

Providing Pastoral Care for Persons with Disabilities:

Disability Empathetic Awareness

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Introduction

On November 3, 2010, while I was going to the university, a traumatic train accident caused me to amputee my leg. Since then, I have been walking using a prosthetic leg. It has been 13 years since I experienced my disability at a young age. I discovered and am still exploring this exciting, mysterious world I entered for the first time. My struggle and life journey with disability shaped my personality, self-understanding, and vocation to pastoral ministry and is still shaping my life. As an ordained minister for six years and a person with a disability for 13 years, I have a deep passion for providing care to others, especially persons with disabilities (PWD), and helping ministers who experience difficulties in providing care to them.

This thesis is intended for ministers and caregivers who are unsure of what they need to begin providing care for PWD. I find the essential need today for PWD caregivers is to have an empathetic awareness of disability. I argue that providing pastoral care for PWD requires caregivers to have both cognitive awareness of disability and the ability to develop advanced empathetic responses. Caregiving for PWD requires a deep understanding of the unique experience of disability. Empathy also plays a crucial role, as caregivers need to be able to imagine and comprehend PWD's experiences. A lack of cognitive awareness and accurate knowledge regarding specific disabilities can hinder the development of empathy.

Definitions of Terms

In this thesis, I will use "PWD" as an abbreviation for persons with disabilities in the plural form. I use "a PWD" as an abbreviation for a person with a disability in the singular form. Because it is a respectful language that acknowledges PWD's diverse disability experiences, it stresses the

individuality and personality of PWD by using the first pronoun rather than defining them by their disabilities. The term is devoid of discrimination or ableism and is widely used and recognized by human rights organizations and governments. Furthermore, I use “persons” rather than “people” since “persons” emphasizes the individuality of the person. Both are appropriate language, but “people with disabilities” stresses more the social model of disability and the collective experience. The usage of “persons” is more appropriate to the thesis topic, as the primary focus is providing care for PWD.

I prefer using “minister” to refer to anyone engaged in providing care. The minister could be the church’s pastor or a Christian leader in a caregiving role within a congregation or one explicitly providing care for PWD. I use the term “ministers” in addition to the widely used term “caregivers” among many counselors and frequently refer to PWD as “care seekers.” I adopted the importance of using “minister” in pastoral care in general from Donald Capps (2001), who explains his preference for using the word minister:

One reason for doing so is that pastor is more closely identified with certain denominations than others, whereas minister applies more broadly (and is inclusive of pastors). Another is that the word minister applies equally well to clergy who are not pastors of congregations. Some of us are teachers or administrators in educational settings (schools, colleges, universities, seminaries), campus ministers, chaplains (hospital, military, prison, state and national legislative bodies), workers in social service agencies or pastoral counseling centers, and many other contexts.

(p. 5)

Methodology

This thesis will demonstrate the application of pastoral care principles and the narrative counseling approach in providing care for PWD. The narrative approach emphasizes the significance of personal experiences and life stories. Many pastoral care scholars and psychotherapists stress the power of life stories. Capps (1998) considers “pastoral counseling is essential to the life of the congregation because it responds to a fundamental human need to give systematic, constructive attention to the ways that individuals ‘story’ their lives so that they may develop new, more fulfilling life stories” (p. viii). In this thesis, I will present ideas by incorporating my personal disability experience as well as the experiences of other PWD. Narrative pastoral care “holds a view of human beings as hermeneutical, or interpretive beings—storytellers who seek to make meaning out of life” (Scheib, 2016, p. 12). The experiences and stories of PWD offer valuable insights concerning their disability. When caring for PWD, it is critical to listen carefully to their experiences, challenges related to their disability, and the meaning behind it from their unique story.

Outline

The thesis is divided into three chapters, with the initial chapter titled “Disability Awareness.” This chapter centers on the fundamental awareness of disability, including the caregiver’s definition of disability, the terminology and the language employed to describe disability, the theologies used in comprehending disability, and the various types of abuse that PWD may encounter during the caregiving session.

The second chapter of the thesis is titled “Disability Contexts.” Its primary objective is to highlight the caregiver’s comprehension of the various contexts surrounding disability. It discusses the significance of such contexts while providing care for PWD. These contexts include social, spiritual, family, gender, economic, and political contexts. The intersection of these contexts plays a crucial role in contributing to the challenges faced by PWD.

The last chapter of the thesis is titled “Disability Empathy.” This chapter aims to assist the caregiver in cultivating both cognitive and emotional empathetic responses towards PWDs. It delves into the meaning and importance of empathy, the methods to develop empathy, the factors behind the absence of empathy, the limitations of empathy, and its goals. Additionally, it examines disability empathy from both pastoral and non-pastoral perspectives.

Chapter I: Disability Awareness

In this chapter, I will cover some essential components for providing pastoral care for PWD that every caregiver should be aware of before counseling them. This chapter aims to increase the caregiver's awareness of disability. There are essential principles any minister involved in giving care for PWD should be familiar with, including the definition of disability, the language used to describe different impairments, and introductory settings that can lead to a successful pastoring for PWD. This chapter increases the ministers' awareness of the different theologies used in understanding disability. It explains some ways PWD face abuse when seeking care. Moreover, this chapter helps ministers provide pastoral care for PWD and discusses how a minister can provide care through worship, preaching, and education.

A. Defining Disability

Many definitions describe different disabilities from a scientific and social point of view. Sometime, these definitions have political uses.¹ There are numerous definitions of disability, and these have evolved significantly in recent decades. Every minister needs to identify the various definitions of disability to deepen their awareness about disability. Caregivers will be unable to provide care for PWD if they do not have enough awareness and knowledge of different kinds of disabilities and learn to identify them. Indeed, not all ministers must be knowledgeable about every kind of disability. There is nothing wrong with ministers who need to learn more about a specific

¹ Politics heavily influence many governments' different definitions of disability. Many countries boast of having the best language to describe PWD and numerous regulations and laws, but these laws are rarely enforced. Many countries only care about preserving its external appearance at the international level based on the statements of human and disability rights. In fact, PWD are unconcerned about these labels; what matters most to them is a language that respect them, empower them in society, and enforcing laws to remove barriers to their disability.

disability because there are many disabilities, for example, physical, mental, or visible and non-visible disabilities.

1. Disability Definitions

I want to differentiate between the definition of disability and the language used to describe disability, which I will discuss in the following point because the definition of disability is somewhat complicated due to the use of many technical terms. Some definitions describe disability in general, and others describe each kind of disability individually. Every minister should be familiar with these definitions, particularly those recently rejected due to their narrow or negative view of disability. Before I present some accepted definitions of disability on an international and social level, I want to emphasize that no single definition is fully adequate in defining disability because different organizations are likely to use different definitions. Smart (2018) considers that “there is a great deal of overlap in clinical definitions of disability; there is no one universal definition” (p. 18).

Without going into complex technical definitions, I believe the most helpful definitions are those that help people understand disability better by addressing PWD without discrimination or racism and without excluding a segment of PWD. The classification and labeling of disabilities are not intended to stigmatize PWD. The goal of defining and classifying disabilities is to help society to understand disability and the rights that come with it more profoundly. It is a two-edged sword that could be used to empower PWD or insult them, “It is a tool or construct, but, like any tool, it can be used in helpful or destructive ways” (Gaventa, 2018, p. 11). The World Health Organization (WHO, 2001) defines disability as:

An umbrella term for impairments, activity limitations, and participation restrictions. It denotes the negative aspects of the interaction between a person's health condition(s) and that individual's contextual factors.

WHO has adopted "ICF"² to classify disability according to the three aforementioned main categories³ or dimensions:

(A) impairment, (b) activity limitation, and (c) participation restrictions. These three categories include the most common types of disabilities: intellectual, physical, vision, hearing, and learning disabilities. (WHO, 2001)

The Americans with Disabilities Act (ADA) defines a PWD as,

A person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

(Guide to Disability Rights Laws, 2023)

I consider that describing disability as a kind of impairment and limitation or restriction are appropriate definitions to be used by the caregivers of PWD during the counseling session. Most definitions derive the definition of disability similar to the WHO. For example, The Centers for Disease Control and Prevention define disability as,

² "ICF stands for International Classification of Functioning, Disability and Health to describe and classify health and health-related states" (WHO, 2001).

³ I am not limiting the types of disabilities to this group only, but I am mentioning the most common types of disabilities.

Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). (Centers for Disease Control and Prevention, 2020, “What is disability?”)

