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# Offering Hope: Ministry with the Chronically Ill

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# OFFERING HOPE:

# MINISTRY WITH THE CHRONICALLY ILL

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All Scripture quotations, unless otherwise indicated, are taken from the New Revised Standard Version of the Bible.

# DISSERTATION ACCEPTANCE CERTIFICATE

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CONTENTS

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Finally, I thank God for finding me in the midst of my struggles with chronic illness and reminding me that I am never alone. I pray that my life might reflect the light and hope of Jesus Christ to a chronically ill world.

## ABSTRACT

One of every two individuals in the United States suffers from chronic illness. While these numbers are staggering, studies indicate that they will continue to rise. The problem exists that the local church is not fully equipped to address the desire and need for wholeness and community felt by the millions of individuals living with chronic conditions. These individuals suffer alone and the contemporary church has failed to minister effectively with them. With proper grounding in a biblical understanding of God's role in illness and suffering, a foundation in the role of pastoral care throughout Church history, and by looking through the lens of both those in the medical field and those within the structure of the Church, effective ministry with the chronically ill can happen. The local church is best able to reverse the feelings of isolation and offer caring Christian community and hope to those dealing with chronic illness.

Chapter One provides a basic overview of this problem and embraces it in the context of narrative. Careful study of Scripture, showing the misinterpretation of sin and suffering in the Bible, is found in Chapter Two. God's healing presence in the midst of suffering is shown as a better interpretation. Chapter Three looks through the course of Church history in relation to pastoral care. Embracing what the field of science and medicine has to offer the church in caring for those with chronic illness is addressed in Chapter Four. Chapter Five discusses what models of ministry to the chronically ill are available in the contemporary church. A final understanding for ministry with the chronically ill is offered in Chapter Six.

# CHAPTER ONE

# INTRODUCTION

She sat in a cold hospital room all alone. The friend that had brought her was kept out in the waiting area while doctors and nurses began poking and prodding her with intravenous fluids and taking numerous blood tests. It had been a long summer. Day after day her body had grown more tired, more depleted. Just getting up in the morning demanded complete concentration. Leg cramps, extreme thirst, a ringing in her head, and daily weight loss had taken its toll. Finally, when she slipped into a coma for twenty hours it was apparent something was terribly wrong.

The worst part was that no one seemed to truly care. As doctors worked feverishly she thought to herself, "They didn't even ask my name." They were going about their business without taking the time to know her. To make matters worse, she lived away from her family, and the friends she did have were not allowed to be with her. "How can I be in the presence of so many people, yet feel so alone?" she thought to herself.

Finally the diagnosis came when a young doctor walked into the small cubicle and stated very matter of factly, "You have Juvenile Diabetes. But don't worry, most diabetic women still have babies." With that the doctor turned, in a hurry to get to all the other "cases" that needed her important time and effort. In that moment, this young woman knew there was nothing worse than being in the midst of community yet having no sense of connection or relationship.

Five days later she left the hospital sure that the caring community of her church would cover the loss in her life. Certainly these well meaning, nurturing, and loving

Christians would provide a base of support. Never could she have been so wrong! Although she tried to reconnect through worship and small group study, it was only a short time before those who didn't understand how chronic illness worked made comments that felt so heartless. Juvenile Diabetes is often an outwardly invisible disease and hearing the words, "Well, you don't look sick," only caused a sense of greater loneliness.

Numerous others tried to provide care and comfort by saying things like, "Just pray hard enough and this will go away." Others responded, "God must have given you diabetes because He wanted you to use this illness as a tool to glorify Him." All were well intended, yet none brought relationship, hope, or healing in the midst of her loneliness. Finally, it became apparent that those within the church suffered from an apparent lack of knowledge about chronic illness and its effects when she was handed a book that essentially told her to search for the sins of her life or her parents' lives. This author claimed that these sins were the source of her illness. If only she could uncover this mystery, then she would be physically healed despite the seeming impossibility of that fact.

That young woman was me. Off at college and away from my family I desired independence yet so hated the feeling of being alone. Alone, yet surrounded by so many that claimed to "care." The only conversations people offered about Diabetes - generally lumping the two very different diseases of Type I and Type II together - were of horrible complications and eventual death. Pastors and people of faith just wanted me to embrace this as my "cross to bear." If they couldn't help me make sense of where God was in the

midst of this darkness and they were people of faith, did that mean that God didn't understand my suffering either?

I wish I could say this is an isolated situation. I have realized, however, that this experience is far too commonplace for those with chronic illness who find themselves in the context of a church. Far too many individuals have been told to pray harder, know God more, be more "spiritual," and that would simply take care of their problems. Pastors who, like myself, have been trained in the theological schools of today receive little to no training in pastoral care and chronic illness. In my experience, this one mandatory class didn't even begin to touch the subject of chronic illness. If the local church is going to effectively minister to the individuals in its community, this problem must be addressed more holistically.

Ilene Lubkin writes:

> Chronic disease is the nation's greatest public health care problem. In the year 2000, the U.S. population was 276 million and nearly 50 percent of that population, 125 million, had some type of chronic condition. Almost 60 million Americans live with multiple chronic conditions, with 3 million of those individuals having five chronic conditions.[1]

Chronic illness takes on many forms from arthritis to diabetes, cancer to cardiovascular disease. It also shows no partiality to age, race, geography, economic status, or church size.

As pastors look out at their congregations on any given Sunday, by these numbers one out of every two people will fall into this group. Add to that the fact that there are family members trying to care for those individuals and quickly it becomes apparent that ministering to people with chronic illness addresses a huge part of our population. Every

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[1] Ilene Morof Lubkin and Pamela D. Larsen, *Chronic Illness: Impact and Interventions*, 5th ed. (Sudbury, MA: Jones and Bartlett Publishers, 2002), 3.

minister and every local church, regardless of location and size is affected by chronic illness. Lisa Copen, founder of Rest Ministries, describes this group of people in this way:

> Despite what you may think, there are *many* people who live with invisible chronic illness who are attending your church right now. If you could take your church, turn it upside down and shake it so all of the people who live with invisible chronic illness fell out, you would lose entire pews...maybe half the choir. Don't be surprised if your pastor and a handful of children are included.[2]

While this group already represents a large percentage of the population, it is only expected to increase. Robert Kane projects the impact that this type of illness will have on the population in his book, *Meeting the Challenge of Chronic Illness*. He writes, "By 2020, a projected 157 million Americans will have at least one chronic condition, an estimated 81 million will have multiple chronic conditions. By 2020, more than 80% of all health care expenditures will be spent for people with chronic conditions."[3] He also indicates that 7 out of every 10 funerals performed by a pastor are the result of chronic illness.[4]

Many may assume that it is only the elderly who suffer most from chronic illness, yet this is not the case. "Most of the people with chronic illnesses are between the ages of twenty and sixty-four, and lots of them are younger than twenty. Less than a quarter of those with a chronic illness are age sixty-five or older. It is a misconception to think that

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[2] Lisa J. Copen, *So You Want to Start a Chronic Illness-Pain Ministry: 10 Essentials to Make It Work* (San Diego, CA: Rest Ministries Publishers, 2002), 13.

[3] Robert L. Kane, Reinhard Priester, and Annette M. Totten, *Meeting the Challenge of Chronic Illness* (Baltimore, MD: The John Hopkins University Press, 2005), 27-28.

[4] Ibid., 27.

chronic illness affects only elderly people."[5] Every aspect of ministry, from children to seniors, is affected by these types of diseases.

One of the main problems for those dealing with chronic illness and for those trying to care for them in the church, is that symptoms may be invisible. Wayne Connell, author of *Not By Sight*, suggests that statistics show 74% of those that live with chronic illness have symptoms that are invisible. This means they do not use any assistive devices, such as a cane or wheelchair. In addition, they may have symptoms such as extreme fatigue, pain, dizziness, or blurred vision, which are not visible. Thus, they appear perfectly healthy to the average observer.[6]

This invisible nature of many of the symptoms of chronic illness leads its victims to feel isolated from society. Susan Milstrey Wells states:

> We can't share our disease with others. We must live with it, learn from it, and manage it on our own. Because of physical limitations, we literally may be isolated from the people and the activities we enjoy. But physical isolation is only the tip of the iceberg. As individuals with chronic disease, we sometimes experience a profound and intense loneliness caused by being different from the people around us and from not having the words to explain how we truly feel.[7]

Emotionally those suffering from "invisible" chronic illness are hurting in more than simply physical ways. These individuals go through life suffering in silence. Because of the invisible nature of some diseases, the church and the world has had difficulty learning to respond.

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[5] Jeffrey H. Boyd, *Being Sick Well: Joyful Living Despite Chronic Illness* (Grand Rapids, MI: Baker Books, 2005), 89-90.

[6] Wayne Connell and Sherri Connell, *Not by Sight: A Guide to Ministering to Believers Living with Chronic Illness and Pain* (Parker, CO: Where Is God Ministries, 2006), 16.

[7] Susan Milstrey Wells, *A Delicate Balance: Living Successfully with Chronic Illness* (Cambridge, Mass: Perseus Books, 2000), 141.

The individual dealing with chronic illness is thrust into a world that is unfamiliar and, at times, very inhospitable. There are encounters with doctors and hospitals, diet and exercise regimens, the hassles of medical agencies and insurance companies, and the guilt of not being available for friends and family. Add to this, the constant reminder of the frailty of life and it becomes obvious why those with these diseases feel so overwhelmed. Chronically ill people need the support and encouragement of a community, yet all too often they are tempted to withdraw because of the reactions of others. Carol Sveilich explains:

> Well-meaning acquaintances, family members, and friends, who say, "But you *look* fine," can often unleash a sense of anger or compound feelings of isolation in the person who lives with multiple challenges that are hidden from view. The person with a concealed disability would much rather hear, "I cannot imagine the difficulties you experience and still manage to live a productive and meaningful life. You are incredible!" Our visually oriented society seldom takes the time to look beyond the appearance. People tend to believe what they see; and if an illness or condition cannot be seen, it does not exist.[8]

Along with isolation due to the invisible nature of many chronic diseases, depression is also a serious factor for those who suffer. "Depression is one of the most common – and potentially dangerous – complications of every chronic condition because it often worsens with the condition."[9] Depression impacts not just the individual, but the family as well. Relationships are challenged by the stress of hospital visits, more doctors' visits, and adjusting life at home to meet the demands of illness.

Individuals suffer from depression, while dealing with chronic illness at a greater average than the healthy general population. Studies have shown that for those who feel

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[8] Carol Sveilich, *Just Fine* (Austin, TX: Avid Reader Press, 2005), 22-23.

[9] Lori Hartwell, *Chronically Happy: Joyful Living in Spite of Chronic Illness* (San Francisco: Poetic Media Press, 2002), 21.

the impact of the rigors of chronic illness, depression is 15-20% higher than for the average person without chronic illness.[10] Chronic illness affects individuals in ways we could never begin to imagine unless we have dealt with these types of illnesses ourselves. Garth Ludwig suggests:

> Anyone who has experienced a serious physical or mental illness will admit that disease is a wrecker of human order. Disease comes at us as an unwelcome attacker on our personhood and brings to naught all our well-ordered plans. It snuffs out our dreams and hopes. But it does more than that. It extends the boundaries of chaos to our entire universe. When disease strikes, everything that is meaningful to us – health, vocation, family and relationships, the life of the spirit – is placed into a state of disorder.[11]

Depression due to the pain and stress of chronic illness has an impact not just on the individual but also on every relationship and family that is connected with these individuals. Families and relationships can be torn apart because of the pressure of these diseases. Doug Weigand notes that:

> Every information clearing house, medical association, or specific illness support group agrees that chronic illness or pain tears at the very fabric of a person's nuclear and extended family. In some areas, the divorce of those who have a chronic illness rate as high as seventy percent. This is considerably higher than the national divorce rate of approximately fifty percent.[12]

This downward spiral of depression and despair can test stamina, faith, and the will to move forward. The vicious cycle of isolation and depression continues as those in the caregiver role expect the person with the chronic condition to simply overcome their problems and illness. When the sufferer cannot just pick up and move on, guilt enters in,

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[10] A. Rifkin, "Depression in Physically Ill Patients," *Postgraduate Medicine* 9 (1992).

[11] Garth D. Ludwig, *Order Restored: A Biblical Interpretation of Health, Medicine, and Healing* (St. Louis, MO: Concordia Publishing House, 1999), 22.

[12] Douglas Wiegand, *Struck Down but Not Destroyed: A Christian Response to Chronic Illness and Pain* (Baden, PA: Rainbow's End Company, 1996), 56.

and once again the individual dealing with the pain of chronic illness is tempted to withdraw. All too often those in the church and other well-meaning caregivers simply assume that the stress and pressure of chronic illness can disappear if the sick person simply has enough desire. Unfortunately, this is not the case and additional pressure leads to despair. Kay Toombs describes the despair this way:

> Because chronic illness is illness that extends into the future, it defines the present from the future in light of the pain, the disability, and ultimately the death that it portends. One crucial concern, therefore, is the meaning and function of hope. Individuals suffering from chronic illness, by definition, cannot by mere exercise of will or professional ministration change the basic nature of their condition. To try only breeds despair. Defenders of the mainstream model of autonomy often forget this compelling point.[13]

To lose hope is to lose the fight against chronic illness. The church must find its place in helping those who suffer hang on in the midst of brokenness. Robert Greer, in his book *Mapping Postmodernism*, writes, "It is my conviction that if theology cannot speak to people who are broken, it cannot speak at all. More than other people, broken people yearn to understand how that which they know to be true can make sense with how they live at a practical level."[14] Theology, in our current cultural context, challenges the church to offer pastoral care that addresses the doubt and questions of those who are hurting.

