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## **Abstract**

### **Game Plan for a Healthy Congregation: A Collegial Group of Clergy**

A pastor in his first assignment is warned several times by different people, "Watch out for Mary." No one would elaborate on what they meant. Months later the pastor goes to Mary with a trusted church leader to confront her about accusations she made against a church board member. She cried and claimed we were "out to get her." Later that day her husband came to the pastor's study in a rage. Feeling physically threatened, the pastor had a revelatory thought: "Church should not be like this."

Thus the purpose of this study is to cast a vision for healthy congregations in the Church of the Nazarene. The literature review focuses on family systems theory as it forms characteristics of a healthy congregation. Both secular and religious material address barriers to health and activities to promote health.

Six pastors from an Appalachian district in the Church of the Nazarene were chosen to form a pastor's group. The charter of that group was to share their experiences and thoughts on congregational health. Through interview sessions and three focus group sessions the pastors developed their visions of health for their congregations and methods to cast them. The researcher developed a church health survey to find any relationship between the pastor's perception of health in his congregation and the vision and methods developed. The pastors spent six weeks casting their visions for health in their

congregations. At the close of that time they debriefed their church boards and returned for a fourth focus group session.

No relationship between the visions and methods the pastors designed and their perception of their congregation's health was found. The study does find that the work of forming and then casting a vision for a healthy congregation was a positive experience. The data also supports forming categories of health the pastors used to describe health in their churches.

Two central methods used by the pastors to cast the vision were sermons or worship service events and teaching time with the church board. Many other methods were developed by the pastors as well. The study closes with suggesting a process that pastors and churches can use to cast and implement their vision of health for their congregations.

## DISSERTATION APPROVAL

This is to certify that the dissertation entitled  
**GAME PLAN FOR THE HEALTHY CONGREGATION:  
A COLLEGIAL GROUP OF CLERGY**

presented by

**B. Scott Buell**

has been accepted towards fulfillment

of the requirements for the

**DOCTOR OF MINISTRY degree at**

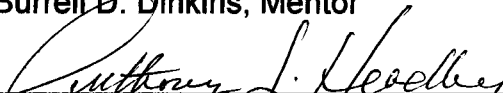
**Asbury Theological Seminary**

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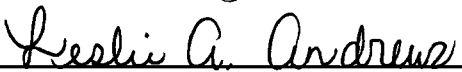
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A Game Plan for the Healthy Congregation:

A Collegial Group of Clergy

A Dissertation

presented to

the Faculty of

Asbury Theological Seminary

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Ministry

by

B. Scott Buell

April 1998

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## **Acknowledgements**

Any time a person comes to a wonderful finishing point in life, he or she did not get there alone. I want to thank and honor the following people who made this possible in my life.

Pastor's Group: Cedric, Jerry, Gary, Chris, Steve, and Mark -- thank you for opening up your lives and ministries to help other pastors.

Jonathan Wright for proofreading and teaching me what my high school English teachers could not.

Dr. Burrell Dinkins, my mentor, and Anthony J. Hedley, internal reader, for guiding the development and research of an idea that greatly interested all of us.

Ronceverte Church of the Nazarene who has begun a journey with me toward congregational health.

Parents: Richard and Linda Buell and Weldon and Betty Pierson, because without your love and support this could not have been possible.

Katie and Nicholas, my children, for putting up with Dad finishing his education as they began theirs.

Donna, my wife, who typed, proof read, encouraged, listened, sacrificed, and loved me through this process.

## **Chapter 1**

### **Overview of the Study**

Tension filled the room as a church member tearfully and angrily read a ten-minute accusation against the pastor. The district superintendent specified no written statements would be allowed, yet she read on. This was supposed to be a time of trying to understand each other. Only more tension, anger, and hostility prevailed. "How did we get to this point?" I asked myself. As associate pastor I was not the target of the hurtful exchanges, but I looked up to the pastor and knew him to be conscientious. This process hurt me as I watched four people tear down a good man.

I found out that these four individuals had been meeting secretly with four to six others in the congregation. When the pastor told me about this, I asked him what the church board would do about this group. "Nothing," he said. He did not want to put the board in that position. As time wore on, the atmosphere in the church worsened and attendance began to drop along with the finances. Soon I had to leave the church because the worsening finances and the hostility were too much for me and my family. Soon after I left the pastor entered a semi-retired status and took a special appointment to a church one half the size of the previous one.

"This church is a real opportunity." "This church abounds with potential." "All this church needs is the right pastor, and you could be the one." These common statements are often made to prospective pastors by either church search committees or denominational executives looking to fill a vacant pulpit.

But too often these statements come back to haunt pastors who cannot seem to turn the church around or to continue the growth. Congregations suffer also as they seem unable to move in the right direction or when the pastor, although he or she is doing a good job and is well-respected, is forced to leave.

Framing the situation in this manner is common and unnecessary. A different way to look at the situation is to view it as a whole and not to place blame or focus on one person or aspect of the church. What is happening to, within, and around the church to make it the way it is? This study explored a systems thinking approach to understanding how churches function. Most literature and thought seem to focus on the problems of the congregation, finding blame, placing it, and fixing it. Another common approach focuses on one aspect of church such as worship, prayer, or growth.

This study focused on the congregation as a system or a whole as it related to the motif of health as with a physical body. Problems or aspects of ill health did not form the major themes. They will be discussed, however, as they illustrated health in the congregation. Reorganizing church governments was not seen as the answer or the problem. Many different types of government exist in Christendom all providing examples of healthy and unhealthy churches. This project did not offer techniques or easy solutions to move a church toward health.

### **The Problem**

The above true-life case and discussion briefly illustrates the trauma of unhealthy ways of relating to each other within the congregation. Many others

have experienced unhealthy ways of relating as well. A pastor's young son is sexually abused by a person in the church. The district superintendent forces silence on the occurrence. A pastor is arrested for solicitation and refuses to give a full accounting of the incident on the advice of his attorney. Pastors and congregations have been hurt by these and other unhealthy ways of relating to one another.

These harmful patterns of behavior within congregations create barriers to reaching their potential. Much of the dissatisfaction in churches is a result of congregational unhealthiness. The pain caused by these relationships, the lack of growth, and the resulting limited finances point to a health problem in the congregation.

Pastors and laity read the apostle Paul's admonitions to the Corinthian church on working together as the body of Christ in love (I Cor. 12-13) and want more than their personal experiences offer. Rick Warren states, "I believe the key issue for churches in the twenty-first century will be church health, not church growth" (17). Organizational health and forms of dysfunction are the topics in Kets de Vries and Miller's The Neurotic Organization. They state they are looking at "sick" organizations and then discuss "treatments" for these groups (5). The concern about organizational health now focuses on the congregation, as Warren stated above. Peter Steinke and Ronald Richardson have written extensively on the healthy congregation. Neither author felt compelled to make a case for congregations to pursue health. They described the healthy congregation and suggested ways to pursue health. What does a

healthy church look like? Can the congregational experiences of the pastors and laity improve? Do the Scriptures speak to the characteristics of a healthy congregation?

### **Purpose Statement**

The purpose of this study is to cast a vision for healthy congregations in the Church of the Nazarene. The research for this study addressed the following research questions: (1) How do pastors differentiate between healthy and unhealthy congregations? (2) What can pastors do within their congregations to promote health? (3) What specific initial plans are being developed to cast a vision of the healthy congregation during the time frame of this study? (4) What short term impact will casting a vision for a healthy congregation have upon the pastor and the congregation?

### **Definition of Terms**

Congregational health is a subjective term. In this study, five characteristics form its basic definition. Chapter 2 discussed the characteristics in detail. These characteristics of a healthy congregation are not achieved once and for all. "Healthy" is a process, and therefore these characteristics vary over the life of the church and the healthy congregation maximizes these characteristics. Congregational health is characterized by (1) leaders as mature individuals, (2) mature relationships, (3) vision for the future, (4) response to challenges to health, and (5) healthy and effective leadership.

A vision for congregational health includes these five items. Chapter 2 defined vision as the leader's act of creating a new future for the congregation.

Vision is a creative act that the pastor initiates under the guidance of the Holy Spirit. It provided a picture of what the congregation attempts to become.

The **church board** in the Church of the Nazarene works in conjunction with the pastor, who is the chairperson, to care for the interests of the church and its work. This specifically includes the raising and accounting of all funds; overseeing of the buildings and grounds; nomination, interview, and recall of the pastor; and performing a self-study every two years. The church board is elected annually by all members age fifteen and above who are present at the congregation's annual meeting. An **ordained elder** is a person ordained in the Church of the Nazarene for the preaching ministry. In the United States, 78 percent of all Nazarene pastors are ordained elders, giving them the primary credential of Nazarene ministers.

In family systems theory, **anxiety** is emotional pain that is passed from one person to the next via triangulation. An emotional triangle results when two people, or a person and an idea, issue or situation, pass their pain with others to a third party. The anxiety transferred can be a dull sense of pain or like a siren wailing in the person's head, signaling imminent danger.

**Reactivity** is a way of reacting out of anxiety and emotional pain instead of responding creatively. Reactivity is always a negative mode of action.

**Current reality** is the congregational system as it now exists. Its unhealthy environment and circumstances form its current reality.

The motif of systems theory, *shalom*, and the church as the body of Christ inform the definition of health. **Health** is the quality of relationship within the

congregation that reflects God's will of *shalom* for the people. This definition emphasizes (1) the individuals who make up the relational system, (2) the relationships, (3) the goal of *shalom*, (4) the unity of the body moving toward *shalom*, and (5) implicitly, the leadership of the congregation who keep the congregation moving toward health, or *shalom*.

### **Context of the Study**

The study took place in a central Appalachian district in the Church of the Nazarene. Geographically, this area comprises West Virginia, Eastern Kentucky, and parts of Ohio. Central Appalachia is economically depressed with many people regularly leaving the state to find employment. The 1990 census dictated West Virginia's loss of a seat in the House of Representatives. Stoddard reports that 170,000 West Virginians left the state in the past ten years due to economic conditions (44). He also states that 20,000 firms went out of business in West Virginia (Ibid.) The West Virginia figures are used because it is the only state completely in Appalachia. The coal industry, which provided most of the well paying jobs in the past, is suffering from the increased environmental regulations on the burning of coal. Thus, unemployment is high and wages are low.

The history and culture of central Appalachia is worth noting as well. Stoddard writes, "Appalachian society . . . centers on personal communities with people related as members of families" (34). This belies a mistrust of institutional communities such as the church as opposed to familial communities. Stoddard reports six "underlying values of Appalachian culture" (29-32). They

are (1) individualism, (2) traditionalism, (3) fatalism, (4) action seeking, that is the resistance of the routine in life, (5) fear and insecurity in economic and social situations, and (6) person-oriented. The last value is described as, "Relationships, rather than goals and objectives, are the primary bases of decision-making."

Six pastors from this area were interviewed and then formed a focus group to cast a vision for a healthy congregation. The pastors are in diverse sizes of churches from 60 in average Sunday School attendance to over 350, and they vary in tenure at their present churches, from six years to thirty years.

### **Methodology**

The study was descriptive and exploratory in nature. It began with interviews of the six pastors selected. The interviews focused on their experiences of health and unhealthiness in their congregations as they connect with congregational health. The interviews were conducted individually before the next step of data gathering.

Following the interviews, the pastors were brought together to form a focus group. The group discussed the concept of congregational health and then moved toward articulating a vision of health for their congregations. The pastors shared their stories of health and unhealthiness as experienced in congregational life. This took place in the course of three meetings.

Included in these meetings was a planning time to develop initial methods for casting the vision developed in their churches. The pastors' group agreed to implement three to six methods of casting the vision within their respective



congregations. The methods varied from church to church depending on that pastor's vision for health in his congregation.

After six weeks of vision-casting within their congregations, the pastors' group reconvened. The discussion covered the effectiveness of the vision-casting methods and the impact of the vision.

### **Subjects**

Six pastors were invited to form the focus group. The criteria for choosing the pastors were that they must be (1) ordained elders in the Church of the Nazarene, (2) pastors (either senior or solo pastors) in a central Appalachian district, and (3) pastors who represent various sizes of congregations. To determine the congregation's size, the average Sunday school attendance for the church year running July 1, 1995, to June 30, 1996, was used. This was the last full statistical year before this study. Sunday school attendance is the primary statistic used in the Church of the Nazarene to judge the size of a congregation.

To decide how many of what size churches to choose, the congregations were broken down into three size categories. The percentage of churches in the district in each category are indicated with the category sizes: (1) 0-99, 73 percent; (2) 100-199, 23 percent; and (3) 200 and above, 3 percent. Six pastors were selected from the three categories. To approximate the above percentages three pastors from category one, two from category two and one from category three were used.

## **Variables**

The independent variable was the vision for congregational health developed by the pastors. This variable had three sub-sets of variables: (1) the methods which the focus group of pastors developed to cast the vision for health, (2) the instruments used in the interviews, focus groups, and board debriefing session, and (3) the criteria used to choose the six pastors. The dependent variable was the perception of congregational health by the church pastors resulting from the vision and methods used to cast it. Some intervening variables were the tenure of the pastors, their skill as change agents and communicators, and the history of the respective churches. The last variable refers to the experiences of the church in its efforts to effect change, such as a lay leader who aggressively opposed change, a pastor who attempted change and left amid the changes, or a previous church split over a particular issue.

## **Instrumentation**

The instruments that were used were researcher-designed face-to-face interviews, focus groups guides, and a church health survey. The initial interviews were done individually with the six pastors. The focus group utilized questions and discussion starters to guide the pastors in creating a vision for their congregation's health. This focus group developed and began implementation of the initial methods for casting a vision. After six weeks, the pastors met with their own boards to seek members' responses to questions developed by the researcher. The church health survey was administered at the

third focus group meeting. The purpose of the survey was to discover the pastor's perceptions of his church's health.

These interviews and focus groups were tape recorded with the subject's permission, and field notes were taken to record the data. As common themes appeared in the interviews and focus groups, they were reported in Chapter 4. Not only were the themes described, but the process of casting the vision was also reported.

### **Theological Foundations**

The primary theological constructs are the Old Testament concept of *shalom* and the congregation as the body of Christ (I Cor. 12 and Rom. 12). *Shalom* presents God's will and blessing of what relationships can be through him. In this context, Paul casts his vision for a healthy congregation. This motif also describes the congregation as a system of believers, which matches the primary theoretical orientation of the research. The church as the body of Christ and the biblical foundations for each of the five characteristics of a healthy congregation form the structure of the research. Theological and biblical foundations will be discussed in Chapter 2.

### **Delimitations and Generalizability**

This study worked with six pastors on one district in the Church of the Nazarene. The subjects were chosen according to the above-stated criteria to represent the district rather than the entire Church of the Nazarene. The study also focused on the pastors' perceptions of what healthy congregations look like.

It did not include the laity's nor denominational executives' perceptions on health. Also, only the initial responses to casting the vision were studied.

This study could find use as a springboard for other pastor groups to cast a vision for health in their congregations. A correlational study could be done after this one to discover the content of a vision for healthy congregations in another district in the Church of the Nazarene or another denomination in central Appalachia.

### **Overview of the Study**

Chapter 2 reviewed selected literature on systems theory and organizational health, making use of both secular and religious published material. Chapter 3 provided the design of the study in detail. Chapter 4 reported the findings of the interviews and focus groups. Chapter 5 discussed the impact of the findings and interpretation of the study.

## **Chapter 2**

### **The Review of Related Literature**

The intent of this study is to develop a vision of a healthy congregation and to begin implementing that vision. This literature review draws out the common themes that inform the goal of a healthy congregation. More specifically, this study describes the characteristics of a healthy congregation and locates strategic changes to enable leadership to bring the congregations into congruence with this description.

### **Systems Theory**

Systems theory provides the primary lens for viewing a congregation. One common description of systems theory's basic premise is to view or understand the organization, family, group, or project as an organism. This promotes a different way of thinking, moving from linear causation thinking such as A then B then C to an interrelatedness of mutual causation such as A, B, and C all pictured in a Gestalt cycle, not a line.

In systems thinking one premise is to focus on how the parts of the system interact with each other; relationships are central. A problem in one part of the system is not an isolated event; the same is true of a positive interaction. Each is interrelated with the functioning of the whole. Systems theory finds application in two major areas of interest for this study: organizational systems and family systems.

These two disciplines overlap in many areas and have core concepts that govern each other. One primary thinker in organizational systems theory is

Peter Senge, who developed the "laws of the Fifth Discipline." The laws pertinent to this study are: (1) easy solutions usually become problems in the future, (2) the system has amazing energy to stay the same, (3) there are no easy answers, (4) breaking the system into smaller parts or viewing only portions of the system does not make it smaller, and (5) there is no blame (Fifth 57ff).

Another main proponent of systems theory is Edwin Friedman. He offers "five basic concepts": (1) the identified patient is the one who displays the symptoms of the entire system's illness or problems; (2) homeostasis is the system's ability to resist change and keep a balance it has found for itself, no matter how sick; (3) differentiation of self is the ability of a person to define his or her goals and values while staying connected to the system; (4) the extended family field refers to the entire family system; (5) emotional triangles are situations in which two parties feel uncomfortable with each other and bring in a third person or issue to bear their anxiety or pain, shifting the pain to another party (19-35).

These ideas of systems theory, both organizational and family, apply easily to the congregation. The congregation is a system that must be viewed as a whole, an organism greater than the sum of its parts.

The concepts listed above are operative in the congregation, since it is a system (Friedman 195). One can see these laws at work when a generous contributor to the church stops giving money in protest to the pastor's actions in a certain circumstance: triangulation between the contributor's wishes, the

church budget, and the pastor's actions. The laws also emerge when the pastor's attempt to increase the attendance by making more calls on absentees and prospects results in a decline in church attendance: the easy answer usually is not the correct one. These examples are only a few experiences this pastor has had that illustrate how the congregation functions as a system.

### **Aspects of Congregational Health**

In thinking of the congregation as a system, especially in family systems, it is natural to think in terms of health and unhealthiness (Steinke, Healthy viii). Peter Steinke asserts health does not equal numerical growth (Ibid.) A growing church is not necessarily healthy and a church that is in a maintenance mode is not necessarily unhealthy. As stated in the definitions, health has more to do with the interpersonal relationships than with the numerical growth of a church. He also states that health is not the end, only a means to the end (Ibid. ix). The goal of a congregation is not health alone. Rather, health is pursued so the congregation can accomplish its mission. The health of a congregation is the context in which it works to fulfill its mission.

The apostle Paul's metaphor of the church as the body of Christ implies health and a lack of it. As he wrote to the Corinthians of the body of Christ, he addressed their lack of health as a congregation (1 Cor. 1:10; 3:1-3). His call to that congregation was to remember its nature as a system, a body, and to work toward their health as a congregational body.

People and systems, such as a congregation, strive for health and have the capacity for health within themselves. The blame or problem is not out there

somewhere, but lies within the system. That is not to say that health is automatic. Many "viruses" can disrupt health. But the system does have the desire and capacity for health (Peck, Drum 68; Steinke, Healthy 10).