In addition, the CDC definition of disability is aware of the social dimension of disability, which I will discuss in the second chapter, and its impact on the daily lives of PWD. Ministers should be aware of different definitions of disability to help them better understand their care seekers. Getting acquainted with the history of the struggle for the rights of PWD is an excellent opportunity to learn about their needs. What are they longing for? What kind of injustice falls on them and hurts them? Through the history of opposition to PWD rights, I see that ministers can deepen their understanding of disability and how they provide care.

2. Disability and Self-Definition

The problem with definitions of disability is that they are often articulated from a non-disabled person’s perspective. In addition, it ignores personal experience with disability. Going through a disability is like a journey in which PWD understand themselves, accept their disability, and adapt to it to reach a deeper understanding of themselves and find the meaning behind their disability. The experience of disability differs from one person to another, and its formation varies depending on the person’s identity and self-image. Some PWD does not mind describing their disability as “persons with special needs,” but others might prefer alternative terms. A group of people with disabilities may agree to describe their disability with specific terms, even if they have different cultural backgrounds.

For example, I was surprised when I first read Nancy Eiesland's book (1994), *The Disabled God*. I assumed Eiesland and I did not have anything in common. We are from different countries, cultures, ages, generations, and gender. However, we have a shared experience of disability that is very similar, which made us agree on the definition that describes disability as a kind of "limitation." Eiesland builds the basis of her book on the functional limitation model of disability. She explains that "the individual or functional limitations model focuses on the private physical impairments and identifies psychological adjustment as the primary rehabilitative goal" (p. 83). Self-definition of disability based on personal experience respects PWD's individuality and uniqueness.

Furthermore, it protects the PWD from discrimination because they define themselves in the best light. The caregiver plays a vital role in helping PWD discover the meaning behind their disability and gain a better understanding of themselves, as I will discuss more in chapter three. Self-definition of disability is one of the steps that help PWD formulate a deep understanding of their disability and self. Furthermore, self-advocacy is a right for every person. PWD have the right to define themselves depending on their disability's experience and from their perspective.

B. The Language Used to Describe Disability

Our everyday language contains numerous meanings. It reflects how we were raised, were educated, and perceived the world around us. The caregiver's language is critical to gain the respect and appreciation of the care seeker from PWD. Ministers should use PWD's preferred language and avoid using discriminatory language that undermines the dignity of PWD.

1. Using Inappropriate Language to Describe disability

Deborah Marks (1999) asks a critical question: Does language disable people? She considers how language is used to separate disabled people from “normal” society and to characterize the experiences of disabled people as different and separate from the rest of society. She argues that language is vital in removing disability from mundane human experience and treating it as radically Other (p. 137). Ministers should not be worried but educate themselves about using appropriate language to describe disability. Sometimes because of the caregivers’ fear of not using appropriate language, they do not use any language to understand, describe or reflect on the disability and engage with PWD. The language and words used to describe PWD have positively developed significantly in the past decades as many communities and organizations strive to use language in more inclusive, empowering, and respectful ways. However, ministers are still required to be aware of the language and have some practice in using it. Ministers should distinguish the differences between an appropriate language to describe disability and another language that is not appropriate and the reasons behind that, as shown in the following table:

Table 1

The Language Used to Describe Disability

The language used to	Appropriate/	Reasons
describe disability	inappropriate language	
Disabled Person	Inappropriate	The term has been used for a long time but now has been replaced by the term “persons or people with

disabilities.” Because it involves defining individuals by their impairment, it is best to start with the person to show that disability is a part of their identity. It is better to avoid describing PWD by their disability. The disability is not determined by whom they are.

A person with + impairment	Appropriate	Using first-person language
Retarded	Inappropriate	Offensive
Handicapped	Inappropriate	Less respectful and outdated
Deaf	Appropriate/ Inappropriate	I find this term offensive because of its translation to my home language, and I would prefer using “mute” instead of “deaf.”
Blind	Inappropriate	Offensive
Lame	Inappropriate	Offensive
Crazy, Insane, Psycho	Inappropriate	Offensive
Crippled	Inappropriate	Offensive
Special needs	Appropriate/ Inappropriate	Some PWD do not prefer to use this term. It is more appropriate to use it to describe persons with mental disabilities.

Differently abled	Appropriate/ Inappropriate	Appropriate if solely used to empower and represent PWD in a good light. However, it may be unsuitable since it overlooks the impact of disability.
Victim/ poor	Inappropriate	Stigmatizing PWD
Brain- Damaged	Inappropriate	Offensive

2. Reasons for Ministers to Consider the Language Carefully

It is essential to point out the reasons that should make any minister pay attention to the language used to describe the disability while counseling or providing pastoral care.

Ease of Demonstrating Disability Inadvertently in a Negative Way

Ministers usually find themselves confused when they learn that one of their congregation's PWD members suddenly stopped attending the church. A PWD might have expressed distress about how a minister or church member responded to their disability, which made them feel rejected, worthless, and disrespected. The language used to describe disability must be used cautiously in teaching, preaching, or liturgical worship. All it takes to make a PWD feel disrespected is a word accidentally misused.

Passive Presence for PWD

Ministers should pay attention to their congregation, including all families and members, to ensure PWD are included. Because it is challenging to be present but absent simultaneously, the language used in the church for a disability should work to make people with disabilities present positively

and effectively. Language encourages and empowers PWD to feel valued and respected in the society to which they belong.

Different Levels of Psychological Maturity

Not all PWD have the same level of psychological maturity in understanding their disability. The language used to describe disability may be appropriate for most PWD. However, it may not be appropriate for others, or they may prefer not to define themselves in this manner. Disability is a journey of adjustment, inner healing, and self-discovery. Not all PWD have reached the same level of psychological maturity or total adjustment and acceptance of their disability. Therefore, the caregiver must be aware that not all persons with the same kind of disability act the same, and their reactions to the language or any other thing could differ from one person to another.

C. Theologies Used to Understand Disability

Theology plays an essential role in providing care for PWD. The theological thoughts of both the caregiver and the care seeker are brought up and projected in caregiving sessions. The theological and biblical understanding of disability shapes pastoral care for PWD. Undoubtedly, these understandings are part of caregivers' awareness of disability.

1. Life-Giving and Life-Limiting Theologies

Carrie Doehring (2015) emphasizes two kinds of theologies: (a) life-giving theologies and (b) life-limiting theologies,

Caregivers bring their theological formation, education, and training to the collaborative work of exploring the religious and spiritual worlds of persons,

families, and organizations. In paying attention to how formative stories point to core values, ultimate beliefs, and spiritual practices, pastoral caregivers balance their narrative knowledge of care seekers with theological knowledge about when beliefs, values, and coping are most likely to be *life-giving or life-limiting* [emphasis added]. (p. xxi)

Many life-limiting theologies could be engaged with pastoring PWD. First, the issue with a disability is that it is an exclusive experience owing to its limitations, and many PWD struggle with life-limiting theologies, attitudes, and values. PWD are not born with positive attitudes towards their disability or a happy life full of hope! They already experience disability with all its suffering and impairments. PWD are struggling against the negative experiences and thoughts they might have about their disability. That is why comes the danger of life-limiting theologies towards disability because it affirms these negative experiences or thoughts that PWD might already have. PWD are yearning to have positive attitudes and life-giving theologies toward their disability.

2. The Hopeful Positive Approach Toward Disability

I will give an example of life-giving theologies toward disability and call it the hopeful, positive approach toward disability. It reflects my struggle with some biblical texts that represent disability negatively, my problem with it, and the life-limiting theologies behind them. Positivity and hope are two critical words that influence the topic of disability and empower PWD. I will give many reasons and explanations about the importance of discussing the topic of disability through this approach, to see how much it touches the lives of PWD and change them to be fully adjusted to their disabilities. Biblical texts about disability always represent a significant challenge in my self-understanding of disability, especially after I had a disability. Before I had a disability, these

challenging texts and biblical stories did not concern me, and I had no trouble reading them. I think this is the same situation for many non-disabled persons. However, after experiencing a disability, my understanding of these biblical stories completely changed. I found myself struggling with any negative representation of disability and being sensitive while reading any scripture or listening to any sermons considering disability. Although I did not have this sensitivity before I experienced my disability. Ministers' awareness of the theology presented on disability is very important due to its significant psychological impact on PWD.