The number of individuals impacted by chronic illness is staggering and the church must find some way to be in ministry to these victims. One problem confronting the church is that this explosion of chronic illness has challenged the thinking and

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[13] S. Kay Toombs, David Barnard, and Ronald A. Carson, eds., *Chronic Illness: From Experience to Policy* (Bloomington, IN: Indiana University Press, 1995), 143.

[14] Robert C. Greer, *Mapping Postmodernism: A Survey of Christian Options* (Downers Grove, IL: InterVarsity Press, 2003), 21.

structures of ministry in the local church. Like society in general, the church, unfortunately, is overwhelmed with the effects of illness and what it means for ministry and care to those who are hurting. Lisa Copen writes, "When it comes to acknowledging physical pain and chronic illness, the church seems swept up with the rest of society, often becoming blind to this hurting group of people and ignorant in ways in which to minister to them. Often people in pain are searching for answers."[15]

Dealing with illness, especially chronic illness, can be difficult. When illness does not go away or a quick fix is not found, it becomes difficult to know what to say. Often, instead of simply listening, like Job's friends we begin to talk, and we make statements that do not offer care. Lisa Copen continues:

> Most people in the church are well meaning, caring, concerned individuals. So why do they say such hurtful things? Most times, they just aren't aware of the fact that what they are saying is demeaning and harmful. People become awkward around people who are suffering and they don't know what to say. Instead of saying nothing, they try to help the ill person or fix the problem. Unfortunately, advice and hollow encouragement is often the last thing an ill person wants to hear. Usually they just want someone who is willing to listen.[16]

Theology that reflects the thought that illness equals sin begins to creep back into our way of thinking. Simple answers are offered that only make matters worse. Mary Earle offers these thoughts:

> Within Christian circles especially, there may be a strange anxiety when sick people aren't cured: maybe they just don't have enough faith, or pray enough, or trust enough. But implicit assumptions about cause and effect are sadly simplistic. There is nothing quite as destructive to a person living with chronic illness as the kind of remark that usually takes this form: "We are praying so hard for you. We just cannot figure out why you don't get well." The implication is that somehow the person living with the ailment is at fault. It's Job's friends in

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[15] Copen, 7.

[16] Ibid., 28.

twenty-first century clothing, still looking for fault, still blaming the victim.[17]

While some organizations such as Stephen Ministry, Rest Ministries, and parish nursing programs are beginning to appear in an attempt to train pastors and local church leaders to meet this need, they have only begun to scratch the surface. Chronic illness statistics multiply far faster than the number of local congregations in the United States. Starting new ministries and simply trying to keep up with the need can be overwhelming for any pastor or local congregation. We must not allow our ministries to be overwhelmed by the statistics. The need is great and the church must make care for those with chronic illness a priority.

Although we live in a very diverse and multi-cultural society with a dividing line between secular and sacred, the need for effective spiritual care is great. According to recent studies, even the unchurched believe in God, have a desire to pray, and are searching for meaning in their lives. Studies found in *Spirituality in Patient Care* by Harold Koenig state,

> No fewer than 96% of Americans believe in God, over 90% pray, nearly 70% are church members, and over 40% have attended church, synagogue, or temple within the past seven days. Being spiritual then, is part of who many people are – it forms the root of their identity as human beings and gives life meaning and purpose. Spiritual needs become particularly pressing at times when medical illness threatens life or way of life.[18]

Every person dealing with a chronic condition, whether churched or not, has the basic desire to know "Why?" "When people are diagnosed with a chronic illness, it affects their entire being, especially their spirituality. Even the person who may claim to

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[17] Mary C. Earle, *Broken Body, Healing Spirit: Lectio Divina and Living with Illness* (Harrisburg, PA: Morehouse Publishing, 2003), 7.

[18] Harold George Koenig, *Spirituality in Patient Care: Why, How, When, and What* (Philadelphia: Templeton Foundation Press, 2002), 6.

be an atheist is suddenly asking, 'Why me, God?'"[19] The chronically ill are seeking hope and relief wherever they can find it. When the church has failed to respond to the need, these victims have turned their attention to other people and treatments that offer help. "Many seek solace in the offices of alternative therapists and faith healers – to the tune of $30 billion a year, by some estimates. Millions more is spent on best-selling books and tapes by New Age doctors such as Deepak Chopra, Andrew Weil, and Larry Dossey."[20]

Chaplain John Vanderzee of Indiana University Medical Center addresses this issue, "The lack of attention given to chronic illness in pastoral literature reflects a general obliviousness to the growing magnitude of chronic illness as a health care problem. Failure to make chronic illness a *pastoral* priority reinforces the medical establishment's deficient concept of health and disease."[21]

We live in a world that is fast paced and wants the quick and easy solution to problems. In this hurry-up culture, however, ministry to those with chronic illness means taking the time to slow down. As a church we can do better and we must do better. Helen Harris offers this suggestion:

> Perhaps the greatest irony is that the true experts on the experiences of those who are ill, dying and bereaved are those who are ill, dying and bereaved. And while they are experts on their own experience, the most therapeutic interventions of others, including professionals and lay ministers, involve significant investments of time. There are no instant solutions and the *salve* is found in experiencing the pain, living the questions, and living through the experience. We become most therapeutic with those who are chronically ill, dying and bereaved when we walk

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[19] Copen, 15.

[20] Claudia Wallis, "Can Prayer, Faith and Spirituality Really Improve Your Physical Health? A Growing and Surprising Body of Scientific Evidence Says They Can," *Time* 147 (1996): 62.

[21] John T. Vanderzee, *Ministry to Persons with Chronic Illness: A Guide to Empowerment through Negotiation* (Minneapolis: Augsburg Fortress, 1993), 30.

their journey with them.[22]

Despite the problems that the local church faces in ministering with the chronically ill, the Center for Disease Control concurs that the church is the best place for individuals to find care. They claim that some of the strengths of the local congregation in community health include the ability to be present in the lives of those who are ill and to convene people around specific problems or opportunities that would not otherwise take place. The local congregation can connect people to resources, provide a framework of meaning to experience, and offer sanctuary and the safety of a caring gathering place. Most importantly, they feel that the local church offers an enduring sense of time to care for those dealing with long-term illness. Churches are enduring institutions that can persist for the long cycle needed to bring about change.[23]

The problem that exists for the church today is that it is not fully equipped to address the desire and need for wholeness and community felt by the millions of individuals living with chronic illness in the United States. This dissertation will show how the local church can have an effective ministry to those with chronic illness. The contemporary church has failed to minister effectively to those with chronic illness. I will show, however, that with proper grounding in a biblical understanding of God's role in illness and suffering, a foundation in the role of pastoral care throughout Church history, and by looking through the lens of both those in the medical field and those within the structure of the Church, effective ministry to those with chronic illness can happen. The

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[22] Helen Wilson Harris, "Congregational Care for the Chronically Ill, Dying and Bereaved," *Journal of Family Ministry* 14 Spring, no. 1 (2000): 31-32.

[23] "Engaging Faith Communities as Partners in Improving Community Health," in *CDC/ATSDR Forum* (Atlanta, GA: 1999), 7.

local church can reverse the feelings of isolation and offer caring Christian community and hope to those dealing with chronic illness.

## Basic Understandings

For purposes of this dissertation some basic understandings and definitions must be put in place. Chronic illness is defined as "The irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care and self-care, maintenance of function, and prevention of further disability."[24] Judith Miller takes this definition farther in her book, *Coping with Chronic Illness*, "Chronic illness refers to an altered health state that will not be cured by a simple surgical procedure or a short course of medical therapy."[25]

Acute illness is the essential opposite of a chronic condition. Joy Selak defines the difference:

> What most *chronic* illnesses have in common are the following: the illness may be treatable, but often has an uncertain cause and no known cure, the symptoms are persistent and recurring, and remissions are possible, but unusual, and often temporary. By contrast, an *acute* illness has a quick or serious onset of symptoms and a more clearly defined prognosis. A person with an acute illness generally gets sick and, in short order, is either cured or dies.[26]

The goal of treatment is very different when it comes to acute and chronic illnesses. In acute illness, the caregivers are trying to restore the individual's freedom from illness. In

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[24] Lubkin and Larsen, 8.

[25] Judith Fitzgerald Miller, *Coping with Chronic Illness: Overcoming Powerlessness*, 2nd ed. (Philadelphia: F.A. Davis Co., 1992), 4.

[26] Joy H. Selak and Steven S. Overman, *You Don't Look Sick! Living with Invisible Chronic Illness* (New York: Haworth Medical Press, 2005), 4.

chronic illnesses, however, it becomes important to restore the person's meaning in life, in spite of the disease.[27] There is no release from the illness, so the care must extend to finding hope in life despite the illness.

Pastoral care will be defined as care not given solely by the ordained clergy but instead, care that exists within a local church community. This pastoral care is not limited to seminary trained professionals, but extends to the priesthood of all believers. Charles Gerkin explains, "It is important to remember that the meaning of the term *pastoral* as it has been used within the Judeo-Christian tradition has had a fundamentally communal connotation. Pastoral care thus denotes the care of a community for its members."[28]

The importance of relationship and community to the care of those with chronic illnesses cannot be overstated. He also writes:

> Pastoral care needs to have as its primary focus the care of all God's people through the ups and downs of everyday life, the engendering of caring environments within which all people can grow and develop to their fullest potential. Not all of God's people will need pastoral *counsel*; all people, however, need the nurture and support of a *caring* environment.[29]

Perhaps the greatest distinction that must be made, however, is the difference between "healing" and "curing." Laurie Skokan explains the difference between the two:

> It is important here to make a distinction between "healing" and "curing." Curing is physical, alleviating the signs and symptoms of disease at the anatomical level. Healing, in contrast, is spiritual, intangible, and experiential, involving an integration of body, mind, and spirit. This integration gives the person a sense of peace. Cure is concerned with wholeness of body, healing with wholeness of being. The two can occur together or separately; it is entirely possible to be healed without being cured or to be cured without being healed.[30]

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[27] Bruce Jennings, Daniel Callahan, and Arthur L. Caplan, "Ethical Challenges of Chronic Illness," *Hastings Center Report* 18, no. 1 (1988): 10.

[28] Charles V. Gerkin, *An Introduction to Pastoral Care* (Nashville: Abingdon Press, 1997), 92.

[29] Ibid., 88.

If the local church is going to attain the ability to effectively minister to those with chronic illnesses, the desire to heal must be our goal. When someone suffers from a chronic condition, the illness will not be going away. Symptoms may decrease for awhile but the roller coaster of the journey will go on until death. Those who suffer must be able to live as fully as possible with disease. This goal is attained when "healing," rather than "curing," brings a restoration to the balance between the body and the soul.

## Proposing a Solution

The number of individuals dealing with the brokenness of chronic illness increases daily and as leaders within the local church we must make a commitment to be the hands and feet of Christ to a hurting world. The lonely times felt during the struggle of chronic illness need not be the end of the story. Allowing the light of Jesus Christ to shine through the touch of the local church will help those in pain draw strength from the love of God.

Looking at St. John of the Cross, Brian Jones writes:

> St. John's story reminds us that even dark nights eventually give way to the sunrise, but while they are happening those dark periods can be difficult beyond comprehension. We must remind ourselves during these painful moments that just because we can't feel God's presence does not mean that he has abandoned us. Sometimes God does his greatest work when we're lost in the desert.[31]

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[30] Laurie Skokan and Diane Bader, "Spirituality and Healing," *Health Progress* 81 (2000): 38.

[31] Brian Jones, *Second Guessing God: Hanging on When You Can't See His Plan* (Cincinnati, OH: Standard Publishing, 2006), 99.

To address the problem of brokenness associated with chronic illness and how the local church can be better equipped for ministry, Chapter Two addresses Scripture, suffering, and hope. Misunderstandings related to suffering and its connection with sin and punishment were common in the early church and this interpretation continues in current culture. God does not desire suffering or evil in the world and this can be seen throughout the writings of the Old and New Testament. Just as Jesus entered into the suffering of humanity through the incarnation, God enters into the suffering of illness today. Careful study of the Scripture shows that God offers a healing presence in the midst of loss.

Although there has been a misunderstanding of suffering, illness, and God's role in the midst of it all, Church history offers a model of successful ministry to those in the local church who are broken by illness. Chapter Three addresses the writings of numerous church leaders from Gregory the Great to the modern day writings of Mother Teresa and seeks a better understanding of pastoral care and local church ministry. Their writings show that the local church is a place where body and soul experiences are brought together. These church theologians recognize that healing is not merely physical in nature but spiritual as well.

The church has had a place in healthcare since the creation of a hospital by Basil the Great in AD 372. These early hospitals offered both medical and spiritual care. Chapter Four shows that once again those in the field of medicine are realizing the role faith plays in caring for those with chronic illness. While the relationship between science and religion has been strained at times, once again the two are combining efforts to care for those broken by chronic conditions. This chapter suggests that working together, the

local church and modern medicine provide those with chronic illness, holistic care for both the body and the soul.