Health is a process and not a fixed entity. As the congregation interacts with its environment and its people experience challenges, a healthy congregation can become unhealthy just as an unhealthy one can move toward health. Once a congregation becomes aware of a healthy dynamic, it must also be aware that constant challenges to this health will upset the balance. In fact, M. Scott Peck states, "no community can expect to be in perpetual good health" (Drum 66).

A last general component of the health of a congregation is the ability to know when health occurs. When the key elements are present, one can experience and perceive the health of the congregation. When a congregation decides to pursue health, these key elements will gauge the health of the congregation (Shawchuck, Leading 215).

### **Characteristics of a Healthy Congregation**

Key elements that appear as common themes in the literature are (1) leaders as mature individuals, (2) mature relationships, (3) vision, (4) healthy and effective leadership, and (5) the congregation's move toward health in response to challenges. These elements serve as the foundation for a healthy congregation.



## Leaders as Mature Individuals

A healthy congregation needs healthy people. Steinke states, "healthy people create healthy congregations" (Healthy 81). The people who make up the system will determine that system's health. Rick Warren states in an interview, "It is possible for an unhealthy pastor to lead a growing church but it takes a healthy pastor to lead a healthy church" (Rowell 26). Steinke writes that mature individuals deserve the major focus of the system as it pursues health (31). This is not to say that every person in the congregation must be a mature person.

Importance of Mature Leadership. Leadership includes the pastor and the lay leaders in the congregation. Steinke states that troubled congregations "are in more danger from their immature leaders than from the contentious issues" (108). Anne Schaef agrees with leaders' potential to destroy an organization due to their own immaturity (83). Leaders must be mature individuals if the congregation hopes to move toward health. The one variable that sets the successful organization apart from unsuccessful ones is leadership (Hersey 90). Ronald Richardson states, "The level of differentiation [maturity] of the leaders in the church is the crucial variable in how well that particular church will run its communal life, deal with the inevitable challenges and crises that come to it, and accomplish its mission" (177). The pastor's maturity level has more to do with effectiveness in ministry than his or her training or talent (Oswald 25). The discussion of the leader's actions to promote health, in

addition to how leaders express the leadership, as well as the rest of the congregation, follows.

Just as the systemic health of the congregation is in process, so is the individual's health. Thus, one aim of the healthy church is to grow mature and healthy people. Friedman states that churches are notoriously guilty of not doing this (59), yet it must be a concern of the congregation to instill health and maturity into its people.

Influence of the Situational Leadership Model. The Situational Leadership Model is devoted to the belief that people and groups stand at different levels of maturity and effectiveness to accomplish the organization's goals and that the level of maturity for the person or group can change over time (Hersey, see chapter 8). Paul Hersey explains that "Situational Leadership is based on an interplay among (1) the amount of guidance and direction (task behavior) a leader gives; (2) the amount of socio-emotional support (relationship behavior) a leader provides; and (3) the readiness level [or "maturity level" 587-88] that followers exhibit in doing a specific task, function, or objective" (189). The focus of the Situational Leadership Model is the leader's behavior, task, and relationship in relation to followers (190). This further emphasizes the necessity of the leader being a mature individual and the power of his or her influence on the organization or church. The leader's behavior toward the rest of the people in the organization is fundamental to his or her effectiveness.

The leader's behavior must flow through four styles of leadership behavior depending on the readiness or maturity level of the followers. The interplay

between task behavior and relationship behavior defines the four styles: Style 1 (telling) reflects high task behavior and low relationship behavior; Style 2 (selling) reflects high task and high relationship behavior; Style 3 (participating) reflects low task and high relationship behavior; Style 4 (delegating) reflects low task and low relationship behavior (Hersey 191-2). The appropriate style for the leader to use is determined by the follower's readiness or maturity level.

Hersey defines readiness as "the extent to which a follower demonstrates the ability and willingness to accomplish a specific task" (193). Readiness or maturity is a function of the follower's ability and willingness in specific situations (193-4). The four leadership styles relate to the four readiness levels: Readiness level 1, unable and unwilling, calls for leadership Style 1; Readiness level 2, unable but willing, requires leadership style 2; Readiness level 3, able but unwilling, needs leadership Style 3; and Readiness level 4, able and willing, needs leadership style 4 (195, 200-207).

Interaction between leader and follower(s) determines the effectiveness of the organization. The leader must be able to vary his or her behavior according to the maturity level of the individuals with whom he or she is working. Notice that the maturity level of the follower is the key variable. It can increase or decrease from situation to situation. The healthy congregation will always attempt to move people to a higher maturity level. This becomes especially important as the other characteristics of a healthy congregation are discussed. Three characteristics will be impacted by the Situational Leaders Model as

discussed above; becoming a healthy and effective leader, accomplishing vision, and responding to challenges to the health of the congregation.

Characteristics of Maturity. The healthy individual demonstrates several important characteristics. Steinke states, "health is always about attitudes, mood, and choices" (Healthy 25). That is to say that every person can move toward health. These are things that lie within a person's control. Steinke mentions that healthy people reveal an attitude of gratitude and caring (Healthy 19) as well as the ability to let anxiety or emotional pain go so as to be able to think clearly about appropriate responses (Works 21).

The major characteristic of the healthy individual in family systems theory is self-differentiation. Steinke defines it as being differentiated yet remaining connected (Works 11). The ability to self-differentiate is the ability to define and act on one's values without breaking relationship or defining those around oneself. Peck refers to this as "individuation" (Drum 54). Henry Cloud and John Townsend describe it as "boundaries." They state, "Boundaries define us. They define what is me and what is not me. A boundary shows me where I end and someone else begins, leading me to a sense of ownership" (29). This is not opposing others; it is being yourself instead of what others want for you while not separating from them. Communication is not discontinued because of anger or disagreement; rather it allows persons to hear each other and respect differing beliefs. The apostle Paul illustrates this as he wrote to the Corinthians, "now you are the body of Christ, and members individually" (1 Cor. 12:27).

The mature or healthy individual is the focus of Daniel Goleman's Emotional Intelligence, which lists five emotional intelligences marking the mature person: "Knowing one's emotions . . . managing emotions, . . . motivating oneself, . . . recognizing emotions in others, and . . . handling relationships" (43). These emotional intelligences, self-awareness, self-control, self-discipline, empathy, and relational skills certainly relate well to self-differentiation as described above. Stephen Covey's definition of maturity mirrors family systems theory of self-differentiation as the ability to stand up for one's beliefs with a sense of the other's feelings and beliefs (61). The mature individual, then, demonstrates ability to direct his or her own thoughts, reactions, and actions as well as the ability to relate with others effectively in difficult circumstances.

Warren offers three indicators of health in pastors which could be applied to all church leaders. The healthy leader 1) practices authenticity which is an awareness of your weaknesses and publicly admitting them, 2) has integrity defined as "congruence between what you say is important in your life and what you actually do" and 3) is always learning (Rowell 26). Steve Sjogren agrees when he says, "healthy churches are led by pastors who are real, who tell their honest, heartfelt stories" (38). Pastors lead the way in demonstrating health to the other leaders in the congregation. Together they impact the health of the congregation.

### Mature Relationships

The second key element to congregational health is mature or healthy relationships. Relationships are central to congregational health. Just as the

congregation needs mature individuals, it needs those individuals to relate in a healthy manner. A congregation cannot exist without relationships. It is impossible to conceive of a congregation without relationships. Steinke believes relationships are the purpose of humanity (Healthy 83). Relationships permeate a congregation and are powerful. Hersey states, "The most significant factor affecting organizational productivity was found to be the interpersonal relationships" (66). How much more for the congregation? Argyris writes, "without interpersonal competence the organization is a breeding ground for mistrust, intergroup conflict, rigidity, and so on" (Hersey 73).

One of the most important characteristics of mature relationships is self-differentiation, which is as much about the way one relates to others as about how one relates to oneself. Cloud and Townsend state, "Boundaries [self-differentiation] are the 'litmus test' for the quality of our relationships" (108). Self-differentiation is the main deterrent to emotional triangles. As described, triangles are relational ways of passing anxiety onto someone or something else (Steinke, Works 36). Anxiety is a "sense of threat" which unbalances the system and negatively affects the congregation's health (Richardson 42). The differentiated person can resist being placed in the triangle by refusing to accept the anxiety and force the other person(s) to deal with the anxiety. Those who are most often the target of triangles are leaders and the immature or vulnerable (Steinke, Works 49). These triangles can keep the entire congregational system in turmoil, unable to change and stuck in emotional pain. The differentiated

person also can respond creatively to these triangles since free-floating anxiety is not accepted and hence does not lock the person into anxious reactivity.

Self-differentiation also aids relationships by allowing people to hear and empathize with other's feelings without becoming stuck or losing one's independence. It also does not allow emotional cut-off (Cosgrove 38). Self-differentiation is the ability to be separate yet remain connected.

To further describe the healthy or mature relationship in a congregation, Deitrich Bonhoeffer's Life Together offers an excellent set of characteristics. "The first service that one owes to others in the fellowship," writes Bonhoeffer, "consists in listening to them" (97). Helping others in simple and practical ways forms healthy relationships (99). Relationships nurtured by mere presence, being there, help the congregation move toward health (19). Ultimately these relationships must be founded in Christ. A vital relationship with Christ is necessary for healthy relationships within the congregation. One cannot be an effective and healthy member of the body of Christ without a strong relationship with the Head of that body (Ephesians 4:15). Bonhoeffer states, "only in Jesus Christ are we one, only through him are we bound together" (24). These healthy relationships within the congregation are a grace that God offers to his people (Bonhoeffer 20).

### Vision

The third key element to a healthy congregation is vision; a sense of mission or becoming is essential to the church. Steinke calls vision a "health promoter" and necessary (Health 25,26). It promotes health as it energizes the

congregation with hope and meaning for the present and future (Ibid. 105).

Vision is important to a congregation's health because it communicates where it is going and what it is becoming. Senge states, "Vision paints the picture of what we want to create" (Fifth 231). Vision is not only a goal (Bennis 89) but is actually creating a new reality (Fritz 175). It breaks the church out of the boundaries of the current reality and sets forth a new future with an impact on the present. According to Warren Bennis, a shared vision "is influential in shaping the future itself" (101).

Primary vision work must begin with the pastor and the lay leadership. Warren asserts "The first task of leadership is to define the mission [vision]" (42). Hersey states "Leaders must be vision creators," and visioning is "fundamental to the process of leading organizations" (92). The pastor must begin the painting of the congregation's future and invite the people to join (Senge 215).

Vision is the leader's function of creating a new future for the congregation. Churches stuck in unhealthy processes often lack vision of how the church can improve. Their history speaks only of pain, unhealthiness, and reactivity with no sense of what they could become. David Waters, using vision in family therapy, states, "One of the great deficits of most therapy is the lack of vision of what people need to move toward as well as a sense of what they need to move away from" (56). The vision frees the congregation from focusing solely on the unhealthy present, to hold that current reality in tension with the vision of



a healthier future (Fritz 173). The vision challenges the congregation with the question "Do you want a better experience of the church than you now have?"

Vision also protects the congregation's present against unhealthiness. When Steinke was asked, "How does a church build a strong immune system?" that is, how does a church protect its health, he responded, "by having a strong sense of vision and mission. Then a church can judge its behavior and activities" (Goetz 47). Warren states, "the percentage of members being mobilized for ministry and missions is a more reliable indicator of health than how many people attend services" (Rowell 24). The resources the congregation commits to work towards its vision indicates its health. The more resources given to vision achievement the healthier the congregation is.

The apostle Paul practices this vision principle. He acts as the congregation's leader, reminding them he is their spiritual father (1 Cor. 4:14-15) and calling upon them to imitate his example (4:16). As their leader, he confronts the many problems in the congregation: factions (1:12-13), immaturity (3:1-2), an unrepentant sinner (5:1-5), lawsuits among believers (6:1-11), improper conduct in the Lord's Supper (11:20-22), and controversy over the importance of spiritual gifts (12:1-11). Paul writes pointedly about their many barriers to health. One could assume this was the most unhealthy church in the New Testament. In the midst of all of this unhealthiness, Paul writes the love chapter, 1 Corinthians 13. He challenged the most dysfunctional congregational body with the highest vision of Christian relationships and health. Paul is not shaking an accusing finger at the Corinthians in chapter 13, saying "live up to

this or else." Rather, he is envisioning a new and healthier future for them. Paul asks them, "Do you want something better than all the problems I have had to confront?" Even Paul's language at the end of chapter 13 (vv. 11-12) demonstrates a process of growing toward the maturity he envisions for the Corinthians. The biblical foundations for this study will be discussed more completely below. This illustrates the power and importance of a vision cast by the leader to the congregation.

This vision is built upon a trust between pastor and people. Trust must be nurtured as vision is developed (Shawchuck, Leading 153). Senge states that not only is trust needed, but "a shared vision is the first step" in building trust (208). Vision will give the congregation a common meaning for its future (Steinke, Healthy 105). This vision will bond the people together if they accept it personally, thus strengthening the system (Senge, Fifth 206).

Lack of vision replaces hope with wishing for the future. Lack of vision mars a picture of the church's future with fuzziness, unclarity, and anxiety over the future (Lindgren 50). Steinke plays on the King Jerry Version of Proverbs 29:18 -- "where there is unclear vision, the people perish in their own anxious reactivity" (Works 116). Covey goes so far as to state that a lack of vision is the root of "all other problems" (166).

### Healthy and Effective Leadership

The fourth key element to a healthy congregation is healthy and effective leadership. At this point only the importance of leadership will be discussed. Its functioning in the healthy congregation demands a more detailed examination

than is possible here. The leadership of the church includes the pastor as well as the official and unofficial leaders of the congregation.

One of the reasons healthy leadership is so crucial is its influence within the system. The leader is in a position to influence the system because others have given him or her the power to do so. Steinke compares leadership to the brain's functioning in the human body (Healthy 21). The brain's workings hold sway over a person's emotional reactions (Goleman, see chapter two). In a similar way, the leaders of a congregation influence its health.

Another reason for the importance of a healthy leader is its unique place in the system to induce change. The leader's function is to accomplish the congregation's goals, whether stated or implicit. Friedman and Hersey emphasize leadership's key position in the system to create change (Friedman 221; Hersey 7, 94). Since health is a process and not a state, as mentioned above, the ability of leadership to create change in order to move the congregation toward health is essential.

### Responses to the Challenges to Congregational Health

The fifth key element to congregational health is for the congregation to respond to challenges with a move toward health. Again, health in a systems view is not a static function; it is a process that flows in all directions. The congregation moves both toward and away from health. Therefore, as challenges to health arise, health is determined by the congregation's response. Steinke states, "a healthy congregation is one that actively and responsibly addresses or heals its disturbances. It is not one with an absence of trouble"

(Goetz 47). This is an important component because many congregations will do nothing, not wanting to hurt someone's feelings, or they are too anxious to respond. Such inaction can do more harm than a wrong action. Steinke states, "Health is ten percent what happens and ninety percent how we respond" (Healthy 17). The congregation must respond because it takes the power out of the circumstances of the challenging situations. Congregations hold within themselves the capability for health, since health is more a function of response than circumstances. The church that stands in a bad location, is small, or is held hostage by a church boss need not resign itself to ill health due to these or other circumstances. How the leadership responds will determine its health.

This discussion now turns to a major barrier to congregational health: problem people -- not just irritants in the church; people who Lloyd Rediger calls "clergy killers," Peck refers to as "evil", and Marshall Shelley has named "well-intentioned dragons." In their own minds these people perform their evil acts under the guise of helping the church, in other words not for selfish motives (Rediger, "Clergy" 7; Shelley 65). Yet that is another hallmark of their evil -- deceit (Steinke, Healthy 60). Peck explains, "The evil are 'the people of the lie' deceiving others as they also build layer upon layer of self-deception" (Lie 66). Peck further describes, "The central defect of the evil is not the sin but the refusal to acknowledge it" (Ibid. 69). These people, the evil, never own the hurt and pain they cause. Peck states such individuals have a completely "unsubmitted will" (Ibid. 78). They will not submit to the pastor, church, or God.

Rediger describes them as "destructive," "determined," "deceitful," and "demonic" ("Managing" 9).

Their power in the congregation lies in their willingness to break all the rules of community (Rediger, "Clergy" 7). Pastors have experienced the full force of this evil. One must assume they are found in many congregations when H.B. London cites a Fuller Institute of Church Growth study indicating 80 percent of pastors "believed that pastoral ministry affected their families negatively" and "70 percent say they have a lower self-esteem now than when they started out" (23). These evil people in congregations do great harm to the pastor's and congregation's health as they consistently practice "scapegoating" (Peck, Lie 73). That is when they shift to someone else the burden for all that is wrong and all the hurt they have caused. The usual target is the pastor (Friedman 30). This is unhealthy for the congregation because it over-focuses on the pastor and allows the rest of the people to be accomplices in scapegoating. It also results in either a severely depleted pastor or continual turnover in the pastoral office (Shelley 41).

Their effect on the larger scene of the congregation proves just as devastating for they indicate general unhealthiness in the congregation (Cosgrove 20). Evil people attack the health and life of the congregation, draining joy, vitality, and creativity from its midst (Peck, Lie 43; Shelley 41). The evil are a source of confusion in the congregation (Peck, Lie 66). The congregation begins to realize what is happening and how to respond, only to be deceived by the evil person about his or her actions.

One may ask, "How can this type of person exist in the church for any length of time?" Rediger responds that most churches and pastors are in denial over the existence of an evil person in their midst ("Managing" 9). Charles Cosgrove attributes the passivity of churches towards the evil person to the function that person serves in the church system (22), such as relieving the church board from having to evaluate a pastor's performance in a productive way since no pastor has stayed long enough to be evaluated; or a layperson who runs an efficient Sunday school through the use of tyranny.

One must acknowledge their presence and devastating impact on congregational health. Until churches begin to respond to these people, such congregations will be held in unhealthy captivity.

Other common challenges to health relate to the relationships of the congregation. Secrecy keeps people apart and forms triangles with those with whom the secret is shared (Steinke, Works 89). Anxiety as it is passed about through triangles keeps people immature and unable to respond in a healthy way since they have to deal with someone else's anxiety or emotional pain. These two challenges are kept active in a congregation by immature people who cannot or will not make the effort to be separate yet remain connected. Immature people thrive in churches that do not respond to them (Ibid. 59). Some are not so much immature as recalcitrant. They will not accept authority, nor do they care about the feelings or values of others. The response to the "evil" person must be by the church body, never just the leader, because by this person's nature he or she will destroy the leader before acknowledging defeat.

The final challenge is the narcotic belief that the problems are "out there" somewhere (Covey 63). This causes people to believe that someone or something else is responsible for the health of the congregation.

The motives behind responding to these challenges are to reconcile and grow. Even when relationship is cut off, it is done so for the health of the congregation and in the hope that the person would come to his or her senses. The congregation takes the problem of evil and suffering seriously; it does not flippantly respond to these relational challenges (Peck, Drum 125).