According to Avalos (2019), there are three theoretical approaches to deal with biblical texts that engage disability: (a) The redemptionist, (b) the rejectionist, and (c) the historicist (p. 348). The redemptionist approach “seeks to redeem the biblical text, despite any negative stance on disabilities” (p. 347). The rejectionist approach argues that “the Bible has negative portrayals of disability that should be rejected in modern society” (Metzger, 2011, as cited in Avalos, 2019, p. 348). The historicist approach “examines the dynamic relationship between writers and texts and the cultures to which they belong in an effort to ‘map out’ the ideological landscape encoded in imagery of disability” (p. 348). The main goal of applying these approaches to disability is to reach a better positive understanding of disability, giving much hope for PWD. Avalos's approaches helped me to always look at the essential primary approach that deals with disability and think about disability in a positive way that gives hope to PWD and their families.

I am presenting the following example to illustrate that specific exegesis of the biblical texts shows disability in a negative light and might give a life-limiting theology to PWD. From my perspective, the biblical story of David and Mephibosheth is the most humiliating negative representation of disability in the Bible. Especially the words of Mephibosheth, “What is your

servant, that you should notice a dead dog like me?” (NIV, 2 Samuel 9: 8). These are powerful negative words in a language engaged with disability. One day I decided to preach in this challenging text. Instead of rejecting what the text mentioned, I used redemption and historical approaches to give a positive message about disability. I engaged with this text by changing all the traditional negative thoughts about Mephibosheth’s character by showing his strengths and intelligence in using this language to avoid David’s explicit attention. I remember it was shocking for the audience to hear for the first time about this story in a positive way because they used to see this biblical character in a way that abuses disability and shows it in a wrong way as it represents the sinful person.

I see the need for these life-giving theologies that focus more on constructing a theology that liberates PWD from all the negative thoughts and abusive stigmatic practices of disability. After all, what is the purpose of theology if it cannot give hope to PWD, if it cannot empower them, if it cannot nourish a positive understanding of their disability? Many popular theological approaches widespread nowadays, such as the prosperity gospel, are destructive to a positive understanding of disability. As Nancy Eiesland (1994) describes, these kinds of theology are “disabling theology” instead of empowering PWD.

D. Disability Abuse

PWD are more likely than others to be subjected to various forms of abuse. Abuse occurs when someone with authority violates boundaries and an individual’s rights are violated, causing psychological and physical harm. Religious and spiritual authority is one of the most potent authorities over humans. Therefore, abuse from a minister or inside the church’s wall causes serious harm because the abuse here does not come from an ordinary person but from someone

who is supposed to represent God. One of the essential fundamentals of providing care for PWD is that ministers should be aware of and knowledgeable about the types of abuse that PWD are likely to face. Ministers should be sensitive to PWD's feelings, not only when providing care to them but also in general church practices such as worship.

1. Kinds of Abuse

There are different kinds of abuse that PWD experience in their life. Abuse can be physical, emotional, sexual, or spiritual and entail domestic violence and neglect. I want to focus only on the kinds of abuse that can happen to PWD in the context of pastoring them. First, I want to distinguish between the abuse that can occur from someone who intentionally abuses their power, exploiting their victims sexually, physically, and emotionally and the abuse that can occur unintentionally, resulting from a lack of awareness or knowledge. In this distinction, I do not deny the extent of the harm caused by the abuser, whether intentional or unintentional. I want to stress that there might be variations both in the intention and the nature of abuse.

A central problem in some religious communities is that no strict policies or transparent accounting systems protect their members from any abuse that a minister or clergy could do. Carrie Doehring (2006) stresses the importance of ecclesiastical accountability in general and the personal responsibility of ministers in the relationship with their care seekers,

The establishment of a pastoral or spiritual care relationship in which care seekers will not be harmed is a basic aspect of care for which a caregiver is accountable. Accountability involves being responsible for offering care that meets professional, legal, and ecclesial/religious standards. More than simply a professional

requirement and inevitable aspect of the increasing professionalization of ministry, accountability to codes of conduct can be understood theologically as part of living out promises made at ordination or occasions in which people are designated as caregivers by their communities of faith. (p. 74)

Therefore, the first type of abuse that occurs, which I will not address in this thesis, is the result of a failed institutional system allowing this type of abuser within the religious institution without any monitoring or follow-up. These protective monitoring systems must be tightened for ministers involved in pastoring with PWD.

PWD are more vulnerable to abuse, and abusers easily exploit them. They cannot protect themselves because of the limitations of their disability, especially those who have intellectual disabilities, young children, or women. Carolyn Thompson (2009) considers that exploited PWD “are often taken advantage of sexually; they may be seen and used only as a sex object, a novelty. Many who spent time in hospitals as children feel of being fondled or sexually abused by medical staff” (p. 217). Church institutions must be aware and concerned for their PWD and their congregations’ members to protect them from any possible abuse. On the other hand, I want to focus on some of the abuse that usually happens without the intention or awareness of PWD while providing care or pastoring them.

2. Disability and Accessibility

Accessibility is considered a big concern for PWD. “Access or accessibility has become a rallying cry among people with disabilities” (Eisland, 1994, p. 28). Accessibility may refer to the provision of accessible and unobstructed to a location, or it may refer to the provision of communication

with PWD. This topic is of great importance for PWD because accessibility is a direct non-verbal message to PWD that they feel welcome in this place. If the church, the minister's office, or any place PWD will meet the caregiver is not accessible, it is a sign of failure even before the beginning of care. Many messages reach PWD, including their sense of neglect because their church or minister does not care about their presence. Therefore, lack of accessibility is considered neglect abuse.

Suppose the church has many obstacles that prevent the entry of a wheelchair or the existence of special corridors. In that case, the church is telling persons with a mobility disability: "Do not come back! Your presence is not desired!" If the church does not have a facility for dealing with disabled children, the message that reaches their families is that your presence with your children causes the church distress. How many families have children with mental disabilities and do not attend church services? If the ministers or the caregivers cannot address and communicate with PWD, how will they be able to provide care for them? Questions make us think about accessibility more seriously. The world around us is developing very quickly to empower PWD. For example, it is now essential for any good website or mobile application to have accessibility for PWD. Sadly, some churches still refuse to invest money to modify the design of their buildings to make them more comfortable for PWD!

It is essential to prepare the settings of the meeting place for PWD before providing care. However, the caregiver should be wary of two things: being overly helpful or exaggerating the provision of accessibility, or completely ignoring PWD's needs. Both extremes make PWD feel uncomfortable. All a caregiver needs to do is prepare the place well without any access barriers. It suffices to ask, "Is this seat or place convenient for you?" or "Where do you prefer to sit down?"

It may sound naïve, but this is a crucial practice. To underscore this point, I cite some voices of PWD and their personal experience on the issue of accessibility and its impact on them. For example, Eisland (2002) talks about her experience when she had communion in her local church as a PWD with limited mobility:

I have been part of several congregations whose practice of receiving Eucharist includes filing to the front of the sanctuary and kneeling at the communion rail. Often, because I am either in a wheelchair or using crutches, an usher alerts me that I need not go forward for the Eucharist. Instead, I am offered the sacrament at my seat after everyone else has been served. (p. 10)

Eisland sees that her congregation cannot handle her presence in the service. A problem like this happens when accessibility is approached from the perspective of non-disabled persons. It would be better if the congregation had asked Eisland how she preferred to approach the Eucharist. Eisland describes her feelings:

The congregation is trying to accommodate my presence in the service. They are undoubtedly trying to be conscientious and inclusive in their own way. But in effect, they are transforming Eucharist from a corporate experience to a solitary one for me, from a sacralization of Christ's broken body to a stigmatization of my disabled body. I am hardly alone. For many people with disabilities, the Eucharist – which should be the ultimate sacrament of unity of believers – is a ritual of exclusion and degradation. (p. 10)

My experience with accessibility as a PWD with limited mobility is familiar to what Eisland experienced but in a different form. Choosing the right place to sit is very important because I use a prosthetic limb, and the socket used in prosthetic limbs, which is the main point of bearing the weight, is always made of a solid material. Sitting on non-upholstered chairs is excruciatingly painful, especially if I sit for more than 15 minutes. So, I appreciate the “Where would you like to sit?” question. I always choose upholstered chairs because they are more comfortable for me. If the question is not asked, I could request to change seats, but sometimes I am embarrassed to do so because the only upholstered chair, which might be occupied by another person.