Effective pastoral care for those with chronic illness requires a broader understanding of healing. Chapter Five discusses the issues of "Faith Healing" and how this model of ministry leads to confusion for those in the local church. This chapter shows how the church has learned to care more completely for those with chronic illness by offering support groups and practical ministry help. When faith healing does not bring a "cure," effective ministry can still "heal." The obstacles to misunderstanding have given way and new ministries are starting. Ministries such as Stephen Ministry, parish nursing, and Rest Ministries are lifted up as models for the local church. All of these are a new beginning for local church ministry to those with chronic illness, yet there is still much more that the church can do to bring wholeness to the broken.

Chapter Six concludes by offering hope for the local congregation as it cares for those with chronic illness. The local congregation is in a unique position to care for the needs of these individuals. By creating relationship and community, and being an advocate and prophetic voice for the chronically ill, the local church can be more effective in this ministry. While chronic illness may cause depression and isolation, the local church can be an instrument of light and hope.

The model for a theology of healing that Jesus Christ offered to us was shown repeatedly in how he cared for the sick and hurting in the incarnation.

> In Jesus' life we see the model of ministryhealing, the ideal of whole person care. This is evident both in the care he gave *and* in the way he gave it. When Jesus ministered to people, he not only cared *for* the whole person, he cared *with* the whole person. Ministry was the central concern of his life; he poured his entire

life into it.[32]

As the church, we must strive to do the same. Chronic illness causes a sense of isolation and despair in its victims and finding hope and wholeness are common desires for many. Questions of faith and God arise and doors are opened so that the local church can meet these needs. The local church can reverse the feelings of isolation and offer caring Christian community and hope to those suffering with chronic illness.

[32] Siroj Sorajjakool and Henry Lamberton, eds., *Spirituality, Health, and Wholeness: An Introductory Guide for Health Care Professionals* (Binghamton, NY: The Haworth Press, Inc, 2004), 17.

## CHAPTER TWO

## SCRIPTURE, SUFFERING, AND HOPE

The issue of suffering, pain and illness has long been a dilemma for Christians. Finding hope in the midst of suffering and an understanding of God's will can be difficult. Paul writes in his letter to the Romans:

> Therefore, since we are justified by faith, we have peace with God through our Lord Jesus Christ, through whom we have obtained access to this grace in which we stand; and we boast in our hope of sharing the glory of God. And not only that, but we also boast in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us, because God's love has been poured into our hearts through the Holy Spirit that has been given to us. (Rom. 5:1-5)

Paul's message is one of hope to people who face suffering and who question God's purpose, yet for many this hope is hard to find. Dealing with the struggles of life and a theology of suffering that is due to sin causes many to stumble in their faith. As Gerald Sittser writes, "Loss may call the existence of God into question. Pain seems to conceal him from us, making it hard for us to believe that there could be a God in the midst of our suffering."[33]

Looking through the Old Testament, many examples can be found of people who felt that God had deserted them. To make matters worse, these were not necessarily people who were weak in the faith; many times these were men and women who had a great heart for God. "David placed his faith in God and was able to slay the mighty giant, Goliath. Later he went on to become one of Israel's most famous kings. Still, in the

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[33] Gerald Lawson Sittser, *A Grace Disguised: How the Soul Grows through Loss* (Grand Rapids, MI: Zondervan, 2004), 160.

Psalms, there were many times when he poured out his anger and confusion to God."[34] For example, David writes in Psalm 10:1, "Why, O Lord, do you stand far off? Why do you hide yourself in times of trouble?" and again in Psalm 22:1-2, "My God, my God, why have you forsaken me? Why are you so far from helping me, from the words of my groaning? O my God, I cry by day, but you do not answer; and by night, but find no rest."

The basic understanding of the Hebrew Scriptures concludes that suffering was a direct consequence of sin.[35] Throughout the Old Testament, writers encourage this equation. For example, Isaiah 3:10-11 states, "Tell the innocent how fortunate they are, for they shall eat the fruit of their labors. Woe to the guilty! How unfortunate they are, for what their hands have done shall be done to them." Rabbi Harold Kushner writes, "One of the ways in which people have tried to make sense of the world's suffering in every generation has been assuming that we deserve what we get, that somehow our misfortunes come as punishment for our sins."[36]

This belief is played out especially in the Book of Job when Job's three "friends" come to visit and care for him. "Job's counselors were convinced that a good God who works in the world would never do such horrible things to Job if Job had not done something to deserve it. Though Job seemed to be innocent, he must have a secret sin of which he needed to repent before his good fortunes would return."[37] Sin was an accepted

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[34] Wiegand, 103.

[35] Anthony J. Tambasco, ed., *The Bible on Suffering: Social and Political Implications* (Mahwah, NJ: Paulist Press, 2001), 30.

[36] Harold S. Kushner, *When Bad Things Happen to Good People* (New York: Anchor Books, 2004), 9.

[37] Daniel J. Simundson, *The Harpercollins Bible Dictionary*, ed. Paul J. Achtemeier (San Francisco: HarperSanFrancisco, 1996), 1070.

answer for suffering and this understanding found deep roots in the theology and thinking of the early church.

As if being sick and perceived to be suffering due to sin was not enough, the ill person was then forced to endure the stigma and isolation that came with disease. Garth Ludwig explains:

> Perhaps the most palpable reason for this alienation is that sickness conferred on the person a stigma of "shame." No wonder disease was so dreaded in Israel. It seems to have brought the added distress of estrangement from human comfort. The diseased person was made to feel, by cultural tradition and religious sanctions, repulsive to his friends and family (Ps. 88:8; Isa. 54:12). This became part of the experience of illness and the implications of sickness. Listen again to the cry of the sick man in Psalm 38, "My heart pounds, my strength fails me; as for the light of my eyes – it also has gone from me. My friends and companions stand aloof from my affliction, and my neighbors stand far off (vv. 10-11)."[38]

Those who were ill were separated from community and forced to suffer in isolation. The stigma of disease caused them to endure the looks of those who believed that they were being punished by God for past sins. The early church held to the belief that sin equaled suffering and finding the hope that Paul talks about in Romans was not always easy.

Unfortunately, this understanding of sin causing suffering became so entrenched in the early church that it made its way into modernity. While a better understanding of suffering and the Scriptures will be addressed, it is important to note that the church still causes individuals who suffer from chronic illness to endure that same stigma and isolation. Doug Weigand adds:

> Today, as a result of the same error of believing that all illness is caused by sin, many Christians who have a chronic illness endure rejection and condemnation from their fellow believers. The condescending attitude brings untold hardship to chronically ill individuals who may doubt their salvation or reject Jesus as being cruel and arbitrary.[39]

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[38] Ludwig, 70-71.

[39] Wiegand, 27.

This treatment is not an effective way to care for those who are suffering, and many who receive this type of "care" often have a more difficult time accepting their illness and continuing with their life.[40]

Rabbi Kushner strives to teach the church that caring for those who are suffering does not mean passing judgment or condemnation. "Too often, the voice of religion has been heard to justify suffering, to tell people that it is their 'cross to bear,' the fate that God has wished for them or the fate that they have brought down on themselves by their sinful thoughts and deeds."[41] Instead of scolding individuals and causing them to feel even more pain, Kushner suggests that we should simply offer compassion.

> Job needed sympathy more than he needed advice, even good and correct advice. There would be a time and place for that later. He needed compassion, the sense that others felt his pain with him, more than he needed learned theological explanations about God's ways. He needed physical comforting, people sharing their strength with him, holding him rather than scolding him. He needed friends who would permit him to be angry, to cry and to scream, much more than he needed friends who would urge him to be an example of patience and piety to others. The phrase "Job's comforters" has come into the language to describe people who mean to help, but who are more concerned with their own needs and feelings than they are with those of the other person, and so end up only making things worse.[42]

For the church to make it to this place of caring community, we must find a contemporary scriptural understanding of suffering, illness, and pain.

Job is often the source for those wanting to connect suffering with God, yet looking closer it can be seen that God was not pleased with this connection. God speaks in Job 42:7, "After the Lord had spoken these words to Job, the Lord said to Eliphaz the

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[40] Sorajjakool and Lamberton, eds., 87.

[41] Harold S. Kushner, *When All You've Ever Wanted Isn't Enough* (Boston, Mass.: G.K. Hall, 1987), 73.

[42] Kushner, *When Bad Things Happen to Good People*, 89-90.

Temanite; 'My wrath is kindled against you and against your two friends; for you have not spoken of me what is right, as my servant Job has.'" While the example of blaming the sick person for their sin is found in the Bible, God speaks to the three friends of Job and expresses disgust with this theology. Job spends significant time dealing with his illness and loss before God speaks, until eventually he has the opportunity to speak directly with God and find peace in the midst of the storm.

Instead of being a God that causes suffering and illness, God wants Job and the entire church to know that God cares deeply for us and does not directly cause this pain. Doug Weigand continues:

> Consider how God answered Job's question, "Why?" Job, as do all people, sought comfort by wanting to understand the reason for his pain and suffering. Rather than answer his question, God simply put things back into proper perspective for Job. What God did, in essence, was read His resume to Job. God reminded Job (in Chapters 38-41) of the majesty of His creation. He spoke in detail of all the things that He had done in the creation of the universe. He never answered Job's question of why he suffered. Instead, God showed Job that He was the Almighty Creator of the universe. He reassured Job that He loved him and that He would provide for him. Indeed, not only did God see Job through the difficult times, He also "...blessed the latter part of Job's life more than the first. (Job 42:12)"[43]

God wanted Job to know that he wasn't alone in his suffering. God was present with him. "The Lord speaks with him out of the whirlwind, acknowledging culpability neither on his part nor on Job's, but demonstrating that he who is the Creator of all the spheres is also Emmanuel, the one who is 'present with us.' This means that those who suffer the effects of evil in the world do so not alone, but in the company of God."[44]

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[43] Wiegand, 51.

[44] William H. Gentz, ed., *The Dictionary of Bible and Religion* (Nashville: Abingdon Press, 1986), 337.

A better understanding of why there is suffering in the world comes from Genesis. As God created the world, the creation was without sin. There was no suffering, pain, or chronic illness. Yet, evil made its way into the Garden which God had intended to keep pure. Again, Doug Weigand concludes:

> God did not create man that he should die. The ravages of illness and old age were not a part of God's plan for man. These things came as a consequence of Adam and Eve's sin. They sinned by disobeying God and eating from the tree of knowledge of good and evil. God had warned Adam saying, "...but of the tree of knowledge of good and evil you shall not eat, for in the day you eat of it you shall die." (Gen. 2:16-17) It was only after God banished Adam and Eve from the garden for their sin that pain, illness, and death became part of the human experience.[45]

Suffering is not directly connected to sin and was not God's original desire for humankind. God desired otherwise, yet evil made its way into the world.

Instead of being blamed as the source of suffering and illness, God speaks through numerous people and experiences in the Bible to offer a picture of companionship and compassion. God comes close to those who suffer instead of leaving them in isolation. In the book of Daniel, the reader is told that Shadrach, Meshach, and Abednego have been placed in the service of King Nebuchadnezzar and told that they will not only serve him, they will worship his gods. Life becomes a choice for these three men – will they serve the King or will they serve God? Knowing that choosing God will place them in defiance of Nebuchadnezzar, they chose God anyway. This choice makes life difficult and they must face intense suffering, yet God proves faithful in the midst of trial. Nebuchadnezzar looks into the fiery furnace where the three young men have just been placed and responds in Daniel 3:24-25, "Was it not three men that we threw bound into the fire?" They answered the King, "True, O King." He replied, "But I see four men unbound,

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[45] Wiegand, 25.

walking in the middle of the fire, and they are not hurt; and the fourth has the appearance of a god."

Rick Ezell responds to this appearance of God in the midst of suffering:

> Nebuchadnezzar looked into the furnace and, upon seeing the fourth man, he too was amazed. He had witnessed a miracle. God was seen, not only *from* the flames but also *in* the flames. Consider it a reminder that, if we want to see God, we should look for him when life gets hot. Granted, we should never wish for the fiery furnaces of life. But when the flames of misfortune leap in our faces, we need to know with total assurance that, if we look for God, he is visible. During the difficult times, God reveals himself to us. If only we look for him.[46]

The three thrown into the fiery furnace found God in the midst of their suffering; they were not alone. Job, the major character in dealing with suffering, called out to God and demanded a response. Just as God appeared for Shadrach, Meshach, and Abednego, God appeared to Job and met him at his point of need. "Job felt the weight of God's absence; but a look behind the curtain reveals that in one sense God had never been more present."[47]

Individuals throughout Scripture show that while God may be blamed for the suffering and isolation that they endure, this may not in fact be the true story. Instead, they find that God is never more present than in the middle of suffering, pain, and illness. The Psalmist expresses this thought in Psalm 34:18, "The Lord is near to the brokenhearted, and saves the crushed in spirit." Brian Jones writes:

> A strange thing happens when we experience troubles and hardship – God can seem more alive and present to us *during* the difficulty than before it began. Sometimes God seems distant to us, and we wonder if we'll ever feel his presence again. But just as frequently the opposite occurs, and we feel God's presence

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[46] Rick Ezell, *Defining Moments: How God Shapes Our Character through Crisis* (Downers Grove, Ill.: InterVarsity Press, 2001), 66.

