted by traumatic events such as disease, which challenge the existential human condition and bring with it a new set of norms. Amidst these social disruptions, the practice of pastoral care, as known traditionally, is also impacted. In the context of the COVID-19 pandemic, for example, communication flows were interrupted and consequently disrupted the physical practices and embodied experiences that are linked with pastoral care. As has been previously noted, verbal and non-verbal communication both play a role in creating an atmosphere of support and safety during the provision of care (Streets 2014). During social disruptions and traumatic events, pastoral care draws upon its foundations of love to provide counselling and guidance (Tillich 1963). In this context, pastoral care resonates with the character of a compassionate God and, consequently, requires a shift in how the theology of care is understood in the traditional clerical, ecclesial model as well as within phenomenological paradigms to capture a theopaschitic approach that embodies relational and inclusive care that embodies the compassion of God (Mouton 2014).

Mouton (2014) proposes that during social disruptions and traumatic events, care praxis must be informed and governed by the concept of *passio Dei* or compassion of the suffering God to bring hope to traumatised and disrupted communities. A theopaschitic approach is inherently inclusive and promotes the notion of a compassionate God who provides the healing; Mouton (2014) argues that it can therefore help to shift pastoral theology from a theistic God (out there) to a passionate God (right here). Mouton (2014) also proposes that this approach can encourage liberating and community-oriented praxis. Thus, in the context of traumatised and disrupted communities, pastoral care is particularly effective when an integrative approach to health and wellbeing is used. This approach conceptualises individuals not only as humans that are spiritually integrated but consider the communal, social and relational dimensions of human living (Mouton 2014). In contrast to individualist narratives, pastoral care emphasises mutual dependence as an asset that can serve as a crucial source of support during difficult times. Streets (2014:3) puts it as follows: "Our failures and disappointments can blur our self-value, detracting from the creation of a healthy self-image and making it difficult for us to remember that we are created by God whose image we as human beings reflect". Against this backdrop, pastoral care and its foundations of love play an important role in providing counselling and guidance during social disruptions and traumatic events.

2.4 *Cura animarum specialis*

In this study, pastoral care is understood from the *cura animarum specialis* perspective and thus has a narrower meaning which concerns the care and counselling that individuals receive on their personal journey of faith, particularly when they experience trials, tribulations, and crises. This form of care depends on personal communication, which includes non-verbal communication and body language. Restrictions because of the COVID-19 pandemic caused disruption in the quality of pastoral care and communication. Pastoral care as *cura animarum specialis* concerns the cure of souls or caring for individuals in their existential situations (Mills1990). For the practical theologian Daniël Louw (2014), the term references a specific form of care. This form of caring relates to caring for human life mainly because it is a creation of God, belongs to God and is saved by God in Christ. *Cura animarum* encapsulates care for the person as an expression of Christian spirituality. This form of soul care prioritises individuals and the centre of their existence, which includes their focus and dependence on God, drawing from their faith. In the contemporary context, both helping and healing professions have been inclined to conceptualise *cura animarum specialis* as spiritual care, which Louw (2014) argues is erroneous. According to Louw (2014), focusing on spiritual healing risks the adoption of a superfluous approach to pastoral care and unnecessary professionalisation. Louw (2014) thus suggests that pastoral care must be understood mainly in terms of the caring of souls as opposed to spiritual healing. As noted by Magezi (2019:2), "the combination between 'soul' (Hebrew *nēphēsh*; Septuagint: *psuchē*; Latin: *anima*), care and cure captures the core identity of caregiving and can be rendered as the basic proposition for a Christian approach to caregiving, which keeps the Christian identity clear*"*.

At the heart of pastoral care is a focus on the total human being and their need for healing or care and cure. This classical conceptualisation of pastoral care includes two distinct but interlinked activities, which are *caring for* souls and the *cure of* souls.

The *cura animarum specialis* perspective recognises that Christian believers also require a spiritual cure. Spiritual cure, unlike spiritual care, does not concern the maintenance of spiritual health. It concerns the restoration and guarding of spiritual health. Like the Good Shepherd, pastors know their sheep and take care of their souls according to their needs. Pastoral care is context specific as Christian believers have different spiritual needs and dispositions which inform the tailoring of pastoral care.

Traditionally, within the philosophy of *cura animarum specialis*, care was highly individualistic. However, this has shifted to more psycho-systemic approaches, which aim to understand the human personality in contextual as opposed to individualistic terms (Magezi 2019). This has led to the emergence of a systems approach in the provision of pastoral care. Systems approaches aim to understand individuals within the context of their dynamic networks of relationships. Consequently, in pastoral care, the problems of the individual are understood not only as located in the person but within the broader system in which they exist. A systems approach to pastoral care is holistic and promotes wholeness or the alignment between the mind, body, and spirit. It also strives for an alignment between the individual and others, as well as between the individual, nature, and God (Magezi 2019).

CHAPTER 3
PANDEMIC-RELATED EMPIRICAL STUDIES AND BOWEN'S FAMILY SYSTEM THEORY

3.1 Pastoral care and COVID-19

This chapter explores the results of empirical studies that emerged following the pandemic. It identifies Bowen's Family System Theory as particularly useful for pastoral care and illustrates how it can be applied to pastoral care during a pandemic or other situations of extreme social disruption.

It has become commonly accepted that health does not only concern the lack of physical infirmity but also encapsulates social and mental wellbeing (Parmer and Rogers 1997; Visser et al. 2009; Mouton 2014; Geer et al. 2018; Visser 2020). Health has also been shown to encompass the faith maturity of individuals, the quality of their relationships, their value systems and the normative aspects of their lives (Mouton 2014; Louw 2008). Pastoral care, with its emphasis on restoration, focuses on the restoration of the wellbeing of communities and the individuals that make them. This includes the spiritual, cognitive, occupational, social, affective and physical aspects of their lives (Fiorita and Ryan 2007; Utley and Wachholtz 2011; Mouton 2014). This suggests a holistic approach to the nexus that exists between life and health. Healing and restoration would then include the use of not only spiritual resources but also cultural, social and psychological ones. In the context of health-related crises, pastoral care and its community-oriented approach acknowledge that individuals function within networks of interpersonal relationships. Consequently, the practice of pastoral care functions for the purpose of society at large.

According to Mouton (2012), the notion that individual wellbeing can only be achieved within communities aligns with biblical perspectives. In the context of the COVID-19 pandemic and its unprecedented social distancing requirements, the practice of pastoral care oriented towards communities amidst health disruptions was challenged considerably. Various studies have analysed the impact of the pandemic on churches. Some of these have recorded the implications for pastoral care by drawing upon the experiences of the clergy

(see Byrne and Nuzum 2020; Hall 2020; Sylvester 2020; Haubmann and Fritz 2022; Spears and Green 2022; Tan et al. 2021; and Mutch et al. 2021).

In Byrne and Nuzum's (2020) study, the researchers considered the limitations of pastoral care and highlighted the potential role of virtual platforms and tools for practising care, focusing on mobile devices and tablets. The scholars focused on disruptions to communication and proposed that virtual video-call technology can be used as a salient tool for pastoral care to counteract the limitations of social distancing. Sylvester (2020) focused on how the pandemic impacted the practice of pastoral care and found that the pandemic has not caused significant changes to pastoral care since pastors are still able to support members by praying for them.

Hall's (2020) research focused primarily on the hospital setting and how pastoral care can be integrated into essential care so that individuals receive the support they require despite the restrictions of the pandemic. Hall (2020) proposed that hospital policymakers and administrators must design policies and approaches that integrate members of the clergy into the provision of emergency care, by categorising pastoral care as essential care. Hall (2020) emphasises the need for adequate protection for pastors in order to circumvent health risks.

Haubmann and Fritz (2022) explored the challenges that arose in pastoral care due to physical distancing and an increase in mental and social distress. They documented that daily burdens linked to the pandemic increased the need for pastoral care across various settings, including church congregations, schools and hospitals. The study drew upon data from 307 pastoral carers in Germany to assess the needs of pastoral carers, inter-professional cooperation, media use and topics of communication. The study found the following (Haubmann and Fritz 2022:141):

> A drastic decline in face-to-face communication, with significant differences between the various fields of pastoral care. The use of media has increased significantly, with a preference for synchronous interaction via telephone and video. Topics of pastoral care varied from everyday hassles to existential concerns, also including spiritual needs and struggles. Social isolation, the need to just talk to someone and the need for comfort and hope were mentioned the most. During the pandemic, pastoral carers used various media and established new ways to enable encounters and maintain contact.

Both Byrne and Nuzum (2020) and Haubmann and Fritz (2022) emphasised the importance of developing new methods for practising pastoral care during a pandemic or other events of social disruption. The study by Sagrove (2021) investigated the impact of the pandemic on churches, the clergy and chaplains. Sagrove (2021:8) puts it as follows:

> One of the most striking aspects of the pandemic and its impact on churches, chaplains and clergy have been the ways in which the constituencies receiving care have changed, and new groups have been drawn to pastoral caregivers in institutional and parish life. The pandemic has shaken up the relationships between churches, parish clergy and the communities that they serve. It has engendered new forms of cross-sectoral partnership, new understandings of the context in which churches are ministering, and, for some, new languages for thinking about the relationships between the 'church', the 'community' and what belonging to the parish, and the Body of Christ might mean. That these new forms of the church community are recognised, explored and understood by the institutional centre is an urgent task.

Sagrove (2021:8) found that in the context of COVID-19, chaplains drew from various geographical and institutional contexts and played a role in addressing national divides through spirituality and

> negotiating and delivering Christian care within a range of institutional and secular cultures, including hospitals, care homes and maritime settings. Chaplains have also demonstrated their skills in extending care across cultural worldviews through ministries to diaspora communities in the UK and beyond. These expert bridge builders, able to understand and speak a number of different institutional, cultural and national languages, continue to minister to communities that are particularly vulnerable to Covid 19 and to the wider social forces that marginalise them.

Against this backdrop, pastoral care targeted marginalised groups which include refugees, asylum seekers, cultural minorities, children, the sick, the elderly, and people locked down on ships or in foreign countries. Pastoral care specifically addressed the inability of these categories of persons to engage with their loved ones and families because of their geographic location, passports, or limited finances due to the Covid-19 pandemic. Johnston et al. (2021:6) in their study, found that:

> As a result of the pandemic, pastors could no longer take the “how-to’s” of ministry for granted. Steven told us that before COVID, “you just kind of had a

> routine," but in the wake of COVID-related restrictions, everything became the focus of conscious thought and deliberation. Without routine practices or explicit guidelines to fall back on, pastors deliberated and decided how best to do the work of ministry in ways that were both safe and satisfying for congregants.

The various studies also found that the pandemic brought about limitations in how pastors liaise with their congregants. Pastors had to meet with a higher number of pastoral teams and lay leaders in order to provide care conjointly. These teams had to decide how to do this in a unique context.

In a study by Abraham et al. (2021), the scholars conducted a descriptive qualitative study concerning the pastoral care of congregations during the pandemic, in the context of Indonesia. The study, amongst other things, found that worship became centred in the home as opposed to in the church building in parallel with the early congregation. The scholars conceptualised this trend as a positive impact of the pandemic on pastoral care because church services overwhelmingly focus on the clergy without considering or involving the congregation, who are members of Christ's body. A key finding made by the study in this regard was that the pandemic revealed the importance of spiritual growth and showed that it is the responsibility of all believers as opposed to pastors alone. The study found that the pandemic caused pastors to become increasingly aware of the importance of training members properly so that they are empowered during times of social disruptions.

Abraham et al. (2021) highlighted the disadvantages of moving away from the church as a place of worship because of the pandemic because worship in church constitutes a form of family discipleship which Jesus mandated before ascending into Heaven. Thus, in this study, the pandemic was conceptualised as problematic in terms of breaking family bonds headed by members of the clergy. The study viewed the breaking down of family bonds as problematic because it argues that family is an objective of Christ's commission. According to the scholars, family is at the core of discipleship and spiritual transformation, and family constitutes the smallest but most powerful unit within which spiritual growth occurs. The scholars thus argue that members of the clergy must devise strategies for ensuring that exemplary family-related activities, training, and mentoring can be performed are performed during pandemics so that the family unit can remain spiritually strong despite social disruptions.

Abraham et al. (2021) also found that the pandemic improved online ministry for members of the clergy due to the limits placed on in-person encounters. They suggested that in the post-pandemic context, members of the clergy must enhance their ministry in the church

building, for example, by leveraging technology to broadcast Sunday worship and boosting the reach of the gospel. They also noted that in a post-pandemic context, social media could be leveraged for members of the clergy to discuss spiritual matters with congregants, especially since the pandemic made people become more cognizant of the fragility of human life. Abraham et al. (2021) hypothesised that in a post-pandemic context, such realisations will cause Christian believers to start looking for God, although, in some instances, they might not want to be tied to specific church institutions. Pastoral care was conceptualised as having an important function in this context, although the scholars argued that it should be provided in a way that takes advantage of technological advances. The study found that many members of the clergy lack skills in using digital resources and equipment, undermining the opportunity to make progress in this area. Abraham et al. (2022) recommended that:

> an adequate allocation of funds is needed for the implementation, as changes due to this pandemic will cause those that lack or are unable to use communication tools or social media to feel marginalised and disconnected from others. This means that the church should be ready to change and pay the ensuing price. Meanwhile, many churches have paid attention to the needs of their congregations or community through the deacon's ministry, for example, by supplying groceries. This is also done by the government and other communities, which provide financial assistance. However, the majority needs more attention than this via communication with others.

The scholars further noted that in the post-pandemic context, pastoral care needs to gravitate towards online ministry so that Christian believers can feel God's presence during experiences of sickness and loneliness and in situations that require spiritual support. The study showed that many Christian believers are using the Internet as part of their daily activities, for example, by communicating through social media, and this trend is accompanied by an increasing reluctance on the part of Christian believers to attend church in person—rather focusing on digital worship via technology and devices such as smartphones.

Consequently, Abraham et al. (2022) argue that the trend that pastors must follow in the provision of pastoral care is to implement online options as they cannot be indifferent to a change that is occurring and that has been quickened by the pandemic. The proposal that pastoral care should shift to online platforms was produced by Abraham et al.'s (2022) belief that online platforms are the best way to target young generations who are also in need of pastoral care.

The scholars noted that younger generations are more dependent on the Internet; thus, members of the clergy can leverage these platforms to provide inter-generational pastoral care that empowers Generations Y and Z to pursue their spiritual growth.

Another study by Isetti et al. (2021) sought to investigate the impact of the pandemic on catholic pastoral care via an exploratory study which was conducted in Italy, specifically, South Tyrol, through an online survey which was distributed to parish priests that had an office in the local Diocese. The study had three overarching aims: to understand how pastoral care was delivered during the pandemic, to understand emergent changes to pastoral care due to the introduction of Information and Communication Technology (ICT) in religious activities, and to understand the future trajectory of pastoral care amidst changes brought on by the pandemic that is leading to the mediatisation of pastoral care. Respondents in the study reported that the pandemic caused a slowed down in pastoral activities despite the fact that the clergy maintained contact with Christian believers, either via the phone or through the Internet. Further, the respondents also noted an increase in the level of digitalisation within parishes, while attitudes towards this process of digitisation were polemical. Some respondents felt that digital media has the propensity to enhance the relationship between the church and congregants, while other respondents reported that digital media would weaken these relationships.

In Isetti et al.'s (2021) study, 164 participants completed the survey, with priests representing 33.1% of the research sample. Since the survey was predominantly administered online, under-coverage in the study was noted because responses were only elicited from priests that had access to the Internet during the data collection period. Due to this limitation, Isetti et al. (2021) sought to determine the representativeness of the research sample by analysing the language of completion and determining whether these aligned with the linguistic affiliation of the parishes. Priests that featured in the study were also from a specific age group and were 77 years in age on average which may also skew results. The sample characteristics indicate that the research findings must be contextualised; however, the scholars found that pastoral care was underpinned by three main attitudes during the pandemic, which were replacement, reproduction, and suspension. Specifically, some priests decided to take a break from providing pastoral care, which Isetti et al. (2021) found was linked to the number of parishes that priests were responsible for in terms of providing pastoral care.

According to the scholars:

> priests with one or two parishes (27.61) tend to agree more with the statement “For many people, religion and spirituality can help to deal with this difficult situation” than priests with three or more (19.63) ($z = -2.203$, $p = 0.028$). At the same time, the latter (26.94) agree more with the statement:Pastoral activity has slowed down during this period of crisis” than those with only one or two parishes (18.07) ($z = 2.340$, $p = 0.019$). These two factors might indicate that respondents administering three or more parishes encountered more difficulties in supporting their parishioners during the pandemic and are therefore generally less optimistic that religion can be a help for the faithful. This is also confirmed by at least six presidents working alongside priests who have to administer to other parish(es) in addition to theirs. For example, when asked within an open-ended question about their perception of the relationship between the faithful and the parish priest during the lockdown period, two of them stated: “In our parish nothing was shared with our priest because he has his seat in the neighbour’s parish and we never saw him the whole time” (respondent 38, president), and “As the pastor is not resident in our parish, contact with him has been broken off. Only in case of urgent questions or in case of death he is ‘consulted’ over the telephone” (respondent 98, president).

It is imperative to note that at the time of conducting the survey, the sample priests were predominantly using technological platforms to provide pastoral care and when disaggregated according to platforms, it was found that WhatsApp (76.2%), e-mail (75.6%) chat and social media platforms such as Facebook (28.0%) were the most predominant. This was followed by other platforms such as the parish website (27.4%), YouTube (24.4%) and Zoom (13.4%), which, comparatively, were less used by priests. Despite the increased use of technology in providing pastoral care, the respondents in the study reported that pastoral care had not been significantly changed by the pandemic. For respondents who believed that the pandemic had sparked the digitalisation of pastoral care, it was believed that this was merely a temporary change which would be undone following the culmination of the pandemic. Respondents that conceptualised digitalisation as temporary held this view because they believed that in the contemporary context, religious life is of little interest to the majority of people, so that God and the need for pastoral care only become pertinent during times of crisis.

According to the respondents, following such crises, there is a return to normal routines and the need for pastoral care declines significantly. Contrastingly, some respondents held the

view that the pandemic strengthened the relationship between members of the clergy and congregants. They argued that there was already a decline in church attendance and the need for pastoral care before the pandemic but despite the reduced need, an increase in commitment can be observed since social distancing measures which were applied during the pandemic have made Christian believers more appreciative of the importance of religious practices and rituals. Digital media was, however, conceptualised ambivalently in the study, whereby respondents viewed it as a factor that could either weaken or strengthen pastoral care. On the one hand, some of the respondents believed that the digitalisation of pastoral care embrittled interpersonal relationships between pastors and congregants, while others believed that limitations in physical relationships inspired new modes of interaction that encouraged spiritual closeness and thus, helped to achieve stronger relationships between pastors and Christian believers.

Respondents who believed that the pandemic had weakened the interpersonal relationship concomitant with pastoral care believed that these bonds were already weakening even before the pandemic due to the failure of the church to modernise and to issues facing the church, such as the abuse of power. Respondents in Isetti et al.'s (2021) study found that owing to the social distancing measures that were concomitant with the pandemic Christian believers stopped attending rituals or attended, at the very least, digitally. They proposed that Christian believers, during the pandemic, became used to switching their religiosity on and off, which undermined not only the concept of church and religious community in their lives but also pastoral care. Some respondents said that the pandemic diminished the need for pastoral care as Christian believers became more independent in their faith. Out of these respondents, a small segment believed that this independence was only temporary, with the post-pandemic context likely to be concomitant with smaller churches that nevertheless maintain a role for pastoral care. Another segment of the respondents believed that in the post-pandemic context, pastoral care is likely to be shaped by the experiences of lockdown since Christian believers are more likely to be inclined towards digital content as used in pastoral activities. Views about the consequences of the digitalisation of pastoral care were, however, divergent, with some respondents conceptualising it either as an opportunity for enhancing pastoral care while others conceptualised it as a factor that could weaken pastoral care. In discussing the impact that the pandemic had on pastoral care, the majority of empirical studies focused on the digitalisation aspects although the research of Hawkins and Dyer (2022) offered a more comprehensive and nuanced discussion of the impacts. Hawkins and Dyer's (2022) study was situated in Haiti and sought to investigate

the impact of the pandemic on pastoral care, albeit by focusing on a specific church, the Rendez-Vous Church and its 3000 members.