### **Congregational Actions Promoting Health**

Now that a description of the healthy church is proposed, what responses or actions can be taken to move congregations toward health? The first set of responses are theological: faith, prayer, forgiveness, and repentance. Steinke calls these the "higher medicines" (Healthy 82). In the gospels people respond to their illness through faith and prayer to Jesus. Several times Jesus tells a newly healed person that faith had made him or her well (Mark 5:34; 10:52; Luke 17:19; Matthew 15:28). Faith and prayer are still therapeutic movements in the lives of the Christians and the congregations. Power in faith and prayer responds to anxiety. Forgiveness is not letting the person off the hook; rather it is letting go of the pain. Repentance is the way back from the depths of anxiety that one used to hurt others and the church and to separate himself or herself from God (Steinke Healthy 88).

Another response, previously mentioned, is self-differentiation. The leader must model and teach this principle. Every person in the system is responsible for either aiding or detracting from the health of the congregation. The principle of self-differentiation is the ability to be one's own person as well as staying in relationship with the congregation. Norman Shawchuck gives several rules for working in an unhealthy organization that illustrate acting as a differentiated self: (1) be a "non-anxious presence," another term for the self-differentiated person who does not receive another's anxiety; (2) do not spend all of your time with the chronically immature, but give sufficient time to healthy people; (3) avoid emotional triangles; (4) communicate openly and honestly; and (5) let people know what health and unhealthiness are (Managing 309-311).

Implied in the description of the healthy church is the church as community. Peck outlines four stages to becoming a community, useful in helping move a congregation toward a sense of community and health. The first stage is "pseudocommunity," fake community. This looks like community, but it is too easy and no price has been paid for it (Drum 86). Chaos eventually breaks out. With pseudocommunity everyone tries to fake it, chaos sees their differences and conflicts rage openly. One attempts to get everyone to be like himself or herself (90). The next stage is emptiness. One and all must be emptied of barriers to communication and community (95). Emptiness is the price of letting go of these barriers, like the wilderness experience of the Israelites in Exodus and Jesus' temptation. Then the group enters community, which Peck describes as a "kind of peace" (103).



The congregation that has become a community is a "safe place" for the members (Peck, Drum 67; Richardson 75). Peck describes the community as a place where "conflicts can be resolved without physical or emotional bloodshed and with wisdom as well as grace" (71). Differences in values and methods are tolerated, even encouraged. The congregation as community does not attempt to make everyone the same under the banner of Christian unity. The child's game of hide and seek illustrates the power of the safe place. The children who are hidden want to arrive at home base, the safe place, where the child who is "it" cannot tag them. They are free from the threat of the person who is "it." The congregation as community becomes a safe place for its people.

The final response or action to take to promote health is worship. Bonhoeffer describes how community is built by a discipline of worship (40 ff.). He describes the common life of people living together, yet the theme is appropriate. Worship of God will help bring health to a church. He includes such habits as corporate worship, singing, Bible reading, prayer, and communion. The church cannot forget it is a community and experiences health only as it worships.

### **Leader as Health Promoter**

The next issue to be discussed is the leader as a promoter of health. The importance of leadership was addressed earlier, yet here the leader's role as an agent of health will be explored.

The leader's great role as health promoter is to be self-differentiated, the leader being separate, defining his or her own goals and values then acting on

them, all the while remaining connected to the congregation, even those who resist (Friedman 229). Steinke relates this type of leader to the body's immune system (Healthy 99). The leader is able to determine what belongs to the congregation and what does not belong. The self-differentiated leader who has set appropriate boundaries around himself or herself can act as an agent of boundaries for the congregation, know what is its "property" and what is not (Cloud and Townsend 29, 31). Those actions, beliefs, and attitudes that do not belong can be exposed as such and ousted from the body (Ibid. 91). As the leader acts in this capacity, he or she must act not on what is best for himself or herself, but rather on what is best for the congregation based on shared values and vision.

As mentioned above, the self-differentiated leader is a non-anxious presence. This non-anxious presence in the leadership serves the congregation by reducing the level of its anxiety (Richardson 51). Richardson attributes clearer thinking, greater creativity, and ability to better manage crises to the leaders who are a non-anxious presence (Ibid.).

The Situational Leadership Model contributes three leadership functions for the pastor as he or she works with key lay leaders in the congregation: (1) contracting for leadership style, (2) positive reinforcement, and (3) disciplining an individual. The pastor can promote the health of the congregation by working with a few essential lay leaders to contract an appropriate leadership style for the pastor to use with the particular lay leader (Hersey 328). Once agreement is formed on the goals and responsibilities of

the lay leader, they establish criteria to measure the effectiveness of the lay person. Once this is done, the Situational Leadership Model is introduced and agreement is formed on an appropriate leadership style for the pastor (Ibid. 332). The Situational Leadership Model also calls for the pastor to use positive reinforcement when it is appropriate in order to sustain desirable behavior in the lay leadership (Ibid. 274). Hersey states that "behavior is controlled by its immediate consequence" (Ibid.). A pastor does not attempt to control the lay leaders, yet he or she does want to affirm health-producing behavior in laity. Conversely, the health-inhibiting or disease-causing behavior in lay leadership must be confronted. Hersey suggests this intervention or constructive discipline take place as soon as possible in relation to the behavior being corrected; that an appropriate emotional intensity be used; that the focus is always on the behavior, never the person; that the pastor be specific about the behavior; and that it be done in private (284-286).

The leader as promoter of health must pay close attention to the relationships he or she builds in the church. First, the leader must believe in the people's potential (Hersey 193). Also, the leader must understand people well enough to know what will motivate them to healthy behavior and attitudes (Ibid. 33). This is built on a relationship of trust. Trust is central to any relationship, but especially when one person attempts to lead another. Leadership cannot exist without trust; then it becomes tyranny (Covey 155). Covey lists three behaviors that will help build trust: "listen to understand, speak to be

understood," and start from a common point of agreement (110). The leadership is the starting place when one considers the health of a congregation.

### **Biblical Foundations**

#### *Shalom* as health

Most people want to move toward "health and wholeness and holiness" (Peck, Drum 68). The health, wholeness, and holiness Peck refers to hearken to the Hebrew word *shalom* (Steinke, Healthy 84). Health in *shalom* is wholeness and a condition of well-being that Steinke describes as "a balance among God, human beings, and all created things" (Ibid.). Youngblood expands the realm of *shalom's* meaning to include "fulfillment, completion, harmony, tranquility, security, well being, welfare, friendship, agreement, success, and prosperity" (732). These definitions of *shalom* focus on the motif of relationship, the interactions of people with one another and God. Lloyd Carr notes that *shalom* carries with it "the idea of unimpaired relationships" (931), more specifically, the relationships that promote love, faithfulness, righteousness, harmony, and balance (Yohn 61, 64; Carr 931). David Yohn states, "Shalom is the interaction of one soul with others to form community. Souls, which act in concert for the common good, create healing shalom and a healthy fellowship" (61).

God is the giver of *shalom*. Often the covenant promises of God to his people include *shalom* as a result of keeping the covenant. One blessing for the people as they obey the law is God giving the land peace [*shalom*] (Lev. 26:6). One of Job's friends counsels him to "acquaint yourself with Him and be at peace [*shalom*]" (Job 22:21). The blessing Aaron is told to offer to the people

illustrates God as the source of *shalom* and its importance to God's people:

"The LORD lift up His countenance upon you, and give you peace [*shalom*]"

(Num. 6:26). Carr writes, "In nearly two-thirds of its occurrences, *shalom* describes the state of fulfillment which is the result of God's presence" (931).

Health is that process that God wills for people and especially the congregation. The healthy congregational system functions (relates) as it should. Right relationships are central to the idea of health. They find balance between closeness and separateness; they provide resources for the congregation and the individuals to survive (Steinke, Healthy viii); and health in relationships allows the congregation to respond to challenges, nurturing its health. The apostle Paul called the Corinthian congregation to health as the body of Christ, using the remedy of love and healthy relationships (1 Cor. 12:31 and chapter 13).

#### The Church as the Body of Christ

The New Testament speaks of the church as the "body of Christ" (1 Cor. 12:12-30; Rom. 12:4-8; Eph. 4:15) which graphically illustrates the congregation as a system that can be either healthy or unhealthy. Though the apostle Paul could not have known about systems theory, he certainly describes the church as a system (Richardson 172). Every metaphor he uses for the church conveys a sense of the church as a system. He refers to the church as the family of God (Gal. 6:10), the people of God (Eph. 2:19), a garden (1 Cor. 3:6), a building (1 Cor. 3:9), the Temple of God (1 Cor. 3:16), and the marriage bride of Christ

(Eph. 5:25). Paul's unique emphasis on the church as the body of Christ stresses its systemic features and its potential for health (Purkiser 570).

Clarence Bass describes three themes prominent in Paul's usage of the church as the body of Christ (531). First, the church is the body of Christ as it is the community formed by Christ. Each member of the body becomes a member as he or she is "in Christ." Bonhoeffer states, "Our community with one another consists solely in what Christ has done to the both of us" (25). Second, the church described as the body of Christ emphasizes the unity of the believers into a new reality. The members are connected by Christ for mutual support and common service or ministry. Third, the church as the body of Christ exists with Christ as its Head. The body serves the Head together in mission and collectively obeys its Head.

#### Biblical Foundations for the Five Characteristics of Healthy Congregations

The five characteristics of a healthy congregation form the structure of the rest of the discussion of the biblical foundations to the church as a system and its resulting health. Paul speaks to the need for mature leadership when he rebukes the Corinthians (1 Cor. chapter 3). To those who should be mature and aiding the health of that congregation, Paul writes, "And I, brethren, could not speak to you as to spiritual people [mature] but as to carnal, as to babes in Christ [immature]" (1 Cor. 3:1). He goes on to chide them for not being mature enough for solid spiritual food, only able to receive milk (1 Cor. 3:2). This language, "babes in Christ", "spiritual milk", and "solid food", presupposes growth and maturity. Later, in the pastoral epistles Paul states the expectation

that the leadership be mature (1 Tim. 3:1-13). He spells out the qualifications of anyone wishing to become a leader in the congregation. He instructs Titus to "set in order" what was lacking in the congregation at Crete, primarily the leadership (1:5). He is "commanded" to appoint elders and then given the qualifications required of them (Titus 1:5-9).

The mature relationships described above are essential to Paul's view of the congregation as the body of Christ. George Eldon Ladd states, "The reason Paul draws upon the metaphor of the church as the body of Christ . . . is . . . to establish the proper relationship of Christians to one another" (591). This proper relationship can best be described as self-differentiated, the ability to balance closeness and separateness in a relationship by defining one's values and acting upon them without breaking relationship. Paul illustrates this concept as he describes the unity and diversity of the body. Paul writes, "The body is one and has many members of that one body, being many, are one body" (1 Cor. 12:12). Later he expresses the concept this way: "You are the body of Christ, and members individually" (12:27). The teaching in this section of scripture shows Paul attempting to balance the opposing needs in relationships; the need for closeness and the need for separation (Richardson 62).

Vision is essential to the healthy congregational body. Apostle Paul does not specifically deal with a definition of vision. He does present a powerful vision of a healthy congregation in the context of the church as the body of Christ. Paul transitions from the body teaching in 1 Corinthians 12 to describe his vision of the body working together in ministry, expressing the gifts God

gives to the various members (1 Cor. 12:28-30). In Romans Paul writes of the church as the body of Christ, expressing his vision of the diversely gifted members functioning together in ministry (Rom. 12:4-8). The first aspect of Paul's vision for health is for the body to use its various gifts in the common goal of ministry.

The second aspect of Paul's vision for the healthy congregation is found in 1 Corinthians 13, the "love chapter." Paul moves from teaching on the body to ministry then to "the most excellent way" (1 Cor. 12:31), loving relationships within the body. Paul's vision for health includes both ministry and relationships. He describes how relationships within the body should be expressed. In Romans 12, Paul again moves from teaching on the body (vv. 4-5) to ministry as the body (vv. 6-8) to what relationships should look like within the body (vv. 9-11).

The apostle Paul wrote to troubled congregations in Corinth and Crete, giving many avenues to health. One avenue he prescribes is the leader as promoter of congregational health. Paul writes to the unhealthy Corinthian congregation imitate him, their leader, as a way to health (1 Cor. 4:16; 11:1). He instructs Titus to promote the congregation's health by building healthy leadership (Titus 1:5-9). Paul encourages Timothy to be an example of Christian maturity as he leads the congregations appointed to him (1 Tim. 4:12). Paul viewed leadership as a primary promoter of health in the church. Steinke states that leaders can either be the "salvation" or "ruin" of a congregation (Healthy 99).



The final characteristic of a healthy congregation is that it responds to challenges to its health. The fact that Paul wrote to the Corinthian congregation in two recorded epistles gives an example of intervening in the unhealthy reactions of a church. Paul states in 2 Corinthians 2 that he wrote forcefully in the first letter and delayed his visit to them out of a love for them that caused him to respond to the unhealthy reactions of the church (2 Cor. 2:1-4). Paul felt the most loving action to take was to confront the challenges to the health of the Corinthian church. Paul even confronted specific situations as he instructed the Corinthian congregation to expel the unrepentant sinner (1 Cor. 5:1-5) and pleaded with two women in the Philippian church to put aside their differences for Christian unity (Phil. 4:2).

### **Conclusion**

This study views the congregation as a system, an organic whole, with special attention given to relationships. The congregation has been shown to hold a great degree of control over its own health. The characteristics of a healthy church are observable: mature individuals, mature relationships, vision, effective leadership, and response to challenges to health. Since they are observable, a congregation can know where it is in the health process. Also, since a church can know where it is, and that it controls its own health, steps can be taken to move the congregation to a greater experience of health. Finally, the leadership of the church, clergy and lay, are the first promoters or detractors of congregational health. Pastors and congregations can experience a better

future and release the frustration and anxiety that has plagued many of them for so long.

Health for a congregation can become reality because God wills it. God's covenant and presence with his people result in the *shalom* discussed above. God provides healing and wholeness in relationships through the *shalom* he offers. The church as the body of Christ points to God's desire to see his church healthy. This motif calls for healthy functioning within the body. More importantly, it shows the possibility of health for the congregation. Central to God's plan for congregation is health.

## **Chapter 3**

### **Design of the Study**

The hope of a healthy congregation calls pastors and laity out of the unhealthiness which traps them to a God-ordained health described in Chapter 2. Chapter 1 assigned many of the problems churches encounter as the root source of congregational unhealthiness. The question has been asked, "Can congregations become healthier and thus address their many needs?" Chapter 2 reviewed selected literature and responded in the affirmative. Strategies are available to congregations to promote health. Chapter 2 suggested several health-promoting actions: (1) faith, prayer, forgiveness, and repentance; (2) self-differentiation; (3) the church as community; and (4) worship. The leader is the greatest asset in promoting a congregation's health.

The congregational health that these actions seek to promote stems from a family systems view of the congregation. Chapter 2 related the key principles of systems theory and the characteristics of a healthy congregation arising from family systems thinking. They are: (1) leaders as mature individuals, (2) mature relationships, (3) vision, (4) healthy and effective leadership, and (5) the congregation's move toward health in response to challenges to its health.

How does a congregation begin this process? Chapter 2 found that the literature placed value and power in the casting of a vision of congregational health to begin and sustain the process toward health. This study investigated pastors' visions of a healthy congregation and how they initially proposed to cast

the vision of health. As stated previously, the purpose of this study is to cast a vision for healthy congregations in the Church of the Nazarene.

### **Research Questions**

#### **Research Question 1**

How do pastors differentiate between healthy and unhealthy congregations?

This question forms the foundation for the study. The pastors' images or definitions of congregational health informs where their congregations are now in the health process. Their responses also revealed what they were willing to work toward in vision casting. Chapter 4 disclosed the pastors' descriptions of healthy and unhealthy congregations in their own words.

#### **Research Question 2**

What can pastors do within their congregations to promote health?

This question causes pastors to focus on themselves as leaders and is essential to any major change in the congregation. Health will not occur without their leadership and their own health. This also focuses on their perceptions of their ability as change agents in the congregation.

#### **Research Question 3**

What specific initial plans are being developed to cast a vision of the healthy congregation during the time frame of the study?

The methods the pastors developed are of interest here. In what ways can a vision for health be communicated to a congregation? The answer to this question is the methods developed, which was reported in Chapter 4.

#### Research Question 4

What short term impact will casting a vision for a healthy congregation have upon the pastor and the congregation?

This question was answered in the board debriefing session and the last focus group session. Did the vision and methods make a difference? Does the pastor see a change on the horizon as a result of the vision casting?

#### **Subjects**

The study focused on six pastors (either senior or solo) pastoring in a central Appalachian district of the Church of the Nazarene. All are ordained elders in the denomination and pastor varying sizes of congregations. Chapter 1 explained the category sizes.

Each pastor was approached personally either in a face-to-face conversation or via telephone to solicit participation in one individual interview and four focus group sessions. Each of them was told that the purpose of these encounters was to produce a vision for a healthy congregation and to develop initiatives for implementation in each congregation over a six-week period. A debriefing focus group protocol would then be supplied to them for debriefing their church boards on their perspective of the vision and the initiatives used in their churches. The final (fourth) focus group meeting would review their own and their boards' perspectives on the vision and the initiatives developed to cast the vision. They were told the interview would last approximately one hour and that each focus group meeting would last between one and a half to two hours.

Seven pastors were contacted with one declining due to scheduling conflicts.

The names of the pastors have been changed to protect their privacy.

Pastors in Category One (0-99)

Cedric is thirty-nine years old and has pastored a total of thirteen years. He has been at his current church for nine years. Cedric's educational background includes a bachelor of arts in religion from a denominationally affiliated college and several hours at the masters level at Nazarene Theological Seminary. The church he pastors averaged sixty in Sunday school attendance for the 1995-96 church year and the church raised a total of \$41,275 for the year. In the past ten years the church averaged as high as seventy-four in Sunday school with this year's sixty the lowest average in the ten-year span.

Jerry is forty-four years old. He is one of three African-American pastors on the district. The church is predominantly African-American as well. He has pastored this church for eight years and has been in the ministry for a total of eighteen years. His educational background includes technical school, classes for ordination at a Bible college extension campus, and a bachelor's degree in sociology at a state college. The church he pastors averaged sixty in Sunday school, 109 nine in worship, and raised \$110,908 in the year concerned. The Sunday school has averaged as high as sixty-nine over the last ten years, while the worship attendance is at its highest point in ten years.

Gary is thirty-five years old. He is pastoring his first church and has been there for six years. He earned a bachelor's degree in religion from a denominationally affiliated college. He holds a masters of religious education

degree from Nazarene Theological Seminary. The church he pastors averaged sixty-four in Sunday school attendance and raised \$70,441. Ten years ago the church averaged eighty-four in Sunday school and quickly declined into the forties. Since Gary has been at this church the attendance has grown back into the sixties.