[47] Philip Yancey, *Disappointment with God: Three Questions No One Asks Aloud* (New York: HarperCollins, 1991), 285.

*because* of the hardship, not in spite of it.[48]

Throughout Scripture, God teaches that suffering is not necessarily divine will. Instead, compassion and companionship are the character of God.

Those who face times of chronic illness and suffering can also learn from Job and others, that when faced with trials, God desires us to remain strong and to seek God's presence. Job especially teaches that people of integrity and faith cling to God and serve God despite the hardships of life. There may be questions, even anger, yet despite all, it is important as people of faith not to let go of that which is most dear.[49]

> The reader has a fine example to follow in Job. Persons of integrity hold fast to their relationships with the Lord in the face of innocent suffering and no vindication or explanation. Their faith may waver and be tried, but they beat Satan's challenge when they choose to serve the Lord for nought as is God's due according to the Creator's wise and just order, which is beyond our fathoming. Humble submission to God in faith not only expresses acceptance of the divine plan but the desire to maintain integrity and a relationship to the Lord for its own sake, no matter what.[50]

God's finest example of love for each individual that endures suffering or illness is shown in the incarnation. Through the act of pouring God's own self into Jesus, God truly entered into human life and suffering. "God was meeting the event of our suffering with the 'sovereign Event' of God's participation in our suffering."[51] Philip Yancey suggests that God answered all the cries of unfairness and injustice not through words,

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[48] Jones, 115.

[49] Tambasco, ed., 68.

[50] Ibid.

[51] Douglas John Hall, *God and Human Suffering: An Exercise in the Theology of the Cross*, . (Minneapolis: Augsburg Pub. House, 1986), 181.

but through a visit to humans by God in Jesus. By this, God answered any questions that might linger about unfairness.[52]

The visit of God on earth in the incarnation was not enough; God offered all that could be given through the act of love at the crucifixion. "God didn't spare himself suffering. When he came to earth in Jesus, he not only came to comfort and save the suffering, he came to know firsthand what it is like to be a suffering human being – and we saw his response, firsthand."[53] God wanted to show that suffering, pain, and loss would not be the end of the story, love would triumph, and God's presence would be known. Katharine Dell writes:

> And yet in his suffering on the cross, Jesus took that evil and wickedness and suffering upon himself and showed that, far from it winning the day, God could overcome evil. Suffering is thus transformed and transcended by God by his presence in the midst of Christ's suffering. On the cross God enters into and bears the consequences of the existence of evil in the world that he has created. He shows his love for the created world, and so hope transcends the evil and the despair. Whatever suffering we may encounter, God is there.[54]

God responded to the questions of suffering by offering Jesus Christ and that gift offers the hope of endurance in the midst of suffering and chronic illness.

## Jesus' Response to Suffering

In the first sermon recorded in the Gospel of Luke, Jesus states his mission as he reads from the prophet Isaiah, "The Spirit of the Lord is upon me, because he has

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[52] Yancey, 215-216.

[53] Beverly Rose, *So Close, I Can Feel God's Breath* (Carol Stream, IL: Tyndale House Publishers, 2006), 61.

[54] Katherine Dell, *Shaking a Fist at God* (Liguori, MO: Triumph Books, 1995), 106.

anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor (Luke 4:18-19)." Jesus is announcing that his main purpose and mission is to deliver people from the suffering and pain that holds them back from life in abundance. The effects of disease have distorted the purpose for the world and he is bringing a new age.[55]

This mission becomes manifested in the numerous miracles that Jesus performs. Repeatedly he shows that suffering, chronic illness, and pain are not what God would desire for creation. "As signs of the kingdom of God, Jesus' miracles assure us, first of all, that suffering is opposed to God's will. It does not belong in his universe. He seeks to eradicate it."[56] Ludwig writes:

> In the first chapter of Mark more healings are reported than in the entire Old Testament put together. Nearly one-fifth of the Gospels are devoted to Jesus' healing. All told, we count forty-one distinct instances of physical and mental healings in the Four Gospels. This does not include the 16 cases of healing in the book of Acts. Clearly, the New Testament does not hide the fact that this is a chronicle about health and healing. It is readily apparent that the accounts of health and healing in the New Testament are far different from those in the Old Testament. The towering center of these accounts is the figure of Jesus, the Healer. For the writers of the New Testament, Jesus the Messiah is at the heart of all their explanations about disease and sickness and about healing and wholeness.[57]

The Gospel of Mark stresses that Jesus' healing power causes the crowds to gather in great numbers. Mark 3:10 states, "For he had cured many, so that all who had diseases pressed upon him to touch him." At the same time, news of Jesus had stretched

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[55] Ludwig, 101.

[56] Sorajjakool and Lamberton, eds., 18.

[57] Ludwig, 81.

far beyond the boundary of Galilee. Matthew 4:24-25 tells that news had reached as far as Syria. "So his fame spread throughout all Syria and they brought to him all the sick, those who were afflicted with various diseases, and pains, demoniacs, epileptics, and paralytics, and he cured them. And great crowds followed him from Galilee, the Decapolis, Jerusalem, Judea, and from beyond the Jordan."

Jesus realized, however, that the impact of illness and suffering meant isolation for most. To address the fault of this belief, he did all that he could to restore these individuals to community.

> Jesus healed people of diseases that carried a strong social stigma, diseases that forced their victims to avoid society, to live apart from family and friends, and prevented them from participating in worship. This was particularly true of lepers and the woman who suffered from a hemorrhage. It was also true of the Gerasene demoniac who was banished to the tombs. When Jesus healed these people of their various ailments, he restored them to their communities.[58]

The theology that taught God caused suffering and pain was directly addressed through the miracles of Jesus. For too long the understanding that sin led to suffering had continued in the church. Jesus confronts this issue when he healed the man that had been blind from birth and restored him to community.

John 9:1-3 states, "As he walked along, he saw a man blind from birth. His disciples asked him, 'Rabbi, who sinned, this man or his parents, that he was born blind?' Jesus answered, 'Neither this man nor his parents sinned; he was born blind so that God's works might be revealed in him.'" Philip Yancey explains:

> In Jesus' day people assumed that tragedy hit people who deserved it. "There is no death without sin, and there is no suffering without iniquity," taught the Pharisees, who saw the hand of punishment in natural disasters, birth defects, and such long-term conditions as blindness and paralysis. Here is where "the man

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[58] Sorajjakool and Lamberton, eds., 24-25.

> blind from birth" entered the picture. Steeped in good Jewish tradition, Jesus' disciples debated what could account for such a birth defect. Had the man somehow sinned *in utero*? Or was he suffering the consequences of his parents' sin – a prospect easier to imagine but patently unfair. Jesus responded by overturning common notions about how God views sick and disabled people. He denied that the man's blindness came from any sin, just as he dismissed the common opinion that tragedies happen to those who deserve them. Jesus wanted the sick to know they are especially loved, not cursed, by God. Every one of his miracles of healing, in fact, undercut the rabbinic tradition of "You deserved it."[59]

This teaching of Jesus was an explicit denial that sin equaled suffering and he put to rest a theology of suffering that causes isolation and pain.

While Jesus taught through his miracles that God did not desire the suffering and evil that happened in the world, he also showed a love of God that reaches to all people. Garth Ludwig states:

> Sickness in the Old Testament bore with it the stigma of shame. Yet Jesus broke through this barrier of shame in order to reach out to the rejected masses of His day. It was especially those who were labeled "unclean" by the church authorities and refused entrance into the temple that galvanize His attention. Jesus seems to have gone out of His way to heal the lame, the blind, and the dumb.[60]

Jesus cared for people in a very personal way and he offered them his compassion and acceptance. Although Jesus was performing his miracles and touching lives in the midst of a system that had definite structures, levels, and laws, he did all that he could to help each individual that suffered to know there was hope. Philip Yancey continues:

> Jesus was often "moved by compassion," and in New Testament times that very word was used maternally to express what a mother feels for her child in her womb. Jesus went out of his way to embrace the unloved and unworthy, the folks who matter not at all to the rest of society – they embarrass us, we wish they'd go away – to prove that even "nobodies" matter infinitely to God. One unclean woman, too shy and full of shame to approach Jesus face-to-face, grabbed his

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[59] Philip Yancey, *The Jesus I Never Knew* (Grand Rapids, MI: Zondervan Publishing House, 1995), 169-170.

[60] Ludwig, 90.

> robe, hoping he would not notice. He did notice. She learned, like so many other "nobodies," that you cannot easily escape Jesus' gaze.[61]

Jesus redefined what healing, caring, and compassion meant for those who call themselves Christians. Not only would he care for those who were afflicted and in times of distress, but the entire Body of Christ was called to that same task in the commandment found in Matthew 22:37-39, "You shall love the Lord your God with all your heart, and with all your soul, and with all your mind. This is the greatest and first commandment. And a second is like it: You shall love your neighbor as yourself." Jesus knew that his followers must be an agent of healing love that reached out to all people.

He modeled this teaching by leading his disciples and training them to pass this ministry on to others. He did not expect that he would be the only one reaching out to those who suffer; he gave them this responsibility as well. Garth Ludwig writes:

> Jesus also involved His own disciples in His healing ministry and gave them instructions in which healing was made a *coordinate responsibility* with preaching the Gospel. If, as some have argued, Jesus healed for the singular purpose of proving that He was the Son of God, then why does He instruct His own disciples to heal? The training of the disciples in the healing ministry was an important part of their work as they accompanied Jesus in His journeys from city to city.[62]

Caring for those undergoing illness and suffering is not an issue that only God can address. Jesus taught the church that it must follow his example and care for those culture had cast aside because of illness.

Jesus also offered a promise to those who were in the midst of pain and loss that they were not alone and could rest in the promise and assurance of God. As Jesus gathered with his disciples he offered them words of hope that he was not abandoning

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[61] Yancey, *The Jesus I Never Knew*, 159.

[62] Ludwig, 105.

them but leaving them with all that they needed to be the church through the gift of the Advocate, the Holy Spirit. John 14:25-27 marks these words of Jesus:

> I have said these things to you while I am still with you. But the Advocate, the Holy Spirit, whom the Father will send in my name, will teach you everything, and remind you of all that I have said to you. Peace I leave with you; my peace I give to you. I do not give to you as the world gives. Do not let your hearts be troubled, and do not let them be afraid.

The image that Jesus is offering to his disciples and to the church is one that comforts when abandonment and isolation is felt. Brian Jones writes:

> The word translated "Advocate" is the Greek word *parakletos*, which is a combination of two Greek words: *para*, meaning "beside," and *kalein*, meaning "to call." A *parakletos* is someone who is "called" to "come to the side of" someone. Other versions of the Bible accurately translate this word "Comforter." The image that immediately comes to mind is a row of people sitting arm in arm alongside a widow offering as much comfort and support as they can possibly muster.[63]

Jesus offers this hope of comfort as well in his words found in Matthew 28:20b, "And remember, I am with you always, to the end of the age." "Jesus did not promise that everything would work out the way the individual would like, nor does he promise health and prosperity. What Jesus promises is that he will be there for his followers, no matter what happens."[64] The journey that takes an individual from suffering to hope can begin with an understanding that God does not cause suffering nor are we left alone to endure without any support.

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[63] Jones, 133.

[64] Mark W. Phillips, *Coping with Chronic Illness: Psychological & Spiritual Perspectives* (Nowata, Okla.: MP Publications 2000), 104.

## Paul's Personal Understanding of Suffering

The journey towards hope that Paul speaks about in his letter to the church in Rome was one that he had to learn personally. By looking at his life, those who suffer can see the impact that Jesus Christ has on those who live with chronic illness. Paul writes in 2 Corinthians 12:7 that he has a "thorn in the flesh" which he has asked the Lord to take away three times. Paul learns that when he is weak there is one on whom he can rely. He admits this in 2 Corinthians 12:8-9, "Three times I appealed to the Lord about this, that it would leave me, but he said to me, 'My grace is sufficient for you, for power is made perfect in weakness.'" Doug Wiegand writes:

> In Paul's case, God used what many biblical scholars believe to be a chronic illness to teach him the true source of his strength. Only when Paul was at his weakest and most helpless could he truly turn to Jesus. This is true, not just in Paul's case, but for all people. It is only when we recognize our helplessness – our inability to control our lives – that we give the control to God.[65]

God's gift to Paul was a sustaining grace that could face any tragedy or fear. Paul's life reflects the all-sufficient grace of God.[66]

Paul addresses the question "Where is God?" by showing that despite the pain and suffering of this life, God is present. More so, Paul echoes the teaching of Jesus through the crucifixion and resurrection, that the sufferings of this life are not the end – there is something greater to come. "In his extended comparisons of temporal and eternal realities, the apostle Paul affirms both sides – that pain is pain in our present reality, but

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[65] Wiegand, 28.