3. Ableism

One of the forms of abuse that PWD experience is ableism, which is considered a form of discrimination. PWD are viewed as physically inadequate and inferior in comparison to individuals who do not have disabilities. According to (Campbell, 2001), ableism refers to:

A network of beliefs, processes and practices that produces a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human. Disability then is cast as a diminished state of being human. (p. 44)

Ministers may be indirectly implicated in ableism when they provide care for PWD. This is the problem of ableism because many of its manifestations do not occur directly but do so covertly and without the caregiver’s awareness. Ableism occurs when caregivers make assumptions about what PWD can and cannot do. Although these presumptions are not always harmful, it is possible to presume some abilities of PWD to the extent that exceeds their actual abilities and go beyond

their limitations to empower, encourage and support them. I see that portraying an unrealistic self-image for PWD is not only offensive but destructive, even if it is meant to support them. Next, I outline some reasons to avoid making assumptions about PWD.

First, PWD already have restrictions regarding what they can and cannot do due to their impairment. This is analogous to asking someone to fly and discovering that they cannot do so because human nature cannot fly. However, they can overcome this inability by using airplanes. Even if some PWD have superior abilities to adapt to their disability, this does not mean that all can be at the same level of challenging their disability. In addition, the caregiver ignores individual differences between PWD and each other. Second, empowering PWD⁴ does not occur in a single counseling session or two but rather as a long journey in which people with disabilities explore themselves and their particular strengths and learn how to exploit them. This might take years and could last a lifetime. Care seekers may suffer significant hurt if they sense they are being pushed hard by their caregivers beyond their physical and psychological capabilities or to accomplish something they are unprepared to do. Eventually, caregivers may fall into the trap of entirely disregarding the disability and treating the person as if they do not have a disability due to their fear or lack of experience that they will PWD. Because how can ministers provide care if they cannot encounter a disability to develop empathetic responses to PWD? It is imperative that caregivers should seek balance in understanding the forms of ableism and how it is happening. In addition to being aware of the traditional ableism forms, it is most important not to put pressure on PWD beyond their natural abilities.

⁴ I will discuss a crucial question in the next section: Is the role of PWD's caregivers is to empower them or not?

Chapter II: Disability Contexts

In the first chapter, I discussed the importance of the caregiver being aware of the disability topic. In this chapter, I will discuss an awareness of disability somewhat different from what I dealt with in the previous chapter, which is the awareness of the different contexts of disability. There is a complex relationship between these contexts and many struggles of PWD. The different contexts that a PWD lives in matter intensely, and the caregivers must pay attention to them. There are many contexts that I will include in this chapter that help the ministers to provide care for PWD, including the social, cultural, spiritual, gender, economic, family, and marriage contexts.

A. Why is it Important to Include Disability Contexts while Providing Care for PWD?

It is vital to consider the contexts in which PWD experience their disability. The caregiver's lack of awareness of these contexts, which constitute most of the experience of PWD about themselves, causes neglect of an excellent opportunity to provide the support that helps a lot in providing care for PWD. I will present the most important reasons that help ministers be aware of the different aspects of these contexts while providing care for PWD.

1. It is not only about Disability

Many caregivers, while providing care for PWD, think that the biggest problem they suffer from is their disability or impairment. The focus should not be on the impairment itself but on the entire context and many facets of disability that affect PWD's lives. The issue of disability occurs in the context in which it is embedded. Specific contexts may work on the oppression of PWD instead of empowering them. Perhaps the problem is not in the struggle of PWD due to their limited abilities, but the problem may be in their society, church, family, work, marriage...etc. PWD have

the same issues that other people have. Yes, disability may be a factor, but it is not everything. In many circumstances, the issue is not the impairment itself but the context that forms and causes the problem.

As a PWD, I prefer using the word “disabled” when I speak about my disability to refer to other contexts that increase the sensation of my limitation. Because I see that PWD are not disabled because of their impairment or the limitation of their disability, but for example, they are disabled because of the exclusive society or inaccessible buildings. Rachele DiTullio (2021), an accessibility engineer, shares the same understanding of describing disability when she points out in her blog that “I am disabled by society and the built environment.” DiTullio rejects referring to being disabled by a medical condition or specific impairment but by different social contexts than the disability itself. She says, “you are not disabled as in broken. You are forced to live in a world that disables you through intentional action by not making society inclusive and accessible.”

As a result, caregivers should ask themselves during the caregiving with PWD what the reasons behind their care seeker might have such a negative experience with their disability instead of embracing it. This question is crucial because it lets caregivers focus on disability not only as a functional loss but also in its various social contexts and other aspects. Providing pastoral care for PWD requires ministers to pay attention to the larger frame of disability rather than narrowing the impairment only to the medical condition.

2. Contexts impact PWD’s experience

The contexts of disability play a crucial part in determining PWD experiences with their disabilities, such as whether they embrace or reject it. Many of the issues that PWD face are

connected to the environment in which they live and experience their condition. The context of disability could include any attitudes, beliefs, meanings, thoughts, or values towards disability, negatively or positively. These contexts involve the entire society, beginning with the family, school, church, and so on. Every context constructs a positive experience for PWD to embrace their disability or to experience a more brutal, challenging unadjusted life with their disability. The significant factor influencing PWD to adjust and adapt to their disability is linked to the context that encourages them to view their disability positively. I do not neglect the individual differences among PWD when adjusting their disability, which can challenge any of these contexts, no matter how negative they are. However, I cannot ignore the significant impact of the context on the lives of PWD in their experience of disability being more difficult or supportive. For PWD, many problems come from the context in which they live, so the caregiver must pay attention to these contexts, which I will discuss in detail in this chapter.

3. Disability Contexts as Oppression Layers

The experience of disability is not limited to a single context. All the contexts and PWD's experiences intersect with different layers of oppression. PWD may have difficulty dealing with a single context, or their problem may be more complicated and come from numerous distinct contexts, but they all create a sense of oppression for PWD. Observing the intersection of these contexts in the experiences of PWD is crucial to fully understanding their life and struggles. According to Nancy Ramsay (2014), providing care involves navigating various intersecting contexts of oppression, and the goal is to empower individuals subjected to different forms of oppressive circumstances. Intersectionality is "engaging the dynamic complexity of multiple forms of inequality," and it "avoids ranking oppressions or inequalities as if one were primary" (p.

455). While it may seem like a particular context is most oppressive for PWD, it combines various intersect contexts. Although the influence of every context varies, the primary aspect is their aggregate contribution to the difficulties that PWD confront.

B. The Various Contexts of Disability

There are many contexts that a caregiver should pay attention to while providing care for PWD. Additionally, it is essential to develop the skill of recognizing and analyzing these contexts during the caregiving session. This requires looking beyond the care seeker's words and seeing the wider frame to identify these contexts more clearly and provide deep understanding and support to PWD. In what follows, I will discuss the most crucial and prevalent situations among PWD that are considered the root of many of the problems they face.

1. The Social Context

The social context plays a paramount role in shaping the experiences of PWD. This is due to the vast array of social structures that connect all members of society, ranging from governments and laws to educational, religious, and civil institutions. The disability laws governments implement significantly impact PWD's degree of empowerment or marginalization. Some countries work to suppress PWD rights, while others work hard to uphold these rights. Individuals with disabilities may have negative experiences associated with their disabilities due to societal and governmental oppression. This can manifest in various forms, such as the absence of accessible roads, buildings, or transportation. Furthermore, individuals with disabilities may also face a lack of suitable job opportunities that respect their rights and preserve their dignity. Or the absence of laws regulating

the work of PWD, which leaves a door for different kinds of abuses instead of laws that protect them.

2. The Family Context

Family context significantly influences PWD. The family serves as the primary nurturing environment. Certain families work on empowering their family members from PWD by promoting disability awareness, education, and skill development in adaptation and social integration. Additionally, these families develop emotional understanding and mutual support among their members. However, it is essential to acknowledge that not all families exhibit such positive attitudes toward disability. For various reasons, such as inadequate education or a lack of disability awareness, some families neglect their members. PWD may be raised in an unsupportive family environment that discourages them from embracing their disabilities and adapting to them.

3. The Spiritual Context

PWD often experience spiritual crises that include feelings of abandonment by God and a sense of being unloved and rejected. They may question why they have been afflicted with a disability and resent God for allowing it to happen. The absence of love in their lives can lead them to focus on God and hold Him responsible for all their difficulties.

PWD may experience guilt and a sense of God's punishment for their sins, believing their disability is a form of divine discipline. This initial thought crossed my mind when I lost my leg in an accident. I questioned what I had done wrong and why God was treating me this way. It is important to note that these emotions are not indicative of one's level of spiritual maturity; rather, it is a natural response to their disability.