#### Pastors in Category Two (100-199)

Chris is thirty-seven years old and has pastored for sixteen years. He has been at his current church for four years. His educational background includes time at two different Bible colleges in the area and a denominationally affiliated college; he has not earned a degree. The church he pastors averaged 106 in Sunday School, 151 in worship, and raised \$172,270. The attendance in both categories has grown moderately since he has been the pastor.

Steve is forty-three years old and has been in the ministry for nineteen years. He has served at his current pastorate for three years. He holds a bachelor's degree and a master of religious education degree from denominationally sponsored schools. His Sunday school averaged 176 and the worship attendance 281. Sunday school attendance has declined from 268 since 1993, while the worship attendance has remained steady. Steve's church raised \$327,453 in the year concerned.

#### Pastor in Category Three (200+)

Mark is fifty-seven years old and has pastored his current church for thirty years. He ministered seven years in two other churches prior to this pastorate. He holds a bachelor of arts degree from a denominationally affiliated college and

a master of arts degree in counseling from a state school. His church's Sunday school attendance is at a ten-year high of 379, and the worship attendance averaged 235, the highest in eight years. His church raised \$298,165 in the 1995-96 church year.

As stated above, these pastors committed to the interview, focus groups, implementation of the initiatives developed to cast a vision for a healthy congregation, and to debriefing their boards on the initiatives.

### **Instrumentation**

The instruments used were interview, focus group protocols and church health survey developed by me. The study sought to guide a group of pastors to discuss their ideas on church health, to develop them into a vision for their congregations, and to begin casting that vision. No tool could be found that approached it from a family systems theory perspective. The protocols are found in Appendix A and the survey is in Appendix D-1. The various protocols were developed around the research questions, characteristics of health discussed in Chapter 2, and the process of formulating a vision for the congregations. Appendix B demonstrates how the protocols seek to answer the four research questions.

A church health survey was added late in the study. The purpose for adding the survey was to relate the pastors' perception of the congregation's health with the vision and methods they developed. No church health survey existed that could reflect the content of our discussions in the interviews and focus groups. One was developed using the five characteristics of



congregational health in Chapter 2 (see pp. 15-29). The survey was a category scale survey calling the subjects to rate the level of their congregations' health in response to a variety of questions.

### Interview Protocol

The interview addressed research question 1; "How do pastors describe healthy congregations?" This was done through asking about their experiences of health and unhealthiness in congregations and about their ideas on what a healthy congregation looks like. Each of the five characteristics of a healthy congregation from Chapter 2 had at least one question covering it in the interview protocol (see Appendix A-1). The interview used only follow-up questions as needed or rephrasing the question when the subject did not appear to understand.

### Focus Group Protocols

The focus group protocols were developed with the goal of guiding the six pastors through a time of sharing with one another their experiences and ideas on congregational health, leading to the formulation of a vision and initiatives to cast that vision in their respective congregations. The focus group's first session overlapped much of the interviews. This allowed the subjects to hear each other's stories. Research question one was the primary focus of this session. Questions pursued the subjects' stories of health and unhealthiness in their congregations. Questions were also asked concerning their ideas on characteristics of a healthy congregation. Research question two received some

attention as the subjects were asked to envision a healthy congregation. This was the beginning of the subjects' affecting their congregation's health.

The second session focused on formulating the subjects' vision for a healthy congregation. Research questions one and two were the primary concerns. Research question three was introduced here and reappeared in the final session to compare the pastors' responses. This session needed to end with each pastor having a strong idea of his vision for his congregation's health.

The third session was a time of stating their visions of a healthy congregation and developing the initiatives to cast that vision in their congregations. The protocol was briefer than the previous ones, since it took some time to develop a set of initiatives for implementation. The third research question was the focus of this session: what specific initial plans are being developed to cast the vision of the healthy congregation?

Since in systems theory health is a process any of the six churches represented could be at different stages in the process of congregational health. Therefore each church would need a different vision for health and different methods to cast that vision. Each pastor formulated his vision for his particular congregation's health and three to five methods for casting that vision. Each pastor received a summary sheet indicating what characteristics of a healthy congregation have been discussed in the focus groups. This sheet is found in Appendix C. The pastors were directed to formulate their visions and methods along the lines of the summary sheet, the health promoting actions described

in Chapter 2 (summarized on page 41) and the five characteristics of a healthy congregation.

The final session of the focus group debriefed the subjects on their boards' responses to initiatives through the board debrief protocol (Appendix A-5), and their own responses to the vision and the initiatives. Research question four focused on the debriefing aspect of the session. Also, the pastors were asked about how this process impacted themselves and the churches (research question four).

#### Board Debriefing Protocol

The board debriefing protocol was presented to the church board by the pastor to receive their feedback on the vision and methods used to cast it. The pastors administered this and brought the resulting notes back to the final focus group session.

#### Church Health Survey

Each pastor received a church health survey (Appendix D-1) to answer indicating his perception of his congregation's health. The survey questions were framed around the five characteristics of church health: leader as mature person, mature relationships, vision for ministry, healthy and effective leadership, and responds to challenges to the congregation's health. This part of the study was added in conjunction with asking each pastor to develop vision and methods for his own church. During the interview and focus group process it became apparent that each church was at a different place in the process of health. So the survey was developed and distributed to the pastors to relate

their view of their congregation's health with the vision and methods they developed.

The survey included three questions in each of the five characteristics listed above. The responses were scored from a +3 to a 0 with +3 indicating the response demonstrating the highest level of health and 0 the lowest (see Appendix D-2 for the survey scoring key). The surveys were then scored to show the level of health for each church in the different categories and as a whole (Appendix D-3). It was a forced choice survey utilizing an ordinal category scale (Fink and Kosecoff 26 and 36).

### **Reliability, Validity, and Pretest**

Yin suggests several tests to apply to determine reliability and validity (32-38). Construct validity relies on multiple sources of evidence (Yin 34). This study used six pastors and two methods (interview and focus group) to arrive at a vision of a healthy congregation. The focus group of pastors and their boards were debriefed, and their responses compared to insure validity of the data. Internal validity was not a concern of this type of study (Yin 35). External validity was tested by the use of six different pastors and churches, comparing their reactions to the process. Reliability was formed in (1) the use of the protocols in Appendix A, (2) the use of the description above of the criteria for choosing the pastors, (3) the descriptions of the pastors, and (4) the development of the protocols. The collection of data also enhanced reliability through the use of tape recordings of the sessions and the keeping of field notes to create a database (Yin 37).

Richardson, Dohrenwend, and Klein report that reliability is tested by examining the consistency of responses throughout the process (130-32). These authors also test reliability by examining the relevance of the questions to the research problem (Ibid. 132). Each question in the interview and focus group protocol was based on one of the four research questions as described in the instrumentation section (see Appendix B).

These protocols were pre-tested using an interdenominational group of pastors, since several Nazarene pastors were not geographically close enough to assemble for this stage of the research. The interview protocol was pre-tested on a Nazarene pastor of a church with twenty-nine in Sunday school attendance and a United Methodist pastor with 150 in Sunday school. The interviews lasted forty-five minutes and fifty-five minutes respectively. Each interview took place in the pastor's office with the pastor seated behind his desk and the interviewer in a chair across the desk. Both interviewees sought to answer the questions in a helpful way, which led to the addition of a explanation at the beginning stating that the interview was to focus on their experiences and thoughts. Also, the Nazarene respondent tended not to tell stories illustrating his experiences, while the Methodist pastor did. The interviewer felt he had to rephrase or redirect a question to the Nazarene pastor on three occasions (questions 6, 7, and 9). Only one question (7) had to be rephrased to the Methodist pastor. Both pastors reported that question was not applicable since they had not encountered any major challenges to health in their opinions. Both were also comfortable with the length of the interview. Asked if the questions

seemed leading to them, they both said no. Asked if the questions let them say what they felt was important, they responded that the questions pushed them into new areas of thinking. Based on the pre-test of the interview, an effective instrument has emerged for this study.

Only the first focus group protocol was pre-tested, due to time concerns (see Appendix A-2). This was pretested with the Nazarene pastor mentioned above, and American Baptist, Church of God (Anderson), and retired Church of God (Anderson) pastors. The focus group session lasted one hour and twenty minutes. The Nazarene pastor who had previously been interviewed supplied more thoughtful and complete answers than in the interview. This suggested that as the process continued subjects were able to share more in response to the questions. After the session they were asked the same debriefing questions as were the interviewees. Their comments affirmed the tested protocol as valuable and relevant. Again, only minor rephrasing of questions was necessary. The interviewer attempted to stay out of the way of the subjects' conversation as much as possible. The board debriefing protocol was not pre-tested since it was based on reactions to yet undeveloped initiatives for casting the vision.

The church health survey was pre-tested on the same two pastors as the interview protocol, the Nazarene and United Methodist pastors. The United Methodist pastors a two-church charge and filled out two surveys, one for each church. All three churches scored in the moderate health range in the perception of their pastors. The pre-testing called for changing question number

nine, adding the words "when necessary" (see Appendix D-1). Question one was changed from "The leaders in your congregation are able to disagree without a break in relationship" to " without a strain in relationship."

Otherwise the pre-test subjects affirmed the readability of the survey. They also stated the survey seemed to be fair in its questions.

### **Data Collection**

Data collection took place as a result of the six individual interviews, the four focus groups, and reports of the pastors from the board debriefing sessions. The sessions were tape-recorded (all participants gave their permission when originally contacted) and notes were taken during the sessions.

The meetings for the interviews took place in the pastor's study, and he chose where to sit. The interviews were scheduled in a two to three day period. The focus group sessions occurred at the church of one of the subjects using a comfortable meeting room with a table and padded chairs. The pastors were given opportunity to negotiate acceptable times and dates for the focus group sessions.

### **Variables**

The independent variable in this study was the vision for congregational health. Contributing sets of variables under the independent variable were the protocols developed, the criteria used for choosing the pastors, and the initiatives formulated to cast the vision. The protocols were closely followed to allow for possible replication of this study.

The dependent variable was the congregational health after the vision casting at the time of the board debriefing and final focus group session. The data collected from interviews and focus group discussions were qualitative in nature, and the variables were described in the context of the subjects' experiences and responses to the protocols.

### **Data Analysis**

The transcribed interviews and focus group sessions were inputted to the Ethnograph software and encoded. This software assisted in finding patterns in the experiences and responses of the six subjects and also aided in detecting recurring themes in their responses. This took place as the data was collected. Patterns and themes were collected into categories using the Ethnograph software as the data addressed the four research questions.



## **Chapter 4**

### **Findings of the Study**

The purpose of this chapter is to describe the process and content of the interviews and focus groups with the subjects addressing the four research questions (see page 3). The process of the study is described first. The research questions are then discussed in light of how the subjects inform them. A discussion of the five characteristics of congregational health developed in Chapter 2 is included under research question one, offering what the subjects had to say concerning these categories. Research question two reveals what the pastors say they can do to impact the health of their congregations. The third research question shows the subject's discussion concerning the short-term impact the vision and methods made in their churches. This section shows how the pastors anticipated the vision impacting their churches from discussions before the implementation. Then their discussion from the last focus group informs how they and their church boards view the short-term impact of the visions. The subjects' visions for their churches' health and the methods they chose are discussed under research question four. The chapter concludes with an attempt to relate the results of the church health survey with the subjects' visions and methods for casting the vision.

### **Process of the Study**

The interviews of the six pastors took place over a three-day period, with one interview on the first day, four on the second, and one on the third. The third day of interviewing was not consecutive with the first two. The pastor,

Cedric, had a scheduling conflict and had to be interviewed later. Each interview took place in the pastor's own study and lasted an average of seventy minutes. During each interview and later in the focus groups, the conversations were tape-recorded and notes taken to document the discussions. In the interviews the pastors seemed relaxed and willing to share their thoughts and experiences as they were questioned. Steve seemed hesitant to share at one point (question four in Appendix A-1) until confidentiality was affirmed. Consistently, question number eight was a problem for the subjects. It asks, "What are the unwritten rules of conduct in your present congregation?" Each subject evidenced significant difficulty answering that question. Initial responses included, "I don't know," and "I've not really processed that through."

Three of the pastors had had recent experiences that impacted their views on congregational health. Mark had just celebrated his thirtieth anniversary with his current church. The church had a weekend-long celebration to mark the occasion. Steve was coming out of a time of conflict in his church. He had followed a pastor who had been there nearly twenty years. During the process of the focus groups, which stretched over a three-month period, a parishioner asked Gary's wife to have an affair. These experiences will be reflected in these pastors' visions and methods.

The focus groups were all conducted at Mark's church in a meeting room equipped with comfortable chairs and a large table, except for group meeting three when the group met at Cedric's home. Every focus group had one person absent for a variety of reasons. In each case, the missing subject was later

taken through the group protocol in a one-on-one situation, except in the last session. Steve missed that meeting, and I asked him over the phone to write down his responses to a couple of questions from the last group protocol and write out the results of his board debriefing meeting. He did this, and it has been entered into the data of this study. The focus group meetings averaged two hours and five minutes.

In the group itself, Mark was the most influential person. At several points members of the group would ask him what he thought on a topic. This could be due to a variety of reasons, including his tenure at the largest church on his denomination's district, his security in expressing his opinions, and his command of respect as a knowledgeable pastor. Cedric and Gary seemed the most reticent to express their views. They pastor the smallest two churches represented in this study. Yet each pastor contributed to the data of this study and was considered valuable to this research.

As the focus group meetings progressed, a major change in the methodology developed (see page 46). The church health survey was developed and added to the study. The third focus group was first conducted with Mark alone, since he was leaving on an extended vacation and would miss the group meeting. He suggested allowing each pastor to develop his own vision for health independent of the others, since each church is at a different level of health. The church health survey rose out of that experience in relating the churches' health to the pastor's vision for health.

I found it difficult to keep the group of pastors focused on the topic of the questions. The conversations often veered off into a variety of directions, with me reminding the subjects of the current question and topic. This proved especially so in the case of the last focus group meeting. The pastors did not want to critique their vision and methods. This meeting may have been better conducted separately as individual interviews to discuss the methods of casting the vision each pastor developed.

### **Research Question One**

How do pastors differentiate between healthy and unhealthy congregations?

This research question by far produced the most data as it formed the theme of the interviews and the first focus group. I coded 155 sections of text that pertained to this question. Research questions two, three, and four had fifty-nine, forty-five, and thirty-six sections of text assigned to them respectively. Due to the large amount of data for research question one, it is divided into three sections: descriptions of congregational health, descriptions of congregational unhealthiness, and a report on how the pastors described the five characteristics of a healthy congregation. In each section the data is further categorized into motifs.

#### Descriptions of Congregational Health

Early in the process, the pastors did not associate health with perfection. In the interview time Mark clearly made this point: "I think we need to make the distinction that a healthy church is not a perfect church. Even a healthy body

has within it germs that can cause illness. But the healthy body can fight off the disease." Here is a systems understanding of congregational health. Health is not a state to enter and then rest, but it is a process of fighting off "germs" that have the potential for causing unhealthiness and possessing the capacity to confront these "germs".

Relational Characteristics of Health. The pastors faced several questions which focused on the relationships in a healthy congregation. Among the questions were, "How do you describe healthy relationships within a congregation?" "If you could describe a healthy congregation, what characteristics would you include?" and "Have you witnessed an instance of relationships impacting the health of the congregation?" Key words in their responses indicated characteristics of a healthy congregation included "love," "transparency," "trust," "commitment," "openness," "joy," "unity," "authenticity," "tolerance," "acceptance" and "forgiveness."

Steve gave an example of the above characteristics in a recent event in his congregation. A person was seeking personal renewal with God and made an apology to a person with whom he had a conflict. Steve reported that the man making the apology had treated him better since that event. Steve hopes the effect of this act of making apology and taking responsibility for one's actions will spread throughout the congregation.

Gary told of a time when his congregation raised money to buy a refrigerator for a lady in the congregation. In another instance in the same church, a member donated material and the church provided the labor to roof

another lady's home. Such examples of love and commitment take congregational health to a practical level.

Jerry revealed what he looks for in gauging the health of relationships in a church: (1) the length of time people stay after services to talk, (2) the availability of several fellowship opportunities outside of worship, and 3) how people regard the mission (vision) of the church in comparison to the relationships; that is, can people overcome their personal differences for the greater good of accomplishing ministry?

These characteristics and the accompanying examples reveal a high view of what the congregation can be, and in some instances actually is, in the eyes of the pastors. Making this a reality in the church is far more difficult than merely listing the characteristics. The pastors mentioned several things people in the congregation must be willing to do to realize healthy relationships. Gary emphasized the need to talk through a problem with someone as God would lead a person to do so. Chris called for a healthiness in relationships that would allow one to "accept people for who they are." Steve saw a need for openness that would allow someone to acknowledge his or her "shortcomings" or brokenness "without the fear of being unchristianized." For this to happen, Steve said, "there has to be a willingness to invest emotional energy into the relationships." Relational health does not just happen in a congregation. It is work and must be intentional.

Relational Health and Conflict. One cannot imagine relationships of any importance without the thought of conflict or disagreement. The ability to

develop and nurture healthy relationships depends on one's success in conflict management. Jerry affirmed that the healthy congregation can "work through adversity" while "maintaining the ministry and focus of the church." Later in the interview he stated, "We cannot be bickering and fighting. We have to come up with another method for resolving conflict if we are going to be healthy."

The pastors focused on one of two ways to deal with relational conflicts. The first was to overlook or accept the differences in a spirit of love. Chris told of a retired pastor in his congregation who holds conservative views on women's dress, jewelry, and even the way they wear their hair. He feels those things are essential to holy living. The majority of that congregation disagrees with him, yet there is a mutual bond of love between them. The second way of dealing with relational conflict was to confront it. Upon arriving at his current pastorate, Gary became aware of gossip spreading through the congregation. He tracked it to its source and confronted the person. One result has been a marked decline of gossip in that congregation.

Congregational health can occur in the midst of conflict if the church has a track record of health. Jerry believes "it is healthy to have some conflict and still minister and not lose focus of our purpose."

Leaders in the Healthy Congregation. The pastors included in their descriptions of healthy congregations the need for leaders to be healthy. The pastors in the study talked about healthy leaders in two ways, according to what leaders are and what leaders do. The subjects agreed that the pastor must be healthy to accentuate the health of the congregation. Gary spoke of the need for

the pastor to be healthy in the context of the regular pastoral review process to decide on the tenure of the pastor, in which he described himself as having "survived" it, and his wife's experience of being "propositioned" by a man in the church. These threats to one's family and employment can test the mettle of the most healthy pastors.

The need for health in church leadership extends beyond the clergy. Steve felt the healthy leader is careful to place his or her life under the authority of the Word of God. Jerry agreed when he stated, "In a healthy congregation, spiritual growth of [the] leaders is one of the primary characteristics." The healthy church must have leaders who are spiritually healthy. Leaders who apply to their lives the spiritual truths they intellectually accept will make a positive difference in the health of the congregation.