[66] Ezell, 138.

in the light of eternity, pain is a tool that God is using to prepare us for a reality greater than we can imagine this side of heaven."[67]

Paul writes:

> We are afflicted in every way, but not crushed; perplexed, but not driven to despair; persecuted, but not forsaken; struck down, but not destroyed; So we do not lose heart. Even though our outer nature is wasting away, our inner nature is being renewed day by day. For this slight momentary affliction is preparing us for an eternal weight of glory beyond all measure, because we look not at what can be seen but at what cannot be seen; for what can be seen is temporary, but what cannot be see is eternal. (2 Cor. 4:8-9, 16-18)

Through the example of Paul managing chronic illness, the issue of suffering is addressed with the eternal hope of life. No longer must individuals feel that because of illness they must live in a world that does not care for them. Hope can be found in the midst of suffering and pain through the promise of God given through the life and love of Jesus Christ.

Scripture not only offers this promise for those who are dealing with chronic illness but also offers hope for the church striving to reach out in care and concern. Paul writes in 1 Corinthians 12:26, "If one member suffers, all suffer together with it." As the Body of Christ, the church must accept its role in caring for those with chronic illness and recognize as Paul does that when one person is in distress, all are. Brian Jones writes:

> Paul clearly points out that when we as the followers of Jesus become spiritually intimate with one another, it is as if our souls grow together and we begin to share spiritual nerve endings. If something happens to you, I can't help but be affected by it. We are connected soul to soul. In the same way a twisted ankle affects every other part of a human body, the hurt a church member feels touches everyone else in that community. In a healthy-functioning community of Jesus followers, people are deeply connected to one another, and when something happens, good or bad, the instinctive response is to rally around one another.[68]

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[67] David B. Biebel, *If God Is So Good, Why Do I Hurt So Bad?* (Colorado Springs, Colo.: NavPress, 1989), 80-81.

[68] Jones, 167-168.

No one is called to carry the burdens of this life alone.

The lesson of the power of community that Paul preaches is based clearly on the life and teaching of Jesus Christ. One example is found in Mark 2:1-12, where a paralytic is carried to Jesus by his friends. The crowd had gotten so large that it was seemingly impossible to get their friend to Jesus so that he could be healed. Instead of giving up, the friends cut a hole in the roof and lower their friend down to Jesus. Mark 2:5 relates that it was the faith of the friends that allowed this man to be healed. "It is clear from this account that healing faith can be demonstrated in a corporate manner with dramatic results."[69] The local church is the best place to care for those experiencing chronic illness when this sense of community is achieved.

Handling suffering and chronic illness is never easy, yet Scripture teaches that this suffering is not a direct reflection of God's punishment of sin nor is it abandonment from God's love and grace. While suffering may not cease in this world, there is a hope found in the compassion of God. "What is vital for the chronic sufferer is to keep the conversation open with God. God gives us permission to say what we want to say, that we are disappointed, that we feel His absence, and that we feel alone. But in this process we find ourselves drawn closer to God and a need for His gift of grace."[70]

This chapter has shown that although the early church understood suffering as God's punishment for sin, this is not the case. God does not desire suffering or evil in this world and although God does not always take away this pain, God is present in the midst of it. Various individuals from the Old and New Testament reflect this hope of God's

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[69] Ludwig, 203-204.

[70] Ibid., 191.

presence in the midst of their suffering and Jesus himself shows that God entered into the suffering of humanity through the incarnation. The modern church is given examples of how to care for those dealing with chronic illness and suffering by entering into community as the Body of Christ. Pain and suffering may not disappear, yet God is faithful. As Douglas John Hall writes:

> Christians are not obligated to tell people that there is "pie in the sky" – no matter how cleverly that may be said. They are obliged to say, rather, that "nothing can separate us from the love of God that is in Christ Jesus, our Lord, neither life, nor death," etc. There is nothing that can cut us off from *this love which we already experience here and now.*[71]

This hope and care for those affected by chronic illness is not just found in the Scripture but will now be addressed by looking at church history.

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[71] Hall, 166.

## CHAPTER THREE

## PASTORAL CARE AND THE CARE OF THE SICK

Gregory of Nazianzus defines the role of pastoral care as he writes:

> The scope of our art is to provide the soul with wings, to rescue it from the world and give it to God, and to watch over that which is in His image, if it abides, to take it by hand, if it is in danger, or restore it, if ruined, to make Christ to dwell in the heart by the Spirit: and, in short, to deify, and bestow heavenly bliss upon, one who belongs to the heavenly host.[72]

Throughout church history there have been many who have encouraged the care of those who deal with sickness. A realization of the need for pastoral care as specialized ministry existed from before the time of Gregory in AD 463. By looking at those who have led the church throughout history it becomes apparent that the local church can be a place that connects the emotional and physical experiences of those affected by chronic illness.

The task of the local church today is not to attempt to replicate the role of pastoral care exactly as those in the past have. Instead, the church must strive to reflect on these leaders and allow them to be a springboard for effective ministry today. Their thinking offers an insight that can shape pastoral work today.[73] The church learns from its past. "The goal in reading ancient texts in pastoral theology is not for us to 'do pastoral care' in a way similar to pastors from other ages. The goal, rather, is to allow these classical texts to provoke us into critical thinking by disturbing our calm, culturebound assumptions concerning ministry, and in so doing to suggest avenues for exploration."[74]

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[72] Andrew Purves, *Pastoral Theology in the Classical Tradition* (Louisville, KY: Westminster John Knox Press, 2001), 9.

[73] Ibid., 3-4.

[74] Ibid., 115.

This chapter looks at numerous examples of pastoral theologians throughout church history and their definition of ministry to the sick. In addition, understanding their explanation of the "Dark Night" that often accompanies suffering and how this understanding shaped pastoral care will be discussed. No matter what time period is represented by these lives, they had the same goal. Andrew Purves, in his book, *Pastoral Care in the Classical Tradition*, states that goal in this way:

> These pastoral theologians understood that pastoral ministry is the lived action in and through the church by the power of the Holy Spirit of the ministering reality of God in Christ for salvation. For them, pastoral care is lived out doctrine at the points of connection between the Gospel and the lives of God's people.[75]

While they desired to care for the physical needs of the sick, they also cared for the soul of the person. Bringing the two together was central. Andrew Purves continues:

> The classical pastoral writers believed deeply that the active reality of God in Christ through the Holy Spirit was a present help in time of trouble. Moreover, pastoral care always had in focus the principle concern for the salvation of the sinner. In the classical tradition, then, pastoral theology and the practice of pastoral care give primary attention to God in Jesus Christ as the source of life, meaning, and the church's ministries of care. A central task of pastoral theology, then, is to remind the church that Jesus Christ is the pastor, the one who is the primary pastoral actor – who guides us to streams of living water, who forgives us our sins and saves us, who heals all our hurts, and who brings life out of death. The ministry of the church is, by the Holy Spirit, a sharing in the ministry of Christ. Ministry can have no other basis. A study of the texts of great pastors of the past puts this front and square.[76]

The gift of the Holy Spirit can offer hope to those dealing with illness. Those who suffer need not suffer in isolation. Early church leaders offered the solace that God mediates all things.[77]

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[75] Ibid., 4.

[76] Ibid., 5.

[77] Ibid., 60.

This thesis claims that the local church is best suited to alleviate the isolation felt by those suffering with chronic illness. Traveling to the fourth century to the time of Athanasius and others, shows that the desire to care for those feeling disconnected because of illness was already a priority for the church. Dionisio Borobio states:

> Early patristic witnesses also speak of the 'visit' as the most important practice in care and cure of the sick. A very brief survey: St. Polycarp states that elders should 'take in the abandoned and visit all the sick, without forgetting widows and orphans.' Hippolytus of Rome, referring to deacons, tells them that they should 'notify the bishop of those who are sick, so that he may visit them. For it is most comforting to the sick to know that the high priest is mindful of them.' St. Athanasius recalls that it is very sad for sick people not to be visited by anyone, since 'they consider this calamity more serious than their illness itself.' And it is said of St. Augustine that he followed the example of the apostle (James 1:27) in visiting orphans and widows in their sorrow, and in going to pray for the sick and lay his hands on them.[78]

It was the belief of many of these early church leaders that pastoral care was a gift that should not be taken lightly. Andrew Purves explains:

> John Chrysostom reminds us of the truth: the pastoral vocation comes from the call of God. Indeed, pastoral work is built into the metaphysical structure of God's re-creation. Pastoral work has a God-given dignity and significance that no one and no church dare take away, and pastors themselves must carefully attend to and exercise this authority with appropriate diligence.[79]

It was not until AD 590 that the church received significant writings on what pastoral care for individuals in the church truly meant. Gregory the Great is credited with providing the basic text for pastoral care.[80] Andrew Purves expounds on Gregory's role:

> Gregory's *Pastoral Care* is the most influential book in the history of the pastoral tradition. It became the dominant treatise on pastoral work for one thousand years – almost immediately after its publication (soon after Gregory became pope) in

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[78] Dionisio Borobio, "An Enquiry into Healing Anointing in the Early Church," *The Pastoral Care of the Sick* (1991): 45.

[79] Purves, 47.

[80] Gerkin, 39.

> 590 until the Reformation of the sixteenth century. In the history of the church Gregory's is the most widely read book, after the Bible, on pastoral care.[81]

Gregory was known for being very generous with time and financial means for those who were suffering and became known as a "monk who had a care for the world."[82] His desire was that those who were suffering would remember that Christ had also suffered and in that they could find comfort. Gregory writes the following in *Pastoral Care*, "To preserve the virtue of patience, the sick are to be admonished ever to bear in mind how great were the evils endured constantly by our Redeemer at the hands of those whom He had created....He who was the life passed to death that He might prepare life for those who were dead."[83]

Gregory the Great's theme of caring was picked up years later by Martin Luther. He had a desire to truly be with people in the midst of their suffering and placed this ministry of presence as a priority in his service to others.

> For Luther spiritual counsel is always concerned above all else with faith – nurturing, strengthening, establishing, practicing faith. Luther's pastoral practice is characterized by warmth, conviction, and identification with the distressed. At Worms, a few hours before his second appearance before the Diet, he went at dawn to the bedside of a dying knight to hear his confession and administer the Sacrament.[84]

The importance of the individual was a significant part of his ministry.

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[81] Purves, 56.

[82] Ibid., 59.

[83] Gregory the Great, *Pastoral Care*, ed. Johannes Quasten and Joseph C. Plumpe (Mahwah, NJ: Newman Press, 1950), 125-126.

[84] Rodney J. Hunter, ed., *Dictionary of Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 1990), 839.

Martin Bucer, a German Protestant Reformer in the early 1500s, also provided a text, *On the True Cure of Souls*, which discussed the care given to those who were sick. Bucer describes a fivefold ministry of pastoral care: "In public and by visitation, ministers draw the alienated to Christ, lead back those drawn away, restore those who fall into sin, strengthen weak and sickly Christians, and preserve those who are whole and strong."[85] The care of the physical condition of a person was tied to the care of the soul in this time period. To care for both was to care for the individual.

Continuing to move through church history to the early seventeenth century, others such as George Herbert in the Anglican tradition continued to stress the importance of the role of the pastor in terms of pastoral care. He filled his days of ministry with not just the "church" duties of preaching and offering sacraments but also with the important task of being with the people.[86] He wrote down these responsibilities in *The Country Parson* which "instructs the pastor in his example and duties towards his congregation in preaching, administering the sacraments, visiting the parishioners' homes, even in using medicine and resolving legal disputes. The pastor's life is to touch the lives of the people of his church in every area. (chs. 7-8, 14, 22-23)."[87]

Richard Baxter, one of the most famous Puritan pastors, is known for his pastoral guidance offered in his book, *The Reformed Pastor*, written in 1656. His primary concern

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[85] Ibid.

[86] Ibid., 840.

[87] William G. Witt, "George Herbert's Approach to God: The Faith and Spirituality of a Country Priest," *Theology Today* 60, no. 2 (2003): 217.

was to encourage other English pastors to spend significant time in "private conference," which was the instruction and personal visitation of families and individuals.[88] He writes:

> We must also visit the sick, helping them to prepare either for a happy life or for a happy death. This is our business all the time, but at this time of illness there is a most extraordinary care needed by both them and us. When time is almost gone and they must now or never be reconciled to God and possessed of His grace, O how much it concerns them to redeem those hours and lay hold on eternal life! Do not wait until strength and understanding have left them, but go to them as soon as you hear they are sick – do not wait for them to send for you.[89]

Baxter also encouraged pastors to be aware of the needs of those in the church. There were times that pastors got more involved with study and forgot that it was vitally important to know the people in the church and what was going on in their lives. He writes, "The things that are necessary are common and obvious. The minister must carefully observe the state of their flock so that they may know what is most necessary for them, both what to do for them and how to do it. First to be regarded is what to do, for it is more important to know what to do then to know how to do it."[90] Care for those individuals with illness is stressed as a personal ministry, not something that can be done for all people in the same way.

Throughout the seventeenth and eighteenth centuries the Lutheran tradition felt the tension between traditional pastoral care offered solely by the clergy and a desire to include the laity in this ministry. Under the lead of Philipp Jacob Spener, Christians were encouraged to lean towards the expression of personal care and response to ministry.

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[88] Hunter, ed., 71.

[89] Richard Baxter, *The Reformed Pastor* (Lafayette, IN: Sovereign Grace Publishers, Inc, 2000), 19.

[90] Ibid., 29.