The study found that the pandemic reconfigured the nature of pastoral care, which became less about spiritual support and the fostering of spiritual growth and more focused on buffering government services in difficult-to-reach areas. The study found that members of the clergy, for example, provided support in the areas of education and health. According to Hawkins and Dyer (2022), although there was a shift in the focus of pastoral care, members of the clergy still relied on service and pillars of faith to support personal growth in young people, especially via an ideology known as 'love in action'. The love-in-action philosophy was based on the idea that youths should be empowered to create change in the country, which is characterised by structural inequalities and poor service delivery on the part of the government. Members of the clergy, in trying to assist in service delivery in the context of the pandemic, also encouraged young people to engage in a self-improvement programme, the Haiti Teen Challenge, which was implemented in poor neighbourhoods and challenged young people to devise innovative solutions for addressing water shortages during the pandemic. Further, members of the clergy encouraged young people to sew and distribute face masks to residents located in Port-au-Prince and other localities within the country. Service delivery also included the feeding of people with the aim to ensure that many do not go hungry. While Hawkins and Dyer's (2022) research showed that pastoral care had been somewhat repurposed to focus on service delivery, it found that there was still a spiritual element in the provision of pastoral care. Despite restrictions on social gatherings, members of the clergy still led members to pray together virtually, supported online Bible studies and devised innovative approaches for demonstrating love in action. As an example, the study found that members of the clergy guided church members to traverse the streets of Port-au-Prince, providing help where needed, to illustrate the church's response to the pandemic as a whole. Pastoral teams worked in conjunction with program leaders and leaders in the music ministry to devise innovative ways of connecting with congregants. Although in-person forms of worship were suspended due to restrictions linked with the pandemic, pastors supported music leaders to take up new assignments supported by donations from various charities around the world. Pastors supported program leaders in delivering medication for homebound seniors as well as non-perishable staples such as beans, rice and dried fish. The role of pastors during the pandemic was not only limited to this form of

support—they played a role in fighting corruption while remaining cognisant of the interconnectedness between the various vulnerabilities experienced by Haitians worldwide.

The repurposing of pastoral care in the context of Haiti, according to Hawkins and Dyer (2022), was crucial for the country's context. It was crucial because the scholars note that Haiti is characterised by severe inequalities, food insecurity, poverty and other structural challenges, which are sources of unrest in the form of killings, robberies and kidnappings. Hawkins and Dyer (2022) underscore that the pandemic exacerbated these forms of unrest because it was concomitant with new forms of insecurities. To prevent the exacerbation of unrest, the scholars note that it was important for members of the clergy to support disadvantaged communities via practices of engaged spirituality.

In another study by Khosa-Nkatini (2022), disruptions to pastoral care due to the pandemic in the Republic of South Africa were focused upon. According to Khosa-Nkanti (2022), the pandemic had multifarious effects:

> a range of regulations and directions were effected in many countries to respond to this pandemic. Essential service workers were deployed across the country to help minimise the spread of the virus. Some of these essential service workers lost their lives in the line of duty. Clergies found themselves having to bury more people in a short period of time. The increase in the death rate resulted in an increase in funerals. Therefore, clergies were also part of the essential workers during this pandemic. Clergies also found themselves having to bury fellow clergies. Congregants and clergies became mourners. The church found itself having to adjust to the 'new normal', because the way church nine-function has changed, it will never be the same again.

Thus, in this study, it was found that clergies engaged with death more intimately and also took up new roles linked with having to bury a large number of people in a short period of time. Aside from having to bury people in general or their fellow clergies, the study found that they further had to bury members from their own congregations as a result of illnesses related to the pandemic. The resultant effect was challenging to the ways in which pastoral care has always been provided. Specifically, Khosa-Nkatini (2022) found that the pandemic challenged members of the clergy to establish new approaches to providing pastoral care while protecting themselves and others and while keeping a social distance. The study also examined practical theology in the context of the pandemic and reflected on the nature of

caregiving, emphasising the importance of clergies engaging in self-care and talking more openly about their own pain.

Like the other studies reviewed above, Khosa-Nkatini (2022) found that following the imposition of lockdown measures, many clergies turned to the use of virtual services in the form of Skype, Microsoft Teams, Zoom, WhatsApp and SMS. Crucially, the study however found that these virtual services were not available for all clergies because of challenges linked to data or access to resources. The study also found that older members of the clergy experienced difficulties in using modern technology to support their provision of pastoral care. Khosa-Nkatini (2022) found that the pandemic enhanced awareness about life vulnerabilities which influenced congregants to seek pastoral care more frequently. According to the scholar, the lockdown was concomitant with various unpleasant losses for people, with the initial stages of the pandemic accompanied by various uncertainties fuelling a higher demand for pastoral care.

The study found that pastoral care became more pertinent because the pandemic was accompanied by losses that many people were unprepared for; individuals have insurance for various unlikely events, however, COVID-19 was not factored into the unlikely event that some individuals may experience. The pandemic affected all individuals, albeit in varying ways, but in ways that impacted their identities and, by doing so, threatened people's faith. For Khosa-Nkatini (2022), faith constitutes the building blocks of individual identities; thus, threats to identity brought on by the pandemic threatened faith. The study found that the implications of weakened faith for pastoral care were that clergies had to find novel ways of bringing hope to church members and claiming their anxieties. Even for clergies, the pandemic emphasised not only the vulnerability of human beings but also some of the challenges they face as part of interpersonal relationships due to social relationships. The exposing of these difficulties highlighted the importance of communication and human coexistence.

Khosa-Nkatini's (2022) study made a novel finding by highlighting how pastoral care extended to clergies' self-care, as the pandemic exposed the need of clergies to take care of themselves spiritually, emotionally, and physically. It became apparent that members of the clergy could not provide pastoral care to congregants if they were themselves tired, drained, and experiencing spiritual emptiness. The pandemic caused pastors to reflect on their own mental health and spiritual discipline, further compelling them to establish

connections with their colleagues and maintain contact with their leadership teams. The study also found that the pandemic made the ministry of presence impossible because of social distancing guidelines which prevented members of the clergy from being present with Christian believers as they experienced some of the most difficult moments of their lives. Some clergies experienced psychological difficulties because they were not permitted to visit their members, but others also had opportunities to re-imagine the meaning of care for congregations and for clergies, where care became associated with spending more time with their families.

The principles that clergies used to provide pastoral care and counselling were also applied to clergies that experienced burnout and stress linked to the pandemic. These principles included the use of spiritual practices such as listening to religious music, reading sacred texts, singing praise songs, watching, or listening to religious programmes, engaging in private devotional practices, attending faith-based services, and praying or requesting prayer. Clergies used these principles to enhance their coping skills, promote healthy behaviours, create feelings of hope and optimism, encourage relaxation, and manage feelings of depression. Pastoral care includes the use of various therapeutic or healing methods to assist Christian believers in managing their problems and crises in a progressive or developmental way. Clergies in the study emphasised that all charismata emerge from God and consequently disrupt individuals' lives—when charisma is placed on individuals, they have a responsibility to apply this charisma in God's service. The study provided various recommendations about how clergies can practice self-care during similar social disruptions. These recommendations pertained to scheduling relaxing and distracting activities over the course of a day or two after stressful work, having weekly pastoral and/or psychological counselling sessions for clergies by leveraging professionals who are unknown to the clergy, establishing mentoring systems within the ministry so that clergies can confide in someone they trust, and by creating support groups of other ministers through church councils, church management or local churches. Further, it was noted that novel ways should be explored for bringing clergies together to promote healing, which can be in the form of retreats involving families if possible. The study highlighted the importance of clergies taking care of themselves as much as they care for Christian believers to avoid stress and burnout, particularly during social disruptions that are concomitant with major demands for essential service workers.

The study revealed the role of Practical Theology, caring for oneself and acknowledging one's own pain in reducing stress and burnout which arises due to the provision of pastoral care. Self-care for clergies, especially during times of crises, helps members of the clergy to respond well to exigencies, although variances in clergies' personalities, social circumstances, and personality will determine how well they adjust to unprecedented events such as the pandemic. In such contexts, some clergies might experience difficulties in providing pastoral care remotely, especially in providing bereavement support. Other clergies might also experience difficulties in engaging with Christian believers who are isolated or might experience difficulties in leveraging modern technology because of the lack of resources or skills.

Domaradzki (2022) investigated the impact of the pandemic on pastoral care in the polish context. The study did not focus explicitly on pastors but, rather, spiritual care practitioners as a broad category. It showed that in conjunction with healthcare professionals, spiritual care practitioners placed themselves at significant risk and made immense sacrifices during the pandemic while offering their services in healthcare facilities, hospices, and hospitals. The study adopted a qualitative, phenomenological design that explored the lived experiences of spiritual care practitioners during the pandemic in Poland. Domaradzki (2022) conducted semi-structured interviews, which featured 24 spiritual care providers and nine emergent themes were identified from the interviews. These spiritual care providers were in Poznan, Poland, and the phenomenological approach which was adopted aimed at understanding the meaning that the research participants ascribe to their unique experiences and eliciting novel information about how these meanings influenced their provision of spiritual care during the pandemic. Overall, the respondents noted that the pandemic impacted the availability of spiritual, pastoral, and religious care; however, it also revealed the importance of such care and enhanced the visibility of spiritual care practitioners in modern healthcare. Concurrently, the issue remained that during the pandemic, spiritual care practitioners were neglected and not properly integrated into the healthcare system.

The study found that such views were specially held by Catholic priests and Jehovah's witnesses. Further, clergies from this background did not conceptualise pastoral care as any different in the pandemic context. They suggested that despite government restrictions, pastoral and spiritual care did not undergo any significant changes—it was not any more difficult or easy than in pre-pandemic times. On the contrary, a rabbi that was interviewed

as part of the study who had forty years of experience found that the pandemic presented a significant challenge as opposed to a threat or problem in the provision of spiritual care. In their roles as hospital chaplains, spiritual care providers experienced significant uncertainties and risks, including daily deaths. Some spiritual care providers adjusted to their new realities; however, others also rationalised their experiences by suggesting that people have had to survive various circumstances in the past, including wars, necessitating that they also adjusted to new normalities.

Although spiritual care providers stressed the negative impact of the pandemic on their daily routines and the provision of pastoral care, they also acknowledged that it had unintended positive consequences. Spiritual care providers suggested that the pandemic inspired individuals to appreciate their lives more and caused them to realise, more intuitively, the true meaning of life. The resultant effect is that they acquired new skills and became familiar with new technologies in the provision of spiritual care. Spiritual care providers also noted that the pandemic impacted their perceptions of spiritual care, motivating them further to serve individuals in need. All the spiritual care providers that were interviewed as part of the study noted how the pandemic limited the provision of spiritual care because of reduced face-to-face interactions.

The challenge was that spiritual care became provided only on-call when spiritual care providers were present in wards. In many instances, spiritual care providers did not have enough time to communicate extensively with patients, discuss their challenges or engage in spiritual activities such as celebrating mass. Spiritual care providers also suggested that due to sanitary restrictions, they experienced challenges when administering the sacraments, implying limitations to their service. Although all spiritual care providers indicated that the pandemic had limited the provision of spiritual care, it was mainly non-Catholic ministers who noted that they were not allowed to enter healthcare facilities and provide spiritual care for their patients. Spiritual care providers within this category highlighted the importance of physical presence for providing spiritual care—social restrictions thus placed a burden on spiritual care providers who emphasised the challenges they experienced in showing up and addressing patients' spiritual needs while trying to maintain a physical distance at the same time. Spiritual care providers collectively emphasised that although they prioritised focusing on the sick and their families, they were also exposed to increased risk and had to grapple with fear, uncertainty, loneliness, and constant pressure (Domaradzki 2022).

All spiritual care providers in the study noted that they were required to support the needs of healthcare professionals which was a key aspect of their role during the pandemic. As part of this role, spiritual care providers responded to requests from nurses or physicians to assist in managing their emotions that were the result of work overload, loneliness and longing for their loved ones, emotional separation and mourning after the death of a patient. Spiritual care providers noted that physicians and nurses wanted to share their experiences and talk about the difficult emotions they encountered, even if these were in the form of simple conversations or small gestures that would assist them in forgetting about the difficulties linked with struggling with the virus on a daily basis. The study specifically found that:

> Although all SCP stressed how important it is to provide spiritual care during the COVID-19 pandemic, they confessed that experiencing the challenges caused by the outbreak was a difficult experience. While talking about their experiences, they emphasised how their service in hospitals has put them at risk of increased distress which resulted in intense feelings of sadness, anxiety, fear or frustration. However, they often stressed that these negative emotions resulted from the awareness that many patients were suffering and dying alone. While the intensity of stress was mainly related to SCP's experience of death, most participants also suffered from loneliness and reported how isolation and lack of social contact negatively affected their emotions. While some participants complained of great fatigue and exhaustion caused by long working hours in their uniforms, others experienced moral stress which resulted from a major dilemma: risking the transmission of the virus to others as asymptomatic carriers, and hesitation whether the SCP needs to be physically present. Consequently, some participants experienced moral remorse resulting from such dual responsibilities and emphasised how torn they felt between their obligation to serve the needs of the sick and the responsibility of not putting them at risk. (Domaradzki 2022)

Crucially, while all spiritual care practitioners expressed concerns about the nature of the health crisis and its negative impact on the provision of spiritual care, they also focused on the impact of the pandemic on religion in general, whereby they conceptualised the pandemic as "a double-edged sword that might become both a religious opportunity and a threat. While stressing that due to the restrictions, fewer people visit churches, attend services, use pastoral guidance and sacraments, SCP defined the pandemic as a threat and emphasised how COVID-19 has negatively affected people's religiosity.

Some even worried that religious life may somehow vanish or “be cancelled” (Domaradzki 2022). They also considered that the pandemic has created a paradox, while religion and spirituality are important resources that help people cope in critical situations, these have been limited by COVID-19 and believers have been left without spiritual assistance” (Domaradzki 2022).

The spiritual care providers were especially concerned that the pandemic would produce spiritual havoc or negative processes within the church, characterised by the privatisation of religion and religious indifference. Alternatively, some spiritual care providers noted that the pandemic was concomitant with new opportunities for spiritual and pastoral care based on the logic that the pandemic created significant anxiety and fear which increased individuals’ awareness of their spiritual needs and desire for trust, hope and faith in a better future that is predicated on religion. The respondents in the study also noted that the pandemic increased the important role of spiritual care providers in the clinical setting as God’s tool. Some hospital chaplains in the study focused on how the presence of spiritual care providers helped patients to regain their faith or acknowledge their spiritual needs. Spiritual care providers noted that although the pandemic disrupted their usual practice and undermined their contact with families and patients, they believed that they made a unique contribution to the healthcare system and provided a supportive and compassionate presence to all individuals who required it.

The spiritual care providers believed that their role was especially salient during the time when no cure was available because the value of spiritual care and a holistic approach was essential. Some Catholic priests in the study emphasised the importance of sacraments in providing spiritual care while others noted that conversations about final issues were most important. Also, spiritual care providers believed that their care enabled individuals who were isolated and overwhelmed by the pandemic or illness to acquire a different perspective on suffering and diseases. Some spiritual care providers however held the view that spiritual care should not be predicated on rituals, or theological discussions pertaining to the meaning of death and life. These spiritual care providers rather emphasised the therapeutic importance of physical contact and maintaining a silent presence so that care can be provided to those who need it.

Domaradzki (2022) highlighted how the Polish Constitution permits all citizens to have freedom of religion and conscience, yet some spiritual care providers noted that the pandemic led to many patients’ right to spiritual care is limited. Some spiritual care providers

were not permitted to enter hospitals at all due to social restrictions, while others had their access restricted to only some wards. The spiritual care providers acknowledged that their contact with patients had to be limited due to public health reasons; however, they concurrently held the view that contact should not be entirely prohibited, especially in the case of chaplains working in hospitals as full-time employees. The limited access of spiritual care providers, the respondents noted, was due to the skewed focus of healthcare professionals on the virus itself and its associated medical procedures. Consequently, spiritual care was not conceptualised as an important element of care because of the focus on healthcare. The spiritual care providers also highlighted how many healthcare professionals and directors do not conceptualise spiritual or pastoral care as essential causing them to limit its provision during the pandemic.

Spiritual care providers also reported that during the pandemic, pastoral or spiritual care in the healthcare setting was cancelled completely, restricting patients to accessing this form of care only through radio or television. Spiritual care providers also indicated that healthcare professionals, for the most part, adopted a prejudiced perspective that caused them to oppose their presence and role in the wards. Consequently, some spiritual care providers felt discriminated against and marginalised; they also felt that they were perceived merely as an ‘infection risk’ that posed a threat to patients. Finally, some chaplains complained in the study that although there is mounting evidence concerning their positive impacts in healthcare settings, their role was misunderstood, mocked, or undervalued. Spiritual care providers felt undervalued because there was a tendency to applaud the work of healthcare professionals who were conceptualised as heroes, whereas they and hospital chaplains were often neglected and conceptualised as useless. Spiritual care providers also held the view that negative attitudes about their role were rooted in existing prejudices about the church and religion, which heightened after reforms that tightened the abortion law in Poland.

In a study by Moodley and Hove (2023), the scholars investigated the potential role of pastoral care in assisting Christian believers with poor mental health worsened by the impact of the pandemic in the context of the pandemic. The study found that the provision of pastoral care was limited by the shift to online platforms, which constituted a form of socioeconomic divider because members of the clergy and congregants lacked the requisite social skills and/or financial resources to use and buy computers and smartphones. Access to Wi-Fi and data for online engagement was limited for members of the clergy and congregants located in areas with connectivity issues or where there was a lack of digital

resources or financial constraints to support live streaming. The study also found that the online space did not offer the same warmth experienced through a Christian embrace during times of desolation; Christian practices such as receiving the Holy Communion were out of the reach of Christian believers with mental health challenges. Consequently, the study found that in some instances, lockdown restrictions fuelled a spiritual decline which exacerbated mental health concerns for Christian believers with pre-existing challenges. Moodley and Hove (2023) hypothesised that declines in mental health were possibly linked to the decline in spirituality and religion, both of which have been conceptualised as a buffer against mental health disorders such as substance abuse, depression, anxiety and stress-related disorders. Based on these findings, Moodley and Hove (2023) highlighted the importance of the church engaging collaboratively with mental health professionals to engage in open dialogue about congregants' mental health. Further, the study suggested that educational initiatives that involve both pastors and congregants should be organised, including in the present post-pandemic context.

According to the scholars, "the Bible provides various insights into mental health struggles amongst even the bravest and wisest stalwarts. When reading the Book of Ecclesiastes, it is easy to become perplexed by the futility of life when reading of Solomon's poetic melancholy and hopeless despair. David's mental anguish in the Psalms is a reminder that even this spiritual giant experienced obvious mental health concerns" (Moodley and Hover, 2023). Drawing from the Bible and the various journeys of the people of faith captured in it was conceptualised in the study as an important strategy for providing congregants with certainty, hope, relief and divine wisdom during periods of mental despair. The study also noted that these Biblical references could help to highlight how even men of great faith experienced mental health issues. According to Moodley and Hove (2023), although pastors developed apps with downloadable messages, it would have been more beneficial if these apps supported congregants to receive one on one prayer and pastoral care if required. Against this backdrop, the scholars proposed that churches must implement education initiatives that include psychoeducation on dealing with congregants that have mental health disorders during a pandemic. They acknowledge that prior to the pandemic, mental health issues were mystified in the church, which became amplified during the pandemic, pointing to the need for the church to talk more openly about mental health issues and demystify them. This process of demystifying mental health, according to the scholars, must be an ongoing process if sustainable change at the community level must be achieved. Alongside this proposal, Moodley and Hove (2023) suggested the importance of moving from spiritual

reductionism to a model where people who suffer from mental illness are accepted based on the Word of God.