The subjects also talked about healthy leaders in the congregation in the context of what they do. The healthy leader will demonstrate and perpetuate congregational health. Steve discussed this in terms of a board member who confessed his responsibility for a conflict in the church and the ensuing pain it caused. The healthy leader will admit when he or she is wrong and then work to bring healing in the church. Gary emphasized the need for strong communication between the leaders, especially church board and pastor. This includes an ability to work through disagreements. The specific issue for Gary was determining the church's direction in vision and ministry. The healthy leader in a congregation can convey his or her strong beliefs to others without going so far as to cause a division in the leadership or congregation. Jerry affirmed that



stance when he said leadership should "diffuse situations before they actually get unbalanced." Healthy lay leaders see problems and then move to address them before they threaten the congregation's health. These qualities express a willingness on the part of leadership to make sacrifices for the congregation, according to Jerry. The leadership is one of the most important aspects of the healthy congregation.

Ministry and the Healthy Congregation. The pastors spoke of a healthy congregation as one that is active in ministry. Its vision must reach beyond itself and look to the people of the community. Health can not be indicated by an exclusively inward focus by the church. Jerry commented that the healthy congregation knows why it exists. He stated that healthy congregation must be able to address the needs in society.

In Mark's thinking relational health and ministry are necessary for each other to exist. He stated that relational health of a congregation "will reveal itself through love, acceptance, forgiveness, trust . . . . But I do not think you will have a healthy congregation fulfilling the true mandate of the Great Commission and the Great Commandment unless you have those factors occurring." To be healthy, the congregation must minister to those outside itself. On the other hand, to be able to minister effectively a church must experience a certain level of congregational health.

Jerry related that an indicator of congregational health is that the needs of the whole person are being met. Obeying the Great Commandment's mandate to love one's neighbor as oneself would go beyond telling the neighbor about

Jesus and the plan of salvation, but it would include addressing his or her other needs as well.

For this ministry to occur, the people of the church will work together under a common vision for ministry. According to Mark, "The basic concept of health is a willingness to be submissive to the plan of God and the vision of leadership -- not submissiveness to a person, but to the vision that is accepted by a congregation." Steve related an example of three women in the congregation who caught a vision to use their church's excellent location as a backdrop for a living nativity scene. They coordinated many groups to work together. Steve said it was a point of ministry to activate the congregation. These ladies continued the project the following Christmas and even more of the church became involved.

Much of the ministry focus of the healthy congregation is evangelism or outreach. Jerry stated, "Evangelism is a sign of a healthy congregation." Steve said the healthy congregation "gives energy to outreach." He and Mark included outreach in their descriptions of the healthy congregation. This theme of reaching out to others as a goal of the healthy congregation permeated the focus group discussions.

Another concept discussed by the pastors under the motif of the healthy congregation in ministry was lay ministry. They affirmed the necessity of the laity to be involved in the functions of the church. Mark felt we too often overlook this aspect to the healthy Christian and that many congregational problems arise out of a concept of ministry that does not use lay people. He

defined the healthy Christian as one who is ministering. This ministry includes those inside and outside the congregation. The lifestyle of the healthy Christian and congregation is ministry. Chris responded to the statement, "Describe the healthy congregation of your dreams" with a description of church where everyone would find a place of affirmation, help, and ministry. The concept of lay ministry includes lay people knowing what their gifts are and using them, according to Mark.

The pastors mentioned three spiritual disciplines of the healthy congregation as it seeks to minister. The first is prayer. Gary said prayer must be the first commitment of the healthy congregation. The second is worship. Gary described the type of worship he envisions for the healthy congregation as "not caught up in legalism and traditions. Sincerely worships and allows others to worship in a way that's authentic to them." The third spiritual discipline is the giving of tithes and offerings.

### Descriptions of Unhealthiness in Congregations

The report on research question one, "How do pastors differentiate between healthy and unhealthy congregations", now turns to their experiences and a discussion of unhealthiness in congregations. This section offers examples of unhealthiness and discusses several characteristics of it.

Examples of Unhealthiness. Chris told of a lady on his church board who possessed great influence in the congregation. After pastoring that church for some time, he found out she literally paid money to people to come to church. One young person asked Chris for the money one Sunday. He was at a loss as

to what she meant. The young person described how she would receive a payment every time she attended. The lady who gave the money fell ill and told a young man that God would heal her if he got saved. When she died seven months later, he fell apart and left the church. This unhealthy behavior sought to coerce a person to do a good thing, becoming a Christian, in a wrong way, bribery and manipulation. This reemphasizes the importance of healthy leadership within the congregation.

Chris saw the unhealthiness of the church lay leadership again in that church when he was in intensive care due to heart problems. The head trustee came into the intensive care room to find out how long he would be there because the church board had met to discuss when his salary would end. The behavior here of insensitivity to the needs of the pastor was extreme in its unhealthiness.

Another example of unhealthiness in a church leader was offered by Mark. He told of a leader who offered money to any member of the church to vote against renewing the pastor's call to that church. The reason behind this was an attempt to maneuver the church out of its intention of building a "family life center" as led by the pastor. Here the leader attempted to sabotage the vision of the church and the pastor's ministry.

The examples demonstrate how devastating unhealthiness can be in a church, especially in the leadership, to the congregation and often to the pastor. The pastors offered many characteristics of unhealthiness in the congregation that could lead to the above examples. Among them were: focusing on outward

behavior and ignoring the attitudes of the heart, gossiping, defending a third party in a conflict, unsubmitiveness to leadership, unresolved relational problems, leaders not growing spiritually, resistance to change, desire to control others' actions, and selfishness. Three other characteristics discussed in greater detail were the lack of vision, failure to respond to unhealthiness, and the impact of unhealthiness on the pastor.

Lack of Vision. Mark paraphrased Proverbs 29:18, "Without a vision the people will perish." He made the point, "If the church does not have a vision, then they would have to be a perishing church or people." Jerry agreed. When asked what he would exclude from his description of a healthy church, he responded, "A lack of focus, no clearly defined direction -- that can't be healthy when a congregation doesn't know where it's going." The pastors were concerned with the lack of unity, direction, ministry, and outreach that accompanies the void of a visionless congregation.

Failure to Respond to Unhealthiness. The pastors expressed a concern that the leadership of their congregations do not respond when they see unhealthiness in the church. Mark stated, "The saddest thing for me being a pastor is that we have very few laymen who will speak the truth in love to other lay persons who are out of line." Cedric saw the fear of losing these people as what is keeping the lay leaders from confronting them. He reported that his people "will be quiet and hope it [conflict or unhealthiness] passes and that everything will be all right." Steve showed exceptional insight into the impact of the lay people's not responding to unhealthiness when he said the lay

people know each other better than does a pastor who may have only eighteen to twenty-four months' tenure at the church. The pastor is often the most ill-suited person to respond to a congregation's or a person's unhealthiness.

The Impact of Unhealthiness on the Pastor. In an unhealthy congregation the pastor is often vulnerable to the pain it harbors. Gary expressed that as he stated, he "survived" his pastoral review which determined whether or not he stayed as a pastor of his church. In that same time frame, a member of the congregation propositioned his wife. Congregational unhealthiness attacked that pastor.

Reflecting on his encounter with the trustee in the intensive care unit, Chris said, "I allowed their unhealthiness to infect me. I allowed that." The church's unhealthiness becomes the pastor's problem not only professionally, but physically and relationally in his family as well.

Cedric told of his first pastorate (after which he left the ministry for a number of years) in which they "expected me to do and be everything," without any type of support. Each of these pastors has given examples, which have already been reported (with the exception of Jerry) of severe congregational unhealthiness that impacted them personally and/or professionally at deep levels.

### Characteristics of Congregational Health

The questions on the protocols for the interviews and first focus group were designed to address research question one. These questions were also developed around the five characteristics of the healthy congregation discussed

in Chapter 2. At this point of reporting how the subjects differentiate between healthy and unhealthy congregations, the study reports how they described these five characteristics: mature leadership, mature relationships, vision, healthy and effective leadership, and response to barriers to congregational health.

Mature Leadership. Chapter 2 discussed the mature leader largely in terms of self-differentiation. The subjects had much to say concerning aspects of self-differentiation. The central issue for the pastors is control: people trying to control others' actions and the proper sense of control over one's attitude and responses. Mark observed that leaders are often tempted to want control over circumstances and other people. But he summarized, "You cannot control the situation; you *can* control yourself." He continued, "I need to control my attitude, my spirit, my response to that set of circumstances." The leadership sets the tone for the way control and power issues are dealt with in the congregation.

A leader who is not up to this challenge can harm the congregation. Steve described the phenomenon: "A lay leader without integrity of the heart in the areas of sanctified attitudes, tithing, cooperative spirit . . . is a crack in the dam that can spill millions of gallons of pain into the congregation." Mature leadership is essential for a congregation to grow toward health.

Mature Relationships. One of the most pervasive barriers to mature relationships, according to the pastors, is triangulation. They did not speak about it in the technical terms but described it on several occasions. Steve called it a "poison" when a lay leader conveys his anger and incorrect

perceptions about a situation in the church to several people yet never confronts the supposed offender. Gary told of a lady who left the church because of what someone else said about her. The lady left without speaking to the offender. A classic description of triangulation came again from Steve: "One of the most common unhealthy responses is when someone tries to defend another person. To try to defend the person wraps you up in the problem."

The process of triangulation can be broken. Steve calls for his people to express their pain, their responsibility for it, and to confess to one another. He wants to allow the congregation to say "I was wrong" or "I am hurting" without "being unchristianized." Transparency and authenticity are words that were used over and over to describe the pastors' dreams for health in their congregations.

Vision. The concept of vision possesses many nuances. During the course of the process, the pastors expressed their ideas on what vision means to the congregation. Steve defined a vision as "what the pastor desires for his church in the future." His focus was on the one anointed leader of God's people discovering and revealing God's vision for the people. Jerry agreed when he stated, "I think it [vision] has to do with direction, actually picking out a destination for where the church is going." Both pastors emphasize the future aspect of vision. Vision deals with where the congregation is going.

Mark connected having a vision with an experience of God. He explained, "Vision is connected with dreaming the dream -- having some sense and awareness of God divinely intervening in the process and helping us to think



and to process that dream into something that is concrete. Then it becomes the vision." Vision rises out of an experience of God and a realization of his plan for the congregation. Chris agreed; "It [vision] is something that comes in a personal encounter with God."

That vision received from God then spreads from the leadership to the rest of the congregation. Cedric stressed this when he said, "The leadership has to have it [vision] for the people to catch the vision." Chris affirmed the point as he stated the "vision is not taught, but caught." All discussion of vision by the pastors stressed the importance of or leaders beginning the vision work and then sharing it with the rest of the congregation.

They also spoke of the importance of having the vision. Steve alluded to his first pastorate that experienced "explosive growth," in his words, when he states, "One factor [for the growth] is that there was a leader with a vision." Mark attributed his thirty-year tenure at his present pastorate to his vision for the church. He stated, "I've always had a greater vision for the church than they have been willing to accomplish. And that has been a part of why . . . it has been easy to stay, because there has always been something greater to do."

Vision can be a driving force that moves the church toward a desirable future. Its importance is emphasized when Mark declared, "I do not see the church or any organization rising any higher than someone's vision." The pastors agreed that vision is a sign of health.

Healthy and Effective Leadership. The leader exerts great influence in the congregation. He or she can move the church toward health or toward

disease and unhealthiness. Steve saw a major problem in the congregation when leaders stopped growing. He illustrated with this comment: "At that point you have a ladder with a leader that is stuck and the people aren't going any higher than their leader." Leadership is the single most important aspect to congregational health. Mark said, "It will certainly never be a healthy congregation unless you have some stability as far as leadership is concerned."

Cedric affirmed the impact of the pastor on a congregation when he told of his current church. The church went from having 100 in attendance to twelve. He felt the primary tension was between the pastor and the congregation. Cedric stated, "The church had an immature pastor, and there was a lot of hurt in the church." He continued by saying that the pastor under whom the decline took place left the church and spread rumors about the nature of the people. As a result, the church had many pastors turn down a call to that congregation. Leadership plays an essential role in the health of the congregation.

Response to Barriers to Congregational Health. A healthy church responds to the things that threaten its health. Every church faces barriers or threats to health. Mark confirmed this statement when he used a term found in Chapter 2. "Every congregation has 'clergy killers' who are determined and deceitful." He added that in his thirty-six years of pastoring, a "clergy killer" in his congregation has not been changed. But there are also people and situations that threaten the health of the congregation that are not the evil "clergy killer."

The subjects presented many ways they have responded to barriers to health. Jerry saw it as the responsibility of the lay leader to confront the person who may be causing a problem as soon as he or she finds out about the potential problem. Gary and Steve both teach their leaders to pray with and for a person who may be a barrier to health. Mark's approach includes creating the general atmosphere of health so when problems do occur, people feel free to express their beliefs, causing the unhealthy person or persons either to seek change or leave. He reminded the pastors that confrontation is not always negative. "We are challenged to speak the truth in love. Truth is confrontational," according to Mark.

Research question one provided the bulk of the material in this study. In response to this question, the pastors described the healthy congregation as one that is healthy in its relationships, deals with conflict, possesses healthy leaders, and ministers to others. They described the unhealthy congregation as one without a vision, that fails to respond to barriers to health, and has a negative impact on the pastor. Also the researcher provided the ways in which the pastors talked about the five characteristics of congregational health as described in Chapter 2.

### **Research Question Two**

#### What can pastors do within their congregations to promote health?

Research question two generated much discussion among the pastors of this study. During the course of the interviews and focus groups they were asked several questions designed to generate conversation on this topic

(Appendix B). They included "Can you tell me a story of an instance in which you impacted an aspect of your congregation's health?" (Appendix A-1) and "How have you impacted your congregation's health?" (Appendix A-3). The focus group generated data under this question also as a result of follow-up questions and application of the data under research question one to their role as pastor. For instance, during focus group session two the subjects were asked, "If God answered your prayers for a healthy congregation, describe what makes the congregation healthy" (Appendix A-3). This question addressed research question one. As discussion ensued, I asked a follow-up question: "How are some of these things possible?" The subjects' responses informed research question two.

The pastors' statements concerning this research question fell into three categories: vision, confronting problems, and modeling health as a leader. The discussion generated two points not thoroughly discussed yet worth mentioning; the first was the need for leaders to grow continually as persons and Christians. The second point was the asset of a long pastoral tenure at a single church. Mark related the typical pastoral tenure to the idea of a family with a father figure rotating in and out of the system every three to four years. This is an almost impossible scenario for a healthy family, so why would one expect a church to be healthy under those conditions? Mark's response, therefore, is to encourage longer tenures for pastors.

## Vision

The theme of vision has been discussed earlier. At this point the pastors affirmed the power and necessity of a vision for the congregation. Cedric stated, "The leadership has to have it [a vision] for people to catch the vision." Mark agreed when he said, "We will not go any further than someone's dreams or visions." The pastor and lay leadership must have a vision of what the congregation can become in order for health to occur.

## Confronting Problems

Confronting problems is the next act the pastor can do to promote health in the congregation. This relates closely to the sections titled "Relational Health and Conflict," "Failure to Respond to Unhealthiness," and "Response to Barriers to Congregational Health." This motif of responding to unhealthiness became an important one in the focus group discussions. Gary led his congregation in setting a "new standard" regarding problems, especially interpersonal tensions. He stated, "It used to be that problems would flourish. The church has adopted the policy of intolerance for nonsense. We've set a standard that [when] those type[s] of people try to come in and cause a problem, through [our] prayer and example tend to feel uncomfortable and leave or come back and submit to the authority of the church." Jerry had been asking his church leadership, "Can we confront each other and tell each other the truth?"

The pastor can set the atmosphere in the congregation in responding to potential problems that could move among the people. The pastors related instances from reminding Sunday school teachers to be on time to finding a

place of useful ministry for a person so he or she can give to others instead of causing problems. The pastors also discussed the idea of watching closely those who become leaders in the congregation. This can be done only by a pastor who knows the congregation very well and exercises influence in that congregation. Steve emphasized this when he said, "You have got to be careful as a pastor to be the gate keeper, [watching those] who do not fulfill the qualifications [of leadership]."

### Modeling Health as a Leader

The pastors with one voice emphasized the importance of the pastor as an example of health. This theme echoed the motif of the mature leader discussed above. The influence of the pastor in the congregation was given voice by Mark when he stated, "I still believe that the shadow of leadership will be reflected in most of our congregations. I'm responsible . . . that I will cast the right shadow."

The pastors discussed several specific concepts to be modeled to demonstrate health. They emphasized practicing what is preached from the pulpit. Another area was to admit when one is wrong and take responsibility for it. Cedric told of returning to his first pastorate to preach a revival. In the course of the services he apologized to the congregation for the mistakes he made while pastoring them. Steve told of revival services in which the music leader was dissatisfied with his preparation for the services. He apologized openly and took responsibility for it.

The pastors believe in the importance of modeling how to deal with confrontation. Gary said when he goes into a confrontation his agenda is "communication for understanding, not chastisement." Steve's church was experiencing widespread conflict early in his tenure, and he told of openly sharing with the congregation what was happening and that the church board was in the process of working through the issues. Another area of modeling health that the pastors mentioned is in the stresses of the family. Mark pointed out that his congregation has witnessed thirty years of his family life, children growing into teens, forming their own families, the birth of a grandson with a partially formed arm, and the stresses of his own marriage. Gary remembered the Sunday he told the congregation his son was diagnosed with autism. He stated, "They have seen me and my family persevere."

The pastors mentioned the motif of being authentic or real before the congregation in order to model health. To be able to do that, Mark advised that "you have a clear understanding of who you are and a clear understanding of your strengths and limitations." This stresses the importance of self-differentiation as discussed above. Mark felt one attitude that has helped him through the years is conveyed in his statement "I have only one boss [God] and [I] know ultimately who that is." This gives the pastor the freedom to be who he or she is and to minister in the way God directs.

The data collected that responds to research question two offers many ways a pastor may impact the health of his or her congregation. According to the data, the subjects insisted the pastor is a visionary leader who will confront

problems when necessary and model health in a variety of ways. The pastors affirmed the role of pastor as essential to congregational health.

### **Research Question Three**

What short-term impact will casting a vision for a healthy congregation have upon the pastor and the congregation?

As stated above, this research question treats the pastors' responses before implementation of their visions and methods and then after the implementation. This shows if they were surprised by what happened in the process of casting a vision for a healthy congregation.

#### Before Implementation

The pastors spoke in positive terms as they looked forward to the casting of their visions for congregational health. Jerry expected a "decrease in frustration level" as the leaders would become motivated toward a common goal. He also anticipated his leaders to become more active in dealing with problem issues. Jerry looked for a rise in motivation and energy level in the congregation. Chris hoped the vision would challenge his people "to rise to a new level." Cedric expected the congregation to experience an infusion of life as a result of the vision. Gary and Jerry counted on greater lay involvement in the church after the implementation of the vision.