Pastoral care for those dealing with illness no longer fell solely on the pastor; lay persons were encouraged to respond to their faith as well.[91]

> In *The Spiritual Priesthood Briefly Set Forth*, Spener expressed his wish that every Christian stand in a special friendship with their pastor or another Christian. He stressed individual conferences and private conversations, visiting in homes, and calling on the sick. Moreover, such work did not belong to the pastor alone. Lay persons were to engage in mutual correction and encouragement.[92]

John Wesley and early Methodism expected followers to care for those who were sick or distressed. Methodists were encouraged to bear the burden of others and seek the spiritual value found in social service. Wesley not only spoke about these beliefs but he also modeled them in the ministry he offered to those around him.[93] Wesley realized that caring for the health of individuals did not necessarily mean caring for their bodily afflictions. Caring for others meant being able to move beyond the surface to heal the pain of the soul. He writes in *Sermon 98: On Visiting the Sick*:

> These little labours of love will pave your way to things of greater importance. Having shown that you have a regard for their bodies, you may proceed to inquire concerning their souls. And here you have a large field before you; you have scope for exercising all the talents which God has given you. May you not begin with asking, "Have you ever considered, that God governs the world; - that his providence is over all, and over you in particular? - Does any thing then befall you without his knowledge, - or without his designing it for your good?" He knows all you suffer, he knows all your pains; he sees all your wants. He sees not only your affliction in general, but every particular circumstance of it. Is he not looking down from heaven, and disposing all these things for your profit?[94]

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[91] Hunter, ed., 840.

[92] Ibid.

[93] Ibid., 843.

[94] John Wesley, *The Works of John Wesley*, Third ed., XIV vols., vol. VII (Peabody, Mass.: Hendrickson Publishers, 1991), 122.

Wesley believed all Christians were responsible for the care of the sick, but felt the church neglected this duty. He admonishes Christians that visiting the sick is, "A plain duty, which all that are in health may practice in a higher or lower degree; and which, nevertheless, is almost universally neglected, even by those professing to love God."[95]

Perhaps one of the greatest modern examples of offering pastoral care by one not ordained is found in the life of Mother Teresa. Realizing the importance of each individual, she offered care and compassion to all, and stressed the role all people should play in caring for others. Peter Lynch writes:

> Despite her critics, who claim she neglected to introduce modern medicine into her institutions, it would be unreasonable to doubt that this woman has contributed immensely to making the world a more humane and loving place. Perhaps more than anyone else in the twentieth century, she reminded people everywhere of the need to serve and love the poor and dying – those in whom she always saw Christ himself.[96]

She writes in her own words, "Don't ever forget whom you are touching. That person is Christ, your brother or sister in the distressing disguise of the poor. Serve that person with compassion. This is your purpose in life, your obligation. This is how you will be judged."[97]

While these are just a few examples of church leaders throughout history, they offer a view of the history of pastoral care and provide models that can still be effective in the care of those dealing with illness, specifically chronic illness, in the church today. Realizing the importance of each person, taking the time to listen, visit, and care, and

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[95] Ibid., 118.

[96] Peter Lynch, *The Church's Story: A History of Pastoral Care and Vision* (Boston, MA: Pauline Books and Media, 2005), 289.

[97] Paul A. Wright, *Mother Teresa's Prescription: Finding Happiness and Peace in Service* (Notre Dame, IN: Ave Maria Press, 2006), 116.

offering the love and compassion of Christ, are models of pastoral care that are timeless in their value.

## The Dark Night of the Soul and Pastoral Care

One area of pastoral care that perhaps makes the greatest connection to those dealing with chronic illness is the understanding offered by John of the Cross in the sixteenth century work *The Dark Night of the Soul*. The darkness he describes is similar to the feelings of abandonment and isolation that those with chronic illness feel. John of the Cross encourages those who offer care to others to realize that pastoral care is not just the responsibility of the pastor and the church but also of the individual. To be healed and make your way out of the "Dark Night" you must want to be healed. He encourages his reader by saying, "Persons who refuse to go out at night in the Beloved and to divest and mortify their will, but rather seek the Beloved in their own bed and comfort, as did the bride, will not succeed in finding him. As this soul declares, she found him when she departed in darkness and with longings of love."[98] John of the Cross believes that everyone experiences dark times of pain in a variety of ways but only those who desire to find God will make it through.

Michael Mayer, in his *Reflections on St. John of the Cross*, helps make sense of how the dark night can feel like a time of abandonment. He writes:

> In this dark time people feel abandoned by God, but they are now learning to love him without the motivation of self-satisfaction. In reality he is providing what they need. God is increasing their longing for him, and growing the fruit of

[98] John of the Cross, *The Dark Night of the Soul*, In the Collected Works of St. John of the Cross (Washington D.C.: The Institute of Carmelite Studies, 1991), 456.

> the Holy Spirit in their lives. John did not see the darkness as happening relentlessly, but as going on for periods, interspersed with peace and feeling of the warmth of God's love, which gave encouragement.[99]

When offering pastoral care to those with chronic illness, this understanding of the "Dark Night" and the feeling of separation from God and others is vitally important. There need not be any feelings of guilt and shame in the lives of those who are ill. Despite what others may think, they have not caused this illness. More importantly, John reminds people that God has not caused this illness either. He writes that imperfections happen in our life and God realizes this because God was the one who created us.[100]

Transformation for those who suffer can be found as the local church helps individuals through this time of the "Dark Night." They no longer have to feel alone. They can find comfort, not only in God, but in being connected to others in the church. Gerald May writes in, *The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth*:

> In my experience, the most universal change accomplished by the passive night of the spirit is the blurring of one's belief in being separate from God, from other people, and from the rest of creation. Increasingly, one feels *a part of* all things instead of *a part from* them. Such softenings can happen with any rigidly held habitual beliefs and concepts.[101]

John of the Cross, along with Teresa of Avila, Brother Lawrence, and Julian of Norwich all taught that God was present in the midst of all parts of life, including suffering. While not directly admonishing that this knowledge was an important part of

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[99] Michael Mayer, "The Dark Night of the Soul: Reflections on St. John of the Cross," *Lutheran Theological Journal* 31, no. 3 (1997): 128-129.

[100] Cross, 365.

[101] Gerald G. May, *The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth*, 1st ed. (San Francisco: HarperSanFrancisco, 2004), 88-89.

pastoral care, they do in fact stress the value of this awareness of God. Carol Zaleski writes:

> Even in the desolute dark night of the soul, indeed especially there, St. John of the Cross taught, God is present, purifying the soul of all passions and hindrances, and preparing her for the inconceivable blessedness of divine union. Along with dark knowing, there is dark loving, no less ardent for being deprived of all sensible and spiritual vision of the beloved. Therefore St. John can say, "Oh, night more lovely than the dawn, Oh, night, that joined Beloved with lover, Lover transformed in the Beloved!"[102]

Each of these pastoral theologians offers comfort for those dealing with illness that God is aware of their pain and desires for them to find hope.

Catherine Garrett believes these theologians are leading us to the understanding that healing does not have to be physical to make a difference in the lives of those with chronic illness. In relation specifically to Julian of Norwich she writes:

> The lesson she drew from this showing was that "God wishes us to know that he safely protects us in both joy and sorrow equally and he loves us as much in sorrow as in joy." "Therefore," she writes, "it is not God's will that we should be guided by feelings of pain, grieving and mourning over them, but should quickly pass beyond them and remain in eternal joy." The point she is making about emotions and reality is that ultimate reality is "weal": "woe" is simply its absence. This is a vital point for people who suffer from chronic illnesses, where pain, because of its ability to obliterate the memory of its opposite, is often expressed as the "really real." Epistemologically, Julian's emphasis on the positive emotions is a reminder that pain constricts our reality and joy extends it. Her interpretation of woe is made from the perspective of weal.[103]

The lesson of finding joy in the midst of the "Dark Night" of illness, pain and suffering is an important aspect of pastoral care. John of the Cross helps us find that hope.

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[102] Carol Zaleski, "The Dark Night of Mother Teresa," *First Things* (2003): 25-26.

[103] Catherine Garrett, "Weal and Woe: Suffering, Sociology, and the Emotions of Julian of Norwich," *Pastoral Psychology* 49, no. 3 (2001): 193.

## The Church and Hospital Care

These pastoral theologians encouraged those in the church to realize that the church played an important role in effective medical care for those suffering. Those dealing with illness were not being cared for sufficiently in secular society and the church needed to respond. Healing and care was both a physical and spiritual process and throughout church history, examples of the church providing both spiritual care for the sick in addition to the practical care of medicine can be easily seen. Peter Lynch discusses this early process:

> Christian institutions that cared for the sick had emerged in the Eastern Church as early as the fourth century, for example, Basil's hospital in Caesarea. In Eastern Christianity, which led the way in the development of hospitals, they were known as a *xenodichium* (from the Greek work for 'stranger'). They performed many functions, such as the sheltering of pilgrims and travelers, but their care of the sick generally took precedence. The Emperor Constantine made provision for institutions that were to care for the sick. By the early Middle Ages in the West, institutions that looked after the sick were common but could also double as places of shelter for the poor and for pilgrims. Medical functions within such institutions, then, were part of a broader social service to those in need. Monasteries were particularly involved in this task.[104]

The local church offered significant leadership for the care of the ill and by the middle of the thirteenth century, The Order of the Holy Spirit (a Catholic Order), had placed hospitals in every important town throughout all of Europe. In addition, many monasteries were transformed into local hospitals.[105]

The church also cared for those who had chronic illnesses that could not be physically healed, such as leprosy. Many times these individuals would simply be cut off

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[104] Lynch, 134-135.

[105] Ibid., 135.

from society and forced to survive on their own. Once again the church stepped in to address this situation. "In France alone, at this time, there were some two thousand leper houses. The great leper hospital of Satin-Lazare in Paris was dependent on the bishop while local authorities took responsibility for some of the smaller institutions."[106]

Numerous groups and orders formed throughout the 1400 and 1500s to take up the cause of caring for the ill. The Capuchins were known for their care of many that became sick during epidemics. The Barnabites took on the pastoral care of those in homes and prisons by visiting them and caring for their needs. The Theatines established numerous hospitals and dedicated themselves to social welfare. Another religious order of priests, known as the Somaschi, worked primarily with the poor children and orphans in the north of Italy.[107] The Methodist tradition also continued this desire to care for the sick and poor:

> Wesley's philanthropic endeavors were an attempt to replicate those acts of charity undertaken by Primitive Christians, but fitted well with the values of English enlightened thought. He wished to revive all that was best about those reforming Anglican societies characteristic of the Restoration period and to which members of his own family belonged. In this vein, the Methodist movement took an *eirenic* stance and strove to promote social projects, which included welfare provision, schools, and medical dispensaries. This project also involved prison work, hygiene movements, and antislavery campaigns.[108]

It was not just the men that were involved with the care of the sick in the early church. Many groups of Catholic nuns, such as the Daughters of Charity in France, took up their role in the care of those who were dealing with sickness. Peter Lynch explains,

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[106] Ibid.

[107] Ibid., 176-177.

[108] Deborah Madden, "Medicine and Moral Reform: The Place of Practical Piety in John Wesley's Art of Physic," *Church History* 73, no. 4 (2004): 757.

"The Daughters ran hospitals and took in abandoned children, something that developed into a program of foster care that was considered novel for the times. In the tough, port city of Marseilles, these women attended to the needs of the galley prisoners and, on the battlefield, they nursed wounded soldiers."[109] These women led the way for others such as Florence Nightingale who, inspired by their care, began nursing reforms and the push for recognition of the importance of this work.[110] Again, we come back to the leadership of Mother Teresa who continued this work into modern times by opening centers of care in Calcutta and around the world to care for all kinds of people in desperate need.[111]

Change is also seen in theological education in 1925 when Anton Boisen introduces the Clinical Pastoral Education (C.P.E.) program. He writes:

> In the summer of 1925 I was given the opportunity to try the experiment of bringing some theological students to the hospital. There students worked on the wards as ordinary attendants. My own experience had convinced me that there is no one upon whom the patient's welfare is more dependent than the nurse or attendant who is with him hour after hour during the day.[112]

The Clinical Pastoral Education movement grew rapidly throughout the 1930s and 1940s. In fact, following its initiative, most schools of theological education began hiring full-time professors to teach the importance of pastoral care to its students. This was a new phenomenon for seminary education.[113] Boisen believed, from his own personal experience, that the church had not been doing a good job caring for those suffering with

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[109] Lynch, 190.

[110] Ibid., 249.

[111] Ibid., 289.

[112] Robert C. Dykstra, *Images of Pastoral Care: Classic Readings* (St. Louis, MO: Chalice Press, 2005), 28.

[113] Hunter, ed., 843.

long term illness, specifically for him, mental illness, and that the neglect must stop.[114] This education is now a standard in many theological schools to prepare its students for ministry to those dealing with grief, loss, and suffering.[115]

## General Principles of Pastoral Care

Church history provides specific instances where institutions have been formed, educational programs have begun or been changed, and individuals have stepped forward to take the lead in pastoral care. It is also possible, however, to draw a connection between these various sources to find overarching themes for pastoral care that can relate today to those adjusting to chronic illness. Regardless of which century or which theologian, three general principles for pastoral care emerge: the importance of caring for each individual specifically, the teaching that pastoral care does not have to be complex and that love is the guiding value for all pastoral care. Purves concludes:

> Each of the classical writers dwelt at length on the complexities of pastoral work. Person and circumstance must shape the pastoral response. What is helpful for one may be hurtful for another. A pastoral response that is correct at one time may be inappropriate at another. A pastor must thus develop a discerning wisdom in order to know what remedy to apply in each case.[116]

Essentially, pastoral care makes its way back to the classic teaching of visitation so that leaders have full knowledge of those within the church. Those pastoral leaders

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[114] Gerkin, 61.