4. Gender and Marriage Context

The intersection of disability and gender results in differing experiences for both men and women with disabilities. Both face the burden of social stigma and ableism. Personally, I have encountered many stigmas for example that PWD are incapable of sustaining a marital relationship, being responsible for a household, or cannot have a normal sexual or romantic relationship. Finding a partner who accepts my disability has been challenging, as many families in my Egyptian community completely reject the idea of their daughter or son being in a relationship with a PWD. One of my most significant concerns was the possibility of not being able to find a partner who would accept and love me for who I am. The challenges are even greater for women, who are often seen as incapable of bearing or raising children naturally. Rather than empowering and showing respect to PWD, specific contexts actively work to oppress and discriminate against them.

Power dynamics between disabled and non-disabled partners can result in various marital tensions and conflicts. The non-disabled partner may feel burdened by constant assistance, leading to stress and exhaustion. Meanwhile, a PWD may feel a sense of dependence on their partner and struggle with self-reliance. These complex issues can be addressed in caregiving sessions, even if they are not openly expressed. Caregivers need to realize that both PWD and their partners are likely to benefit from family and couple's care.

5. The Sexual Context

In a session, with therapist Steve De Shazer, Simon, who became paraplegic due to a devastating car accident and lost his will to live, pointed out that he found sexual relief with his partner and engaged in activities that completely transformed his outlook. In the initial session, Simon

appeared highly depressed, but in a subsequent one, he seemed transformed entirely, and part of this transformation was due to satisfying his sexual needs (I Want to Want to, 2008). In conservative societies, PWD often face significant challenges in expressing their sexual needs, leading to various problems. The stigma surrounding disability further compounds the issue, as they are often viewed as incapable of enjoying a normal sexual life.

With the sexual context, PWD face additional challenges in expressing their sexual needs or finding a partner, which can lead to tension and frustration, especially if their spouses experience a lack of understanding or are not used to talking about these topics. In some cases, individuals with disabilities may be married to a non-disabled person who is expected to take the initiative, causing their needs to be postponed or left unfulfilled. This context highlights the difficulties that people with disabilities face when it comes to expressing their sexual desires. Paying attention to this context, caregivers can support PWD to find relief from depression and tension they might be facing.

C. Functions of Pastoral Care with the Contexts of Disability

Pastoring people with disabilities has a unique nature. It calls into question the caregiver's position and the nature or functions of pastoral care for PWD. According to Emmanuel Larney (2003), these functions are contextual: "questions about the functions of pastoring are contextual questions and demand contextual responses. In each cultural context, however, it is important that these questions be posed, and adequate responses sought" (p. 60). Larney highlights the minister's role context in providing pastoral care, which is why there are many functions of pastoring, not specific ones, and

it depends on the context of care in general.⁵ Lartey discusses in detail these functions of pastoral care,

There are four classic functions that pastoral care has been seen as serving. These are incorporated in the definition of pastoral care offered by Clebsch and Jaekle considered in Chapter 1. These are *healing*, *sustaining*, *guiding* and *reconciling*. To these, Clinebell has added a fifth, namely *nurturing*. In what follows we shall consider each of these functions in turn. But before we do that, I wish to suggest that there are at least two other functions that intercultural pastoral care and counseling clearly serves. In point of fact, the absence of these two invalidates much pastoral care in particular cultural contexts. These two are *liberating* and *empowering*. Let us then examine each of these functions in turn [emphasis added].
(p. 62)

Lartey (2003) includes six pastoral care functions: healing, sustaining, reconciling, nurturing, liberating, and empowering. Regarding the care of PWD, I find that not all of these functions are appropriate. Ministers should know how to employ these functions and when to focus on or avoid them.

For example, Lartey considers, “healing presupposes that we have lost something we once enjoyed and that it is possible to regain what we have lost” (p. 62). If healing is exploited and emphasized as the primary function of pastoral care for PWD, the consequences will be disastrous.

⁵ Lartey emphasizes on the minister's role and the functions of pastoral care for PWD. I put them here because I believe they are necessary for understanding the nature of giving care for PWD and its connection to the contexts of disability.

After all, how will a PWD heal from a permanent disability? The caregiver should take caution not to presume that the disability is curable. This is because it will cause the abuse that I see as the most widespread, especially in Christian circles, that disability can be cured through prayers or a more robust faith from the person. Indeed, healing can be used appropriately in the context of care when PWD are struggling with psychological anguish resulting from the failure to adjust to their disability or any other negative emotions. So, using healing in the context of wounded emotions and feelings is more suitable than using it in the context of disability.

On the other hand, many other functions, like sustaining PWD, are essential in providing care. “To be sustained is to find strength and support, from within and without, to cope adequately with what cannot be changed” (Lartey, p. 64). Since achieving disability adjustment, which I will cover in chapter three, is one of the main goals of developing empathy for PWD, sustaining is very appreciated in providing care for PWD. “Pastoral caregivers give support in such times not by promising a favourable outcome or better times, but by enabling and facilitating coping mechanisms within them” (p. 64).

Another function of care is guiding as “problem-solving or ‘decision-making’ skills” (p. 64). Lartey refuses the term’s paternalistic use and considers that guiding “is about enabling people through faith and love” (p. 65). Guiding helps PWD to practice these essential life skills in dealing with their problems. Reconciling could help PWD to accept themselves and their disability and achieve self-reconciliation or even their relationship with God. Sometimes, a PWD blames God because of their disability, which is why “pastoral caregivers need the sensitivity to culture, faith and personality that reconciliation calls for” (p. 66). The caregivers’ understanding of PWD’s psychological and inner spiritual struggles encourages them to take caution when approaching

these circles because it is a sensitive area for PWD. Another function is nurturing, letting ministers help PWD grow in self-understanding. “The function of the pastoral practitioner is to be a facilitator of growth” (p. 66). Liberating could be used with the injustice contexts of disability and to help ministers to be engaged with the positive change towards PWD in society.

Finally, Lartey uses empowering, one of my preferred terms when dealing with a disability. Empowering is about enabling and motivating persons “to think and act in ways that will result in greater freedom and participation in the life of the societies of which they are a part” (p. 68). PWD requires significant empowerment and encouragement, particularly from their caregivers, as well as the creation of a friendly, inclusive atmosphere in which they may feel understood, listened to, and valued.

However, it is crucial to recognize that some pastoral care tasks can harm PWD if caregivers overuse or misuse them. I will mention only the most crucial reason that caregivers for PWD could be trapped in “inspiration porn.” Stella Young, a disability rights activist, used this term in her 2012 TED Talk titled “I Am Not Your Inspiration, Thank You Very Much” (Young, n.d.). I was first introduced to this term by Hardwick (2021),

One of the great challenges for me as a pastor with autism is the battle to be seen as more than an inspiration. When I was diagnosed, I began to study and learn more about autism and about the disability community. I discovered the term inspiration porn, which was first coined by the late disability rights activist Stella Young. Inspiration porn is defined as the portrayal of a person with a disability as an inspiration solely based on their disability” (p. 111).

Caregivers could easily fall into this mistake by empowering their care seekers from PWD without focusing on their abilities or personalities. Although empowering, in general, is a positive thing, it hurts PWD more than supporting them when caregivers emphasize the function solely based on disability. The point here is that caregivers empower the disability as an object of inspiration, not considering PWD as persons or their contributions in life. That is why I refer to it as a trap that caregivers must be aware of these false inspirations.

Chapter III: Disability Empathy

In the previous two chapters, I highlighted how it is vital that ministers be aware of the topic and the context of disability to provide pastoral care for PWD. The awareness of disability is very crucial to any caregiver engaging with PWD. However, the pastoral care of PWD also requires developing and practicing advanced empathetic responses. The goal of having cognitive awareness of disability is to be empathetic toward PWD. Empathy is the backbone of any effective, successful pastoral care, but practicing empathy is the most outstanding support any minister can provide for PWD. In this chapter, I will show that developing empathy toward PWD can achieve profound understanding and support for many of their problems. In addition, PWD have a deep psychological need for a minister or a trusted other who is able to express empathy for the struggles and suffering of the care seeker's disability. Empathy helps PWD feel understood, heard, respected, and valued and develops self-awareness and self-advocacy.