The scholars noted that dedicated support groups and safe spaces that integrate biblical teachings and mental health care are crucial as referrals to psychological professionals can be via such groups. These referrals between psychological practitioners and pastoral care were conceptualised as important forms of collaboration that, during pandemics, can assist in addressing psychological distress that cannot be managed through pastoral care. They, however, note that it must be highlighted to congregants that referrals constitute forms of negotiated processes that assist in achieving helpful results—the implication is not congregants have been abandoned by their pastor by suggesting treatment via another professional who is essentially a stranger. Consequently, Moodley and Hove (2023) recommend that pastors must discuss the importance of referrals with their congregants so that they are aware and accepting of these additional services. The scholars further note that the adoption of various online technologies as part of pastoral care must not be lost in the post-pandemic context because these technologies can facilitate the promotion of mental health well-being.

Moodley and Hove (2023) noted that online technologies, including video calls, instant messaging, chats, and emails, are already being used in other counselling professions as communication tools; however, they can be leveraged in the post-pandemic context to reach congregants who remain at home during times of difficulties. According to the scholars, technology enabled congregants to reduce their stress levels during the pandemic because they could talk to their pastors, seeing their faces as sources of comfort. In South Africa, the scholars note that online technologies enabled vulnerable groups such as the elderly, single mothers and immobile people resident in rural areas, who are unable to attend cell groups to access pastoral care. Through participation in cell groups, albeit only, these vulnerable congregants were able to address daily issues, including mental health concerns, which pastors discuss and pray about. Against this backdrop, Moodley and Hove (2023) suggested that in future social disruptions, online technologies can be better leveraged to identify at-risk individuals early on, enabling appropriate interventions and referrals to be made. Further, they proposed that in the post-pandemic context, pastoral care can merge both virtual and contact pastoral care approaches, subject to access to the Internet and the context, enabling congregants who cannot attend contact pastoral care services to access opportunities for pastoral care.

Similar findings were established by Situmorang (2020), who noted how the proliferation of technology had had valuable impacts on the provision of pastoral care. The study showed how during the pandemic, pastors were able to practice humanity towards others and offer counselling services via technological tools. This study traced the history of Web utilisation in counselling as a broad field and noted how this introduced shifts in pastoral care. The historical approach taken by the study aimed to engage in discourse about the long-term use of online technology in a post-pandemic context. Acknowledging the overriding centrality of technology for pastoral care during the pandemic, Situmorang (2020) found that many pastors lacked formal instructive material on how to use technology in pastoral care, which may be due to the fact that pastoral education has no formal instructive material on technology use within their education programmes. Situmorang (2020) proposed that advance planning must be made by churches and educators to examine the requirements and make resources available. Specifically, the study noted that "pastoral/spiritual counselling program chairpersons, educational programs chiefs, and course engineers ought to note this clear demand for current graduate counselling students to discover information about online/ cyber counselling. The current pastoral/spiritual counselling programs need to be upgraded to reflect the changes within the counselling field and the requirements of students" (Situmorang, 2020). Situmorang (2020) further added that "to be successful in any setting, pastoral/spiritual counsellors or psychologists must be prepared, and special conditions require specialised preparation…. Pastoral/ spiritual counsellors or psychologist teachers ought to start introducing prospective pastoral/spiritual counsellors or psychologists to this new medium to extend the knowledge and viability of these future specialists, whilst also focusing on and encouraging specialised preparation."

The study found that some pastors that leveraged technology during the pandemic had some form of pre-existing knowledge. However, despite this pre-existing knowledge, more training was required to assist pastors in overcoming some of the barriers to incorporating technology into the provision of pastoral care, such as the lack of skills and resources. It suggested, like Moodley and Hove (2023), that churches must more directly address modern approaches to acquiring skills and proficiency so that pastors can be better positioned to take advantage of the benefits of technology in the post-pandemic setting. Most empirical studies in the literature concerning pastoral care during the pandemic focus on the use of technology and the advantages or disadvantages that were concomitant with it. As can be seen above, some of the studies focused on the barriers to technology use.

A unique perspective is, however, offered in the comprehensive study of Snowden, which discusses the role of pastors during the pandemic and changes that arose to the nature of their work. Snowden (2021) found that chaplains made a unique contribution to healthcare during the pandemic by responding to the religious, spiritual and pastoral needs of both staff and patients. The study showed that the sole purpose of chaplains was to be present and create a safe space for meeting the individual needs of staff and patients, promoting their healing even when a cure was not possible. Snowden (2021) documented that chaplains offered valuable support during the pandemic. However, their roles were commonly downplayed, misunderstood and undervalued by organisations that placed more value on healthcare professionals. Although in some settings, chaplains, along with health professionals, were conceptualised as heroes, in other settings, they were perceived as an infection risk (Snowden, 2021). The study designed a survey which aimed to report the experiences of chaplains during the pandemic, drawing from the responses of 1657 chaplains, who provided their views from 36 countries. Their data was captured in June 2020. All chaplains reported disruptions to their usual routines and practices because of enforced social distancing. Chaplains reported embracing technology out of necessity to maintain contact with patients and their families. Chaplains also reported a shift in their focus of pastoral care towards staff. They recounted being conceptualised as non-essential employees by their organisation, although a few reported that they were conceptualised as essential staff. The majority of chaplains featured in the study's survey believed that organisations had an understanding of their role, but chaplains themselves lacked clarity about what their role should be during and after the pandemic. As a caveat, Snowden (2021) reported that chaplains' lack of clarity about their roles existed before the pandemic. Overall, Snowden (2021) found that chaplains lacked leadership skills and were confused about their roles.

Snowden (2021) provided nuanced information about disruptions to pastoral care during the pandemic. It found that most chaplains worked in the same organisation during the pandemic as they had previously done. Nevertheless, an estimated 14 chaplains experienced displacement as they were moved from hospitals to other settings such as the parish, community, military, private practice, prison, continuing care, or primary care. This is a small number of the 780 chaplains who reported that they historically worked in a hospital and remained there during the pandemic. Further, chaplains interacted more with non-infected patients, although some engagement with infected patients and their families was reported. There were, however, variances in the various country settings in how chaplains

interacted with infected patients in the ICU. The study found that American chaplains frequented the ICU more than European or Australian chaplains. Generally, chaplains reported similar response patterns globally. Although chaplains spent a higher proportion of their time supporting non-infected patients, technology use was still high. Some chaplains continued to hold face-to-face counselling sessions, sometimes meeting with patients outside wards. Some chaplains were not able to meet with both infected and non-infected patients because they lacked PPE and because of the fluctuating nature of the pandemic. Since there was a lack of baseline measures, chaplains had to treat inferences about potential change with caution. The resultant effect is that using technology to access patients became the new norm, although this was not the case prior to the pandemic, suggesting a substantial shift to technology use regardless of patients' infection status.

Chaplains reported that other staff became involved in providing spiritual care—for some respondents, spiritual care is mainly the purview of chaplains, while for others, spiritual care is the business of everyone. Thus, some chaplains felt their role was being devalued by recruiting other staff to perform their duties, while others believed that the provision of care should be universal. Chaplains in the former category believed that they could have been deployed more usefully during the pandemic, particularly in terms of supporting healthcare staff who experienced immense stress during the pandemic. Chaplains felt that they were underutilised because of poor communication, poor organisation and lack of engagement by management. The survey asked chaplains whether their organisations understood the role and contribution which they could offer to infected patients. The majority of respondents (n=911) responded in the affirmative, although 240 chaplains answered no, while 120 chose the 'other' option. Consequently, a substantial number of chaplains (n=360) reported feeling misunderstood. Not only did organisations misunderstand chaplains' roles, but chaplains themselves also lacked an understanding of their roles.

The majority of chaplains provided neutral responses, whereby they were neither clear nor unclear about their roles, particularly during the early phase of the pandemic, although clarity increased at the mid-point. Consequently, there were fluctuations regarding how confident chaplains felt about their roles. The survey also made enquiries about chaplains' self-care during the pandemic via Likert item responses ranging from zero (not at all) to 4 (all the time). Self-care activities that were captured on the survey included prayer, sport, meditation, time and formal support structures (Snowden, 2021). Out of these self-care strategies, prayer, faith and support from friends were the most predominantly adopted. Further, the study found that hobbies were taken up more frequently for self-care as opposed

to more formal types of support. Compared to America and Australia, European chaplains engaged the least in self-care. Chaplains reported that social distancing had the most impact on chaplains globally, although they also reported that the dignity of patients greatly impacted their work.

Chaplains were also concerned with practical issues concomitant with the pandemic, including the shortage of materials, as these practical concerns invariably impacted their work and ability to help others. The survey enquired whether chaplains felt that their faith groups and professional associations were supportive during the pandemic, and a majority of the respondents reported that they lacked support, especially through personal contact or formal activities such as webinars. For chaplains that received support, online and email support groups were the primary source of support. Snowden (2021) found that European chaplains, in particular, did not experience significant organisational support when compared to their Australian and American cohorts. Overall the study found that:

> …many chaplains from countries around the world felt valued and understood by their employing organisations, adapted to using technology for communicating where necessary, got the right support from their professional associations, knew what to do to look after themselves and were very clear about their place in the healthcare team both before and during the pandemic. At the same time, a substantial proportion experienced the opposite. All the respondents experienced an impact. Nearly all reported changes in work conditions. Social distancing had a substantial impact on chaplains in relation to reported barriers to them doing their job, with the dignity of patients being their biggest concern… The upheaval to working conditions that followed exacerbated enduring problems pertaining to professional identity, leadership and status... For example, a majority stated they could have been better deployed, and a substantial minority suggested their organisations did not understand their role.

Per the excerpt above, chaplains reported feelings of exclusion and a lack of chaplain leadership. There is a myriad of ways that chaplains in the study felt that chaplain leadership could have been provided. One strategy that was mentioned pertained to chaplain leadership at the executive level to influence discussions that were held about how to manage the pandemic, as well as patient isolation and family anxiety due to being separated from their hospitalised loved ones. Chaplains also suggested that while they were officially identified as integral team members, they were not included in discussions about patient

care management from the beginning of the pandemic in relation to both infected and non-infected patients, which they believe should have happened.

Chaplains also opined that they should have been more involved in the provision of direct care throughout the pandemic; however, such opportunities were undermined because nurses and management perceived them as infection risks. Leadership and nursing, according to the chaplains, adopted attitudes that implied that everyone except nurses and doctors would spread the virus. Consequently, only nurses and doctors were permitted to have close contact with infected patients. Thus, as opposed to being conceptualised as essential employees and valued colleagues, chaplains, for the most part, were conceptualised as an infection risk. According to Snowden (2021), "many pointed to the lack of chaplain leadership as the root cause of the problem, but very few acknowledged that 'leadership is everyone's business' ... This lack of confidence was evident elsewhere. For example, the average response to the question 'how clear was your role to you' was consistent both pre and post pandemic at a neutral point between 'unclear' and 'clear' ... This meant that, on average, chaplains were not clear about what their role was before the pandemic."

What can be deduced from this finding is that both leadership and chaplains themselves were unclear on how best to utilise chaplains' roles—pointing to a professional issue. The majority of chaplains did not report being part of a professional association, except in Australia. This suggests that there is a lack of an agreed code of practice for chaplains per the guidelines of their professional body. Chaplains reported the importance of their relationship with healthcare professionals because both before and during the pandemic, the majority of spiritual care was targeted at them. While there is a pre-existing record, caring for staff became a more substantial part of chaplains' work during the pandemic due to declining levels of mental health among staff in this context. Medics, in particular, required the support of chaplains due to the nature of their work. They required pastoral care to help them overcome their inability to save patients in some instances. While medics acknowledged the contributions of chaplains to their care, Snowden (2021) found that this did not translate into them being regarded formally as part of the healthcare team. In a few country settings captured in the survey, it was found that chaplains are increasingly being regarded as members of healthcare teams in the post-pandemic context; however, on the whole, Snowden (2021) found that chaplains remain outsiders because of poor perceptions about their professional status.

A study by Afolaranmi (2022) analysed the new normal of pastoral care following the pandemic and revealed the increasing use of social media by members of the clergy in order to remain relevant in the post-COVID context and contribute to society's sustainable development. The study provided an in-depth analysis of the nexus between pastoral care, sustainable development social media in the context of Ibadan, Nigeria. Via semi-structured interviews of a purposive sample of pastors located in Ibadan, the study found that despite the shift towards social media in the post-COVID context, pastors are experiencing immense challenges with regard to social media use, which is undermining the possibility of realising new opportunities offered by technology. Against this backdrop, recommendations were delineated for pastors, the government and church members to capitalise on the opportunities brought on by the new normal.

Afoloranmi (2022) highlighted the importance of pastors' changing their negative philosophies about the Internet and social media so that they can consciously explore the opportunities concomitant with modern technologies. Alongside the importance of a mindset shift, the study also underscored the importance of formal and informal training for pastors on how to use social media as part of pastoral care. Lack of literacy was recognised as a barrier to the effective use of social media during the pandemic, and the study viewed training as crucial for ensuring that pastors are not left behind in the new normal and for ensuring that they can contribute meaningfully to post-COVID norms of pastoral care via social media.

Alongside training for pastors, the study highlighted the imperative of technology training for church members so that, conjointly with pastors, new forms of pastoral care can be explored with the support of social media. Aside from training, Afoloranmi (2022) showed that the pandemic highlighted the importance of pastors adopting proactive and strategic approaches to pastoral care as opposed to a reactive approach. A proactive approach will ensure that pastoral care is resilient and can easily respond to social disruptions such as the pandemic. Social media use was conceptualised in the study as a tool for adopting a proactive approach. This finding was rooted in the rationale that social media transcends physical boundaries; thus, in public health crises such as a pandemic, barriers to physical engagement and communication can be negotiated. Pastors were perceived as potential contributors to technological advancements via the novel ways in which they use technology

to provide pastoral care. The scholars also recommended that pastors must work conjointly with trained experts in ICT so that they can overcome challenges in areas that are too complex or technical as part of their use of social media for pastoral care. The study found that partnerships established with ICT professionals can include collaborations with social media managers so that pastors can better manage their ministries and activities online, which was a challenge during the pandemic. Despite the importance of multistakeholder partnerships for enhancing technology use as part of pastoral care, Afoloranmi (2022) highlighted the importance of skills development for pastors due to the importance of confidentiality in pastoral care and safeguarding against data disclosure to a third party.
Pastors' skills development was also conceptualised as an important first step for them taking charge of the enlightenment of their church members on the use of social media via workshops, seminars, training and other similar platforms. This form of training was deemed important for pastors' own learning because they would also build on their skills and knowledge during the process of teaching and training. Training was conceptualised as important for transitioning from congregants that are e-illiterate to e-literate.

While social media was conceptualised as an important tool in the new normal of pastoral care, the scholar highlighted the importance of pastors being careful about how social media is used—specifically, it must be used in an edifying way that reflects Godly values as invariably; pastors are representatives of God in society. The theme of carefulness in social media use was also highlighted with regard to maintaining congregants' confidential information by being abreast with privacy norms and tools on social media.

The scholars proposed the idea that "as representatives of God among people, pastors should be sensitive to the leadership of the Holy Spirit in what kind of social media they will use, and how they will use the social media in pastoral care. As the global COVID-19 pandemic and the resultant lockdown and physical or social distancing have changed the ways many things are been done in the world in the last two years, pastors should think of alternative ways of doing things to meet up with the changing world."
Alongside the roles ascribed to pastors, the study highlighted the importance of social reforms to actualise the new normal of pastoral care. Afolaranmi (2021) was writing in the context of Nigeria, where power supply is rampant; this was perceived as a barrier to leveraging technology to provide care, and the study encouraged government reforms in this area. Proposed reforms revolved around the exploration of alternative modes of power

generation to ensure a constant supply for citizens. Other barriers to the new normal explored in the study concerned policies that limited the use of social media in Nigeria. The scholars highlighted the importance of an enabling environment so that the provision of pastoral care online can be supported. At the time of writing, a total ban on Twitter in Nigeria had been implemented, attesting to how the government regulation of social media can undermine the new opportunities for pastoral care in the post-COVID context brought on by modern technology.

While Afolaranmi (2021) focused on pastoral care in Nigeria within a post-pandemic context, Diego-Cordero et al. (2022) focused on changes to pastoral care that occurred during the pandemic in the context of Spain. The study found that, as opposed to chaplains, it was nurses that were responsible for pastoral care during the pandemic. Nurses conceptualised spirituality as an important element of care as it was perceived as a coping strategy for disease. Nevertheless, they lacked an understanding of spirituality and did not have adequate training to handle this form of care. Further, there were multifarious barriers to spiritual care provided by health professionals, including insufficient time and work overload, aside from the lack of training. Due to social restrictions, the study found that nursing professionals and not chaplains were afforded responsibility for providing spiritual support to patients. In the context of Spain, visits from religious leaders and family members were not permitted. With religious leaders unavailable to provide spiritual support, nurses served as proxies; however, they lacked adequate training and were largely unprepared for the situation. Nurses were used to chaplains and families serving as the main pillar of faith and spiritual support in patients' lives in the pre-pandemic context; thus, they were compelled to fill a void which they had not anticipated. The study derived data from a sample of nurses who reported several barriers to their provision of spiritual care as a precursor to discussing how these can be mitigated to improve the provision of spiritual care in emergency care units.

The barriers which were cited in the study included the absence of breaks and work overload during the pandemic, lack of time, lack of training and a high nurse-patient ratio. Importantly also, nurses did not have the requisite training, knowledge and experience to answer the transcendental questions posed by patients as they confronted illness and death. Amidst this challenge, they also had to grapple with the issue of a lack of recognition of the importance of spiritual care in the healthcare profession in general. Further, because nurses

lacked training in providing spiritual care, they experienced difficulties in identifying the religious repertoires and symbols that are crucial to their faith. Nurses also felt handicapped because of restrictions placed on families, who they believed would have served as an important source of comfort for patients in critical condition. Due to restrictions placed on family members and chaplains, some patients experienced anxiety, uncertainty and anguish because they were not able to derive spiritual and moral support from them and were not familiar with nurses playing the role of spiritual carers.

With nurses lacking training and unprepared for this role, many found that they had different beliefs from patients, which constituted a barrier to providing integrative spiritual care. Nurses found it difficult to provide spiritual care to patients who held different beliefs. This was especially the case for atheist nurses who found it difficult to counsel patients that rejected medication on religious grounds. The nurses interviewed in the study reported that having shared beliefs would have made the provision of spiritual care easier since a common religion can encourage bonding which will serve as a platform for further engagement and dialogue, which is a crucial element of spiritual care. Although nurses experienced barriers in providing spiritual care, they reported the various strategies they used to overcome these. Reported strategies included having silent moments devoid of interruptions to establish connections between patients and nurses and thereby build trust, which was viewed as crucial for providing spiritual care. Some nurses also developed their own protocols and guidelines for providing spiritual care, but these guidelines were not necessarily built on religious scripture.

One nurse reported that they set objectives for spiritual care using quality scales derived from the field of psychology. Some nurses also derived support from being granted access to appropriate spaces, which they used to perform contemplative practices such as yoga and meditation. These spaces were conceptualised as crucial for religious practices to be enacted. Some nurses also engaged in self-training about spiritual care to improve their provision of care or joined support groups online, which typically involved various stakeholders such as chaplains and priests. Chaplains and priests, through these online support groups, served as a crucial source of support for nurses in the provision of spiritual care. Online platforms enabled coordinated work between spiritual and healthcare professionals. Owing to the various barriers encountered by nurses, they highlighted the importance of spiritual care training in the post-pandemic context so that they have the competencies to provide this form of care during unprecedented health crises that limit

physical interactions. While nurses conceptualised competency training as crucial in the post-pandemic context, they lamented that they had not received any training in this area after the pandemic because it was not prioritised by health administrators. A key takeaway in Diego-Cordero et al.'s (2022) study, therefore, was that all health professionals must be offered training in spirituality so that they can manage spiritual care during crises.