#### After Implementation

In the treatment of research question three, each pastor and his church board's responses are referred to separately. This allows the reader to compare



the responses with the actual vision and methods presented under research question four separately as well.

Cedric reported the vision was accepted but the board rejected the methods he developed. This is detailed under research question four. He was anxious to see how a key board member who had been contrary would respond in the board debriefing discussion. Cedric felt this individual was positive about the vision and complimented him on how it was communicated to the church. The overall impact of the vision on Cedric's church was summed up in his saying, "I appreciate the fact that they were starting to feel responsible. That is the first sign I've seen of that."

Cedric's board responded in positive terms to the question "If it [the vision] would be fulfilled, what differences would it make in your congregation?" The board members said the church would grow numerically and spiritually; they would become a closer fellowship; and they would be more willing to reach out to the community. One board member stated the vision caused him/her to reevaluate his/her efforts for the church. Two board members stated they felt more responsible for what happens in the church. Cedric had each board member fill out the board debrief protocol and gave me their responses. Not every pastor did that.

Jerry's vision for his church has been articulated for over a year. He reported surprise to discover that board members who were in agreement and supportive of the vision last year were no longer in tune with it. He concluded that this speaks to the need to communicate the vision to the people continually.

As he began rearticulating the vision, one board member challenged him, asking if this vision was the pastor's vision or the church's vision. Jerry was surprised by this.

Jerry reported the debriefing session with the board via a written summary of the event. In indicating what differences the vision would make in the congregation, he reported the board saying it would result in less burnout for the leaders, more support for the church, a sense of belonging, and spiritual growth. The board members expressed excitement for the vision and the fact that it made them feel important and proud of their church.

Gary said he felt he did not do a good job communicating the vision. Even so, he felt the church board had expressed to him a willingness to take on more responsibility for the church. He said, "They [board members] see themselves as a part of making the church a success." He also felt that the church leaders have a greater sense of teamwork in ministry. He stated, "We're all in this together trying to minister."

Gary had his church board fill out the debriefing protocol and turned in their responses. In response to the question "What differences would the vision make in your congregation?" the board members offered a variety of answers: numerical growth, a greater sense of unity, love demonstrated toward others, a positive feeling of the church moving forward, and more people participating in ministry. Asked "How does this vision make you feel as a church board member?" they stated, "proud," "willing to work to fulfill the vision," "excited,"

"this has been long awaited," "challenged," and "hopeful that God would use the church in a mighty way."

Chris reported a growth in relationships among his people. He said, "People are now beginning to call one another . . . They talk about what they're doing in their daily lives, the church . . . [and] their prayer life." At a personal level he shared that he has "a greater appreciation for my people and a greater love." In the board debriefing session Chris had hoped the board members would have more to say in adding to or adjusting the vision. He wanted their input but was disappointed.

Chris led the discussion with the board debriefing protocol and turned in a summary sheet. As participants discussed the differences the vision would make in their church, several answers were recorded. The board said the church would grow, the Great Commission would be fulfilled to a greater degree, the congregation would live what is preached, there would be unity, and the Holy Spirit would have greater freedom to work in the church. The vision caused the board members to feel an excitement to reach toward the goal of a "New Testament church." One board member expressed appreciation for the pastor leading the church "closer to God." Another board member sensed great blessing as the church sought to serve God. The board affirmed the vision presented by the pastor.

Steve, as reported earlier, missed the final focus group meeting. He was contacted by phone and asked to write out his responses to two questions: (a) How has the experience of vision-casting on the healthy congregation changed

your expectations of the congregation? and (b) What type of resistance did you experience as you began to cast the vision? He was then asked to report on the debriefing protocol.

Steve reported seeing progress. He shared that his church lost seventy people due to a conflict over a variety of issues. As will be revealed under research question four, one of his methods was a service of confession and rededication. Since that service Steve reported hearing of people who were at odds beginning to reconcile. During the service itself, most of the people participated in a time of confession and rededication to the Lord at the end of the service. He expects the healing to take some time but sees hope for the future.

His report of the board debrief again was a written report. He wrote it was not easy because of the depth of feelings involved. Steve did report that a majority of the board felt the service of confession and rededication made a significant impact on them personally. The board was split evenly between much impact and little impact on the service's effect on the congregation.

Mark felt encouraged by the response to the vision. He led the board in evaluating how effectively several of the programs of the church measured up to the vision. He stated, "That is a part of scrutinizing and saying, Does this really carry out our purpose and vision of what we say our ministry is?"

The board members indicated they felt good about the vision. Mark reported that no major adjustments of his church's vision were discussed since his board felt it was solidly and biblically based. The board members reported feeling challenged by the accepted vision, but did call on the pastoral leadership

to continually communicate the vision. This report on the board debriefing session was given orally at the last focus group meeting.

The responses to the visions cast by the pastors were positive. The pastors indicated a desire to move their churches toward health, and the lay people showed they want to see their churches be healthy. None of the pastors or board members reported strain or tension as a result of the vision.

#### **Research Question Four**

What specific initial plans are being developed to cast the vision of the healthy congregation during the time frame of the study?

Research question four focuses the pastors on what they will do to cast their visions of the healthy congregation. This section treats each pastor separately looking at his vision of health for his congregation, the methods he developed to cast the vision, and what feedback he offered on the process of casting the vision. This data results from focus group meeting three, when the vision and methods were developed and the final focus group meeting. One week after the third focus group meeting, a letter reminded each pastor of the necessity of follow-through and confirming that I understood what each pastor wanted to do (Appendix E).

#### **Pastors in Category One**

Cedric envisioned for his church a follow-through on their love for others by developing relationships with the new people visiting the church. The methods he developed to implement that vision were (a) preaching a sermon series titled "The Measure of a Great Church," (b) developing a lay pastor

program with each Sunday school class having a lay pastor, (c) training for lay pastors, and (d) conducting a spiritual gifts seminar to help the people find how they can best reach out to new people.

The church board rejected the lay pastor program when Cedric presented it to them. He said, "I was shot down for the first time in a long time." He replaced it with other methods that reach toward fulfilling the vision. First was a schedule of the follow-up contacts to each visitor. The Sunday afternoon of the visit the pastor will call the new person on the phone. The following Monday a layperson will visit the home with a pie or cookies. Then on Friday or Saturday a layperson will telephone inviting the person back to church on Sunday. In addition to that, Cedric developed a plan of keeping contact with church attenders who have recently missed. Each week the person is gone he or she receives a different type of contact from a lay person in the church for four weeks. He also implemented a lay hospital visitation plan. Two to three laypersons will coordinate with the pastor visits to people in the hospital.

Gary needed guidance in developing his vision. The focus group spent at least one half hour helping him focus his thoughts on what he wanted to see happen. He articulated a vision that calls for the people to grow in discipleship and take greater responsibility for ministry. The methods he developed were (a) developing a mission statement, (b) developing and teaching requirements for spiritual leadership, and (c) becoming a healthier pastor by spending Friday night with the family, taking daily walks with his wife, and holding family devotions.

Gary presented a mission statement to his church board that read, "We need to set a goal for our church to help people develop relationship with God. God's church is a church family loving and supporting each other and is open to all." He also presented the church board with a "Worker's Covenant" (Appendix F) from the Manual: Church of the Nazarene. Gary did this to challenge the board to rise to the requirements of spiritual leadership. As stated earlier, he told of his wife's being propositioned to have an affair. During this time of implementation in becoming a healthier pastor in his relationship with his wife, she was propositioned again. He said, "I'm really thankful I had that on my agenda to be working on it [family relationships], because I feel like God was really preparing me for some of the things I needed to face."

Jerry took this study as an opportunity to recast the church's mission statement for ministry. This was developed about one year ago. The mission statement reads, "We exist for the purpose of winning souls to the Lord. We are here to educate, nurture, and train believers to the point that the lives of families are changed." The methods he chose to use are (a) visit each board member and other key leaders to talk to them about the mission statement and reenlist their support, (b) ask several of these leaders to teach the mission statement to small groups in the church, and (c) preach three sermons on the mission of the local church.

Soon after adopting these initiatives, Jerry called me to adapt the first one. Due to time constraints, instead of meeting with each leader one-on-one, which would have required over fifteen meetings, he decided to begin a

leadership round-table discussion meeting. At these meetings they discussed the mission, shared relational concerns among the church's leadership, and examined the ministries of the church. The first of these meetings fell in the time span of the study. Jerry reported that it went well but found out that several key leaders did not understand the mission and were not aware of it as a driving force in the church.

### Pastors in Category Two

Chris' vision for his church was "to model and lead the congregation in growing relationships where needs are understood and people are able to be transparent before others." He developed three methods to cast this vision: (a) start a relationship-oriented small group focused on married couples, (b) conduct a personality profile with the church board and lead them to understand how the people on the board are different, and (c) preach a sermon series on worship and how it relates to evangelism and loving others. He reported no changes in the methods.

Steve adopted the following as his vision for the church: "to become a confessional people offering forgiveness and working through conflicts in a healthy way." The methods he developed to cast this vision were (a) a service of confession and rededication (Appendix G for order of service), (b) a service of healing led by a layperson from another church who has seen healing in his life and family, and (c) renewal of wedding vows, focusing on forgiveness in the home.



Steve reported that he and a lay person developed a plan of devotions in preparation to the service of confession and rededication. No other changes were reported in his methods. Steve was asked to include some method with his church board to discuss how to deal with conflict and anger. He reported that he took the board through several teaching times on these topics about a year ago and did not feel it would be appropriate to cover these topics again so soon.

### Pastor in Category Three

Mark's vision statement was also one that was previously developed. He took this study as another opportunity to teach it to the church. The vision statement was "upward to our God, inward to ourselves, and outward to our world." The methods Mark agreed to pursue were (a) preaching two to three sermons highlighting the vision, (b) leading the church board in discussing the vision and the church's ministries, (c) conducting a spiritual gifts seminar, and (d) communicating the vision to the church through other communications, primarily the newsletter. Mark did not find it necessary to make any major changes to the methods.

Each pastor except Gary made use of the public worship service to cast the vision to the congregation. Four of the pastors -- Gary, Jerry, Chris, and Mark -- focused at least one method on the church board. Again four of the six - - Cedric, Gary, Chris, and Steve -- did not report any prior mission or vision statements for their churches.

### Church Health Survey

The church health survey (CHS) described in Chapter 3 was developed to enable the pastors to rate the level of their congregation's health. This survey was added to the study for the purpose of discovering any relationship between the pastor's vision and methods for his church and the health of his congregation. A summary of the churches' scores is found in Table One.

Table 1

A Summary of the Church Health Survey Scores

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Name	Leader as a Mature Individual	Mature Relationships	Vision	Healthy & Effective Leadership	Response to Challenges to Health	Total
Chris	9	9	6	6	6	36
Mark	6	6	6	5	5	29
Steve	5	5	5	5	6	26
Jerry	7	3	5	4	4	23
Cedric	5	5	4	3	4	21
Gary	5	2	4	4	5	20

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The pastors' individual score sheets that show the score for each question and which particular questions address each category are found in Appendix D-3. Table Two gives the scale for the preceding scores.

Table 2  
Church Health Survey Scale

Single Category	Level of Health	Total Score
8 - 9	Significant Health	36 - 45
5 - 7	Moderate Health	22 - 35
2 - 4	Moderate Unhealthiness	9 - 21
0 - 1	Significant Unhealthiness	0 - 8

Table Three relates each pastor's score to the level of health as he rated his church.

Table 3  
The Churches' Level of Health

Name	Level of Health (Total Score)
Chris	Significant Health (36)
Mark	Moderate Health (29)
Steve	Moderate Health (26)
Jerry	Moderate Health (23)
Cedric	Moderate Unhealthiness (21)
Gary	Moderate Unhealthiness (20)

Table Four takes the information from the CHS and relates it to the vision the pastors adopted and the methods they chose to use in implementing the

vision. The vision and methods are summarized by a few key words so that the data can be presented in a concise format.

Table 4  
CHS Scores Related to Vision and Methods

Name	Score	Vision	Methods
Chris	36	needs understood and transparent before others	(a) small groups (b) profile of the board (c) preaching on worship
Mark	29	upward to God, inward to ourselves, and outward to our world	(a) preaching on vision (b) discussion of vision with the church board (c) spiritual gifts seminar (d) newsletter
Steve	26	confessional people	(a) service of confession (b) service of healing (c) renewal of wedding vows
Jerry	23	families are changed	(a) round-table discussion with leaders (b) leaders teaching vision (c) preaching
Cedric	21	develop relationships with new people	(a) lay follow-up of visitors (b) lay visitation of absentees (c) lay hospital visitation (d) spiritual gifts seminar (e) sermon series
Gary	20	grow in discipleship and responsibility	(a) mission statement (b) teaching spiritual leadership (c) healthy pastor

I found no relationship between the CHS score and the vision and methods developed by the pastors. The pastors who focused more on relational

health in their vision and methods, Chris and Steve, rated their churches as significantly healthy and moderately healthy respectively. Each pastor used the worship service event as a part of his methods except Gary.

The relationship I saw in the CHS is its relationship to church size. The larger the church, the healthier its pastor scored it. The one exception is Chris, whose church is third in size. He scored it as the most healthy of the group. The churches that scored the lowest averaged around sixty in Sunday school attendance: sixty, sixty-four, and sixty-nine. The other three all averaged over 100, with Mark's church averaging over 200.

Perhaps the relationship between congregational health and the type of vision and methods developed does not exist. The history of the church, attitude of leadership, what types of methods have failed in the past, and the personal skills of the pastor could all serve as intervening variables.

### **Summary**

Chapter 4 attempted to open the door of the meeting room and offer a view of the pastors' experiences and opinions on (a) what a healthy congregation looks like to them, (b) what they can do to impact their congregations' health, (c) what they see as the short-term effect of vision-casting, and (d) what they planned to do to cast their visions. The Church Health Survey did not reveal a relationship between the level of the church's health and the vision its pastor developed. Chapter 5 presents the implications of this research.

## **Chapter 5**

### **Summary and Conclusions**

Jerry pastors a church near several chemical manufacturing plants. Many people in the community are concerned about the danger. He reports that one plant stores the same chemical that caused the Bhopal, India, disaster. Jerry was invited to join a safety assessment committee to speak to the dangers this presents. His associate pastor and a board member work at this chemical plant. They derive their livelihoods from it and the church benefits from their tithes and offerings, but families in the church are concerned about the risks. The board member confronted Jerry and threatened, "If you march against us, I'll organize a march against you."

Considering the serious ethical questions involved in the manufacturing and storing of such dangerous material in a population center, one sees the anxiety this situation creates within a congregation. How can a pastor navigate the congregation towards seeming opposite goals, all the time moving toward a healthy church? This study has attempted to give form to what a healthy congregation looks like in the eyes of pastors. Chapter 4 revealed how six pastors think about a vision for health and what they are willing to do to implement that vision. This chapter summarizes and draws conclusions from that data.

## Conclusions

The study was composed of six subjects selected according to the criteria stated in Chapter 1 (8). The data collected from these subjects and reported in Chapter 4 suggest several conclusions.

1. Pastors think about congregational health in certain categories. The categories described above could be called qualities of relational health, responses to barriers to health, healthy leadership, and effective ministry. The data did not suggest a single, concise vision statement of the healthy congregation. It did point to these categories that give pastors a starting place to think about and formulate a vision for their congregation's health.

The categories listed above affirm the five characteristics of congregational health in Chapter 2. Qualities of relational health inform the two characteristics, mature leader and mature relationships. Category responses to barriers to health confirmed the proposed characteristic responds to barriers to congregational health. The healthy leader category affirmed the characteristic healthy and effective leadership. Effective ministry is a component of the characteristic of vision in Chapter 2. The research of Chapter 4 and this conclusion affirmed the five characteristics of congregational health as presented in Chapter 2.

The category labeled "qualities of relational health" serves to draw *shalom* back into the congregation. Steinke asserts *shalom* provides a "balance among God, human beings, and all created things"(84). *Shalom* calls the congregation to the healthy relationships God wills for his people. He offers

*shalom* through his relationship with his people. This vision of congregational health reflects this *shalom* in relationships.

The purpose of this study as stated in Chapter 1 was to cast a vision for healthy congregations in the Church of the Nazarene. The data reported under research question one offered a lengthy discussion of how pastors described health in a congregation. The healthy congregation possesses qualities such as love, trust, commitment, acceptance, and forgiveness. It is willing to confront problems that threaten its health. The leaders of a healthy congregation are healthy themselves and act in healthy ways. The healthy congregation ministers to its own people and seeks to reach out to the community.

2. The experience of the pastor casting a vision and beginning to pursue it was a positive one for the congregation's leaders and the church board. The church board debriefing reported in Chapter 4 showed the board members as excited, challenged, and hopeful. Even Steve's church, often in conflict and facing a declining membership, felt a positive impact among members of the church board as a result of the vision .

The dependent variable of the study was the perception of congregational health by the pastors (8). Research question three provides data that addressed the dependent variable. Each pastor reported in positive terms his church's responses to his vision. Even Steve expressed hope for the future.

The caution here is the brief nature of the study. The intent of the study was to look at the six-week period of vision casting. This time frame in the life of the congregation is not long enough to evaluate a lasting course of change. The



initial positive effect of vision casting for a healthier congregation could soon be lost if the leadership does not follow through over the long term.

3. The church board and the Sunday morning worship service were the two key arenas for vision-casting for the healthy congregation. Four of the six pastors focused their vision-casting initiatives on the church board. The methods included teaching spiritual qualifications, teaching the vision, discussing the vision in the context of the church, and profiling the church board. Five of the six pastors used either a sermon series or a worship service event, such as a service of confession, to cast their vision for the healthy congregation.

The importance of the church board in vision-casting for the healthy congregation exists because it targets the leadership of the congregation. The pastors expressed the belief that the leadership is vital to the healthy congregation. This can take place in two ways. Gary approached his board to call them to a healthier way of leading. Jerry used his board to disseminate the vision to the congregation. These illustrate two areas where the church board is necessary for the vision-casting of the healthy congregation. First, leadership must be healthy. Second, leadership influences the congregation's attitude toward the vision.

4. The health of the congregation impacts the pastor's health. In Chapter 4 the pastors reported in several ways their congregations' impacted their lives. A relatively young pastor found himself in the intensive care unit with heart problems. Another pastor learned his wife was asked to have an affair.

One more found out that a lay person was trying to buy votes against him in the congregation's pastoral recall vote.

These experiences revealed the congregation's impact on the pastor in his or her physical health, family life, and professional career. This does not take into account the ways these experiences could have introduced anger, fear, desire for revenge, and self-doubt into the pastors' lives impacting their spiritual and emotional lives as well. The congregation's health impacts the pastor's health at every level of existence.

The pastor does not experience *shalom* without the help and health of the congregation. Perhaps the most devastating effect of a congregation's unhealthiness as it impacts the pastor is that it destroys *shalom* in his or her life. Then how can the pastor offer *shalom* to God's people (Num. 6:26) if he or she is not experiencing it?