A. Definition of Empathy and its Significance

Many counselors and scholars emphasize the importance of empathy in any effective counseling. According to *A Dictionary of Psychology*, empathy is “the capacity to understand and enter into another person's feelings and emotions or to experience something from the other person's point of view. The word was introduced into English in 1909 by the English psychologist Edward Bradford Titchener” (Colman, 2015). There are many definitions for the term as it has been significantly developed in the last decades, primarily from Carl Rogers, who considers empathy from a humanistic approach as a way of being with others. Carl Rogers (1995) defined empathy as:

An empathic way of being with another person has several facets. It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing. It means temporarily living in the other's life, moving about in it delicately without making judgments. (p. 142)

Perceiving the world of disability is an entirely different world for caregivers, and it is incredibly unusual for them to take on this world. Based on their previous pastoral experience in dealing with crises and people's pain, ministers may be able to imagine the world of many of their congregations, regardless of the nature of the problem, and imaginatively enter their world. However, disability is a mysterious and risky world. Rogers mentions that empathy requires sensitivity to others' conflicting emotions. While entering the world of PWD, a deep understanding of disability and its various problematic aspects helps to increase emotional sensitivity. This is why having empathy skills is crucial when caring with PWD. Caregiving would be shallow and insufficient without establishing empathy and embracing the world of PWD. Disability is a powerful experience that requires ministers to constantly verify the accuracy of every thought and comment and never make assumptions about the PWD's experience. Rogers (1951) confirms that empathy's primary reference and perceptions refer to the other person's world:

This formulation would state that it is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside

all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client. (p. 29)

According to Hojat (2007), empathy can be viewed from two perspectives: (a) cognitive empathy, such as “mental activities involved in acquiring and processing information for better understanding, and emotion is sharing of the affect manifested in subjectively experienced feelings”; (b) emotional empathy, as an emotional response and “experiencing the emotional state of another” (p. 7–8). I emphasize that empathy is more than just focusing on feelings. Empathy comprises many components, including emotions, but feelings are not the only component. Empathy includes a person’s ideas and experiences related to their disability. Emotions are a component of or a result of the larger context of a person’s experience and thoughts. Empathy is the caregiver’s emotional response, as well as the larger perspective of the world of others. I stress the experience of disability because developing empathy for PWD requires seeing beyond a particular situation or some spur-of-the-moment problems. Instead, what is required is empathy for the long-life experience of disability. Cognitive empathy occurs “when you cognitively or intellectually understand how someone is feeling” (Hartman et al., 2023, p. 54). In order to provide care for PWD, the caregiver has to practice both cognitive and emotional empathy. Without them working together, the empathic response will be incomplete and will not provide the desired support for PWD. According to Doehring (2015), there are three essential components or steps to developing empathy,

Empathy involves imaginatively stepping into another person’s emotional experience while remaining aware of and anchored in one’s own emotional state.

Empathy has several components: 1. Caregivers take the perspective of the other

person. 2. Caregivers vicariously experience the care seeker's affect. 3. Caregivers use emotion regulation in order to not be overwhelmed by the other's emotional state or their own affective response. (p. 39–40)

Donald Capps (2001) explains that empathy is a complicated process, “approximating this empathic entry into the experiencing of the other is difficult enough, but communicating how the world looks from the other's point of view compounds the difficulty” (p. 29). In fact, if the caregiver is a non-disabled person, the situation gets more problematic since ministers have to understand the emotional and intellectual world of the care seeker and the world of their impairment, which entails accessing a significantly different world.

Engaging in empathic active listening is essential for caregivers. Active listening and passive listening are the two types of listening. The difference between them is that the caregivers assume the role of the recipient in order to understand PWD fully. Empathetic listening entails paying attention to nonverbal and vocal cues, such as facial expressions of emotion, voice intonation, eye contact, etc. The caregivers pay close attention to what is said and not stated in the care session. They listen intently to comprehend what PWD are saying in the different contexts of disability.

Based on my personal experience, the presence of numerous people who consistently spent much time listening to me only for my suffering and distress, listened to my world from my perspective without any judgment, and constantly emphasized empathic listening helped me accept and adjust to my disability. Their sincere listening was the greatest demonstration of their love, which led to a miracle in my life of coexisting with my disability. Listening alone is sufficient to provide the most significant support for PWD. A severe problem that PWD suffer from is that they

do not find anyone who listens to them. Not all experiences of PWD are emotionally intense or complex. Sometimes, they only need someone to hear their life's simple details.

B. Limits of Empathy

Although developing empathy is essential for providing care to others, it has limits. The human capacity to be empathetic to the experiences of others is not always ideal. Since humans are not flawless and have limited mental and emotional capacities regarding what can be grasped, handled by others, or expressed, according to Miller-McLemore (2018), "Sometimes we must admit our inability to fully comprehend and respond to the oppressions suffered by others. That is, there are boundaries or limits beyond which empathy itself cannot go" (pp. 305–321). Caregivers often feel unable to develop empathy for their care seekers, which is normal. Humans do not have the supernatural ability to understand every experience and feeling. People's emotions and experiences are incredibly complicated, and their sorrow and suffering can be difficult to tolerate or fathom. Regarding disability, the limits of empathy will tend to increase. Because disability is a unique and different human experience that most people ignore, and though many people experience some form of disability at some point in their lives, this experience remains limited compared to PWD who have permanent disabilities.

A caregiver's personal experiences facilitate the understanding of others' feelings. Personal experiences can serve as a reference point for empathy and complex emotions. However, this shared experience is often missing when providing care for PWD because most caregivers do not experience disability. For instance, if a care seeker is grieving for losing someone, the caregiver's shared experiences about loss can help them grasp the nature of these feelings. The absence of caregivers' personal experience with disabilities is a critical barrier to developing empathy in

providing care for PWD. This absence results in further limitations to the caregiver's empathic ability.

1. Causes for a Limited Empathy

There are several explanations for the caregiver's lack of empathy and inability to respond appropriately. I should first differentiate between two causes of limited empathy. The first reason refers to humans' limited ability to understand other persons' feelings and pain. As I explained above, this is a natural implication of our humanity, so ministers should not feel bad for themselves or disappointed if they fail and cannot fully understand and be empathetic with PWD. Caregivers should consider that they will not always be able to offer the desired support to PWD. However, in future pastoral encounters, the caregiver's empathetic responses will likely improve once they have established a trusting connection with their care seekers and gained a more profound knowledge of the situation.

The second reason that might lead to a lack of empathy refers to the caregiver's poor skills. Caregivers might not be qualified enough, often because they still need to develop their empathetic skills. Empathy is like any social skill that needs to be developed and exercised. Empathy is an essential language between people and each other, and like any language, it will be weak if there is not enough time to practice it. Some ministers can establish effective empathy responses in many contexts, but they may be unable to give empathy to others, such as when providing care for PWD. Often, the problem lies in the caregivers' lack of awareness of the disability contexts (discussed in the previous chapter). In this case, raising an understanding of disability in its different contexts and problems would be highly beneficial in practicing empathy with PWD.

2. Lack of Empathy

Several examples demonstrate a lack of empathy in providing care for PWD. I include them here as red flags for ministers to pay attention to their responses and how they offer empathy with PWD. Ministers' empathetic responses are crucial and risky at the same time since they might cause them to lose their care seekers and make PWD feel uncomfortable, less respected, unappreciated, or emotionally abused. Not all responses are at the same level of risk, some weak responses can be remedied while providing care, and their effect is superficial. However, some responses are particularly harmful, especially when responses unintentionally stigmatize and degrade PWD.

Hyper-Empathetic Responses

Hyper-Empathy is a term mainly used to describe the experience of persons with autism disabilities because the "experience of hyper-empathy is common for Autistic people" (Hartman et al., 2023, p. 54). I am using the term differently to describe excessive empathy towards PWD. People who frequently interact with PWD commonly exhibit excessive pity and exaggerated emotions, which can also occur among caregivers. This tendency to overstate feelings often stems from a lack of empathy.

Caregivers are developing empathy to understand the care seekers' world and share their feelings. To be empathetic for PWD does not imply that the caregiver has fully experienced the care seeker's disability. It is not as if the caregiver shares the disability as if they had it too. *Empathy is not for the disability itself but for imagining the lives of PWD, their pain, problems, and emotions.* Sometimes the caregivers bring up their personal experience of a temporary or minor disability similar to the disability of the care seeker and use that experience as an attempt to

convey empathy. The issue is that the caregiver compares their direct experience to PWD. The message conveyed to PWD is that the suffering they are going through is manageable because, as a minister, I have been in their shoes before, and I completely understand how they feel. However, PWD are likely to feel insulted by such responses when their disability is minimized, and their emotions are denigrated.

Inauthentic Empathetic Responses

Ministers' use of insincere verbal and body language is another example of a response demonstrating a lack of empathy. This kind of inauthentic empathetic response might take the shape of an exaggeratedly repeated sorry statement, making PWD feel that their caregiver is feeling pity for their situation. Generally, caregivers should avoid "I am sorry" except when the phrase is authentic and pertinent to the caregiving context.