Another study by Vandenhoeck et al. (2021) sought to investigate the impact of the pandemic on pastoral care by posing three qualitative questions, which were administered to a sample of chaplains. These questions were: "What was the most important aspect of spiritual care that was lost during the pandemic? What was new to you during this pandemic? What are the new ways of delivering spiritual care you have experienced? And, of these new experiences, what do you think was the most effective, and why?". In response to these questions, the study found that for some chaplains, their role in pastoral care was non-existent either because they were made redundant or compelled to remain at home owing to social distancing requirements. For some chaplains, no changes to the provision of pastoral care were experienced except for increased assignments and visibility. The scholars found that the majority of chaplains had experiences located between these two extreme positions. With respect to the question pertaining to the most pertinent aspects of pastoral care which were lost, the scholars lamented the loss of physical presence and support as well as physical gestures such as touch, the loss of shared community and group moments, the inability to work, lack of feelings of safety, the loss of working with volunteers and the lack of a backup theology.

With respect to the loss of touch and being present, the study found that chaplains conceptualised this as the most important element of pastoral care that was lost during the pandemic. Chaplains reported that even when they were permitted to visit patients, the mandatory wearing of masks caused pastoral care to become a faceless experience. This faceless experience, they noted, runs counter to traditional approaches to pastoral care, where the emphasis is placed on being present in order to build trust and establish connections with patients. Vandenhoeck et al. (2021) suggest that being present is a core competency of chaplaincy that was lost. Despite this loss, the study found that chaplains tried to acquire some opportunities from their experiences. The scholars noted that:

> in chaplaincy there is a tension between a personal, vocational identity, which emphasizes presence and spirituality, and a professional identity which is in the process of being developed at through research emphasizing skills and integration in

healthcare. Chaplaincy is best served when both poles are present and chaplains make appropriate use of them.

(Vandenhoeck et al., 2021) Chaplains also noted disconnectedness in relation to their colleagues or cohorts, although disconnectedness was viewed as especially problematic in relation to patients who have cognitive challenges and thus already have limited communities. Overall, chaplains lamented the loss of casual and spontaneous interactions with their cohorts, patients and families. Vandenhoeck et al. (2021) found that the pandemic enhanced awareness among chaplains that touch and non-verbal expressions constitute a crucial part of pastoral care. Chaplains also experienced difficulties in negotiating boundaries with their patients because discussions and cultural differences concerning the ethics of permission and touch were relegated during the pandemic. The wearing of masks and other protective gear made it difficult for chaplains to read emotions which were exacerbated by telechaplaincy.

In this study, chaplains also reported the loss of shared spiritual experiences with families and patients. Shared spiritual experiences were conceptualised as important because grave illness and end-of-life experiences typically require symbols and rituals, which chaplains perform by bringing people together. Through shared spiritual experiences, chaplains use symbols and rituals to connect with the divine, facilitate transition, mourn and remember. In the study, the sample of chaplains noted that they had not been able to meaningfully mark life events using symbols and rituals during the pandemic because of social distancing restrictions. Sacred sites such as chapels, prayer rooms and interfaith rooms were inaccessible as they were closed or repurposed for alternative use. The lighting of candles was not permitted, and rituals that are typically performed at the bedside were limited without family members present. In some cases, chaplains reported performing rituals remotely, for example, in a chapel on behalf of a patient in a hospital room. During the pandemic, it was also impossible to give sacraments. The study found that these losses went hand in hand with loneliness. Family members and bereaved parents experienced immense loneliness when they could not participate in ritual services for the deceased and were denied connectedness with others because the sacred could not be mutually expressed. Due to the loss of rituals, the chaplains reported a loss of religiosity. Chaplains reported this loss of religiosity with regard to being unable to bring communion to patients, for example, which left a void for many Christian believers who needed it at a very challenging time in their lives. Chaplains also reported missing other moments of community forming,

such as singing together during services or with residents. Other moments of community forming which were referenced were discussion groups, prayer groups and mediation groups. Chaplains also encountered frustration because their work was stifled, evoking feelings of helplessness, frustration and sadness because they were not always able to deliver end-of-life care to patients. Not being able to perform their roles was a source of moral stress for chaplains, as patients sometimes died alone, which led to feelings of guilt because chaplains felt they allowed healthcare professionals to take the lead on pastoral care and did not advocate enough for it to be taken more seriously. Other chaplains noted that the demand for spiritual care far exceeded staff availability, and many chaplains felt that their professional value was deprived because they were not invited to participate in multidisciplinary teams. Further, chaplains reported a dearth of collegial responses since medical care was primarily emphasised during the pandemic. Further, chaplains lamented a general lack of protective material during the pandemic since they were not prioritised and their roles were largely performed by other healthcare professionals. For many chaplains, telehealth options were not provided because of perceived power grabbing by other professionals, and they found that their role was relegated or, at best, tokenistic.

Chaplains also reported feeling lonely and invisible due to these experiences, and feelings of loneliness were exacerbated by limited communication between team members and staff. Crucially, the provision of pastoral care was limited by the technical aspects of communication with residents and their families. Vandenhoeck et al. (2021) note that “the fact that patients or residents needed help with devices had an impact on the confidentiality in contact with the chaplains. Part of being a professional healthcare chaplain is discerning who might benefit from your support and taking the initiative to contact them. This reaching out was limited by the pandemic, and efficient patient care was impacted when communication between team members became harder.”

Chaplains also reported the lack of volunteers to support pastoral care because they were mostly assigned to at-risk groups. Chaplains also lacked the support of outside faith representatives, which was concomitant with increased pressure because of the implications of the pandemic. Chaplains found it most difficult when they were not able to support patients, and despite their experiences of moral distress, there was often little time for self-care or relaxation which meant that they had to grapple with a persistent feeling of helplessness as they witnessed sickness and dying, often without dignity, due to the pandemic. Chaplains reported feelings of safety prior to the pandemic, which was subsequently lost alongside expressions of trust. The loss of feelings of safety for chaplains

was conceptualised as detrimental to their jobs because they must feel safe in order to function fully. Reduced feelings of safety emerged because of the lack of protection material, the fear of being at risk, the illusion of being invulnerable staff members, and the lack of effective policies and protocols to manage the role of chaplains.

The study found that some chaplains were particularly concerned about being potential spreaders of the virus when engaging with patients. Chaplains also reported a lack of a backup theology and meaning. The scholars note that “chaplains have their own meaning system, tied to their personality and faith, which through confrontation with a pandemic brings forth the need to attribute meaning to suffering, loneliness and death. Existential questions are also experienced by chaplains. Where is God in all of this?”.Chaplains reported that they experienced tensions between their knowledge of God and the lived realities of believers in their hospital rooms. Other chaplains noted that they experienced reduced connectedness with spiritual resources because their personal faith was impacted by the experience of caring for dying patients. Against this backdrop, some chaplains lamented the lack of pastoral theological reflections pertaining to spiritual care during the pandemic, as this could have been a source of support for them.

Despite these findings, some chaplains in the study reported that they experienced limited changes to pastoral care as they continued seeing patients either in person or via services without significant changes. Others, however, noted new practices as part of pastoral care, such as the use of digital technologies to connect with and care for patients, their families or staff. For some chaplains, this constituted the primary mode of communication, and they described themselves as working from home. Some chaplains also used new forms of digital and print communication, such as newsletters, to communicate with patients and staff. Pastoral care was also reconfigured in terms of a shift to staff support. The shift from patient to staff support was a new dimension of chaplaincy which reflects the stressors experienced by staff during the pandemic but also the fact that counselling with patients was often limited. Chaplains also reported performing new forms of prayer, for example, praying in hallways as opposed to rooms, to circumvent physical distancing rules. Further, as a result of social distancing rules, many chaplains reported playing the role of intermediaries between patients and their loved ones. Chaplains also reported an enhanced role in the provision of end-of-life care due to the nature of the virus. New forms of end-of-life care reported by the chaplains include increased demands for blessings provided by chaplains for deceased patients because of the reduced ability of families to organise funerals. Chaplains also held

video-streamed or digital funerals, which involved reciting prayers during the transfer of bodies from the morgue.

3.2 Bowen's family systems theory

From a systems approach to pastoral care, the study has identified Bowen's family systems theory (Bowen, 1966) as a useful primary theoretical framework. Bowen was born in Tennessee Waverly in 1913 as the firstborn of Jess Sewell Bowen and Maggie May Luff. In 1937, Bowen earned an M.D. degree from the University of Tennessee Medical School, after which he served five years in the U.S. Army during World War. Although after the war, he gained entry into a fellowship program at the Mayo Clinic, the war had fomented a shift in his interests from surgery to psychiatry. It is within this context that he formulates his family systems theory as a prism for understanding why humans act as they do. Importantly, Bowen's (1966) original formulations were rooted in cellular biology as opposed to psychology, whereby he sought to analyse the differentiations in how unhealthy and healthy function. This investigation influenced his widely cited phrase, differentiation of self, which is a cornerstone concept in his family systems theory. There are parallels between his concept of differentiation of self and the concept of differentiation of cells in cellular biology, which describes how cells become distinct and separate while concurrently remaining connected to an organism as a whole.

As shall be discussed in the ensuing sections, Bowen's (1966) concept of differentiation of self was used synonymously with human maturity. Bowen (1966) held the view that human beings inherently have the capacity, albeit to varying degrees, to differentiate as a result of a naturally occurring and evolving motivation to become individualised, distinct and separate from their families while, at the same time, maintaining healthy connections to them and others. Thus, differentiation of self marks the beginning of the human maturation process. In proposing his theory, Bowen (1966) was particularly concerned with the following overarching question: if human beings have an innate and God-given capacity to mature, why are some prone to immaturity, aggression, violence, petty splintering and divisiveness? Using the process via which cells differentiate and mature, Bowen established correlations between cell differentiation and how families, individuals, institutions and organisations function. According to Matthews (2005:425), this theory is particularly useful for the study of pastoral care because it "serves as a personal resource for the minister seeking to assume the non-reactive stance necessary for any attempt to understand more clearly the dynamics

involved in a ministry situation. Closely related to this is the capacity of the theory's conceptual framework to provide an accurate and in-depth understanding of the often unrecognised but always determinative emotional process present in a situation". This theory has been widely used in studies that analyse Christian relationships, including those related to the practice of pastoral care in a congregational context.

At the heart of the theory is the idea that the anxieties, behavioural patterns and belief systems of individuals are derived from a system of emotions that are transmitted linearly across a minimum of three generations (Brown 1999; Titleman 2012; Papero 1983). Bowen (1966) conceptualised the family as an interconnected system which provides an important conduit for understanding individuals. Because individuals form part of a system in which they are connected to others, the individuals in the system affect one another. An important focus of the theory is the familial patterns that are conveyed over generations. An individual's level of emotional functioning is shaped by their family origin due to this interconnectedness. The family, therefore, constitutes an appropriate unit for conceptualising individual functioning, particularly concerning the individual's basic level of differentiation of self.

Bowen (1966) focuses extensively on the emotional processes that underpin human relationships. Pastors and church leaders are increasingly applying family systems theory to gain nuanced insight into relationship processes within their churches (Richardson 2005). The theory has also been applied by pastors in order to learn how they themselves can function within these relationships (Richardson 2005). This theory provides insight into how individuals in the church are emotionally interconnected in ways that can produce congregational difficulties or good congregational health (Richardson 2005). Crucially also, faith communities have long defined themselves as a family. With regard to Christian identity, this notion of family is highlighted in Ephesians 5:1, where the Godself references 'dear children' and Galatians 3:26, where reference is made to the 'children of God'.

Bowen's theory applies 8 main concepts to describe the anxieties experienced by families. It explains the emotional processes of the family by drawing upon concepts that relate to the *self*. The 8 concepts that Bowen (1966) employs are:

- differentiation of self;
- the nuclear family's emotional system;
- triangles/triangulations;
- multigenerational transmission process;
- sibling position;

- family projection process;
- societal regression;
- emotional cut-off.

According to Bowen's theory, anxiety and self-differentiation are important concepts for understanding group dynamics. Bowen (1966) uses self-differentiation as a measure of emotional maturity which is marked by characteristics such as self-awareness and independence. Differentiation levels are observed among others in how individuals relate to God. According to Bulut (2020:5), humankind's relationship with God "starts with the divine, continues and develops through stages of differentiation, and proceeds towards a reintegration where God is understood in terms of the relationship. This concept of God, beyond both the traditionally religious view of God outside the ego as well as the psychological view of God as the ego, has vital importance for understanding healthy human and family relations."

Bowen's theory focuses on how to deal with anxiety in the family, how families deal with various degrees of family differentiation, interconnected family dynamics, and interventions to address these. The theory has therefore been applied effectively in care with religious and spiritual families as well as church congregations more broadly (Daneshpour 2017). The theory considers spiritual aspects in relation to its 8 concepts. For example, the concept of "differentiation of self" is a central component of Bowen's Family Systems Theory (1966). Differentiation concerns self-awareness of one's thoughts and emotions, but it also relates to maintaining one's existence independent of others (Bulut 2020). Bowen (1985:15) explicitly noted that "differentiation of self" can be conceptualised as "the psychological distinction of the self from the internal intellectual and emotional systems, and as a result, the simultaneous distinction and freeing of the self from the family's origins and other individuals within the social structures to which one is linked".

Differentiation pertains to the ability of individuals to work independently as per their personal choices while maintaining an emotional connection to the family system and the relationships that are of importance to them. Bowen (1966) proposed that in the family, differentiation between spouses plays an important role in the development of family functions. Bulut (2020:70) explains Bowen's idea as follows:

> While the developmental levels of nuclear family functions are low for couples and families with low levels of differentiation, the tendencies to develop nuclear family functions is at a higher level for couples with high levels of

> differentiation…Self-differentiated individuals are under no one's influence while making choices, have a strong sense of self, and see themselves as valuable...Alongside this, self-distinguished individuals are aware of themselves, can recognise their feelings and thoughts, take responsibility for their choices, and abide by these choices.

There are two underlying dimensions of differentiation. The first concerns the ability of individuals to make both cognitive and emotional distinctions between the self and family, and the second concerns the ability of individuals to establish distinctions between their personal emotional and cognitive processes and those of others (Bowen 1978). Bulut (2020:67) explains it as follows:

> The first dimension is the balance of unity and individuality. Individuals at the highest level regarding differentiation both maintain their own individuality and establish flexible relationships with others …These individuals possess the ability to distinguish feelings and thoughts from one another, don't allow their emotions to get in the way of their logic, have a clear stance, and easily tolerate and adapt to changes... In the second dimension, individuals with low levels of differentiation cannot distinguish real life from their feelings, make decisions with their emotions and implement these decisions, block their cognitive abilities due to their excitement, and are vulnerable. All these cause individuals like this to remain in dilemmas within the family.

Bowen understood spirituality and individuality to be important concepts in relation to differentiating the self (Mert and Topal 2018). Spiritual individuals are able to conceptualise transcendental dimensions and the idea of the sacred. Through spirituality, individuals express their faith, drawing from the idea that a transcendental reality beyond the physical, exists. Though there is a tendency to conflate spirituality and religiousness, the concepts are distinct. As argued by Zinbauer and Pargament (2013), religion is understood from a holistic perspective to include spirituality. Through religion, individuals are able to express their spirituality. Scholars have tended to address religiousness through group analyses, but spirituality is analysed at the micro-level and is distinct from religion in this manner. It has been proposed that "spirituality involves great deep change throughout the human developmental process, and many ways exist for conceptualising this change or maturation process, which comes to mean spiritual development" (Bulut 2020:70). Against this

backdrop, Bowen (1985) conceptualised differentiation as having a notable impact on the spiritual orientation of individuals.

Explicitly, Bowen (1985) proposed that individuals with high differentiation levels have a high level of spirituality, whereas individuals with low differentiation levels tend to also have a low level of spirituality. Similarly, Bowen (1966) proposed a link between the spiritual orientation of individuals and their individualism. Individualistic people tend to have a low spiritual orientation (Mert and Topal 2018). Bulut (2020:70; see Bowen 1978, 1985) explains it as follows:

> Evaluating the differentiation levels of each family member depends on many factors, such as individual stress levels, how each individual reacts to various stressors, and the frequency of interactions an individual has with extended family members. A hypothetical differentiation exists for a person who can resolve the emotional bond with the family and can see functioning easily without emotional fusion in the family system. The process of differentiation lasts all life long, and individuals don't always differentiate. When looking at this issue from a spiritual or religious perspective, families in traditional cultures, especially Islamic-oriented lifestyles, are seen to have highly intertwined ancestral relational dynamics and many families take responsibility for problems in the extended family.

Against this backdrop, Bowen (1966) argued that where individuals can learn to differentiate from one another while keeping their family bonds, functional interaction networks can be established. Another concept that is crucial to Bowen's Family Systems Theory is triangulation which, according to him, has a spiritual dimension. Triangulation occurs when a third person becomes involved in a relationship in order to mitigate tensions or anxieties that arise between two people. Bowen (1978:43) explained triangulation as an important strategy for family therapy as follows:

> A fixed structure and social environment are located at the base of the triangle. The triangle is the building block of the family's emotional system and is the smallest, fixed, and stationary interaction system. As long as the triangle remains constant, the two-person system also remains constant. However, if anxiety arises, someone from outside enters the family to form the triangle. This person exposes the tension by entering into conflict with the family.

The presence of a third party can be part of a healthy triangulation. However, when viewed from an emotional perspective, there is the prospect that boundaries can be violated. This would exacerbate existing anxieties within the family system. Families with more differentiation can apply triangulation as a strategy for dealing with anxiety. The process of differentiation involves both personal and interpersonal capacities. Triangulation can be potentially disruptive to relationships because it involves a third person. People are invariably placed against each other. Ultimately, triangulation as a response to anxiety within the family system reflects a lack of differentiation among the individuals within the system. At the same time, it undermines the differentiation which occurs in the system. Although triangulation is believed to cause dysfunction in relationships, it can be productive, for example, in the case of religious families who conceptualise God as a member of the family relationship. Since God constitutes a member of the relational system, the values of the gospel message can be utilised to address conflicts and problems. In this context, triangulation only becomes destructive when God is blamed for family problems or is used only temporarily to relieve the pain of the family. Nevertheless, God can play an assistive role in managing family tensions and anxieties. As noted by Bulut (2020:72):

> The following can be said when looking at triangulations from the perspective of Christianity: Christians have such a strong sense of belonging and meaning toward marriage that they regard marriage as “sacred” ... Christian traditions regarding marriage involve the couple promising to stay connected to each other for life before society and God, so even if the marriage has problems, marriage still has religious and moral significance for them. Couples who experience problems in their marriage generally use triangulation as a means of managing conflict and anxiety…This situation is also valid for Christian couples. Triangulation in marriages arises in order to eliminate the problem in the couple’s relationship without resolving it or in order to avoid conflict ... Triangulation damages the boundaries that separate marriage from other structures. Although defining boundaries is important for the therapist of any couple, if the therapist wants to include the triangulation of God in the marriage, the couple's religious values and thoughts need to be given importance … Triangulation can also appear between the client, therapist, and God. God and the self-relationship can have an important position in the client’s problems. The therapist wants the God-and-client relationship to be interconnected positively, emotionally, and intensely

interrelated. Clients' certainty of their stance on God is important for the therapy process.

Against this backdrop, Family Systems Theory can be useful in the field of pastoral care and counselling and can be applied in church congregations, which largely consist of families. The behaviours identified by Bowen can be found even in high-functioning church groups. Consequently, Bowen's theory is useful for addressing tensions and anxieties that exist in the group. This theory emphasises the value of building people's self-differentiation since this results in greater emotional awareness and empowers people to define their roles more clearly. They also become more cognizant of the disruptive behaviours that can undermine the achievement of their mission. This theory aligns with a postmodern approach to pastoral care. Doehring (2014) points out that after the caregiving relationship has been established, the care seeker's community of support should be examined in order to assess the quality of the support that is available to them. This includes the family of origin and the faith community.

Scholars such as Matthews (2005) have argued that the theory supports theological reflection, which constitutes an important part of the decision-making processes that shape pastoral ministry acts. Matthews (2005) applied the framework in a study of pastors within a heterogenous inner-city congregation to illustrate how the theory can support a pastor's ability to perform essential work. The study showed that the theory constitutes a personal resource that pastors can use as they try to adopt a non-reactive stance in providing pastoral care. The theory and its underlying conceptual framework also have the capacity to provide a nuanced understanding of the emotional processes that are determinative but often overlooked in the provision of pastoral care. Bowen's family systems theory provides a lens through which pastors can see the systemic dynamics outlined, which is crucial for theoretical reflection. Richardson (2005) also notes how church leaders and pastors are increasingly applying the theory to comprehend normal relationship processes that manifest in their churches and to learn how to operate and function within them. The theory assists pastors and church leaders to engage more closely with how individuals are emotionally interconnected and how these interconnections can manifest to facilitate enhanced personal and congregational health or enhance difficulties (Richardson, 2005).