[115] Lynch, 276.

[116] Purves, 119-120.

throughout church history, whether Richard Baxter, Gregory the Great or others, realized that being with people was vital for effective ministry to the ill.

Gregory the Great challenged pastors in his writing *Pastoral Care* to accept that each particular situation in life demanded individual and contextually relevant attention.[117] Richard Baxter stressed that for this type of pastoral care to truly be effective in the local church, the congregation must not get too large for the pastor to handle or an assistant must be hired. For him, pastoral care is a personal ministry to each individual person. "Flocks must ordinarily be no greater than we are capable of overseeing....If the pastoral office consists in overseeing all the flock, then surely the number of souls under the care of each pastor must not be greater than he is able to take such heed to as is here required."[118] Perhaps Mother Teresa sums this desire for individual care up best herself:

> Remember, it is the individual that is important to us. In order to love a person, one must come close to him or her. If we wait until there is a given number of people, we will get lost in numbers and will never be able to show respect and love for one concrete person. To me, every person in the world is unique.[119]

This individual understanding of those dealing with illness allows the pastor and those offering pastoral care to become interpreters for those in the midst of a "Dark Night." Charles Gerkin writes:

> For pastoral theologians, that meant finding ways to open dialogue between Christian ways of speaking and the ordinary language of the people. Pastors needed to become more proficient interpreters: interpreters of the Christian language and its ways of seeing and evaluating the world of human affairs, and interpreters of the cultural languages that shape much of everyday life. Christian communities needed to become more self-aware in their Christian identity as they lived out their lives in a world of many languages and ways

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[117] Gerkin, 38-39.

[118] Purves, 111-112.

[119] Mother Teresa, *No Greater Love* (Novato, CA: New World Library, 2002), 56-57.

of speaking.[120]

If the local church is to be the one most effectively caring for those with chronic illness, then it must remember that the classic authors of pastoral theology taught that ministry must value each individual in every situation.

Pastoral theologians throughout church history have also shown that pastoral care need not be complex. There is no requirement for fancy formulas or extensive educational requirements. Pastoral care throughout church history shows that effective care to those dealing with sickness involves compassion. Mother Teresa writes, "Everyone can reach this love through meditation, the spirit of prayer, and sacrifice, by an intense interior life. Do not think that love, in order to be genuine, has to be extraordinary."[121] Pastoral theologians have taught that healing does not necessarily mean the absence of physical symptoms, as in the case of chronic illness. Pastoral care has been more concerned with the cure of the soul. The *Dictionary of Pastoral Care and Counseling* offers this definition:

> Pastoral care derives from the biblical image of shepherd and refers to the solicitous concern expressed within the religious community for persons in trouble or distress. Historically and within the Christian community, pastoral care is in the cure-of-souls tradition. Here cure may be understood as care in the sense of carefulness or anxious concern, not necessarily as healing, for the soul.[122]

Mother Teresa writes, "We cannot cure them. We ease their pain, give them compassion and lots of love. One of the worst forms of nakedness is the lack of human

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[120] Gerkin, 76.

[121] Teresa, 22.

[122] Hunter, ed., 836.

dignity. The worst hunger is to be unloved, wanting love and to be nobody to anyone."[123] To find this connection between caregiver and one in need requires, in Mother Teresa's perspective, simply the ability to be present with another person. The correct words are not important. Simply being a presence with one in the midst of a "Dark Night" will open the soul up to God. "Silence gives us a new outlook on everything. We need silence to be able to touch souls. The essential thing is not what we say but what God says to us and through us. In that silence, He will listen to us; there He will speak to our soul, and there we will hear His voice."[124]

Gregory the Great does offer a word of caution, however, when it comes to being a presence with those going through times of suffering. It becomes easy to lose balance between helping and entering into a place in ministry that is unhealthy. Andrew Purves explains:

> The pastor should be a neighbor in compassion to all and exalted above all in thought. Thus by the love of his or her heart the pastor must draw near to all who hurt, yet by contemplation transcend his or her own woundedness that accrues from solidarity with the pain of others, and thus maintain a right relationship with God. Too much compassion and the pastor ceases to seek that which is above; too much contemplation and the pastor neglects his or her neighbors. Gregory understands the biblical nature of compassion as a taking into oneself the suffering of others, and he knows well its dangers. Again, the lesson is one of balance.[125]

To care for those that are hurting, Gregory encourages leaders to listen to the will of God, yet make time for those in the world. Spending too much time in contemplation denies care to those who are hurting; while spending too much time offering compassion

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[123] Wright, 45.

[124] Teresa, 8.

[125] Purves, 70.

without seeking spiritual guidance from God hinders the ability to offer effective pastoral care. Pastoral care requires a balance between compassion and contemplation, yet it does not require complexity.

Finally, the most important value taught by pastoral theologians is that ministry to those who suffer, especially the chronically ill, must be done with an attitude of love. Martin Bucer believed that this love need not come solely from those ordained in ministry. Andrew Purves explains that to effectively care for the Body of Christ, every member has a role to play:

> Bucer argued that in Christian love each member of the body of Christ is to serve others. Christian love is a love that always turns away from oneself and towards others; because the Christian is, by definition, secure in Christ, he or she need take no heed for himself or herself. As such, however, Christian love is not mere altruism, but is the good work towards and for others that is God's will for them. As the primary fruit of the Spirit, after faith, love is to guide all gifts of the Spirit.[126]

Love comes from each person, not just those in the profession of ministry.

Richard Baxter steps to the forefront of this area of pastoral care in his work *The Reformed Pastor*. For Baxter, showing love to those that are the recipients of pastoral care is not so much about saying the right words or doing the right things. Effective pastoral care to those who are hurting requires showing our love through our actions. He writes:

> Bare words will not convince men that you have any great love for them. When you are not able to give, then show that you are willing to give if you had it, doing all the good you are able to do....When the people see that you love them, without pretense, then they will hear anything you tell them and they will bear anything you lay upon them.[127]

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[126] Ibid., 82.

[127] Baxter, 32.

Actions indeed speak louder than words.

Leaders in the church throughout history have shown that effective pastoral care can happen when love is the guiding principle. An understanding that the local church is an outreach of Christ, himself, allows care and spiritual healing to reach those with chronic illness. No matter what period of history in which the church finds itself, the church is still the Body of Christ. Love given to those experiencing a "Dark Night of the Soul" is pastoral care that can make a personal connection and end the isolation and loneliness felt by so many suffering from chronic illness. Mother Teresa summarizes this goal best:

> When we handle the sick and the needy we touch the suffering body of Christ and this touch will make us heroic; it will make us forget the repugnance and the natural tendencies in us. We need the eyes of deep faith to see Christ in the broken body and dirty clothes under which the most beautiful one among the sons of men hides. We shall need the hands of Christ to touch these bodies wounded by pain and suffering. Intense love does not measure – it just gives.[128]

Those who offer the type of pastoral care that Mother Teresa is suggesting create a connection between the one who suffers and Christ. By offering compassion and love to one with chronic illness, Christ can be seen in the life of those who suffer and in the caregiver as well. When this connection is made, the local church offers the hope that can end the isolation felt by those with chronic illness.

This chapter has shown that by looking through church history, theologians have offered a model that suggests the local church can be a place that connects the soul and body experiences of those dealing with chronic illness. From Gregory the Great to Mother Teresa, the church has recognized that true healing is not just physical but

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[128] Teresa, 30-31.

spiritual as well. Healing beyond the church walls and what is currently being realized in the hospital setting will be addressed in the next chapter.

# CHAPTER FOUR

# SPIRITUALITY AND HEALTHCARE

In 1984 Randolph Byrd, a San Francisco cardiologist conducted a landmark study which opened the door for spirituality and healthcare to join forces. Byrd studied approximately four hundred patients at San Francisco General Hospital that were admitted to the coronary care unit. Each patient was assigned an initial score based on the severity of their case and the likely outcome. One hundred and ninety-two patients were entered into a group that was the recipient of prayers from an intercessory prayer group while two hundred and one patients were put into a control group that did not receive prayers.[129]

Harold Koenig, a leader in the field of spirituality and medicine writes:

> All the patients were carefully screened for the progress of their heart disease and their response to medication and other therapy in the coronary care unit. The results were highly provocative. The heart patients who were prayed for suffered significantly fewer complications than those who received no prayer. Patients who were prayed for were five times less likely to require antibiotics for infection (a sign of good immune response), two and a half times less likely to suffer congestive heart failure, and had a significantly lower risk of sudden cardiac arrest.[130]

After this study, others in the medical field began to accept the possibility that spirituality did in fact have a positive effect on healing. William Haynes writes, "The group for whom prayers were offered had a shorter hospital stay, fewer episodes of pneumonia, and

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[129] Gary Thomas, "Doctors Who Pray," *Christianity Today* 41, no. 1 (1997): 22.

[130] Harold George Koenig, *The Healing Power of Faith* (New York: Simon and Schuster, 2001), 223.

were less frequently intubated and ventilated. This study suggests that intercessory prayer to our God does have a favorable effect on a patient's medical condition."[131]

These findings encouraged many in the field of medicine to continue the research. It became apparent, especially in the care of those with chronic illness, that the current practices of medicine were not adequately providing for people's total needs. Hospitals tend to function under the premise that all illnesses are acute, or able to be diagnosed and healed. Chronic illness, however, cannot be dealt with simply and the patient suffers in ways that acute care models cannot address.

> The acute care model leaves little room for the social, psychosocial, and behavioral dimensions of chronic illness. It does not provide for the commitment to continuing care. It is also not broad enough to account for and aid understanding of the types of human distress experienced by people with chronic conditions. These include challenges to the person's self-image and sense of meaning and purpose in life and the suffering that occurs due to the disruptions in the patient's extended system, including their family, friends, work associates, and community.[132]

Since the results of the Byrd Study became public in 1988, numerous studies have been done to analyze how spirituality and healthcare can combine to offer better care for those with both acute and chronic illness. Harold Koenig suggests that more than twelve hundred studies have been done which examine the relationship of health and spirituality. A majority of these studies have proven a "significant positive association."[133]

Even the World Health Organization (WHO) has taken note of these developments and responded. "The World Health Organization (WHO) has declared that

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[131] William F. Haynes, Jr. and Geffrey B. Kelly, *Is There a God in Health Care?* (New York: The Haworth Pastoral Press, 2006), 21.

[132] Kane, Priester, and Totten, 48.

[133] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 8.

spirituality is an important dimension of quality of life. Quality of life consists of multiple facets. How one is faring spiritually affects one's physical, psychological, and interpersonal status, and vice versa. All contribute to one's overall quality of life."[134] In addition, a new field of study within medicine is working to define the relationship between the emotional and spiritual life with the immune system of the body. This new field, which will be discussed more thoroughly in chapter six, is called psychoneuroimmunology. Studies by those in this field are leading the way in showing how our beliefs counteract the germs and diseases that attack the body as well as the importance of relationships in holistic healing.[135]

Before looking at the findings of some of these studies it is important to note that some within the field of medicine still discount these findings. "Spirituality is such a complex and personal construct that perhaps it cannot be adequately studied with quantitative methodology. Spirituality, meaning, and inner life are subject to personal interpretation and therefore difficult to define quantitatively."[136] It is the understanding of this thesis, however, that numerous studies do provide adequate grounds for the belief that spirituality does in fact impact health and healthcare. Spirituality can help those facing the physical and emotional affects of chronic illness.

One of the first studies showing how church involvement plays a role in better health was done in 2000. "Established studies examining religious involvement and death

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[134] Daniel P Sulmasy, *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care* (Washington, D.C.: Georgetown University Press, 2006), 132.

[135] Ludwig, 146.

[136] Christina M. Puchalski, *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (New York: Oxford University Press, 2006), 12.

by any cause summed 42 study samples totaling nearly 126,000 people and found active religious involvement increased by 29% the chance for living longer."[137] In addition, researchers at Duke University found that people who attend religious services at least once a week, have consistently lower blood pressure rates and are 40% less likely to have heart attacks or strokes. Their studies also show that six months after surgery, those who attend church have a lower death rate. Depression is affected, in that those who attend worship services are less likely to be depressed or recover more quickly from the effects of depression. Transplant patients recover better physically and emotionally and those patients who have a prayer group praying for them have a more favorable outcome. One study shows that the elderly with religious affiliation and activity average ten days of hospital care per year while those without religious affiliation average 60 days.[138]

Within the hospital setting, the role of spirituality is increasingly playing a major part in care. Hospitals and experts within the field of medicine are responding to the research. Physicians' desire that patients be as well as possible and this means addressing all issues that patients face. "The work of healing our ills, whether they be physical, spiritual, or emotional, takes place primarily in the spiritual relationship in faith with which God has gifted us if we chose to accept it. A genuine spirituality inspired by faith can infuse a dynamic power into today's health care ministries."[139]

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[137] David B. Larson and Susan S. Larson, "Spirituality's Potential Relevance to Physical and Emotional Health: A Brief Overview of Quantitative Research," *Journal of Psychology and Theology* 31, no. 1 (2003): 38.