Robotic Empathetic Responses

Despite significant advancements, such as ChatGPT and other chatbots that simulate human reactions, artificial intelligence still has limited empathetic and emotional responses. Robotic empathetic responses cannot understand human emotions because they are complicated, and it takes a high degree of emotional intelligence to generate these empathetic responses. In the same way, many caregivers seem content with developing automated empathic responses through repeated sentences or body language without the real sense of the world of the other. The main reason for this is that the caregiver does not even attempt the first stage of empathy of entering the world of the care seeker. This could happen to some ministers so accustomed to caring for many people's problems that they have lost the passion for authentic responses. Maybe they are afraid

of embodying the world of the other with its pain and are emotionally isolating themselves through these kinds of responses or are burned out or emotionally exhausted and want to withdraw themselves. Beginners, too, can feel tempted to overuse textbook responses that are likely to come across as inauthentic.

The Caregivers' Withdrawal

Caregivers often experience empathic distress and a desire to withdraw. There are several reasons why caregivers are at risk of withdrawal, especially with PWD. The experience of disability is emotionally intense and chock-full of negative emotions and pain. In addition, PWD may have life-rejection tendencies that may reach suicidal ideation, which may lead to withdrawal, because “caregivers are more likely to experience empathic distress when they suspect care seekers are at risk of suicide. They will feel fearful, angry, even disgusted and will be more likely to withdraw” (Doehring, 2015, p. 150).

Some PWD feel a lack of love, attention, and rejection, especially from God and others, and their expressions could be very sharp and full of anger, which makes some ministers feel uncomfortable because they take a position of judging the other or make a projection from their doctrine and life-limiting theology. “A caregiver’s withdrawal could be associated symbolically with divine judgment and shunning by one’s community of faith” (Doehring, 2015, p. 150). If a caregiver is experiencing a strong desire to withdraw, they should consult with a supervisor or trusted other.

The Caregivers' Anxiety

Anxiety considers one of the famous forms of caregivers' withdrawal, and there are many reasons behind it. The anxiety problem is that it is working on limiting the caregivers' empathic responses and impeding care. Capps (2001) discusses many various reasons for anxiety. I want to emphasize some that are likely associated with the care of PWD. Some topics about PWD, like thinking of suicide, rejecting life, or some sexual topics, could make the caregivers anxious while providing care (p. 16). Another possibility is that caregivers are worried about how to interact with PWD, where they should sit, and how to deal with disability medical equipment, which may generate all this worry. According to Capps, another factor that is likely to generate anxiety the "inability to understand what the other person is saying,"

Here, the anxiety does not concern the subject matter or the person who is speaking, but the difficulty the hearer is having in understanding what is being said. The reason for the difficulty may be that the minister does not know much, if anything, about the topic of discussion or about how the person who is speaking about the topic appears to be viewing it. (p.17)

This inability to understand may happen to caregivers who lack experience in providing care for PWD and caregivers who might have previous negative caregiving experiences.

Empathetic Responses for PWD from Disabled and Non-disabled Caregivers

What if the caregiver has a disability? Does this guarantee that there will be no limited empathy for PWD? The answer is yes and no. In some cases, if the caregiver is a PWD, they might be able to provide adequate empathetic responses to PWD. Because in this situation, both the caregiver

and the care seeker share the experience of disability, it will be easier for the caregiver to practice empathy and develop appropriate responses. This will be considered a point of strength for a disabled caregiver over the non-disabled in providing care for PWD.

Nevertheless, the hazard lies in the caregiver's experience overlapping with the experience of the care seeker. The caregiver's experience and world might shape the development of most of the responses while ignoring the care seeker's own experience. Alternatively, some memories of the caregiver may be projected onto the entire care process. Even if two persons share the same experience of disability, each person experiences things differently. If the caregiver has a different disability than the care seeker, the disabled and non-disabled caregiver will actually be in the same boat.

D. Developing Empathy

1. Intercultural Empathy

Referencing disability in the same manner that caregivers provide cross-cultural counseling is one of the most effective ways to develop empathy for PWD. Seeing disability as a different and unique culture helps ministers comprehend it better. As with any culture other than one's own, the caregiver must first learn about it to be able to comprehend it. Augsburger (1986) developed an intercultural pastoral care concept called "interpathy" (p.31). Interpathy is a sort of empathetic response, but it differs in its emphasis on the importance of cognitive element,

Interpathy is an intentional cognitive and affective envisioning of another's thoughts and feelings from another culture, worldview, epistemology. In interpathy, the process of knowing and "feeling with" requires that one temporarily

believe what the other believes, see as the other sees, value what the other values. In interpathy, I seek to learn a foreign belief, take a foreign perspective, base my thought on a foreign assumption, and feel the resultant feelings and their consequences in a foreign context. Your experience becomes both frame and picture. Interpathy is the experience of a separate other without common cultural assumptions, values, and views. It is the embracing of what is truly other. (p. 31)

Although Augsburger's primary concentration is providing pastoral care across cultures, I found his approach relevant for caregiving with PWD. Augsburger's interpathic approach is the missing primary key for developing an advanced empathic understanding of PWD. Interpathy stresses the importance of the cognitive envision of other PWD's world. Augsburger called it "the process of knowing." In order to achieve an excellent understanding of PWD, caregivers must make all the assumptions, beliefs, feelings, and values as if they were becoming citizens of a foreign world (the context of disability). Interpathy helps ministers genuinely understand PWD because they attempt to embrace the totality of their foreign world. They consider themselves total foreigners in the other world. Through the care sessions with PWD, caregivers develop a better understanding of disability and begin to learn from the experience of PWD.

It sounds like developing interpathy is a more complex and challenging task than developing empathy. This is because it places an additional burden on caregivers to be more mindful of a broader cultural context and have accurate knowledge of others' context. In his book *Playing and Reality*, Donald Winnicott (1991), a British pediatrician and psychoanalyst, coined the well-known phrase "the good enough mother." He explores the idea of a mother's care for her children, noting that a good-enough mother may experience frustration when she cannot

immediately fulfill all her child's needs. However, this temporary frustration can be beneficial for the child, as it can help them learn and grow (Wedge, 2016).

I believe expecting any caregiver always to have perfect interpathic responses is unrealistic. However, providing a "good-enough" interpathic response can be what is needed to provide care for PWD. The "good-enough" attempt could involve the caregiver's awareness of a particular disability, appropriate language use, and attention to the different disability contexts. The caregiver's efforts to gain accurate interpathy and develop advanced empathy responses for the PWD's world are much appreciated. Perhaps the "good-enough" attempt is when caregivers recognize their limitations that may not fully comprehend the context of disability until it is described to them by PWD. When appropriate, caregivers should acknowledge their insufficient knowledge of specific disabilities during caregiving encounters by expressing statements such as "I apologize for not fully comprehending the extent of your suffering with your disability until you explained it to me. As you have described, I didn't realize how challenging it could be." In this case, the message that reaches a PWD is that "they listen to me and pays attention to what I say."

2. Compassionate Empathy

I wonder what essential needs PWD are seeking to meet in caregiving encounters. From my perspective, PWD are seeking a sense of respect and worth. They want a caregiver who is able to empathize with their suffering, circumstance, and daily life struggles. They need a minister who listens to them carefully and is able to feel their pain. According to Doehring (2015), "Compassion plays a vital role in the process of pastoral care. Care seekers often bring narratives of pain. Entering into the mystery of another's pain requires compassion" (p. xvi). Caregivers who are compassionate and empathic are better able to honestly want to listen to their care recipients on an

emotional, spiritual, and moral level. The pastoral care compassionate relationship between ministers and care seekers emphasizes all this meaningful care because “a compassionate and respectful care relationship can provide a trustworthy space for exploring new meanings” (p. xv).

The idea of empathy ends with a perception of the other’s world and the ability to return to the caregiver’s world once again to avoid becoming overly absorbed to the point of psychological exhaustion. However, “Compassion involves empathically experiencing the other’s pain and being moved to help” (p. 42). Compassionate empathy is willing to bear the other’s pain for a more extended period without fear of psychological burnout as a part of the caregivers’ passion for helping and support their care seekers. Doehring considers that “If listening means empathically receiving the care seeker’s pain, then spiritual practices will help caregivers receive this pain with care and concern rather than fear and withdrawal” (p. 56). PWD need their caregivers to accompany them on their suffering journey by paying attention to their pain and caring. Indeed, I am not inviting ministers to exercise compassion to the point of burning and breaking. This sense of compassion requires a high degree of psychological and spiritual maturity as well as bearing the pain of others. It requires a pastoral heart that can endure in order to help others.