This study draws on Bowen's family systems theory and applies it to pastoral care to understand pastoral care in the context of suffering congregations during the pandemic. There is a suggestion in the literature that when a congregational body suffers as per the context of the pandemic, the resultant effects are far-ranging and significant. In the context

of the pandemic, due to public health rules, members suffered from strained relationships, which in some cases were irretrievably broken. Although some families enjoyed spending additional time together during the pandemic, some relationships were immensely strained and failed to thrive during the pandemic, which was characterised by unprecedented uncertainties and upheavals. Families experienced disagreements about COVID restrictions and rules, vaccinations, and even about whether the virus existed or not—these disputes pushed many relationships to a breaking point during the pandemic, in many instances, irretrievably so (Singh and Sim, 2021; Rose et al., 2022; Fadmawaty and Wasludin, 2021). Even families that did not experience significant problems before the pandemic experienced notable shifts in their relationships due to changing dynamics related to finances and household health, which made them susceptible to break-ups (Rose et al., 2022). Invariably, the pandemic interrupted the well-established routines that served as a source of stability and comfort for families.

Against the backdrop of such experiences, Christian believers might find worship difficult because they shift their focus from the divine to their realities and difficulties. Sometimes, this shift in focus is to the extent that the existence of God may be questioned. When Christian believers experience rejection, pain and discord, this overrides and challenges some functions of the congregation, such as love. A resultant effect is that the body may be less capable of ministering to members of its community. If, during times of difficulties or social disruptions such as the pandemic, Christian believers are not able to discern a positive purpose for their pastors and the congregation, they might forsake the church entirely and retreat from their Christian community as a whole. During times of crisis, congregations that are experiencing suffering are in immense need of help, which clearly delineates a role for pastoral care. Bowen's family systems theory enables the provision of pastoral care to the congregation as a whole to be analysed using the cornerstone concept of the theory, differentiation of self, as a crucial starting point. This concept points to the importance of pastors maintaining self in their relationships with Christian believers in a manner that positively enhances their functioning but also the maturity of the relationship system as a whole. There are two aspects of the theory that are crucial for analysing pastoral care in the context of the pandemic, the first pertaining to its profoundly relational understanding of humans. The relational nature of humans is crucial for understanding the disruptions to pastoral care during the pandemic, as the remaining chapters will show. In conceptualising the changes to pastoral care during the pandemic, it is important to provide an overview of what constitutes a functioning system (including the role of pastors within these systems)

per the theory as a precursor to understanding how these systems were disrupted during the pandemic.

Bowen's (1966) systems theory conceptualises systems as dynamic in nature; thus, they are in constant motion and not inherently static. Systems are also inherently interconnected, and disruptions to one dimension of it impact all dimensions. This is linked to Bowen's (1966) submission that systems exist in a steady state whereby a movement within it instigates a counter-movement for balancing purposes. The implication here is that systems are resistant to change which may also be explained by the fact that they are defined by strict boundaries, which determine what is inside and outside. In healthy systems, boundaries are clearly demarcated; nevertheless, they are permeable. In unhealthy systems, Bowen (1966) notes that boundaries are rigid. According to the theory, families should be conceptualised as dynamic emotional systems so that interventions must focus on the whole system as opposed to only the member that is sick. Focusing on only one individual is conceptualised by Bowen (1966) as unhelpful. Per the tenets of family systems theory, there are two overarching forces in systems relationships. These are the desire for togetherness or the desire to have emotional connections with others and the desire for separateness. Threats from within the family system and the resultant anxiety are absorbed by triangles (the smallest unit within the family system), and other mechanisms for managing anxiety are also formulated.

These mechanisms include establishing a distance to remove emotional connections or under-functioning to manage anxiety. In some instances, projection is used to problematise the system as a strategy for releasing anxiety. Despite anxiety and disruptions, the theory suggests that differentiation is key to remaining connected to the system while maintaining a sense of self and remaining emotionally unreactive. Well-differentiated persons are able to manage existing tensions between separateness and togetherness in a healthy way, whereas poorly differentiated persons are emotionally reactive and become enmeshed in the system. The emotional patterns and responses described above relate not only to society but also churches which have similar characteristics to family systems. It has been noted, for example, that:

> Just as a family is built up of interlocking relationship triangles, so in society as a whole there is a more complex version of the same system – and emotional patterns of relating from families will be replicated in society at large. Acute anxiety is temporary stress in the emotional system; chronic anxiety is anxiety which is ingrained in the functioning of a system – this sort of anxiety may have built up over

> time because of repeated incidents. Chronic anxiety in society mirrors chronic anxiety in a family and may result in regression: where the herd-mentality of togetherness over-rides the need for individuality (the desire for separateness). Symptoms might appear such as violence, polarisation and rigid beliefs, fear or risk, a 'blame' or 'scape-goating' culture, litigiousness, all of which can be magnified by the media 'reflecting back' anxiety like a mirror into the system. These issues are not causing the anxiety; they are the symptom of the anxiety. Churches are complex family systems, and these symptoms of anxiety may appear in churches too: as a symptom of anxiety in church relationships; or as a result if anxiety at large in society, from which people might 'seek refuge' in churches. (Chemlsford Anglican Church, 2011, para.8)

In the case of anxious systems such as the status of the church during the pandemic, how does the theory propose that pastors can work with congregants who are suffering due to anxieties either linked directly to the pandemic or those that are chronic and have been building over time? The theory suggests that a significant skill of pastors is to play the role of a non-anxious presence. Thus, within the pandemic, pastors must be well-differentiated so that they can work with the church system and help it to understand emergent patterns of relating brought on by social restrictions and respond directly to the concomitant stresses and tensions. Concurrently, based on the theory, there is the suggestion that pastors must be able to refer to historic patterns of relating in order to redefine new ways of relating. In anxious systems, leaders will experience responses that the theory conceptualises as predictable. Some of these responses include resistance since, as previously noted, systems gravitate towards a steady state and will try to re-establish the equilibrium so that attempts to define new approaches may be perceived as a threat. In extreme cases, individuals within the system will establish alliances for the purpose of resisting change. Scape-goating and blame are also common responses to changes in the system which may lead to the targeting of individuals within the system, particularly if they are perceived as responsible for the problem of the group. Invariably, systems must find outlets for relief during times of anxiety, and the theory suggests that pastors must be well-differentiated within the system to resolve these anxieties in a healthy way.

The theory suggests that well-differentiated pastors can build relationships and foster an environment within which people in the system can explore their issues in a healthy way without being attacked. As leaders, they must show, through their character, the way of

being non-anxious. Concurrently, as loving pastors, there is also a duty to accept and nurture the various patterns of behaviours that people display within the system and acknowledge that these behaviours may take time to change. Amidst the context of social disruptions, pastors must support individuals within the system to express their feelings openly and outline what their needs and hopes are. In other words, they play a role in self-definition, which is partly achieved by not directing people in the system on how they should be but rather responding to their needs by drawing on religious practices such as the reading of scripture and provision of biblical examples to illustrate models of behaviour and living in the kingdom. What can be inferred from the theory is that this will support Christian believers to define themselves more clearly, as well as the role of the church in their life.

Pastors also have a role to play about maintaining connections during periods of anxiety so that individuals within the system can move away from the source of anxiety. This requires emotional contact with people who are experiencing difficulties, and pastors have a role to play in terms of helping such people to rebuild their emotional contact with others as well. Moreover, pastors have a role to play regarding serving as a source of stability amidst processes of change, maintaining their convictions while also being flexible so as to adapt to emergent processes. The characteristics of well-differentiated leadership in the context of pastoral care have been summarised as follows:

> Clear self-definitions, purpose, convictions, identity (hence the importance of clear objectives) ; Non-anxiety: The capacity to stay calm in the face of difference and anxiety, and to avoid getting reactive; Maintain healthy relationships: The ability to model intimacy and good boundaries; Maintain connections: The ability to stay connected with those you disagree with and dislike; Teamworking: drawing on the wisdom of others and sharing the load with peers (transition teams!); Resilience: the ability to stay on course in the face of opposition and disappointment; Humility: the ability to be able to recognise and admit your own limitations and mistakes; Courage: the willingness to rock the boat at the right time and disrupt the status quo, especially when faced with injustice or wrong-doing. Poor differentiation may be marked by an over-functioning, authoritarian approach – not listening, inflexibility, lack of consultation and collaboration. (Chemlsford Anglican Church, 2011, para.1)

While the theory evidently ascribes a role for well-differentiated pastors during times of anxiety such as the pandemic, it is important to explore further, whether these theoretical propositions were reflected in reality during the pandemic. The empirical evidence reviewed

in this chapter, already points to the difficulties that pastors experienced with regards to differentiation and playing the role outlined by Bowen (1966).

3.3 Summary

The underlying theory of this study, Bowen's Family Systems theory suggests that a significant skill of pastors is to play the role of a non-anxious presence during periods of anxiety. Thus, within the pandemic, pastors must be well-differentiated so that they can work with the church system and help it to understand emergent patterns of relating brought on by social restrictions and respond directly to the concomitant stresses and tensions. The theory suggests that well-differentiated pastors can build relationships and foster an environment within which people in the system can explore their issues in a healthy way without being attacked. As leaders, they must show, through their character, the way of being non-anxious. The evidence from this research however suggests that pastors were not always able remain non-anxious and well-differentiated during the pandemic. Some clergies experienced psychological difficulties because they were not permitted to visit their members, but others also had opportunities to re-imagine the meaning of care for congregations and also for clergies, where care became associated with spending more time with their families.

Spiritual care providers in some of the studies that were analysed also reported that during the pandemic, pastoral or spiritual care in the healthcare setting was cancelled completely, restricting patients to accessing this form of care only through radio or television. Spiritual care providers also indicated that healthcare professionals, for the most part, adopted a prejudiced perspective that caused them to oppose their presence and role in the wards. Consequently, some spiritual care providers felt discriminated against and marginalised; they also felt that they were perceived merely as an 'infection risk' that posed a threat to patients. Evidence suggests that some chaplains complained that although there is mounting evidence concerning their positive impacts in healthcare settings, their role was misunderstood, mocked or undervalued. Spiritual care providers felt undervalued because there was a tendency to applaud the work of healthcare professionals who were conceptualised as heroes, whereas they and hospital chaplains were often neglected and conceptualised as useless.

Chaplains were also concerned with practical issues concomitant with the pandemic, including the shortage of materials, as these practical concerns invariably impacted their work and ability to help others. Chaplains reported feelings of exclusion and a lack of

chaplain leadership. They also opined that they should have been more involved in the provision of direct care throughout the pandemic; however, such opportunities were undermined because nurses and management perceived them as infection risks. Leadership and nursing, according to the chaplains, adopted attitudes that implied that everyone except nurses and doctors would spread the virus. Consequently, only nurses and doctors were permitted to have close contact with infected patients.

In some cases, the role of pastors was relegated completely. In a study that was conducted in the context of Spain, as opposed to chaplains, it was nurses that were responsible for pastoral care during the pandemic. Nurses were used to chaplains and families serving as the main pillar of faith and spiritual support in patients' lives in the pre-pandemic context; thus, they were compelled to fill a void which they had not anticipated. The study derived data from a sample of nurses who reported several barriers to their provision of spiritual care as a precursor to discussing how these can be mitigated to improve the provision of spiritual care in emergency care units.

Pointing to the anxieties experienced by pastors, some chaplains reported that even when they were permitted to visit patients, the mandatory wearing of masks caused pastoral care to become a faceless experience. This faceless experience, they noted, runs counter to traditional approaches to pastoral care, where the emphasis is placed on being present in order to build trust and establish connections with patients. Chaplains also noted disconnectedness in relation to their colleagues or cohorts, although disconnectedness was viewed as especially problematic in relation to patients who have cognitive challenges and thus already have limited communities. Overall, chaplains lamented the loss of casual and spontaneous interactions with their cohorts, patients and families.

During the pandemic, it was also impossible to give sacraments. A found that these losses went hand in hand with loneliness. Family members and bereaved parents experienced immense loneliness when they could not participate in ritual services for the deceased and were denied connectedness with others because the sacred could not be mutually expressed. Due to the loss of rituals, the chaplains reported a loss of religiosity. Chaplains reported this loss of religiosity with regard to being unable to bring communion to patients, for example, which left a void for many Christian believers who needed it at a very challenging time in their lives. Chaplains also reported missing other moments of community forming, such as singing together during services or with residents. Other moments of community forming which were referenced were discussion groups, prayer groups and mediation groups. Chaplains also encountered frustration because their work was stifled,

evoking feelings of helplessness, frustration and sadness because they were not always able to deliver end-of-life care to patients. Not being able to perform their roles was a source of moral stress for chaplains, as patients sometimes died alone, which led to feelings of guilt because chaplains felt they allowed healthcare professionals to take the lead on pastoral care and did not advocate enough for it to be taken more seriously. Other chaplains noted that the demand for spiritual care far exceeded staff availability, and many chaplains felt that their professional value was deprived because they were not invited to participate in multidisciplinary teams. Further, chaplains reported a dearth of collegial responses since medical care was primarily emphasised during the pandemic. Further, chaplains lamented a general lack of protective material during the pandemic since they were not prioritised and their roles were largely performed by other healthcare professionals. For many chaplains, telehealth options were not provided because of perceived power grabbing by other professionals, and they found that their role was relegated or, at best, tokenistic.

Chaplains also reported feeling lonely and invisible due to these experiences, and feelings of loneliness were exacerbated by limited communication between team members and staff. Crucially, the provision of pastoral care was limited by the technical aspects of communication with residents and their families.

While pastors were anxious, there is also evidence that shows that they made a unique contribution to healthcare during the pandemic by responding to the religious, spiritual and pastoral needs of both staff and patients. One study showed that the sole purpose of chaplains was to be present and create a safe space for meeting the individual needs of staff and patients, promoting their healing even when a cure was not possible. According to the tenets of family systems theory, amidst the context of social disruptions, pastors must support individuals within the system to express their feelings openly and outline what their needs and hopes are. In other words, they play a role in self-definition, which is partly achieved by not directing people in the system on how they should be but rather responding to their needs by drawing on religious practices such as the reading of scripture and provision of biblical examples to illustrate models of behaviour and living in the kingdom. What can be inferred from the theory is that this will support Christian believers to define themselves more clearly, as well as the role of the church in their life.Pastors also have a role to play with regard to maintaining connections during periods of anxiety so that individuals within the system can move away from the source of anxiety. This requires emotional contact with people who are experiencing difficulties, and pastors have a role to play in terms of helping such people to rebuild their emotional contact with others as well.

Moreover, pastors have a role to play with regard to serving as a source of stability amidst processes of change, maintaining their convictions while also being flexible so as to adapt to emergent processes.

One study found, against this backdrop, that the pandemic improved online ministry for members of the clergy due to the limits placed on in-person encounters.The study found that the pandemic reconfigured the nature of pastoral care, which became less about spiritual support and the fostering of spiritual growth and more focused on buffering government services in difficult-to-reach areas. The study found that members of the clergy, for example, provided support in the areas of education and health. Notably although there was a shift in the focus of pastoral care, members of the clergy still relied on service and pillars of faith to support personal growth in young people, especially via new ideologies. Evidence was found indicating pastors' flexibility in the context of Haiti. Pastors supported program leaders in delivering medication for homebound seniors as well as non-perishable staples such as beans, rice and dried fish. The role of pastors during the pandemic was not only limited to this form of support—they played a role in fighting corruption while remaining cognisant of the interconnectedness between the various vulnerabilities experienced by Haitians worldwide. It was found that clergies engaged with death more intimately and also took up new roles linked with having to bury a large number of people in a short period of time. Aside from having to bury people in general or their fellow clergies, the study found that they further had to bury members from their own congregations as a result of illnesses related to the pandemic. Nevertheless, the resultant effect was challenging to the ways in which pastoral care has always been provided. Another example of the flexibility adopted by pastors was the turn to social media. Following the imposition of lockdown measures, many clergies turned to the use of virtual services in the form of Skype, Microsoft Teams, Zoom, WhatsApp and SMS. Technology enabled congregants to reduce their stress levels during the pandemic because they could talk to their pastors, seeing their faces as sources of comfort.

CHAPTER 4

INTERGRATION AND INTEPRETATION

4.1 Overview

This chapter explores how COVID-19 impacted the nature and practice of pastoral care by means of a thematic analysis of the emerging literature. Five major themes with respect to the changes in the nature of pastoral care amid the pandemic are identified: communication, soul care, counselling, pastoral visits and healing.

Under the theme of *communication*, this study found that the pandemic required pastors to find creative ways of providing pastoral care because of social distancing and communication barriers. Creative ways of establishing connections with congregants were mostly based on making use of online spaces. The telephone and the Internet were utilised more extensively than before in order for pastors to provide pastoral care from their homes. The study also found that transitioning from providing pastoral care in-person to virtual platforms was challenging for pastors who were familiar with in-person contact when doing pastoral care work. The main loss that they experienced due to the lack of in-person contact was the benefits of social interaction that form part of face-to-face communication.

Under the theme of *soul care*, the study found that the COVID-19 pandemic had an unsettling impact not only on the body and minds of individuals but also on their souls. The demand for pastors to provide a "cure" for the human soul (*cura animarum*) rose exponentially. Pastors were called upon to provide spiritual care based on the exigencies of the pandemic, which included prayer, worship, and communion with God. This had to take place by means of the use of technology. There was a heightened need for spiritual care because the pandemic has launched an assault on the soul in a myriad of ways.

Under the theme of *counselling*, this study found that during the pandemic, traditional therapies, in particular, were ill-equipped to deal with the gospel-centred and existential questions of Christian believers. Pastoral care and counselling had to bridge this gap. Through the integration of the gospel within an overarching counselling relationship, pastoral counselling provided a unique opportunity for Christian believers to experience the transformative healing of Christ during the pandemic. The nature of pastoral counselling changed in two main ways: congregants were, more than ever before, experiencing depression, anxiety, loneliness and bereavement. Therefore there was an increased

demand for counselling. Pastors also had an increasing need for self-care as they, too, experienced these feelings due to the pandemic and social distancing. The challenge was to adjust with spiritual and mental strength to the changing nature of and changes regarding their role. Pastors often found themselves caught between the needs and demands of parishioners and those of their own families.

Under the theme of *pastoral visits*, this study found that the pandemic caused a reduction in pastoral visits compared to previously. The nature of pastoral visits also changed. Hospital visits were reduced greatly. If they occurred, they required protection, planning, permission and coordination. Where hospitals allowed visitors, strict protocols such as handwashing and the wearing of a mask had to be followed in order to prevent the spread of the virus. Pastoral visits were disrupted during the pandemic because this form of pastoral care usually requires physical presence. This aspect changed because of the health restrictions.

Under the theme of *healing*, the study found that with a few exceptions, it included exhortation, the laying of hands, celebrating Holy Communion, performing of rites to the sick, anointing and Scripture reading. Within the context of the pandemic where sickness was rampant and unprecedented, it was expected of pastors to perform healing rites. However, given the nature of the virus, this was not possible. The risk of infection and even death meant that these rites were modified. Anointing, the laying of hands, visitation and exhortation require physical contact, which was made difficult due to social distancing protocols and restrictions.

4.2 Communication

Pastoral care practice has always been about a “ministry of presence” and constitutes an embodied experience. Pastors or spiritual caregivers would usually be physically present with people in need. The task of pastoral care is to listen, encourage and pray with and for people. As an embodied and physical experience, the actions and gestures of pastors play a role in providing support. Pastoral care involves and is enhanced by embodied experiences. The use of appropriate touch, gestures and rituals plays a significant role (Byrne and Nuzum 2020). Further, pastoral care relies on silent reflection and deep listening as persons share their personal concerns with their pastoral caregivers (Byrne and Nuzum 2020). The first step is to listen to the story of the care seeker with empathy and to "imaginatively step into the shoes of another person and see the world from his or her perspective" (Doehring 2014: p.18). In order to accomplish this, pastors should concurrently utilise two opposite relational skills: connecting with the care seeker by empathising with

them, yet maintaining separation from their experiences by being aware of the pastor's own thoughts and feelings (Doehring 2014).