5. Responses to barriers to congregational health are not the pastor's responsibility alone. Often the pastor takes on that responsibility, as Gary did in confronting gossip in his congregation. The pastors emphasized the need for the lay leadership to provide responses to congregational health barriers. This can be done by the lay person being accountable for his or her role in the unhealthiness. It is also achieved when a lay leader confronts a person or situation threatening the health of the church.

*Shalom* emphasizes the connectedness of the congregation as the people of God. The relational connection *shalom* expresses intensifies the call for the congregation to act as a whole when barriers to health develop. The

congregation is not just a group of individuals pursuing their own goals. Rather it is the body of Christ (1 Cor. 12:12-30) seeking together the goal of *shalom*.

### **Possible Contributions to Research Methodology**

This study used a group of pastors to begin the vision process that is to be completed in their churches. It purposefully used pastors from different size churches: three pastors in congregations under 100, two pastors in congregations 100 to 199, and one pastor in a congregation over 200.

The use of pastor groups to begin the vision process could be significant. The interaction and new modes of thought introduced to a pastor by a collegial group could challenge him or her to reshape his or her vision. This could also help the pastor who is not familiar with recent information on church life to gain that exposure via a colleague's reading or experience.

The collegial group could also find importance in its role as a support group. When a pastor begins the implementation of the vision in the congregation, resistance is possible. The pastors could help the one experiencing resistance. The collegial group could help this pastor view the resistance in its proper context and to adapt the vision and/or methods appropriately.

### **Relation of Results to Previously Published Studies**

Although the scope of this study was limited in size and duration, I hope it encourages further research in a systems view of congregational health. The issues raised in this study topic suggest areas in which the literature needs to be revised.

The pastors closely linked lay ministry with congregational health. As stated earlier, Mark defined the healthy Christian as one who is ministering (65). A view of congregational health must take into account the necessity of lay ministry to the church's health.

The categories of congregational health culled from the subjects' discussions could prove to be useful beginning points for research on congregational health. They are qualities of relational health, responses to barriers to health, healthy leadership, and effective ministry. These could widen the arena of discussion and research on congregational health.

These categories offer areas for pastors and their churches to focus their efforts in the pursuit of health. As further research fleshes out the content of these categories, churches can find direction in their pursuit of congregational health. Case studies could be developed for use by pastor and church to illustrate healthy and unhealthy scenarios in each category.

Congregational health viewed from a systems perspective is a rapidly growing area of research. During the course of conducting this study, I became aware of two books on this topic (Steinke, Healthy; Richardson) along with an issue of Leadership Journal devoted to church health. This study's relationship to this and other literature will now be reviewed.

This study reflects Steinke's assessment of vision in the life of the congregation when he states it is a "health promoter" and necessary (Healthy 25, 26). The conclusion found vision-casting to be a positive experience in the eyes of the pastor, and church boards support Steinke's view. He believes

vision promotes health as it energizes the congregation with hope for the future (Ibid. 105). As reported in Chapter 4, some church board members expressed their feelings of excitement and challenge for the future.

The value of vision for a healthy congregation is that it offers a goal to move toward (Waters 56). Fritz declares that it actually creates a new reality for the organization (175). One board member felt so positively about the vision the pastor was presenting that he thanked him for leading the church "closer to God." *Shalom* reflects the vision as God's goal for his people. He calls his people to receive the blessing of *shalom* from himself.

Hersey states, "Leaders must be vision creators," and visioning is "fundamental to the process of leading organizations" (92). Warren asserts, "The first task of leadership is to define the mission [vision]" (42). The church boards realized this was a part of what they should be doing.

The qualities of relational health as a category of the vision for the healthy congregation is largely indebted to Goleman's emphasis of five emotional intelligences of the mature person: "knowing one's emotions," "managing emotions," "motivating oneself," "recognizing emotions in others," and "handling relationships" (43). A further description of a quality of healthy relationships comes from Cloud and Townsend. They state, "Boundaries [self-differentiation] are the 'litmus test' for the quality of our relationships" (108). A key to this kind of relationship is what Steinke calls a "higher medicine"-- forgiveness (Healthy 82). The pastors believed trust was an important facet of healthy relationships. Covey lists three behaviors that build trust: "listen to

understand, speak to be understood," and start from a common point of agreement. (110).

The literature has much to say about the need for healthy leadership. This forms one of the categories of the vision for health. Steinke states that troubled congregations "are in more danger from their immature leaders than from the contentious issues" (Works 108). Richardson emphasizes the importance of healthy leadership. He states, "The level of differentiation of the leaders in the church is the crucial variable in how well that particular church will run its communal life, deal with the inevitable challenges and crises that come to it, and accomplish its mission" (177). Chapter 4 emphasized this need for leaders who are healthy and act in healthy ways. The pastors affirmed the importance of healthy leaders when Mark stated, "I still believe that the shadow of leadership will be reflected in most of our congregations."

Warren offers content to what a healthy leader can be when he describes three indicators of health in pastors that could be applied to all church leaders. The healthy leader (1) practices authenticity, which is an awareness of one's weaknesses and publicly admitting them, (2) has integrity, defined as "congruence between what you say is important in your life and what you actually do," and (3) is always learning (Rowell 26). The healthy leader is able to adjust his or her behavior according to the readiness level of the other person to contract for a leadership style. The leader, clergy or lay, then uses positive reinforcement and constructive discipline to guide the person's behavior (Hersey 328).

The biblical foundations of this study, *shalom* and the church as the body of Christ (34ff.), emphasize the interconnectedness of the congregation. This stresses the importance of a healthy leadership for the health of the congregation. The leaders' influence in the congregation is pervasive. The health of lay and clergy leadership filters through the congregation, to the point of touching every component of the congregational system.

This study confirmed the import of a Fuller Institute study cited by London. It states that 80 percent of pastors "believed that pastoral ministry affected their families negatively" (23). Though the pastors did not reflect the overwhelmingly negative impact of pastoring on their lives, they did affirm its impact on their health. Several of the stories presented in Chapter 4 illustrated Friedman's assertion that the usual target of unhealthy people in the church is the pastor (30). Shelley sees as a result of this a severely depleted pastor, as Chapter 4 showed in Chris and Gary's experiences, or continual turnover in the pastoral office (41). The unhealthy experiences Chris reported occurred in a previous pastorate. He left that church after three years. Gary revealed he had asked the district superintendent's opinion on moving from his current pastorate. None of the other pastors discussed considering a change in pastorates.

Responses to barriers to congregational health formed a category of the vision for the healthy congregation. This chapter concluded that lay leadership should be included in the response to barriers. Steinke emphasizes the congregation's response to unhealthiness instead of the pastor alone responding. He states, "A healthy congregation is one that actively and

responsibly addresses or heals its disturbances" (Goetz 47). He does relate the leadership, specifically the pastor, to the body's immune system in its role of dealing with unhealthiness before it destroys the congregation (Healthy 99). The reader must remember that "health is ten percent what happens and ninety percent how we respond" (Ibid. 17).

The conclusions and related literature find expression in an experience that took place during the writing of this study. A church member who had not been attending for some time called me. She was angry that her daughter was not allowed to take a friend on a trip the teenage Sunday school class was taking to a concert. During my explanation as to why this could not happen, she exploded in emotion and accused me of being an awful pastor. A friend's (also a member who had not attended in some time) mother had cancer and I had not been to see her. From that point she began to inform me of many ways I had hurt her and her family.

I was angry, hurt, and not sure how to proceed. I decided to trust the church board with this situation. Secrecy was not going to be my strategy (Steinke, Works 89). Even though she was correct in the fact that I had not visited her friend's mother, her emotional response was inappropriate. I let the board know the situation and that the main reason for her anger was that I did not make a pastoral visit to the sick mother. This gave the church board an unexpected opportunity to affirm my pastoral ministry to them and the church. Instead of carrying the anxiety in secret, I received encouragement by being transparent.



The church board took another step. They took the initiative to say that this was not my problem alone. If she continued to express her anger in inappropriate ways, they would deal with her. I was allowed by the board to step out of the emotional triangle, between (a) the woman and her anger, (b) her friend's sick mother, and (c) me. The anxiety would not be mine to carry.

The board expressed their vision of a healthy congregation that day. They wanted to be able to express hurt appropriately, respond to someone who was threatening the peace, and protect the health of the pastor. This encompasses three of the four categories the pastors used to discuss congregational health described earlier: qualities of relational health (the board recognized relational unhealthiness), responses to barriers to health (they would not ignore the problem), and healthy leadership (they actively sought to ensure the pastor's health as well as reinforce the pastor's experience of *shalom*).

This story and the conclusions in Chapter 4 helped me realize that I do not need to be a victim of the church's unhealthiness. I always have the power of response. In the above story the board received my response, openness, and honesty, and supported me. Friedman and Hersey offer hope to me and other pastors who see ourselves as victims when the authors emphasize the ability of leaders to create change (Friedman 221; Hersey 7, 94). Instead of allowing the unhealthiness of a congregation to destroy me, I play a key role in preparing the church for the health it needs. As noted above, even the pastors who experienced the worst of congregational unhealthiness still hold high hopes for

what the church can become. This also relates to the power of a vision, discussed previously.

### **Limitations of the Study**

This study was comprised of a group of pastors from one district in the Church of the Nazarene. With only six pastors, the vision categories found earlier in the chapter may not be accurately generalized to the denomination. The study's intent was to describe how these pastors talked about their visions for their congregations' health and to find categories that might apply elsewhere.

As stated in the conclusions, the study did not produce a single vision statement for the healthy congregation. Through the course of an interview and a focus group session relating the pastors experiences of and views on the healthy congregation, much data was collected. This was read and studied to generate the categories of vision for the healthy congregation related in the conclusions sections.

I would like to have conducted the final focus group as a set of interviews conducted individually with the pastors. This would most likely produce better data on the third research question. That approach would allow each pastor more time to express the impact of his vision on the congregation. I would have been able to probe more deeply into what I felt were the results of the process both personally and congregationally.

Another limitation was the pastors' reporting of the board debriefing session. I now see the value of asking each board member to fill out the debriefing protocol to be returned to me. This would help lead the board to

discuss their views on the vision and methods. The pastor could report on his or her analysis of their discussion as well as hand in the debriefing protocols filled out by the board members.

The major limitation to this study is the time frame in which it operated. Six weeks is too short a time period to see significant change in a congregation. I realize that only short-term and preliminary impact has been reported.

### **Unexpected Conclusions**

I was surprised at the positive nature of the board debriefing reports. Steve reported tense feelings at this meeting, and Cedric told of the board rejecting one of his vision-casting methods. But even these pastors reflected a positive board response to the vision and methods.

The pastors included the motif of lay ministry to the concept of congregational health. This agrees with Warren when he states, "The percentage of members being mobilized for ministry and missions is a more reliable indicator of health than how many people attended services" (Rowell 24).

I noticed how Mark influenced the others and received deference in relation to his views. He did not hinder any discussions, and it is my opinion that he did not seek that type of influence. But the other pastors often asked his opinion on several issues. This could be the result of a variety of issues such as his tenure at his church (thirty years), pastoring the largest church on the district, or confidence in his expertise. When forming a collegial group this issue of influence must be considered. A pastor who exerts this type of influence could

easily steer the group from its goals to his or her own goals. This could be addressed by forming the collegial group with pastors of similar sized congregations and experience.

Two pastors who experienced the worst of congregational health expressed their responsibility to control their attitudes. They showed no bitterness at all in the focus groups. Chris, reflecting on his experience in the intensive care unit, said, "I allowed their unhealthiness to infect me." Mark, who experienced a campaign against his pastorate and the church's adoption of a plan to build a "family life center," maintained, "I need to control my attitude, my spirit, my response to that set of circumstances."

An implied conclusion of this study was that a focus on congregational health benefits the pastor. The method of the collegial group provided a positive experience for the pastors involved. As the congregation moves toward health and exhibits a healthier atmosphere the pastor gains as well. He or she gains a better atmosphere in which to pastor, a congregation focusing on ministry, a congregational willingness to respond to problems, a willingness to develop lay leadership, and lay people involved in ministry.

### **Practical Applications and Speculation for Further Studies**

Another study to replicate this one could be conducted in another district of the Church of the Nazarene to find if the content or categories of the vision would be similar. Also, a correlational study in the same geographical area but with a different denomination would be useful.

A study could be conducted in a single congregation with the official leadership to cast and implement a vision for the health of that church. The implementation could be tracked over a six-month to one-year time frame. Also, the entire congregation could participate in a survey on its perceptions of its health before and after the implementation.

As suggested in the discussion of the Church Health Survey in Chapter 4, a study could be conducted to look for a relationship between church size and perceptions of church health.

The Church of the Nazarene could make practical application of this study. The denomination already has in place a requirement for each newly elected pastor to develop a written statement of goals and expectations with the church board and to review and renew these once every two years in the context of a self-study with the board (Manual 75). This research project can be used to inform that process already mandated by the denomination.

Before a pastor begins to develop a statement of goals and expectations with the church board or conduct the self-study, he or she should join a small group of clergy colleagues. This group should gather for the purpose of developing a vision of health for each one's congregation and to affirm one another in that process. The result of this group would be that each pastor develop a vision of health for his or her congregation and methods to cast that vision. The ongoing role of the vision-group would be to support each other during the process of casting and implementing the vision in the various congregations.

A small group manual could be designed to guide the pastors through the process, including a summary of the literature on systems theory; a presentation of the categories of a vision for the healthy congregation presented earlier; then a series of session plans inciting story-telling, sharing of ideas, and reflection as the group helped one another develop methods to cast that vision.

The pastors then implement the methods in the local church, while the group continues to meet for support and to modify the vision. Chapter 4 suggested the use of a sermon series to present the vision of health to the congregation. The pastor has the opportunity to operate in one of the prime leadership functions: vision-casting. This suggestion affirms Warren's statement, "The first task of leadership is to define the mission [vision]" (42). The congregation receives the privilege of viewing the pastor as a leader in the congregation. Hersey states, "Leaders must be vision creators" (92).

Soon after the sermon series, Chapter 4 also suggested two activities with the church board. First, in some way, cast the vision before the church board. The pastor would do well to remember that members of the church board are leaders as well and should be allowed to participate in the visioning function of leadership. Second, Chapter 4 presented an extremely positive response to the pastor listening to the board members' reactions to the vision. The pastor should debrief the board regarding their thoughts and perceptions of the vision for health.

Church leaders could use Peck's four stages to community: pseudo community, chaos, emptiness, and community (Drum 87-103, Chapter 2, 30).

The pastor whose board has not moved through these stages should understand that part of vision-casting for the healthy congregation is creating a healthy atmosphere in the church board, moving toward community.

A church board moving into the chaos stage would experience much reactivity in the vision process. Reactivity and resistance can be lessened by the pastor who guarantees a respectful hearing to the board, moves forward into the vision at a pace they can tolerate, and allows them to participate in the casting of a vision for the health of the congregation.

The pastor who experiences serious reactivity or anxiety in this process has the benefit of the collegial group's support and guidance. They can help him or her modify the vision in useful ways to gain acceptance by the church board. They could also encourage him or her to stand firm in certain aspects of the vision that should not be changed. Another function of the clergy group would be to design new methods of casting the vision. Cedric found that it was not his vision that was rejected, just the methods he chose. After consulting with me, he adjusted the methods and the board affirmed the results (Chapter 4).

Shawchuck calls for the leader in an unhealthy organization to be a "non-anxious presence" (Managing 309). This is a self-differentiated person who does not receive another's anxiety. The collegial group of clergy could play an active role in assisting the pastor to be this non-anxious presence.

The district superintendent should be an asset in the congregation's movement toward health. The district superintendent's many responsibilities impact the local church and the pastor (Manual 105-107). He or she supervises

the churches on the district. An annual visit to each church is required (with reference to spiritual, financial, and pastoral matters). The church board consults with the district superintendent on potential pastors to fill the pulpit and he or she has veto authority on each nomination. The district superintendent conducts the regular pastoral review and any special pastoral review requested by the church board. He or she may appoint the pastor to a new church, a small church, or one receiving financial assistance from the district. An unofficial role of the superintendent is the leadership of the annual ministers and spouses retreat.

If the district superintendent chose to focus his or her ministry on helping the churches move toward health this would be an asset in the endeavor of the local churches. He or she could begin by encouraging collegial groups of clergy to gather for the purpose described above. Church boards and pastors would be held accountable for conducting the self-study and reporting on the vision and methods developed by pastor and board. During the annual visit the district superintendent could challenge the congregation and pastor to consider avenues effective in leading the church to health. The regular pastoral review (once every four years) offers opportunity for the district superintendent to help the church board and pastor in their pursuit of congregational health. The annual retreat is an excellent format to encourage and challenge the pastors to pursue congregational health in the context of collegial groups.

The district superintendent's focusing on congregational health as described would be giving the pastors permission to meet in collegial groups and



to plan for health in their churches. This course of action would offer help to the pastors as it allows them to expect healthy responses from their congregations and from lay leadership. As the district superintendent leads the churches toward health, the unhealthy churches and pastors can be offered help and perhaps outside intervention. These actions would create an atmosphere of health on the district level that this study proposes for the congregation.

The denomination would be challenged to train district superintendents in congregational health issues, perhaps even leading them into collegial groups to cast a vision of health for the district. The Church of the Nazarene would need to do further research in congregational health as described above. Also the denomination would need to research congregational health in other cultures. A healthy congregation in the United States may look very different from one in Thailand. An organization will measure what it deems important. The denomination would need to develop ways to measure or examine congregational health, so health as a priority would need some form of expression to the denominational leadership.

Considering the experiences shared in this study, the pursuit of congregational health moves up on the priority list. Steve expressed pain in a time of undisclosed conflict; Gary found his family attacked by unhealthiness; Chris lay in an intensive care bed wondering how serious the heart attack was as a board member ask him when his salary should be terminated; and Mark stood as a target of a vote-buying scam. Yet these same pastors hold high hopes and aspirations for what their churches can become.

The journey to health as a congregation is unending, but it does have a beginning -- a vision of what can be: a congregation whose people live in love, forgiveness, trust, and acceptance of others. This congregation will not accept unhealthiness and works to eliminate the threats to its health. This congregation nurtures its people to maturity and health. This congregation's leaders are examples of the best in Christian character and not merely office holders. This congregation reaches out with ministries to others, and its people are actively touching the lives of those around them in the name of Jesus.

This dissertation attempts to stir that vision of health in the participating pastors and offer the vision as a gift to the church. I believe this study achieved this goal.

**Appendix A-1**  
**Interview Protocol**

Interview Date: \_\_\_\_\_

Name: \_\_\_\_\_ Place: \_\_\_\_\_

May I have permission to record this interview on audiotape?

Thank you for your time and help today. I will be interviewing you on your experiences and perceptions on congregational health. I want to know what you think and have experienced.

My study of congregational health shows it includes the following:

- (1) leaders who are mature individuals,
- (2) mature relationships within the congregation,
- (3) vision for the future,
- (4) response to challenges to health, and
- (5) healthy and effective leadership.