C. The Goals of Pastoral Care⁶

The goals of pastoral care for PWD are multiple and should be practiced by caregivers during their care sessions. The importance of these goals lies in their function as tools to evaluate caregiving encounters or as indicators of positive advancements for the life of PWD.

⁶ In chapter one, I discussed the functions or the diverse roles of pastoral caregivers but in this section my focus is on the goals of empathy or pastoral care for PWD.

1. Self-Understanding

Lamar Hardwick is a minister who tell the story of struggling with his disability and ministry since he was diagnosed with autism.⁷ Hardwick's experience with autism is exceptional; it helped him to have a better self-understanding.

Some of the qualities or traits often associated with autism have actually served me well as a pastor. When I was diagnosed, I continued to see my therapist for nearly two years so that I could make sense of my life. Next to becoming a Christian, it was perhaps my most spiritual experience. The entire process helped me to *understand who I am* [emphasis added], how my brain works, and most importantly how to leverage my gifts for greater effectiveness. (Hardwick, 2021, p. 153)

Education about autism, what it is and how it really affects people, is how I gained both the power and courage to stop explaining away my experience and instead start embracing who I am without fear of rejection. (Hardwick, p. 185)

Hardwick's experience with his disability led him to a better self-understanding. There is a connection between disability and identity because disability impacts PWD's self-understanding and self-image. The primary goal of providing care for PWD is to assist them in embracing positive attitudes about themselves. From my personal experience, I have learned that living with a disability is like a journey that involves intentionally developing positive thoughts rather than negative ones to better understand myself and fully accept my disability and limitations.

⁷ For more information about Lamar Hardwick go to his blog. <https://autismpastor.com>.

2. Adjustment

Humans face many obstacles and challenges in their daily life, includes traumatic incidents. The human body can adapt to face these obstacles and live with them in peace. Similarly, a disability entails a long journey of shift, between shock and denial of having a disability to the peace of living with a disability and accepting it. I see adjustment as an important goal to be achieved in providing care for PWD. The caregiver's central role is to help a person with a disability deal with their denial by helping them express negative emotions, accept their realities, and achieve psychological balance. A PWD's anger could turn on themselves, their family, society, or God. Expressing these negative feelings of bitterness helps more to the next stage of adjustment and acceptance.

3. Self-Advocacy

Another pastoral care goal for PWD is to help them express themselves better and discuss what disturbs or angers them. Ministers play a role in empowering PWD to advocate their rights or express their thoughts. Caregivers motivate PWD to express their needs and emotions.

F. Disability Empathy from Pastoral and Non-Pastoral Approach

In providing care for PWD, I want to distinguish between pastoral and non-pastoral approaches. This comparison does not show the superiority of one approach over another because I believe we need both. However, my concern is how to underscore pastoral caregivers and ministers have an excellent opportunity to develop enhanced empathy, profound understanding, and support for PWD. First, I acknowledge that one of the most significant benefits of secular therapy is that it is

more specialized in giving care from a scientific standpoint. In this respect, one of the downsides of pastoral care is the lack of a specialty that deals only with most people's everyday problems.

On the other hand, I find that the pastoral care approach is necessary to help PWD understand their pain. Because as I mentioned in previous chapters, disability is a complicated experience, and it is essential to address spiritual needs when providing care for PWD. There are many spiritual components, including the reason for pain, existence, the meaning of life, and others related to disability that are usually not addressed and ignored in non-pastoral care. The spiritual aspect is an integral part of understanding disability. Ministers can develop deep empathic responses and understanding of PWD's questions about the reasons behind their disability and the role of faith in empowering PWD. Pastoral caregivers help PWD express more of their spiritual and existential questions and share their confusion about what is happening in their lives.

Through my experience with disability, I find that most questions concerning disability are tied to the problem of pain. When PWD ask about the reasons behind their disability, they have theological questions about understanding the pain, its reasons, and its meaning. This spiritual dimension is strongly present in pastoral caregivers because of the nature of their ministry and their spiritual experiences of pain through caring for others in similar circumstances. Disability is more like a spiritual experience; through it, PWD try to embark on a journey of self-understanding and their relationship with God and others. The spiritual aspect helps PWD to live meaningful lives with self-acceptance and adjustment to disability.

As previously stated, Doehring's compassionate empathy approach affirms the pastoral caregivers' willingness to go into the other's world to sense, bear, and share the care seekers' pain. Compassionate empathy distinguishes pastoral care; ministers are called by their sense of vocation

to sincerely go through other people's demanding situations and share in their pain. According to Van Deusen Hunsinger (2015), "the church relies not solely on a community of caring individuals, but more fundamentally on a belief in the *Compassionate One* [emphasis added], the source of all human compassion" (p. 41).

In addition, many care seekers find comfort in finding someone who listens to them honestly and attentively. Nowadays, many psychiatrists rush to prescribe drugs rather than exercising empathic listening to their clients. Furthermore, many care seekers prefer speaking and being more open with their pastoral caregivers than paid counselors. Moreover, care seekers may feel that they are paying to be heard in other counseling sessions or that the caregiver's empathy is not authentic because it is a part of their paid job. This is quite different in pastoral care because all that motivates ministers to care for people is a passionate desire, not just a job duty. An essential element of pastoral care is that the care seeker trusts their minister. The absence of the trust element in the beginning stages of paid psychotherapy necessitates a significant effort from the caregiver and the care seeker to establish a trustworthy relationship that allows them to be more open.

A Dialogue between Carl Rogers and Paul Tillich in 1966 stresses many aspects concerning the nature of man.⁸ The topic of this conversation emphasizes my point about the distinction of the pastoral care approach, specifically how it encompasses various aspects of the human experience. According to Tillich, human life has two dimensions,

⁸ Saybrook University. (2012, June 26). A Dialogue with Carl Rogers and Paul Tillich [Video]. YouTube. <https://www.youtube.com/watch?v=8gHSKdX66tY>

Man lives not only in the horizontal dimension, namely the relationship of himself as a finite being to other finite beings, observing them and managing them, but he also has in himself something which I call, metaphorically, the vertical line; the line not to a heaven with God and other beings in it, but what I mean with the vertical line is towards something which is not transitory and finitude and finite; something which is infinite, unconditional, ultimate – I usually call it. (Bower, 2019, p. 16)

Pastoral caregivers can address the two dimensions, particularly the vertical dimension. This kind of care with the vertical dimension is crucial for PWD as it provides them with a sense of purpose, life's meaning, and an understanding of their experiences. Tillich argues that only a theological language is able to link both vertical and horizontal dimensions,

I don't believe that scientific language is able to express the vertical dimension adequately, because it is bound to the relationship of finite things to each other, even in psychology and certainly in all physical sciences. This is the reason why I think we need another language, and this language is the language of symbols and myths; it is a *religious language* [emphasis added]. (Bower, 2019, p. 17).

As Tillich discusses, religious or theological language is not foreign to ministers. Personally, this language has sustained me with hope during difficult times. While I acknowledge that science played a crucial role in restoring my leg using a prosthetic leg, faith restored my life.

Conclusion

In this thesis, I argued for two essential ingredients of providing pastoral care to PWD: the caregiver's awareness of disability and the development of advanced empathy responses. I consider disability awareness is the primary key to providing adequate care to PWD. The first and second chapters focused on different types of awareness: the caregiver's awareness of disability and the contexts of disability that require the caregiver to have essential disability knowledge. The third chapter focused on caregivers' skills to develop deep empathetic responses to understand PWD. Without such awareness, caregivers may neglect critical components in providing care for PWD. In addition, I emphasized that empathy is a crucial skill that caregivers must develop.

I tried to cover the essential topics and skills required for providing care for PWD. However, due to this study's limitations, many important topics need to be addressed in future research. These topics include providing care for persons with mental disabilities, children with disability, the families of PWD, and more. This thesis is meant to introduce some of the most critical components of providing care for PWD. The topics I discussed in this thesis are common to all disabilities. For future projects, it is essential to focus on each disability separately for more specialization because different forms of disability have needs that must be addressed in their contexts and circumstances.

I encourage readers interested in disability studies to focus on pressing issues other researchers do not cover. Some authors address disability from biblical and theological perspectives. However, there is an ongoing need to address disability from the perspective of pastoral care, primarily based on the personal experience of PWD. Ministers remain among those who can effectively address their care needs.

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