An embodied provision of pastoral care was the norm until the advent of COVID-19 (Byrne and Nuzum 2020). Pastoral care is supremely relational in nature (Byrne and Nuzum 2020). As a practice, it is rooted in communication which was, however, limited due to the exigencies of the pandemic, which caused communication to be stifled and disrupted. The pandemic thus effectively constituted an unsettled cultural period (Swidler 1986) that required pastors to find creative ways of providing pastoral care in the context of social distancing. These creative new ways of establishing contact with congregants mostly revolved around the use of various technologies. However, such technologies can clearly never replace embodied experiences of human interaction which is even more crucial to people when they experience need and disruption. The literature has shown that amidst the social isolation of the pandemic, technologies did play a crucial role in the provision of care. The challenge was to humanise that care and ensure that human beings were placed at the centre of care (Byrne and Nuzum 2020). Using technology to facilitate pastoral care during challenging and uncertain times, such as during a pandemic, therefore, requires adaptability.

Although other aspects of ministry such as worship services were severely disrupted during the pandemic, pastoral care was probably most adversely affected by the pandemic. This is because the physical presence and person-to-person interaction define pastoral care. It cannot really be done effectively if these aspects are severely restricted (Johnston et al. 2021). In practices such as worship, a virtual presence can be maintained more effectively. The study by Johnston et al. (2021) found that pastors did not feel positive about digitally distanced pastoral care because it served to exacerbate the deficits brought on by the pandemic. The study by Bryson et al. (2020) found that pastors made more extensive use of the telephone and Internet than before in order to provide pastoral care from their homes. Studies by Carey et al. (2020) and Issetti et al. (2021) found that the use of technology created a new meaning for religious belongingness, community and religious participation. Amid the pandemic, pastoral care was provided by means of online counselling sessions. These needs for pastoral support escalated due to pandemic-related stressors. Pandemic-related stressors meant that pastors did not have the option of delaying their responses to congregants. Therefore, while the use of virtual platforms was not necessarily seen as equally effective to in-person sessions, they were important for continuing pastoral care during a time of crisis (Parish 2020).

A study by Arasa et al. (2022) found that most (58%) priests preferred to communicate verbally with congregants during or at the end of religious celebrations or through a billboard or bulletin. Before the pandemic, 42% of the pastors communicated with their congregants via social media, while 30% communicated through calls or text messages and 28% communicated via a website. Therefore, virtual communication was already used fairly extensively before the pandemic. However, this was not necessarily the case for the practice of pastoral care. Arasa et al. (2022) found that prior to the pandemic, pastors had not considered using virtual platforms for pastoral care. Many of the pastors already had a social media account or website prior to the pandemic. They did not need to create these modes of communication when the pandemic struck. The pandemic did influence how they were used by pastors for the practice of pastoral care. The study of Afolaranmi (2022) produced similar findings, but in this study, not many pastors were using the Internet and social media before the pandemic. This could be explained by the fact that this study focused on pastors above the age of 60. These pastors who, prior to the pandemic, did not use the Internet or social media did, however, learn to make use of technology during the pandemic. They developed a mixed approach to pastoral care, utilising text messages, social media and telephone calls to practice pastoral care. They began by using telephone calls and later progressed to social media and instant messaging applications such as Telegram Messenger and WhatsApp Messenger (Afolaranmi 2022). The study found that even if pastors did not want to use social media or the Internet in their ministries, the effect of the lockdown forced them to explore other options for pastoral care (Afolaranmi 2022:5).

For pastors, the pandemic was concomitant with a new normal (Iglesias-Sanchez et al., 2021), which compelled them to devise new means of reaching out to their church members. Johnston et al. (2021) found that pastors were connecting with their congregants during the pandemic through various practices, such as:

- telephone paired-prayer calls and telephone “chat” services;
- communicating convenient times for shared religious practices such as telephone prayer;
- encouraging the observance of spiritual practices and prayer in the household;
- circulating prayer requests from congregants so that they can be supported by all members.

Johnston et al (2021) found that during the pandemic, pastors strengthened their communities and mitigated the self-isolation associated with the pandemic by contacting

people mainly via the telephone. This strategy was found to be especially useful for providing pastoral care for the elderly who were living alone, with a disability or with other challenges and vulnerabilities. These methods required pastors to ensure that their contact list was updated. Some pastors created a "calling tree" system according to which individual members call specific persons on a regular basis in order to enquire about their wellbeing. These calls replaced in-person visits, which were discouraged during the pandemic. Virtual platforms were found to be useful for offering family-unit pastoral care during the pandemic.

The study by Tata et al. (2021:26) among hospital chaplains found that the inability to provide in-person care and engage with hospital staff on a face-to-face basis interrupted their provision of pastoral care. The study explains it as follows:

> Many of the chaplains grieved the "unplanned interactions, moments of prayer, or encounters" that allowed them to listen to staff members' "daily joys and complaints" and promote wellbeing. Chaplains from across the continents grieved the loss of human contact, especially actions such as "a simple touch on the shoulder or holding a hand as a sign of comfort when praying, sharing a hug when staff is distraught, as well as providing a "supportive arm or shoulder for staff to cry on." Chaplains lamented that this lack of human contact led to the loss of "the spiritually healing significance of touch," the "hands-on" approach of spiritual care; the physical aspect of "journeying with, and the feeling of being alongside the medical staff." The chaplains who were only able to work remotely reported the "loss of a sense of solidarity" with staff and felt like they had lost some of the strong "interdisciplinary relationships" that they had formed prior to the pandemic. As a result, there was an "interruption in the continuity of care and a loss of the sense of team cohesion." While many responses indicated that face-to-face contact was more comfortable and familiar, chaplains embraced new means of making connections which worked effectively. Doing work from a distance through phone calls and zoom was new, as was regularly wearing PPE for those serving staff in person.

This quote illustrates that pastoral care is an embodied and relational experience. These aspects were lost during the pandemic. This, in turn, meant that spiritual care did not feel complete. There was, for example, a loss of a sense of solidarity between pastors and congregants. There was also a loss of personal connection. The study by Tata et al. (2021) found that as the pandemic progressed, there was a higher need among chaplains to talk about their own struggles and personal concerns relating to their fear of the future, their health, mortality or the prospect of becoming ill. As the anxiety of chaplains increased, they

required in-person opportunities to vent their concerns and access support. However, this was not always available due to communication restraints.

Hospital staff also experienced significant stress and anxiety. Chaplains adapted to their needs by communicating with them mainly via the telephone or by participating in support hubs. “Telechaplaincy” was the most prevalent and safe approach. It involved the use of technology to provide pastoral care in order to avoid spreading the virus. The study found that though participants found face-to-face interaction more familiar, comfortable and effective for practising pastoral care, they nevertheless embraced the new strategies for making connections so that they also worked effectively (Tata et al. 2021). In some respects, the use of online platforms was found to have some additional positive outcomes, such as that staff members who otherwise would not have met at all were linked through these media. Online pastoral care was also found to be time-saving. It encouraged more open participation.

Through the usage of technology, chaplains could administer wellness surveys and disseminate educational resources concerning stress, anxiety and self-care to staff and patients. According to the study, chaplains placed "positive messages around the hospital" and, in many settings, shared videos, social media posts and thank-you notes. At one hospital, they made "blessing jars for all staff areas in the hospital containing words of encouragement and reflection" (Tata et al. 2021:25). In some settings, chaplains did this work on their own, while in others, they were part of teams supporting staff. At one hospital, the chaplains worked "closely with colleagues from other disciplines to provide a coordinated approach to staff care and support" (Tata et al. 2021:25). These strategies produced a more inclusive conceptualisation of pastoral care among staff who, prior to the pandemic, had viewed chaplains as different from other health staff.

Although interruptions in communication encouraged new virtual approaches to the practice of pastoral care, it was also concomitant with interruptions and disadvantages, such as the loss of fellowship, which was reported by Osei-Tutu et al. (2021). In their study, they defined loss of fellowship as "the absence of face-to-face interaction and religious assembling. It also refers to the lack of community felt by the religious leaders" (Osei-Tut et al. 2021:1). The study found that transitioning from providing pastoral care in-person to virtual platforms, was difficult for pastors who were used to in-person contact. The lack of in-person contact was found to culminate in the loss of the many social factors that are part of face-to-face interaction. Congregants felt a loss of consolation from their pastors during times of conflict,

anxiety and trauma. They could no longer meet with the pastor. Pastor found that a sense of fellowship and community in the Christian community was mainly achieved through face-to-face interaction. The disruption of this led to feelings of despair and hopelessness.

Another consequence of the pandemic was that pastors were compelled to meet more with pastoral teams, denominational leaders and lay leaders so that they could conjointly decide on how to address the exigencies of the pandemic. The pandemic introduced various questions that they had to address together. Pastors' lives had become extremely busy, not necessarily because they were doing more pastoral care, but because the routines they had established over the years were disrupted, and they had to create and put in place new forms of practice. This required much time and mental energy.

4.3 Soul care

The COVID-19 pandemic had an unsettling impact not only on the body and mind of individuals but also on the soul. As the pandemic damaged people's bodies, it also had a deleterious effect on the soul. Doctors had to work extensively to treat the sick and contain the spread of the infection. The demand on pastors for *cura animarum*, the cure of the human soul, rose exponentially. There was a heightened need for spiritual care because the pandemic assaulted the soul in a myriad of ways.

Studies have shown that people experienced a heightened sense of powerlessness during the pandemic. This was the effect of the rapid spread of the virus, rampant deaths and limited agency to move around as before due to social distancing protocols (Fosu-Ankrah and Amoako-Gyampah 2021). Many people lost one or more loved ones. The devastation of their lives was compounded by the closure of local cemeteries and restrictions on traditional funeral services. It resulted in a sense of powerlessness in the face of the pandemic, which was sometimes accompanied by a loss of faith in God's promises (Bussing et al., 2022). The familiar Christian rituals of mourning that facilitate healthy adaptations to loss were not necessarily available due to social restrictions linked with the pandemic. Those that had lost loved ones as a result of the pandemic could therefore experience their grief on more levels than were previously experienced in everyday life (Anicich et al. 2020). The pandemic had an adverse effect on the adaptive mechanisms that people would typically employ to deal with their grief (Anicich et al., 2020). Grief not only concerned the loss of loved ones but was also the response to the loss of savings, employment, security, social support, the pleasures of everyday life, and visitors (Zhai and Du 2020). On a deeper level, many people were grieving the loss of their previously protected lives. Alongside this was a

loss of faith and trust in God for many. Pastors were not available to take on the task of *cura animarum* in the traditional way due to lockdown restrictions, despite the heightened need for soul care. For many Christian believers, their faith did not succeed in serving as a buffer against the fears, grief or anxiety linked with the pandemic (Bussing et al. 2022). They needed help.

The experience and feeling of loss went hand in hand with a sense of mistrust which escalated during the pandemic (Carey et al. 2021). There was a general lack of trust in medical treatment, vaccines, and the news. There was a flood of both information and misinformation. Having to sift through and distinguish between factual information and conspiracy theories caused individuals additional stress (Boabeng 2021). Mistrust related to these dynamics can afflict the soul in profound ways because mistrust can permeate all aspects of a person's life. People are especially vulnerable in the face of uncertainties about their livelihood and the trajectory of the disease. Many individuals also experienced displacement from the roles to which they have become accustomed, both in the workplace and in other aspects of their lives. Displacement is not only physical but also relates to being deprived of agency, control, power and certain privileges (Carey et al. 2021). The pandemic was also associated with feelings of loneliness, which can be soul-crushing. People then lack the reassurance of the social support they once had (Carey et al. 2021). People who were isolated from friends, family or their supportive communities had to endure feelings of loneliness and abandonment. Pastors could not provide *cura animarum* in the traditional way, for example, through face-to-face care and counselling. For some pastors, the Internet was a useful tool. However, it was not a sufficient substitute for the personal connection between people. Soul care is embodied care. It requires in-person-specific conversations, which technology does not enable. In this way, technology restricted pastors' ability to provide adequate soul care.

Soul care includes a focus on serving others in love and finding joy in God. Soul care aims at facilitating personal change. The faith community forms the context for soul care because it functions as an interpersonal means of grace. The pandemic-related restrictions disrupted the flow of community life in churches. Soul care facilitates God's people to serve and love one another as they themselves receive the grace of God. This aspect of soul care was also limited due to social restrictions. Neither pastors nor fellow believers could get to the heart of people's personal and interpersonal problems because this is not readily achieved on a computer or the telephone. Pastors should come to a nuanced understanding of the pain,

confusion and struggles of people in order to equip them with the resources to live a life of fullness. This is difficult if they do not have access to people who are often not willing to provide the necessary personal information outside of face-to-face interaction.

A study by Porter et al. (2021) among African American Christian believers showed that generational trauma linked to racial oppression caused heightened levels of anxiety and fear during the pandemic. They were often reluctant to ask for help with their mental health issues. Porter et al. (2021) also found that Black churches were not fully equipped to respond to the heightened need for soul care. Many churches were unprepared to provide the degree of spiritual care that was required during the pandemic. Because of the heightened risk of infection, pastors were often reluctant to engage in in-person consultations. Some aspects of pastoral care could be successfully accommodated on virtual platforms. However, the nature of soul care has not lent itself to such modifications because it is deeply personal. Soul care requires pastors to listen to members of congregants who are trying to process their anxieties and fears. However, the physical risks prevented this from occurring in a comprehensive way, making soul care during the pandemic difficult.

When people are in distress, they often lack the ability to talk about their challenges. Then non-verbal communication is especially crucial, both for the person to express and for the pastor to understand what is going on. Apart from the communication aspect, there is also the aspect of conveying empathy and comfort. Physical proximity, body language and physical touch are utilised as signals of hope and comfort in the practice of pastoral care (Liegeois 2016). During times of social disruption and traumatic events, pastoral care draws upon the foundation of love in order to provide counselling and guidance (Tillich 1963). Through pastoral care, the character of a compassionate God is mirrored. Mouton (2014) proposes that during times of social disruption and traumatic events, care praxis must be informed by the *passio Dei* or compassion of the suffering God in order to bring hope to traumatised and disrupted communities. A theopaschitic approach is inherently inclusive and promotes the notion of a compassionate God who provides healing.

While the pandemic was concomitant with higher levels of stress and fear and a heightened need for soul care, for some Christian believers, their faith enabled them to cope. They learned to draw closer to God by themselves and did not need the direct support of their pastor. Various studies have illustrated the centrality of their Christian faith to the coping mechanisms of various individuals (see Edara et al. 2021; Porter et al. 2021; Barmania and Reiss 2020; Peteet 2020; Koenig 2020). So some Christian believers relied on the resource

of their religion in order to cope effectively with the challenges of the pandemic. This means that the heightened need for soul care is not applicable to all. A study by Porter et al. (2021), which includes a biographical element, showed how the pandemic induced her to spend more time in solitude and silence with God, reading Scripture and praying. In this way, it became possible to rest and rejoice in God, although she lamented the pain and suffering of millions of people around the world. Porter (2021:95) explains it as follows:

> I also prayed more throughout the day, and especially during my walks as part of my regular exercise routine. Pastors and church leaders tend to be over-involved in the doing mode: in ministry projects and plans, and busy, driven activities. Many of us are in a hurry and live hurried and harried lives. The spiritual mentor (the late Dallas Willard) of John Ortberg gave this now well-known word of wisdom to John years ago when asked about how John could remain spiritually healthy in the midst of a busy ministry in a mega-church: "You must ruthlessly eliminate hurry from your life." We have all had to learn to pause, stop, slow down, and be still (Ps. 46:10), and to live more in the being mode of our lives, including spending much time with the Lord and keeping the Sabbath. I have described this as being shepherded more deeply by the Lord Himself as our Shepherd (Ps. 23:1) before we go on to shepherding others or God's people in the church.

This illustrates that the pandemic contributed in some way to a spiritual breakthrough which enabled her to draw closer to God.

Louw (2014) emphasises the centrality of hope for soul care. French philosopher Gabriel Marcel (1962:10) explains hope poetically as "the availability of a soul which has entered intimately enough into the experience of communion to accomplish in the teeth of will and knowledge, the transcendent act – the act establishing the regeneration of which this experience affords both the pledge and the first-fruits. Hope is only possible on the level of us, or we might say of the *agape* [Christian love]." Hope is, therefore, a spiritual category that, among other things, pertains to change and to expecting something new and different.

The pandemic changed life and existing norms. It was accompanied by a lack of insight into the future and whether life as it once was would ever return. This created an environment for regression. Many people lost faith in God and the notion of a God who is present for them and loves and protects them. The task of pastors was to emphasise that hope should not be rooted in anxieties about death and pandemic-related uncertainties. It is about hoping in spite of these things. Pastoral care provides a platform for people to commit themselves to God. This is facilitated through a relationship with the pastor, which in turn is predicated on

love and care that reflect God's love and care. In a relationship with the eternal God, the ultimate purpose of a human life transcends the present and present realities. Eschatology concerns itself with the transcendental aspects of human life, and earthly life is not all there is in Christian theology. This shapes pastoral care and expands its scope from care rooted in the present to care also for the future, even when the receiver of care is in danger of death (Woldemichael et al. 2013).

From a theological perspective, the message of hope also for the unknown future is based on the faithfulness of God, as illustrated in various theological markers. These markers include the life and work of Jesus Christ and eschatology. The basic tenets of Christian hope could be utilised by pastors to inspire those who had lost faith. Ultimately, Christian hope is inextricably linked to the faithfulness of God. This universal Christian message of hope became even more significant during the pre-pandemic era. The central message emphasises the embodiment of God's grace and the hope that God can and will create a new future. Louw (2014:5) points out that "this certainty already transforms daily life into a doxology to God's eschatological kingdom rule. Resurrected life can be realised daily by the spirit in the forms of faith, hope, love and peace. The process of making resurrection life real finds expression daily in thanksgiving and praise". These modes of expression were stymied during the pandemic. Pastoral care aimed to encourage people to have hope, embrace life with gratitude and thanksgiving, and love one another unconditionally.

4.4 Counselling

Pastoral counselling focuses on the needs of individuals who seek help not only for their mental health and wellbeing but also for their spiritual wellbeing. In pastoral care, individuals also reflect on their faith (Maynard and Snodgrass 2015). Prior to the pandemic, pastoral counselling was sought by Christian believers when they encountered difficult or troubling times. Pastoral guidance was provided in accordance with the faith of the individuals. Pastoral care and counselling engage with existential questions of faith and meaning, whereas mental health therapies focus primarily on psychological, emotional and relational matters. The pandemic engendered many questions of meaning and thoroughly threatened people's existence. Through the integration of the matters of faith and meaning in the counselling relationship, pastoral counselling has provided a unique opportunity for Christian believers to experience the transformative healing of God during the pandemic. The overarching aim of pastoral care and counselling is to facilitate hope, not to give advice. The nature of pastoral counselling changed during the pandemic in two main ways: congregants

were experiencing higher levels of depression, anxiety, loneliness and bereavement, and pastors also experienced a more urgent need for self-care as they, too, experienced higher levels of stress and work-related stress due to the pandemic and social distancing.

Insights from the existing literature show that the pandemic engendered concerns about the future, increased domestic violence, anxiety, depression and bereavement (Usher et al. 2020; Duncan 2020). Pastors had the critical function of providing support to those who were marginalised, unwell or socially isolated during the pandemic. The level of care and counselling that was part of their daily work escalated to unprecedented levels during the pandemic. Johnston et al. (2021) found that older congregants, for whom congregational participation was their main source of social interaction, experienced significant loneliness during the pandemic. Older people often felt more disconnected and therefore were in greater need of pastoral care. Pastors in this study reported that, before the pandemic, they utilised the weekly worship services as an opportunity to provide counselling and identify members who were struggling. During the pandemic, the opportunity to do so was undermined, but the need for counselling had increased.