1. Will you tell me about a major occurrence in one of your churches that has greatly impacted your thinking on congregational healthiness?
2. What experiences have you had with a congregation's unhealth?
3. What are some major characteristics of congregational health?
4. What are some of the ways in which you think your congregation exhibits health? Unhealthiness?
5. Can you tell me a story of an instance where you impacted an aspect of your congregation's health?
6. How do you describe healthy relationships within a congregation?
7. How has your present church responded to individuals or small groups who have challenged the health of the congregation?
8. What are the unwritten rules of conduct in your present congregation?
9. Describe the healthy congregation of your dreams.
10. What biblical stories or theological themes seem relevant to what is discussed today?

## **Appendix A-2**

### **Focus Group Protocol: Session 1**

**Theme:** Story -- sharing and discussion of congregational health

Permission to record session on audiotape

My study of congregational health shows it includes the following:

- (1) leaders who are mature individuals,
- (2) mature relationships within the congregation,
- (3) vision for the future,
- (4) response to challenges to health, and
- (5) healthy and effective leadership.

1. Can you identify and share an experience that defines congregational health for you?
2. How has your congregation's health and or unhealthiness impacted you?
3. What difference has your congregation's relative health or unhealthiness made in the laypeople?
4. What are some recent "unbalancing" events in your congregation, and how did you see people deal with the experience?
5. If you could describe a healthy congregation, what characteristics would you include?
6. What would you exclude from your healthy church description?
7. What indicates of a healthy congregation?
8. Can a congregation be healthy or become healthy?
9. Is it important for a congregation to be healthy?  
Why or why not?
10. What Biblical stories or theological themes relate to what is discussed today?

### **Appendix A-3**

#### **Focus Group Protocol: Session 2**

**Theme:** Vision for a healthy congregation and its potential impact

1. What is "vision"?
2. What impact does a vision have on a congregation?
3. What biblical stories or theological themes speak to a vision for a healthy congregation?
4. If God answered your prayers and desires for a healthy congregation, describe what makes the congregation healthy?
5. How is this possible?
6. Can you tell me an episode of how a lay leader's maturity or immaturity affected the congregation's health?
7. Have you witnessed an instance of relationships impacting the health of the congregation?
8. How have you impacted your congregation's health in the past?
9. How do members of your congregation attempt to achieve "peace& unity" in the church, in the midst of significant differences? (Richardson 65)
10. How would the casting of this vision for a healthy congregation change you?

## **Appendix A-4**

### **Focus Group Protocol: Session 3**

**Theme:** Articulate vision and formulate initiatives to cast it within the congregation

1. Based on our previous discussions and your further thinking what is your vision for a healthy congregation? What would it look like?
2. What three to five methods could you use to cast this vision to your congregation?
3. Taking each method separately, how could you use it to cast the vision?
4. Let's plan how to use these methods to cast this particular vision.
5. What are you willing to do in six weeks to cast the vision?

## **Appendix A-5**

### **Board Debriefing Protocol**

1. In your opinion what vision of the healthy congregation has the pastor been communicating?
2. If it would be fulfilled, what differences would it make in your congregation?
3. How does this vision make you feel as a church board member?
4. How would you adjust the vision?
5. On a scale of one to ten, with ten being the most effective, how effective was each of the methods used in communicating the vision?

## **Appendix A-6**

### **Focus Group Protocol: Session 4**

#### **Theme: Debriefing and future**

1. Once you started sharing the vision what changes did you want to make in the vision itself?

In the methods we chose?

2. How do you feel the church received the vision?
3. Which methods of vision-casting seemed most effective to you and why?
4. What type of resistance did you experience as you began to cast the vision?
5. How has the experience of vision-casting on the healthy congregation changed your expectations of the congregation?
6. Review church board debriefing schedules.
7. How did this vision-casting process make you feel in relationship to the congregation?



## Appendix B

### Relationship of Protocol Questions to Research Questions

A-1: all of the questions in A-1 answer RQ#1 except interview questions #5 and #7 which relate to RQ#2.

#### A-2 (focus group #1)

Focus Group Question #	Research Question #
1	1
2	3
3	3
4	1
5	1
6	1
7	1
8	1 & 2
9	2
10	1

#### A-3 (focus group #2)

Focus Group Question #	Research Question #
1	2 & 3
2	3
3	3
4	1
5	1 & 4
6	2
7	2
8	2
9	1
10	3

**Appendix B (cont'd.)****A-4 (focus group #3)**

Focus Group Question #	Research Question #
1	1
2	4
3	4
4	4
5	2 & 4

**A-5 (board debriefing)**

Board Question #	Research Question #
1	1
2	3
3	3
4	1
5	4

**A-6 (focus group #4)**

Focus Group Question #	Research Question #
1	1 & 4
2	3
3	3 & 4
4	2 & 4
5	3
6	see A-5
7	3

The number of times the research question was addressed in the protocols:  
 RQ #1 - 22, RQ #2 - 10, RQ #3 - 11, and RQ #4 - 8.

## **Appendix C**

### **Statements on What is a Healthy Congregation**

1. Needs to be faith and works -- we have to do more than talk about it
2. Carry out your purpose or mission statement that is Biblically grounded
3. Be authentic -- real
4. Adopt what the Bible says
5. Try to get the congregation to see the real task
6. Important that the leadership models what it wants
7. Good communication
8. An atmosphere of trust
9. Laypeople who will speak the truth in love to another who is out of line
10. A sense of vision
11. Maturity -- ex. follow-through on planning
12. Laypeople assuming the necessary leadership
13. Accepting others who are different from yourself
14. Love, acceptance and forgiveness
15. Accepting of new lay leadership
16. Truth, righteousness
17. Healthy pastor
18. Trust
19. Ability to confront a person who is attacking the congregation's health
20. God's Word setting the parameters for behavior

My research also shows certain general actions which can promote health. They are, the "higher medicines of faith, prayer, forgiveness, and repentance," setting interpersonal boundaries, developing community within the church, and worship.

## Appendix D-1

Church Health Survey

Circle the one response that most fits your church at this time.

**definitely agree = 1    agree = 2    disagree = 3    definitely disagree = 4**

1. The leaders in your congregation are able to disagree without a strain in relationship.        **1 2 3 4**
2. People in your congregation form coalitions around certain issues.    **1 2 3 4**
3. The people of your congregation have a sense of where they are headed as a congregation.    **1 2 3 4**
4. The leaders in your congregation feel they must agree with each other in order to be friends.    **1 2 3 4**
5. The leaders have demonstrated a willingness to change their ideas on ministry.        **1 2 3 4**
6. The congregation is not accepting of a person who repeatedly challenges the church's leadership.    **1 2 3 4**
7. The congregation seems to focus on the past accomplishments of the church.        **1 2 3 4**
8. Your congregation is tolerant of diverse opinions on important issues.        **1 2 3 4**
9. The church leadership has confronted a person or small group who has challenged the health of the congregation when necessary.    **1 2 3 4**
10. Your church has a clearly articulated vision for ministry.    **1 2 3 4**

**Appendix D-1 (cont'd.)**

11. The leaders in your congregation are committed to their methods of ministry.  
**1 2 3 4**
12. The leadership in your congregation are able to express their beliefs without  
being offensive to those who disagree. **1 2 3 4**
13. The leaders in your congregation initiate change in the church. **1 2 3 4**
14. Your church has a person or small group challenging the health of your  
congregation over a period of years. **1 2 3 4**
15. The people in your congregation feel the freedom to express their own point  
of view. **1 2 3 4**

## Appendix D-2

### Church Health Survey Key

#### Leader as Mature Individual (self-differentiation)

Question	Answer Value	Answer Value	Answer Value	Answer Value
1	1 = +3	2 = +2	3 = +1	4 = 0
4	1 = 0	2 = +1	3 = +2	4 = +3
12	1 = +3	2 = +2	3 = +1	4 = 0

#### Mature Relationships in the Congregation (handling disagreement)

Question	Answer Value	Answer Value	Answer Value	Answer Value
2	1 = 0	2 = +1	3 = +2	4 = +3
8	1 = +3	2 = +2	3 = +1	4 = 0
15	1 = +3	2 = +2	3 = +1	4 = 0

#### Vision for Ministry (people know the vision)

Question	Answer Value	Answer Value	Answer Value	Answer Value
3	1 = +3	2 = +2	3 = +1	4 = 0
7	1 = 0	2 = +1	3 = +2	4 = +3
10	1 = +3	2 = +2	3 = +1	4 = 0

#### Healthy and Effective Leadership (openness to change)

Question	Answer Value	Answer Value	Answer Value	Answer Value
5	1 = +3	2 = +2	3 = +1	4 = 0
11	1 = 0	2 = +1	3 = +2	4 = +3
13	1 = +3	2 = +2	3 = +1	4 = 0

**Appendix D-2 (cont'd.)****Response to Barriers to Congregational Health (clergy killer)**

Question	Answer Value	Answer Value	Answer Value	Answer Value
6	1 = +3	2 = +2	3 = +1	4 = 0
9	1 = +3	2 = +2	3 = +1	4 = 0
14	1 = 0	2 = +1	3 = +2	4 = +3

**Church Health Survey Scale**

Single Category Score	Level of Health	Total Score
8 - 9	Significant Health	36 - 45
5 - 7	Moderate Health	22 - 35
2 - 4	Moderate Unhealthiness	9 - 21
0 - 1	Significant Unhealthiness	0 - 8

### Appendix D-3

#### Results from the Church Health Survey

Chris

##### **Leader as Mature Individual**

1.3 + 4.3 + 12.3 = 9      significant health

##### **Mature Relationships**

2.3 + 8.3 + 15.3 = 9      significant health

##### **Vision**

3.2 + 7.2 + 10.2 = 6      moderate health

##### **Healthy and Effective Leadership**

5.3 + 11.1 + 13.2 = 6      moderate health

##### **Responds to Barriers to Congregational Health**

6.2 + 9.2 + 14.2 = 6      moderate health

##### **Total Score**

9 + 9 + 6 + 6 + 6 = 36      significant health

Note: The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8



**Appendix D-3 (cont'd.)**

Steve

**Leader as Mature Individual**

1.1 + 4.2 + 12.2 = 5      moderate health

**Mature Relationships**

2.1 + 8.1 + 15.3 = 5      moderate health

**Vision**

3.2 + 7.1 + 10.2 = 5      moderate health

**Healthy and Effective Leadership**

5.2 + 11.1 + 13.2 = 5      moderate health

**Responds to Barriers to Congregational Health**

6.3 + 9.2 + 14.1 = 6      moderate health

**Total Score**

5 + 5 + 5 + 5 + 6 = 26      moderate health

**Note:** The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8

**Appendix D-3 (cont'd.)**

Jerry

**Leader as Mature Individual**

1.2 + 4.3 + 12.2 = 7      moderate health

**Mature Relationships**

2.0 + 8.1 + 15.2 = 3      moderate unhealthiness

**Vision**

3.1 + 7.2 + 10.2 = 5      moderate health

**Healthy and Effective Leadership**

5.2 + 11.1 + 13.1 = 4      moderate unhealthiness

**Responds to Barriers to Congregational Health**

6.1 + 9.2 + 14.1 = 4      moderate unhealthiness

**Total Score**

7 + 3 + 5 + 4 + 4 = 23      moderate health

Note: The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8

**Appendix D-3 (cont'd.)**

Greg

**Leader as Mature Individual**

1.1 + 4.1 + 12.3 = 5      moderate health

**Mature Relationships**

2.0 + 8.1 + 15.1 = 2      moderate unhealthiness

**Vision**

3.1 + 7.2 + 10.1 = 4      moderate unhealthiness

**Healthy and Effective Leadership**

5.2 + 11.1 + 13.1 = 4      moderate unhealthiness

**Responds to Barriers to Congregational Health**

6.2 + 9.1 + 14.2 = 5      moderate health

**Total Score**

5 + 2 + 4 + 4 + 5 = 20      moderate unhealthiness

**Note:** The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8

**Appendix D-3 (cont'd.)**

Cedric

**Leader as Mature Individual**

1.2 + 4.1 + 12.2 = 5      moderate health

**Mature Relationships**

2.3 + 8.1 + 15.1 = 5      moderate health

**Vision**

3.1 + 7.2 + 10.1 = 4      moderate unhealthiness

**Healthy and Effective Leadership**

5.1 + 11.2 + 13.0 = 3      moderate unhealthiness

**Responds to Barriers to Congregational Health**

6.1 + 9.1 + 14.2 = 4      moderate unhealthiness

**Total Score**

5 + 5 + 4 + 3 + 4 = 21      moderate unhealthiness

Note: The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8

**Appendix D-3 (cont'd.)**

Mark

**Leader as Mature Individual**

1.2 + 4.2 + 12.2 = 6      moderate health

**Mature Relationships**

2.1 + 8.2 + 15.3 = 6      moderate health

**Vision**

3.2 + 7.2 + 10.3 = 6      moderate health

**Healthy and Effective Leadership**

5.2 + 11.1 + 13.2 = 5      moderate health

**Responds to Barriers to Congregational Health**

6.2 + 9.2 + 14.1 = 5      moderate health

**Total Score**

6 + 6 + 7 + 5 + 5 = 29      moderate health

Note: The first numeral indicates the question number from the survey. The second numeral gives the score for that question (e.g. 1.3 is question number 1 with a score of 3).

Scale:	Single Category	Total Score
8 - 9	Significant health	36 - 45
5 - 7	Moderate health	22 - 35
2 - 4	Moderate unhealthiness	9 - 21
0 - 1	Significant unhealthiness	0 - 8

## Appendix E

### Sample Letter to Subject After Third Focus Group Meeting

October 11, 1997

Dear Greg,

I hope this letter finds you doing well. I am writing you to remind you of the vision and methods to cast that vision for congregational health you developed last week. This is a very important part of the study and it is in your hands to follow through on your vision for health.

The vision for church health that you articulated is for the people to grow in discipleship and be more action oriented.

The methods you developed are: (1) to develop and articulate to the board a mission statement, (2) to develop and teach requirements for spiritual leadership in the congregation, (3) become a more healthy pastor by delegating ministry to others, Friday night family night, daily walks with your wife, and family devotions together.

If this does not agree with your notes and memory please let me know. I trust you are already working on these and will be prepared to report back in November. Thank you for your great help and work on this project. You have been a great help.

Sincerely,

B. Scott Buell

## **Appendix F**

### **Worker's Covenant**

In consideration of the confidence placed in me by the church in being selected for the office I now assume, I hereby covenant:

To maintain a high standard of Christian living and example in harmony with the ideals and standards of the Church of the Nazarene.

To cultivate my personal Christian experience by setting aside each day definite time for prayer and Bible reading.

To be present at the regular Sunday School, the Sunday morning and Sunday evening preaching services, and the midweek prayer meeting of the church, unless providentially hindered.

To attend faithfully all duly called meetings of the various boards, councils, or committees to which I have been, or will be, assigned.

To notify my superior officer if I am unable to be present at the stated time, or to carry out my responsibilities in this office.

To read widely the denominational publications, and other books and literature which will be helpful to me in discharging the duties of my office.

To improve myself and my skills by participating in Continuing Lay Training courses as opportunity is afforded.

To endeavor to lead people to Jesus Christ by manifesting an active interest in the spiritual welfare of others and by attending and supporting all evangelistic meetings in the church.

(Manual 254-255)

## **Appendix G**

### **Order for service of Confession and Rededication**

#### **A Service of Confession & Rededication**

Organ & Piano Processional:	"A Mighty Fortress is Our God"
Offering	
Worship and Praise to God:	"Majesty"
	"All Hail King Jesus"
	"All Hail the Power of Jesus Name"
Reflections of Grace	
Song:	"We Are Standing on Holy Ground"
Reading of God's Word:	Jeremiah 19:10-15
Choir:	"It's Still the Cross"
Message:	Pastor
Prayer Chorus:	"Purify My Heart"
Pastoral Prayer	
Our Prayer of Confession	
Song Chorus:	"Spirit of the Living God"
Vows of Rededication:	Pastor
Prayer:	Layperson
Holy Communion	
Hymn:	"Our Great Savior"



Rededication Vows

Hereby, O Lord, we pledge before God and man to keep our covenant with you -- the covenant of the children of God -- to love the Lord our God with all our heart, soul, mind and strength and our neighbor as ourselves, so as not to make the name 'Christian' an empty claim.

We pledge to nourish our fellowship with God in regular habits of prayer and Bible reading and thus take personal responsibility for our souls.

We pledge to refrain from and renounce the sins of gossip, envy, pride, self-indulgence and indifference and remove from our lives and homes those things that cause those sins to prevail.

We pledge to obey Christ and the Holy Scriptures.

We pledge to honor God with our talent, time and treasure, and we renew our vow to "seek earnestly to perfect holiness of heart and life in the fear of the Lord."

Confession

O God, the enemy has invaded your inheritance; he has defiled your holy temple, hurt our witness and slandered your holy Name in this your family.

We feel badly. We are humbled and ashamed. We did not recognize his wicked scheme and blamed each other. We are caught in sin's trap and we feel embarrassed. We fell victim to bitter feelings, unholy attitudes, anger, gossip, envy and more.

Father, release us from the snares that bind -- our obsession with status, and things, the covetousness of our day, our pre-occupation with self when you said, "If his cross." We confess our self-indulgence. Our indifference and possibly rejection of your holy Word. Forgive us. Cleanse us of our pride. It is time for your people to renounce our comfort and seek your purpose for our lives and church in this community. Renew in us a concern for the souls of those perishing around us. Put in our hearts a fresh new love for God and man.

We have seen the wounds and come before you with repentant hearts. We will not let this happen again.

For the glory of your Name, deliver us from our sins and those of our fathers. For your Name's sake, restore us O God. Wash over our hearts with a right spirit. Help us remember your holiness. Restore to us the joy of our salvation, and make your face to shine upon us again.

Through the costly blood of our Savior Jesus Christ in whose precious name we pray. Amen.

## Appendix H

### Sample Letter to Subjects Preceding the Final Focus Group Meeting

November 3, 1997

Dear Greg,

Hopefully this will be the last letter you get from me on the focus group work. I greatly appreciate your willingness to help me in what I feel is needed research in our church. Your investment of time will be of more use than to helping me finish my degree. Thank you for your time.

Our last meeting will be 1:00 p.m. on Friday, November 14, at First Church. This will be our debriefing session to report on the perceptions of the vision and methods you are using in your church. Two items are of utmost importance: 1) to continue the follow through with these methods and 2) conducting the church board debrief **before** our meeting on November 14.

I have enclosed the board debrief protocol. Please use this as your guide for the discussion with your board. You know your board the best, so you choose whether you want to lead the debrief orally, much like I conducted our focus group meetings, or to present it as a handout to be given to the board. It is essential that verbal discussion take place in the board meeting. Please bring your notes on the discussion to our focus group meeting. If you have any questions please call me.

This is an important and the last meeting. I appreciate your faithfulness to this process. See you next week.

Sincerely,

B. Scott Buell

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