Prior to the pandemic, face-to-face interaction meant that pastors could enquire about the wellbeing of their congregants and identify those in need of care. During the pandemic, more people required counselling, but pastors were not necessarily in a position to provide such care. Pastoral counselling services were more likely than secular resources to collapse as a result of poor funding and inadequate resources. Pastors in small ministries who worked part-time, for example, did not have the funding or resources to provide counselling services. They often served at great cost to themselves.

The study by Johnston et al. (2021) found that during the pandemic, pastors had to be more intentional about providing counselling as opposed to reacting to impromptu connections during worship services. The provision of counselling during the pandemic required pastors to put more time and effort into reaching out to congregants. This mostly had to be done via the telephone because of restrictions on social interaction. Johnston et al. (2021) found that while more congregants needed counselling, reaching out to them directly was difficult and, in some cases, impossible. Some pastors had to implement new approaches to counselling. Pre-existing congregational care teams could be utilised, for example, or new groups could be created. Members could pledge to telephone, text or send a card to someone at least once a week. In such cases, pastors empowered members of the congregants and relied on them to provide mutual pastoral care. This represents a shift from the traditional mode of

doing where the clergy alone provided counselling and care for congregants (Vaccarino and Gerritsen 2013). Oates (1974:4) calls it “the traditional expectation” that “the pastor, priest or rabbi has been the primary person responsible for dealing with the needs of people”. In addition to providing counselling and care and empowering congregants to care for one another, pastors had to focus on self-care more than ever before.

During the pandemic, pastors reported an increase in traumatic events and pressure on themselves. This included testing positive for COVID-19 themselves, dealing with the death of a colleague, and meeting the demands of their family. Along with this, they had to support congregants, many of whom were questioning God's presence during the pandemic. Pastors were an important source of hope and strength for congregants, providing counsel and comfort for those in crisis. This meant that pastors often forgot to care for themselves and address their own mental difficulties in dealing with the pandemic. Pastors were not immune from the effects of the pandemic and, in some instances, were overwhelmed. Horsfall (2010:52) puts it as follows: "It is so easy for those who are carers of others to neglect their own welfare. We give ourselves to other people – listening to their hurts, mending their wounds – yet fail to care for themselves".

Village and Francis (2021) in their study found that the psychological wellbeing of the clergy was affected more than "lay" people by pandemic-related stress. Clergy in their fifties and sixties, in particular, showed the highest level of stress. Village and Francis (2021) point out that clergy persons in this age bracket, as "senior pastors", typically bear the greater responsibility for the ministry in the congregation. Poor emotional regulation was found to have a particularly detrimental effect on the wellbeing of clergy persons. Many of them experienced burnout, which Barnard and Curry (2011:49) describe as "a decline in energy, motivation and commitment". In the study by Schoonhoven (2020), pastors described their COVID-19 experience as concomitant with "new levels of irritation and stress" and "as an overwhelming sensation of business". The study by Earls (2020) captured the views of 400 pastors. Of these, 26% reported that they were worried about finances, 16% reported that they were experiencing technological challenges, and 12% reported that they had to offer pastoral care remotely. Of the research sample, 11% did not have sufficient access to technology. This was problematic since the anxiety levels of the people in the congregation escalated. The pastors themselves were experiencing higher stress levels which placed them at risk of mental health challenges. They acknowledged that they needed counselling themselves (Earls 2020). The vulnerability of pastors was found to be linked to various

factors. The main cause, however, was traumatic events in their personal life and family context. The increased risk was also linked to pastors' repeated exposure to the traumatic information shared by congregants.

Pastors experienced tension because of their inability to meet the demands for counselling from both the church members and the members of their own families. Lockdown measures and restrictions on social interaction caused an increased need for biopsychosocial and spiritual care (Tanhan et al. 2020), including among family members. Biblical scriptures such as 1 Timothy 5:8 emphasise the responsibility of Christian believers to care for their family members. The great need for counselling in the workplace meant that pastors could not always address the needs of their own families. This was often a source of great stress. Balancing the demands of both the family and the church was a source of mental strain for pastors during the pandemic. Historically this has been a significant stressor for pastors, which means it is not peculiar to the pandemic. Previous studies by Han and Lee (2004) and Lee (2007) have investigated these tensions. However, during the pandemic, these tensions escalated to unparalleled levels. Restrictions on social interaction during the pandemic meant that pastors spent more time at home with their families. Many felt helpless as a result of not being able to do their work as they thought was necessary because of restrictions.

As a result of their own stressors and vulnerability to mental health challenges, pastors were inclined to seek help more than ever before. The study by Tanhan et al. (2020) showed that finding a "ministry buddy" was an important coping strategy for pastors. It enabled them to speak safely and openly about their stressors and, in this way, strengthen their mental wellbeing. Social support from trusted cohorts was also found to be a unique way of fostering peer-to-peer support and engaging in stress management. This study further showed that pastors who traditionally found themselves in a counselling role as part of the practice of pastoral care sought help from mental health services for themselves during the pandemic. Talking with mental health practitioners was found to be essential for the psychological health of pastors. They were aware that poor mental health would interfere with their occupational and relational functioning. Seeking mental health services, therefore, made it easier for some pastors to cope with the life and social changes of the pandemic.

Other pastors turned to their faith for strength and support. One example was practising an “attitude of gratitude”. They would give thanks despite the adverse circumstances and negative impact of the pandemic on them and on their congregants. This attitude is articulated in 1 Thessalonians 5:18: “Give thanks in all circumstances; for this is God’s will

for you in Christ Jesus." So also Philippians 4:4-7: "Rejoice in the Lord always. I will say it again: Rejoice! Let your gentleness be evident to all. The Lord is near. Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus."

The study found that thankfulness was linked to greater self-efficacy, less stress and fatigue, and greater mental wellbeing among pastors. Gratitude was linked to adaptive coping among pastors. A related faith practice for coping with mental stress is that of being hopeful. Psalm 71:5 expresses this hope: "For you have been my hope, Sovereign Lord, my confidence since my youth", and Psalm 119:114 indicates that hope can be found in God's word: "You are my refuge and my shield; I have put my hope in your word." The practice of hopefulness was important for pastors in coping with pandemic-related stressors and changes.

4.5 Pastoral visits

Because of the pandemic, pastoral visits could not occur in the same way as previously. The nature of pastoral visits has also changed. Previously, pastors could visit a congregant's house to provide pastoral care. Social distancing rules and the danger of the spread of the virus meant that permission and advanced preparation for visits were needed in order to adhere to social distancing regulations. Pastors were at risk themselves as they dedicated themselves to others who had been displaced or experienced loss. During the lockdown measures, because of the pandemic, hospital visits by pastors were greatly reduced. If such visits did occur, protection, planning, permission and coordination were required. Where hospitals did allow visitors, strict protocols were followed in order to prevent the spread of the virus. The wearing of masks and the use of hand sanitisers were obligatory.

In practice during the pandemic, rather than spending the most time on personal visits, pastors made more extensive use of pastoral teams to jointly address the challenges of the pandemic with regard to pastoral care and to devise effective strategies (Johnston et al. 2021). The pandemic changed the face of pastoral care. The workload of pastors increased during the pandemic, mostly because the usual ways in which the work was previously done were so severely disrupted. This meant that new forms of practice had to be devised.

The lack of presence and personal contact during the pandemic disrupted pastoral care and counselling. In the study of Johnston et al. (2021), pastors found in-person pastoral visits crucial since the human touch and interaction are important aspects of pastoral care and counselling. These requirements cannot be fulfilled wholly by relying on technology. In their sample of 26 respondents, 54% reported that they were unable to visit congregants who were isolated or sick or to conduct funerals. They were unable to provide comfort to bereaved congregants in person. One pastor reported that a congregant who died of COVID in the hospital was completely alone and without the physical support of a pastor. A telephone call or card does not have the same emotional value as a physical presence. Another pastor found that the inability to visit a person in a hospital contravened the basic pastoral role of caring. Pastors could also not visit elderly congregants who were homebound and serve them communion, which is what they did before the pandemic (Johnston et al. 2021). The study found that “pastoral care was deeply tied to pastors’ sense of identity and their understanding of what it meant to be a pastor. The practices and actions of caregiving defined the role of ‘pastor’ for themselves and for members of their community” (Johnston et al. 2021:7).

Historically, the Judaeo-Christian tradition conceptualised pastoral care as supportive and crisis care provided by ordained and lay members of their respective religious communities (Doehring 2015). This care embodies the love of God (Gerkin 1997). Isiah 40:11 refers to God’s care as follows: “God tends the flock like a shepherd: God gathers the lambs in God’s arms and carries them close to God’s heart; God gently leads those that have young.” In Psalm 23:3, reference is made to dispirited sheep who are in need of shepherding in order to be restored. The apostle Paul appointed "shepherds" in the towns where he planted a church (see Titus 1:5, 3:9). The Scriptures portray God as present with creation, caring, loving and showing concern for all. God's provision of care as a helper is the subject of Isaiah 41:10: "So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand." In 1 Peter 5: 7, believers are encouraged to "cast all your anxiety on him because he cares for you." Pastoral care is about the provision of care and spiritual guidance akin to how God cares for the flock.

Pastors' inability to fulfil this task freely during the pandemic was found in the study to have a significant emotional toll on pastoral caregivers (Johnston et al. 2021). In the study by Johnston et al. (2021), pastors expressed profound sadness about being unable to be physically present with people who were experiencing difficulties, trauma and loss. Johnston

et al. (2021:10) summarise the results of their study as follows: “The most common approaches to pastoral care mentioned in the interviews were telephone calls (20, 78%), emails and/or text messages (8, 31%), socially distanced porch or drive-way visits (7, 27%), and physically mailing letters or cards (5, 19%). Most pastors used some combination of these approaches to connect with congregants and hoped that ‘this patchwork would somehow feel like we're in ministry together’.”

In contrast to practices such as worship, where pastors can still maintain a virtual presence even during the pandemic, they found it more challenging to maintain the necessary protocols when providing pastoral care. Johnston et al. (2021) found that pastors did not regard digitally distanced pastoral care to be effective. It rather served to emphasise the deficits brought on by the pandemic. Key deficits noted by pastors in the study include the inability to visit sick or isolated congregants; the inability to conduct weddings and funerals; the inability to comfort grieving family members; and the inability of pastors to visit elderly and homebound congregants. These deficits have had a wide-ranging impact. It caused some participants to struggle with their pastoral identity. When pastors are unable to honour their calling and do their work, it takes an emotional toll.

The study by Porter et al. (2021) showed that pastors had to devise creative ways of meeting their congregants in person. These meetings could, for example, take place outside, in a parking lot, or a park, while the required social distance was observed and the people were wearing masks. The researchers report their insights from the study as follows: "We have learned that church is not a building or even a meeting, but it is a spiritual connection that can be made through virtual means and the phone, and prayer for one another connecting in the Spirit, although regularly meeting in person cannot be replaced and should be returned to, as soon as possible" (Porter et al. 2021).

Outreach was an important concern for pastors during the pandemic since social isolation resulted in loneliness. This presented an acute need for spiritual care and connection which mainly had to be provided through remote or virtual means. One respondent in the study of Porter et al. (2021:96) explains it as follows:

> As a pastor, I made many more phone calls to reach out to people in my church and others with pastoral care and counselling and prayer, and also kept in touch through other social media including texts, emails, and Zoom meetings. I also visited people in person when possible but with appropriate physical distancing and wearing masks, in places such as backyards or parks or parking lots, or at

> front doors, sometimes bringing food and snacks and devotional materials. "Visiting" neighbors next door or across the street was also important, especially the elderly, where and when appropriate. Some people have lost jobs and have therefore been in financial need during this long pandemic, and as the senior pastor, I have made available love offering funds from our church to help support those in deep financial need, as much as possible.

This illustrates that restrictions on pastoral visits meant that pastors had to adopt a multi-pronged approach to establish contact with their congregants and perform outreach activities. Despite the heightened need for pastoral visits in the face of social isolation, the risks associated with physical contact meant that this was not always appropriate. Drive-bys or drive-throughs became more common.

4.6 Healing

Traditional healing rites prior to the pandemic included those mentioned in James 5:13-16: prayer, anointing, confession, visitation, songs of praise and confession for healing (Schiefelbein-Guerrero 2020). Prayer is identified in the text as the primary ritual action. Along with other ritual actions, it is an embodied experience. In the Apostolic tradition, a specific prayer is outlined for setting apart oil during the eucharist—the function of this is to provide healing and strength to individuals who use this oil (Schiefelbein-Guerrero 2020). In the Christian tradition, oil was often utilised when visiting the sick. Anointing oil can be administered to the sick by a pastor, or it can be self-administered. Such healing rites were typically performed outside the church building and involved the laying on of hands.

Traditionally, healing was seen as going hand in hand with the forgiveness of sins. Since the 12th century, healing has been linked with the anointing of the sick. Anointing of those who were dying was not about healing, but rather about preparing the soul. This ritual was an important part of the last rights of penance. Since the Reformation, healing rites have included the laying on of hands and greeting the sick with a message of peace. This could be accompanied by reciting the Creed and the Lord's Prayer over the sick individual. A prayer would reiterate God's promises to assist those in distress and ask for protection and the strengthening of faith. The ritual care for the sick has also historically included the reading of Scripture.

With a few exceptions, healing in pastoral care has continued to include exhortation, the laying of hands, Holy Communion, visitation rites to the sick, anointing and the reading of Scripture (Louw 2008a, 2008b). During the pandemic, when sickness was rampant and unprecedented, there was a great need for pastors to perform these healing rites. However, given the nature of the virus, this was not possible (Sarmiento 2021). Since it was highly infectious and there was a great risk of infection and even death, these rites could not be performed as they once were. Anointing, the laying of hands, visitation and exhortation require physical contact. This was made difficult or impossible due to social distancing protocols and restrictions. Largely pastors did not have access to the sick in hospitals. Those who were granted limited access had to modify their healing rites. With the laying of hands, for example, pastors were required to use a face covering. They had to sanitise their hands before and after performing the rituals. The pastoral teams could not function together since only one person was allowed to visit the sick. When a patient was formally diagnosed with the virus, healing rituals could not be performed at all.

Since illness is typically associated with isolation, healing rituals are traditionally communal in nature. Schiefelbein-Guerrer (2020:7) explains it as follows: “The healing rite thus serves as a transitional or transformational phase: participants, for whom sickness has created loneliness, are intentionally brought into the community for specific prayers related to sickness and health. Worshippers who participate in the healing rite are ‘incorporated’ into the community that is not ‘afraid’ of the sick or does not see them as outcasts but intentionally includes them in their fellowship and prayers”. This congregational approach to healing was not possible during the pandemic due to the high risk of infection. In countries where social distancing protocols were not so rigid, pastors could lead worshippers to gather in small groups – albeit limited to family or households – to perform healing rites. As opposed to having a large group or long line of worshippers gathered to receive healing gestures, these rituals were provided on a one-on-one basis. Only the pastor could perform these tasks due to the restrictions of the pandemic.

Louw (2014) emphasises that the healing aspect of *cura animarum* is inextricably linked with *change*. Healing is not only about physical gestures but also about reframing in spiritual terms. In contemporary approaches to pastoral care, the Greek word *therapeuo* is of significance. In the New International Dictionary of New Testament Theology (Reeves and Brown 1971), this word pertains to recovery. However, in the New Testament itself, it is used primarily as a willingness to serve or give. *Therapeuo* encapsulates the process of healing

and its associated process of renewal and restoration, not only in the context of individuals' relationship with God but also in their relationship with others. Healing involves pastors counselling congregants to reveal that things that appear unchangeable can be changed (Capps 1990). In the context of the pandemic, this included the message that the pandemic, too, will pass, despite the uncertainties and vulnerability it brought about.

Louw (2014:5) explains that "to reframe means to 'change' the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame or paradigm (pattern of thinking) which fits the facts of the same concrete situation equally well or even better, and thereby changes its entire meaning". Reframing is at the heart of theology. Reframing requires interaction between pastors and the people. Both the physical and spiritual dimensions of healing were therefore affected by the pandemic with its ban on social gatherings and social distancing regulations. Pastoral caregivers were severely restricted in performing their role. Their practices had to be amended, and much of the impact of the practices was lost.

4.7 Summary

This chapter has documented the profound changes to pastoral care that have occurred as a result of the COVID-19 pandemic with respect to communication, soul care, counselling, pastoral visits and healing. The strength of this study is that it has made a pertinent and original contribution to the literature by drawing data from studies published in various countries, including the United Kingdom, Italy, Germany, Ghana, Nigeria, India and the United States of America.

As outlined in Chapter 2, Bowen (1966) conceptualised the family as a whole interconnected system and believed that it offered an important path or conduit for understanding individuals. Bowen (1966) proposed that individuals form part of a system within which they are connected to others; consequently, the individuals in the system affect one another. Bowen’s theory focuses on how to handle anxiety in the family, how families handle degrees of family differentiation, interconnected family dynamics, and interventions to address these; consequently, it has been applied in therapy for religious and spiritual families as well as church congregations more broadly (Daneshpour 2017).

Faith communities and church congregations are akin to families. The studies show that the pandemic has meant that faith communities have had limited opportunities to gather, while

pastors are limited in their ability to practice pastoral care in the same way as pre-pandemic levels. Currently, with social distancing protocols renounced, including the wearing of masks in the majority of countries, the physical constraints which shaped the practice of pastoral care are no longer present. The pandemic has nevertheless had long-term impacts on pastoral ministries as pastors have been compelled to refocus and take stock of the aspects of their ministry that are really important. During the pandemic, pastors went to great lengths to practice pastoral care, whether this meant praying for congregants via Zoom or conducting pastoral visits in parking lots at safe distances. With social gathering activities largely curtailed during the pandemic, it is important to enquire further about what Bowen's Family Systems Theory reveals about how viable emotional contact can be maintained in faith communities so that they can function during pandemics such as the COVID-19 pandemic. The majority of the rituals associated with pastoral care are embodied experiences, and thus, throughout this dissertation, this study has highlighted the disruptions that have been brought on as a result of social isolation. Bowen's Family Systems Theory suggests that via concepts such as individuality, togetherness and differentiation of self, which develops in relationships with others, pastors can play their role within faith communities in such contexts.

The pandemic was concomitant with unprecedented levels of press and anxiety on systems, individuals and the Church as an institution. Pastors had to grapple with new norms and limits of living while, at the same time, experiencing social transitions themselves and uncertainties about the future. Bowen Family Systems Theory points a way forward for pastors to practice pastoral care in a more controlled way despite social disruptions. The theory primarily concerns human behaviour and the emotional forces that underpin these behaviours in family systems and throughout society. Bowen (1966) highlights the importance of being more attentive to emotional processes and managing these with maturity or differentiation of self.

The evidence from this research however suggests that pastors were not always able remain non-anxious and well-differentiated during the pandemic. They experienced mental health difficulties with one study highlighting how the pandemic caused pastors to reflect on their own mental health and spiritual discipline, further compelling them to establish connections with their colleagues and maintain contact with their leadership teams. The study also found that the pandemic made the ministry of presence impossible because of social distancing guidelines which prevented members of the clergy from being present with

Christian believers as they experienced some of the most difficult moments of their lives. This was also a source of anxiety for some pastors. Some clergies experienced psychological difficulties because they were not permitted to visit their members, but others also had opportunities to re-imagine the meaning of care for congregations and also for clergies, where care became associated with spending more time with their families. The principles that clergies used to provide pastoral care and counselling were also applied to clergies that experienced burnout and stress linked to the pandemic. These principles included the use of spiritual practices such as listening to religious music, reading sacred texts, singing praise songs, watching or listening to religious programmes, engaging in private devotional practices, attending faith-based services, and praying or requesting prayer. Clergies used these principles to enhance their coping skills, promote healthy behaviours, create feelings of hope and optimism, encourage relaxation and manage feelings of depression.

Spiritual care providers in some of the studies that were analysed also reported that during the pandemic, pastoral or spiritual care in the healthcare setting was cancelled completely, restricting patients to accessing this form of care only through radio or television. Spiritual care providers also indicated that healthcare professionals, for the most part, adopted a prejudiced perspective that caused them to oppose their presence and role in the wards. Consequently, some spiritual care providers felt discriminated against and marginalised; they also felt that they were perceived merely as an ‘infection risk’ that posed a threat to patients. Evidence suggests that some chaplains complained that although there is mounting evidence concerning their positive impacts in healthcare settings, their role was misunderstood, mocked or undervalued. Spiritual care providers felt undervalued because there was a tendency to applaud the work of healthcare professionals who were conceptualised as heroes, whereas they and hospital chaplains were often neglected and conceptualised as useless.

Chaplains were also concerned with practical issues concomitant with the pandemic, including the shortage of materials, as these practical concerns invariably impacted their work and ability to help others. Chaplains reported feelings of exclusion and a lack of chaplain leadership. They also opined that they should have been more involved in the provision of direct care throughout the pandemic; however, such opportunities were undermined because nurses and management perceived them as infection risks. Leadership and nursing, according to the chaplains, adopted attitudes that implied that everyone except nurses and doctors would spread the virus. Consequently, only nurses and

doctors were permitted to have close contact with infected patients. Thus, as opposed to being conceptualised as essential employees and valued colleagues, chaplains, for the most part, were conceptualised as an infection risk. In some instances, chaplains themselves were unclear on how best to utilise their roles—pointing to a professional issue. The majority of chaplains in a particular study did not report being part of a professional association, except in Australia. This suggests that there is a lack of an agreed code of practice for chaplains per the guidelines of their professional body.

In some cases, the role of pastors was relegated completely. In a study that was conducted in the context of Spain, as opposed to chaplains, it was nurses that were responsible for pastoral care during the pandemic. Nurses conceptualised spirituality as an important element of care as it was perceived as a coping strategy for disease. Nevertheless, they lacked an understanding of spirituality and did not have adequate training to handle this form of care. Further, there were multifarious barriers to spiritual care provided by health professionals, including insufficient time and work overload, aside from the lack of training. Due to social restrictions, the study found that nursing professionals and not chaplains were afforded responsibility for providing spiritual support to patients. In the context of Spain, visits from religious leaders and family members were not permitted. With religious leaders unavailable to provide spiritual support, nurses served as proxies; however, they lacked adequate training and were largely unprepared for the situation. Nurses were used to chaplains and families serving as the main pillar of faith and spiritual support in patients' lives in the pre-pandemic context; thus, they were compelled to fill a void which they had not anticipated. The study derived data from a sample of nurses who reported several barriers to their provision of spiritual care as a precursor to discussing how these can be mitigated to improve the provision of spiritual care in emergency care units.

The barriers which were cited in the study included the absence of breaks and work overload during the pandemic, lack of time, lack of training and a high nurse-patient ratio. With nurses lacking training and unprepared for this role, many found that they had different beliefs from patients, which constituted a barrier to providing integrative spiritual care. Nurses found it difficult to provide spiritual care to patients who held different beliefs. This was especially the case for atheist nurses who found it difficult to counsel patients that rejected medication on religious grounds. The nurses interviewed in the study reported that having shared beliefs would have made the provision of spiritual care easier since a common religion can encourage bonding which will serve as a platform for further engagement and dialogue, which is a crucial element of spiritual care. Although nurses experienced barriers in providing

spiritual care, they reported the various strategies they used to overcome these. Reported strategies included having silent moments devoid of interruptions to establish connections between patients and nurses and thereby build trust, which was viewed as crucial for providing spiritual care. Some nurses also developed their own protocols and guidelines for providing spiritual care, but these guidelines were not necessarily built on religious scripture. Pointing to the anxieties experienced by pastors, some chaplains reported that even when they were permitted to visit patients, the mandatory wearing of masks caused pastoral care to become a faceless experience. This faceless experience, they noted, runs counter to traditional approaches to pastoral care, where the emphasis is placed on being present in order to build trust and establish connections with patients. Chaplains also noted disconnectedness in relation to their colleagues or cohorts, although disconnectedness was viewed as especially problematic in relation to patients who have cognitive challenges and thus already have limited communities. Overall, chaplains lamented the loss of casual and spontaneous interactions with their cohorts, patients and families. One study found that the pandemic enhanced awareness among chaplains that touch and non-verbal expressions constitute a crucial part of pastoral care. Chaplains also experienced difficulties in negotiating boundaries with their patients because discussions and cultural differences concerning the ethics of permission and touch were relegated during the pandemic. The wearing of masks and other protective gear made it difficult for chaplains to read emotions which were exacerbated by telechaplaincy. The evidence further shows that

chaplains also reported the loss of shared spiritual experiences with families and patients. Shared spiritual experiences were conceptualised as important because grave illness and end-of-life experiences typically require symbols and rituals, which chaplains perform by bringing people together. Through shared spiritual experiences, chaplains use symbols and rituals to connect with the divine, facilitate transition, mourn and remember. In one study, the sample of chaplains noted that they had not been able to meaningfully mark life events using symbols and rituals during the pandemic because of social distancing restrictions. Sacred sites such as chapels, prayer rooms and interfaith rooms were inaccessible as they were closed or repurposed for alternative use. The lighting of candles was not permitted, and rituals that are typically performed at the bedside were limited without family members present. In some cases, chaplains reported performing rituals remotely, for example, in a chapel on behalf of a patient in a hospital room.

During the pandemic, it was also impossible to give sacraments. The study found that these losses went hand in hand with loneliness. Family members and bereaved parents

experienced immense loneliness when they could not participate in ritual services for the deceased and were denied connectedness with others because the sacred could not be mutually expressed. Due to the loss of rituals, the chaplains reported a loss of religiosity. Chaplains reported this loss of religiosity with regard to being unable to bring communion to patients, for example, which left a void for many Christian believers who needed it at a very challenging time in their lives. Chaplains also reported missing other moments of community forming, such as singing together during services or with residents. Other moments of community forming which were referenced were discussion groups, prayer groups and mediation groups. Chaplains also encountered frustration because their work was stifled, evoking feelings of helplessness, frustration and sadness because they were not always able to deliver end-of-life care to patients. Not being able to perform their roles was a source of moral stress for chaplains, as patients sometimes died alone, which led to feelings of guilt because chaplains felt they allowed healthcare professionals to take the lead on pastoral care and did not advocate enough for it to be taken more seriously. Other chaplains noted that the demand for spiritual care far exceeded staff availability, and many chaplains felt that their professional value was deprived because they were not invited to participate in multidisciplinary teams. Further, chaplains reported a dearth of collegial responses since medical care was primarily emphasised during the pandemic. Further, chaplains lamented a general lack of protective material during the pandemic since they were not prioritised and their roles were largely performed by other healthcare professionals. For many chaplains, telehealth options were not provided because of perceived power grabbing by other professionals, and they found that their role was relegated or, at best, tokenistic.

Chaplains also reported feeling lonely and invisible due to these experiences, and feelings of loneliness were exacerbated by limited communication between team members and staff. Crucially, the provision of pastoral care was limited by the technical aspects of communication with residents and their families. Some chaplains were particularly concerned about being potential spreaders of the virus when engaging with patients. Chaplains also reported a lack of a backup theology and meaning. Chaplains reported that they experienced tensions between their knowledge of God and the lived realities of believers in their hospital rooms. Other chaplains noted that they experienced reduced connectedness with spiritual resources because their personal faith was impacted by the experience of caring for dying patients. Against this backdrop, some chaplains lamented the lack of pastoral theological reflections pertaining to spiritual care during the pandemic, as this could have been a source of support for them.

For the various pastors that were featured in the studies, there were various disadvantages of moving away from the church as a place of worship because of the pandemic because worship in church constitutes a form of family discipleship which Jesus mandated before ascending into Heaven. Thus, the pandemic was conceptualised as problematic in terms of breaking family bonds headed by members of the clergy. One study viewed the breaking down of family bonds as problematic because it argues that family is an objective of Christ's commission. According to study, family is at the core of discipleship and spiritual transformation, and family constitutes the smallest but most powerful unit within which spiritual growth occurs. The study argued that the family brings honour and glory to God, making it the most effective target of discipleship; however, this opportunity was negated by the war. It was thus argued that members of the clergy must devise strategies for ensuring that exemplary family-related activities, training and mentoring can be performed are performed during pandemics so that the family unit can remain spiritually strong despite social disruptions.

While pastors were anxious, there is also evidence that shows that they made a unique contribution to healthcare during the pandemic by responding to the religious, spiritual and pastoral needs of both staff and patients. One study showed that the sole purpose of chaplains was to be present and create a safe space for meeting the individual needs of staff and patients, promoting their healing even when a cure was not possible. According to the tenets of family systems theory, amidst the context of social disruptions, pastors must support individuals within the system to express their feelings openly and outline what their needs and hopes are. In other words, they play a role in self-definition, which is partly achieved by not directing people in the system on how they should be but rather responding to their needs by drawing on religious practices such as the reading of scripture and provision of biblical examples to illustrate models of behaviour and living in the kingdom. What can be inferred from the theory is that this will support Christian believers to define themselves more clearly, as well as the role of the church in their life. Pastors also have a role to play with regard to maintaining connections during periods of anxiety so that individuals within the system can move away from the source of anxiety. This requires emotional contact with people who are experiencing difficulties, and pastors have a role to play in terms of helping such people to rebuild their emotional contact with others as well. Moreover, pastors have a role to play with regard to serving as a source of stability amidst processes of change, maintaining their convictions while also being flexible so as to adapt to emergent processes.

One study found, against this backdrop, that the pandemic improved online ministry for members of the clergy due to the limits placed on in-person encounters.The study found that the pandemic reconfigured the nature of pastoral care, which became less about spiritual support and the fostering of spiritual growth and more focused on buffering government services in difficult-to-reach areas. The study found that members of the clergy, for example, provided support in the areas of education and health. Notably although there was a shift in the focus of pastoral care, members of the clergy still relied on service and pillars of faith to support personal growth in young people, especially via new ideologies. Evidence was found indicating pastors' flexibility in the context of Haiti. One study found that members of the clergy guided church members to traverse the streets of Port-au-Prince, providing help where needed, to illustrate the church's response to the pandemic as a whole. Pastoral teams worked in conjunction with program leaders and leaders in the music ministry to devise innovative ways of connecting with congregants. Although in-person forms of worship were suspended due to restrictions linked with the pandemic, pastors supported music leaders to take up new assignments supported by donations from various charities around the world. Pastors supported program leaders in delivering medication for homebound seniors as well as non-perishable staples such as beans, rice and dried fish. The role of pastors during the pandemic was not only limited to this form of support—they played a role in fighting corruption while remaining cognisant of the interconnectedness between the various vulnerabilities experienced by Haitians worldwide. It was found that clergies engaged with death more intimately and also took up new roles linked with having to bury a large number of people in a short period of time. Aside from having to bury people in general or their fellow clergies, the study found that they further had to bury members from their own congregations as a result of illnesses related to the pandemic. Nevertheless, the resultant effect was challenging to the ways in which pastoral care has always been provided.

Another example of the flexibility adopted by pastors was the turn to social media. Following the imposition of lockdown measures, many clergies turned to the use of virtual services in the form of Skype, Microsoft Teams, Zoom, WhatsApp and SMS. Technology enabled congregants to reduce their stress levels during the pandemic because they could talk to their pastors, seeing their faces as sources of comfort. In South Africa, a study noted that online technologies enabled vulnerable groups such as the elderly, single mothers and immobile people resident in rural areas, who are unable to attend cell groups to access pastoral care. Through participation in cell groups, albeit only, these vulnerable congregants

were able to address daily issues, including mental health concerns, which pastors discuss and pray about. Nevertheless, one study found that the provision of pastoral care was limited by the shift to online platforms, which constituted a form of socioeconomic divider because members of the clergy and congregants lacked the requisite social skills and/or financial resources to use and buy computers and smartphones. Access to Wi-Fi and data for online engagement was limited for members of the clergy and congregants located in areas with connectivity issues or where there was a lack of digital resources or financial constraints to support live streaming. The study also found that the online space did not offer the same warmth experienced through a Christian embrace during times of desolation; Christian practices such as receiving the Holy Communion were out of the reach of Christian believers with mental health challenges. Consequently, the study found that in some instances, lockdown restrictions fuelled a spiritual decline which exacerbated mental health concerns for Christian believers with pre-existing challenges. Another study found that many pastors lacked formal instructive material on how to use technology in pastoral care, which may be due to the fact that pastoral education has no formal instructive material on technology use within their education programmes.

Some research also highlighted the importance of pastors' changing their negative philosophies about the Internet and social media so that they can consciously explore the opportunities concomitant with modern technologies. Alongside the importance of a mindset shift, the study also underscored the importance of formal and informal training for pastors on how to use social media as part of pastoral care. Lack of literacy was recognised as a barrier to the effective use of social media during the pandemic, and the study viewed training as crucial for ensuring that pastors are not left behind in the new normal and for ensuring that they can contribute meaningfully to post-COVID norms of pastoral care via social media. Alongside training for pastors, one study highlighted the imperative of technology training for church members so that, conjointly with pastors, new forms of pastoral care can be explored with the support of social media.

Bowen's (1966) theory suggests that during periods of emotional stress in families, the tendency to fixate on a limited perspective and neglect the bigger picture is high, which can intensify stress levels. In the previous chapter, this study documented that more so than ever before, pastors had to spread the message of Christian hope as part of pastoral care, emphasising the importance of faith in the resurrection to illustrate that hope should not be rooted in anxieties about death and pandemic-related uncertainties, but about hoping in spite of these things. Pastoral care provides a platform for people to commit themselves to

God through a relationship with the pastor, predicated on love and care. Since God is eternal, the ultimate purpose of a human life transcends the present. Eschatology concerns itself with the transcendental aspects of human life, and earthly life is not the end within Christian theology. This shapes pastoral care and expands its scope from one that is rooted in the present to the future, even where the receiver of care is in danger of death (Woldemichael et al. 2013). This posture was a strategy for moving away from cause-and-effect thinking and formulating a system of thinking that situates the experience of the pandemic within the broader context of God's promises. This modification of pastoral care helps congregants to understand that everything that is happening to them is not about them but rather occurring in a larger systemic and relational context. When Christians live their lives with this understanding despite their uncertainties and anxieties, it culminates in less internalising of one’s problems.

Chapter 5

Summary of Findings and Recommendations

5.1 Summary of Findings

This study explicitly explored the impact of the pandemic on pastoral care through an extensive analysis of the secondary literature, drawing out the available and emergent data concerning the research question: how has COVID-19 impacted the nature and practice of pastoral care? Following a search of the literature, data from studies published in various countries, including the United Kingdom, Italy, Germany, Ghana, Nigeria, India and the United States of America, were compiled for this study. The data from these studies were analysed with the assistance of thematic analysis. Following the thematic analysis, five major themes emerged from the literature with respect to the changing nature of pastoral care amidst the pandemic: communication, soul care, counselling, pastoral visits and healing.

Under the theme of communication, this study found that the pandemic required pastors to think about creative ways of providing pastoral care in the context of social distancing and communication barriers linked with these. Creative new ways of establishing connections with congregants were mostly been based on leveraging online spaces. Pastors used the telephone and Internet more so than ever before to offer pastoral care from their homes. This study also found that transitioning from providing pastoral care in-person to virtual platforms was difficult for pastors who were used to in-person contact. The lack of in-person contact was found to culminate in a loss of social benefits that are accrued from face-to-face interactions.

Under the theme of soul care, this study found that the COVID-19 pandemic had an unsettling impact not only on the body and minds of individuals but also on their souls. The demand for pastors to cure the *cura animarum* or human soul rose exponentially. Pastors had to provide spiritual care based on the exigencies of the pandemic, which included praise, prayer, worship, Doxa and communion with God but through creative ways, which include the use of technology. There was a heightened need for spiritual care because the pandemic launched an assault on the soul in a myriad of ways.

Under the theme of counselling, this study found that during the pandemic, traditional therapies, in particular, were ill-equipped to deal with the gospel-centred and existential questions that Christians have, and pastoral counselling was crucial in bridging this gap. Through the integration of the gospel within an overarching counselling relationship, pastoral counselling provided a unique opportunity for Christians to experience the transformative healing of Christ during the pandemic. Further, the nature of pastoral counselling changed in two main ways: congregants were, more so than ever before, experiencing depression, anxiety, loneliness and bereavement; thus, there was an increased demand for counselling. Pastors also had an increasing need for self-care as they, too, experienced these feelings due to the pandemic and social distancing. Thus, they also had to counsel themselves in order to keep up spiritually and mentally with the changing nature of their role. Pastors also experienced tensions in meeting counselling demands from both church members and members of their own families.

Under the theme of pastoral visits, this study found that the nature of the pandemic meant that pastoral visits occurred less often when compared to previous trends. Further, the nature of pastoral visits changed. Hospital visits were reduced greatly, and if they occurred, they required protection, planning, permission and coordination. Where hospitals allowed visitors, strict protocols such as handwashing and mask-wearing were followed in order to prevent the spread of the virus. Pastoral visits were disrupted during the pandemic because this aspect of pastoral care requires physical co-presence and, consequently, cannot be effectively practised where there are health restrictions.

Finally, under the theme of healing, this study found that with a few exceptions, healing in pastoral care continued to include exhortation, the laying of hands, the Lord's Supper, visitation rites to the sick, anointing and Scripture but in a modified state. Within the context of the pandemic, where sickness was rampant and unprecedented, it was expected that pastors would be able to perform these healing rites; however, the nature of the virus did not lend itself to this. The highly infectious nature of the virus and the risk of death and infection means that these rites could not be performed in the way that they once were. Anointing, the laying of hands, visitation and exhortation require physical contact, were made difficult due to social distancing protocols and restrictions.

5.1 Recommendations

While this study has made an original contribution to the literature, future studies can investigate the impact of the pandemic on pastoral care through interviews or focus group discussions that feature pastors to attain more nuanced data. The literature on the lived realities of pastors during the pandemic remains scant and phenomenological approaches can assist in addressing this gap. In terms of how pastoral care should look in the post-pandemic context, this study proposes that thoughtful action, as opposed to reactive responses during moments of anxiety and stress, is required from pastors during periods of social disruptions. This is a challenging task in the context of pandemics, where there are high levels of anxiety and communal tension. Further, pastors must develop their skills for playing the role of a non-anxious presence during periods of anxiety. Thus, they must be trained to be well-differentiated so that they can work with the church system and help it to understand emergent patterns of relating brought on by social restrictions and respond directly to the concomitant stresses and tensions during pandemics.

Pastors must also be able to refer to historic patterns of relating in order to redefine new ways of relating. In anxious systems, leaders will experience varied responses. Some of these responses include resistance since, systems gravitate towards a steady state and will try to re-establish the equilibrium so that attempts to define new approaches may be perceived as a threat. In extreme cases, individuals within the system will establish alliances for the purpose of resisting change. Scape-goating and blame are also common responses to changes in the system which may lead to the targeting of individuals within the system, particularly if they are perceived as responsible for the problem of the group. Invariably, systems must find outlets for relief during times of anxiety, and this study suggests that pastors must be well-differentiated within the system in order to resolve these anxieties in a healthy way. Ultimately, well-differentiated pastors can build relationships and foster an environment within which people in the system can explore their issues in a healthy way without being attacked. As leaders, they must show, through their character, the way of being non-anxious.

Another recommendation proposed by this study is that pastors can assist individuals who refuse to seek pastoral counsel as a result of internalising their anxieties during pandemics by adopting a postmodern approach to pastoral care. Pastors effectively draw upon a premodern lens when they focus on the care seeker's religious and spiritual experiences of feeling a connection to God. Through a premodern lens, pastors can explore the way in

which care seekers experience their connection to God. Further, they can determine the extent to which religious and spiritual practices effectively induce God's presence in their lives. A postmodern approach also involves drawing upon biblical critical methods, modern theological perspectives, as well as medical or psychological perspectives in relation to life events such as grief and death. Pastors that adopt this approach consider how the unique experiences of care seekers influence their responses to life events. During pastoral care conversations, pastors can leverage language and religious practices to participate in the process of co-constructing religious ways of establishing a connection with God and making sense of life events.

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