[138] Jay Copp, "Faith and Medicine: A Growing Practice," *St. Anthony Messenger* 107 March, no. 10 (2000): 25-26.

[139] Haynes and Kelly, 26.

The problem for those with chronic illness is that these diseases do not go away and these patients begin to question the role of God and spirituality in their life while in the hospital setting. The church must do a better job of caring for these individuals because these questions can have adverse effects on health and wholeness. "Chronic illness may result in some individuals questioning their religious beliefs. Any loss of religious faith as a source of meaning or support that enhances coping will compound the loss associated with the change in health status resulting from chronic illness."[140]

It is unfortunate that many dealing with chronic illness do not find the support and encouragement that spirituality and effective pastoral care can offer. While studies have shown the positive effects of faith, all too often those suffering with chronic illness are made to feel as if they are being punished by God. Instead of helping, insensitive pastoral care mixed with a lack of understanding on the part of the healthcare system, negatively affects those who suffer. Harold Koenig states:

> Religion may become so rigid and inflexible that it becomes excessively restricting and limiting. Religion may encourage magical thinking as people pray for and expect physical healing as if God were a giant genie at the beck and call of every human whim. If that physical healing does not come immediately, then the person may be disappointed and disheartened, claiming that prayer was not answered and that God does not care, or worse, that the illness was sent by an angry, vengeful God as a punishment. These uses of religion are common in healthcare settings, causing distress and potentially having a negative impact on illness and its response to medical treatment.[141]

Patients who doubt God and have negative views of spirituality, have reflected incredible results and impact on the role of spirituality in healthcare. When patients responded that they, "Wondered whether God had abandoned them," they had a 28%

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[140] Wendy Greenstreet, "From Spirituality to Coping Strategy: Making Sense of Chronic Illness," *British Journal of Nursing* 15, no. 17 (2006): 940.

[141] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 78.

increased risk of mortality. When the patient, "Questioned God's love for me," the risk was 22% and when those who were ill said that, "The devil made this happen," the risk of death went up 19%.[142] When spiritual struggles go unresolved, the link with depression, poorer quality of health, lack of self-esteem, and slower recovery all increase as well as the risk of death.[143]

The role faith has in health is being recognized by both patients and physicians, yet making this connection is still difficult.

> A study surveying more than 200 hospital inpatients found that 77% said physicians should consider patients' spiritual needs. Furthermore, 37% wanted their physician to discuss spiritual beliefs with them more frequently, and 48% wanted their physicians to pray with them. A Time/CNN poll found that 65% of people surveyed want their physician to address spiritual issues. In a *USAToday Weekend* health survey, the majority of people polled felt that doctors should talk with their patients about spiritual concerns, yet only 10% reported that their doctors had discussed such issues with them. This statistic is understandable because, until recently, spirituality has been overlooked in medical school curricula and in the standards of medical care.[144]

Progress is being made within the field of medicine in addressing the role spirituality plays in caring for those with illness and specifically those with chronic illness, yet it will continue to take time for this progress to be realized more fully. Spirituality combined with medicine is nothing new. It is merely a rebirth of the understanding that the two fields have much to offer each other.

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[142] Larson and Larson: 40.

[143] Boyd, 123.

[144] Puchalski, 14.

## The Birth of Hospitals and Healthcare

Chapter Three briefly addressed the beginning of the healthcare system but this chapter looks more in depth at that birth. The idea of spirituality being an important part of healthcare is not new. This belief was at the foundation of the birth of hospitals. The church and faith both played a vital role in caring for the sick. Healthcare today is just returning to that beginning. Harold Koenig writes:

> Although addressing spiritual needs of patients as part of medical care is seen today as something new and different, this practice is actually a very old one. In fact, only within the past several hundred years have medicine and religion pursued separate paths and physicians ignored these issues. Indeed, throughout most of recorded human history, religion and medicine walked quite closely together.[145]

In the first century, the church began the ministry of healthcare and hospitals. "One of the earliest, and perhaps the best known, was the Basileias, which was founded in about AD 372 by Basil the Great, who was Bishop of Caesarea in Cappadocia. Basil provided as well accommodations for travelers and apparently a section for the treatment of lepers. This hospital had both nurses and medical attendants."[146] These hospitals were not merely places where the ill could come to die. It was expected that they would be properly cared for and that both physical and emotional wholeness could be achieved.

Early hospitals in the fourth century had three distinct characteristics. First, they had inpatient facilities where patients were given a bed and food as long as treatment lasted. Secondly, they offered professional medical care by trained and educated doctors

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[145] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 15-16.

[146] Ronald Numbers and Darrel Amundsen, eds., *Caring and Curing: Health and Medicine in the Western Religious Traditions* (Baltimore, MD: The John Hopkins University Press, 1986), 49.

and nurses in addition to spiritual care offered by monks. Thirdly, care was provided out of charity and as a response to the Gospel of Jesus Christ. The ability to pay was not a prerequisite. Anyone needing care, especially the poor, was welcome.[147]

Basil the Great defined what charity meant as he established this first hospital. Charitable care was broken into six categories that met the basic needs of those who were suffering. For Basil, charitable care was meant for the poor, strangers and the homeless, orphans, the elderly and infirm, lepers, and the general sick.[148] It was important to him that the church maintain a connection to the hospital. "The hospital was not, however, a secular institution, although it was staffed to a large degree by professional doctors and nurses. Rather, Basil linked his hospital administratively to his monastery, and monastics were expected to serve in the hospital as one of the standard monastic duties."[149]

Basil's hospital was not just one building, it was in fact an entire complex of buildings that came to be nicknamed "a new city." This city included the medical facility, a hostel for visitors, the monastery, as well as a full range of support facilities such as baths, storehouses, kitchens, workshops, stables, and housing for the staff.[150] This desire for the church to reach out to the ill began to spread and soon hospitals were being created in many locations.

> Theodosius in Palestine, for example, established around the year 479 three affiliated hospitals, one for monastics, one for the poor, and one for paying

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[147] Andrew T. Crislip, *From Monastery to Hospital: Christian Monasticism and the Transformation of Health Care in Late Antiquity* (Ann Arbor, MI: The University of Michigan Press, 2005), 101-102.

[148] Ibid., 105-106.

[149] Ibid., 116-117.

[150] Ibid., 104-105.

> clients. By the turn of the fifth century, the establishment of hospitals had become a common vocation of ecclesiastical and ascetic leaders, following the lead of Basil of Caesarea. John Chrysostom founded a number of hospitals in Constantinople, while Jerome's friends Fabiola and Pammachius founded similar institutions in Rome and Ostia. As the commentators on these institutions testify, by the fifth century the hospital was an accepted feature of Late Antiquity.[151]

The underlying principle in the birth of the hospital was to offer the charity and love shown throughout the Gospel. The connection between spirituality and healthcare was strong and faith was incorporated into care. In response to the illness and suffering seen by those within the church, a system of healthcare was established to care for those in need. "It was especially in response to the widespread suffering and disease in the growing towns and cities of the late eleventh and twelfth centuries that Augustinian canons and various lay brotherhoods established houses of charity that included institutions or facilities for the succor of the destitute ill."[152]

In the thirteenth century, control of healthcare and hospitals began to shift, however, from the church to local governments.

> By the beginning of the thirteenth century, many hospitals had one or more trained physicians. The hospitals themselves were owned by church orders. During the thirteenth and fourteenth centuries, especially in Italy and Germany, the control of many of these institutions passed into the hands of municipal governments also as part of the general laicization of European society.[153]

By the sixteenth century, the state became the legal binding force in the licensing of medical schools and physicians and the church's influence continued to decrease due to the scientific revolution in the seventeenth and eighteenth centuries with the philosophy

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[151] Ibid., 102-103.

[152] Numbers and Amundsen, eds., 86.

[153] Ibid.

of the Enlightenment. Scholars state that by the time of the French Revolution in the nineteenth century the church's control had basically disappeared.[154]

Despite the shift in the administrative control of the medical facilities, the church continued to be a strong witness to the role of spirituality in healing. Those in the church realized that treating the whole individual meant taking care of the physical needs as well as the spiritual. This connection was represented strongly in the field of nursing. Harold Koenig writes:

> Even closer than the connection between religion and medicine is the historical link between religion and nursing. The profession of nursing came directly out of the church, as the Daughters of Charity of St. Vincent de Paul began to organize Catholic sisters to serve both religious and secular hospitals in 1617. By 1789, there were more than four hundred hospitals run by the Daughters of Charity in France alone. In 1803, the Daughters of Charity officially started the first organized nursing group in the United States at Emmitsburg, Maryland. After receiving a "calling from God" in 1837, Florence Nightingale sought training among the Daughters of Charity and the Protestant deaconesses, later applying the principles she learned to help found the modern practice of nursing.[155]

A holistic approach to treating individuals was the desire of those involved in the creation of the nursing field and with their help spirituality and healthcare came together. Young and Koopsen maintain that:

> Nursing is a manifestation of God's love expressed through caring, compassion, and charity toward the sick and the poor. Nursing saw the patient as a whole and treated him or her holistically. Nightingale was an advocate of holistic care and did not treat the patient as simply a disease. She recognized a force that healed and was greater than herself.[156]

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[154] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 16-17.

[155] Ibid., 17.

[156] Caroline Young and Cyndie Koopsen, *Spirituality, Health, and Healing* (Thorofare, NJ: Slack, Inc., 2005), 25.

Although some degree of control has been lost by the church in the administration of hospitals today, the church continues to strive to make a difference in the quality of healthcare. Many are continuing the push for medical facilities to return to their original connection to spirituality. "During the late nineteenth and early twentieth centuries, all the major religious bodies in America – Catholic, Protestant, and Jewish – established hospitals, and by the mid-twentieth century, church-related hospitals were caring for over a quarter of all hospitalized patients in the United States."[157]

The push for the separation of spirituality and medicine centered largely around those in the field of psychiatry, such as Sigmund Freud, who dismissed religion as "infantile helplessness and a regression to primary narcissism."[158] Harold Koenig writes, "The final nail in the coffin was placed by Sigmund Freud, who from 1908 till his death in 1939 wrote and spoke widely about the neurotic aspects of religion. His teachings would dramatically change the views of the next generation of psychiatrists toward religion."[159]

In 1960, geriatric expert Dr. Nila Kirkpatrick Covalt pushed the separation even farther. As a physician she encouraged other physicians to overlook the past relationship between faith and physical care. She taught that those who brought a Bible with them to the hospital and openly displayed it were merely insecure individuals who were

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[157] Numbers and Amundsen, eds., 2.

[158] Wallis: 59.

[159] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 18.

anticipating trouble.[160] The chasm between these two fields, however, is now beginning to be crossed.

Daniel Sulmasy writes in *The Rebirth of the Clinic*:

> Religion, medicine, and health care have been closely interconnected throughout most of recorded human history. After the turn of the nineteenth century, however, a wall of separation rose between these two disciplines. But over the past several decades, scientific studies have begun to examine the effects of religious beliefs and practices on mental and physical health. The goal of the studies has been to explain such effects through natural mechanisms. The majority of these studies suggest that religious involvement is associated with better mental health, greater social support, and avoidance of negative health behaviors.[161]

Science and religion have come full circle, in the realization that holistic healing for the long-term needs of those with chronic conditions means touching not just the physical but the spiritual as well. Harold Koenig maintains:

> Clinicians on the front line of patient care are only slowly learning to incorporate the potential of faith's healing power into the preventive medicine they practice each day. This cautious approach to the melding of religion and medicine has long been justified because there simply has not been enough scientific evidence that religious faith and involvement produce tangible benefits to physical and emotional health. That situation is beginning to change.[162]

As those in the fields of medicine and religion work together, those who suffer especially with chronic illness, can find hope and emotional healing despite the continuation of their disease.

The desire for change in the current healthcare system and the connection between spirituality and health is being driven not just by individuals and families dealing with chronic illness, but also doctors and health organizations that desire to see

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[160] Koenig, *The Healing Power of Faith*, 19-20.

[161] Sulmasy, 27.

[162] Koenig, *The Healing Power of Faith*, 258.

more effective care happening for those with chronic illness. The World Health Organization specifically addressed the subject of dealing with chronic illness and named the issues that must be fixed in chronic illness care.

> WHO has outlined a number of problems in health care systems around the globe that make caring for those with chronic conditions difficult. Dominant issues include: (1) the overall failure to empower patients, value patient interactions, address prevention, and connect with community resources; (2) health care workers' lack of tools and expertise; (3) practice that is not informed by scientific evidence; and (4) a lack of existing information systems. These issues leave both those who live with chronic illness and governments that face the challenge of coping with the escalating costs of care voicing frustration with the current systems of chronic care and calling for revision of chronic care systems.[163]

## Healthcare Changes in the Current System

The realization that holistic care can happen by joining forces with spirituality and medicine is causing change within the healthcare system. "The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals, recognized that spiritual concerns are often important for patients and that hospitals should provide spiritual care."[164] As a result of this statement many hospitals have worked to create a "Patients' Bill of Rights" that requires healthcare facilities to provide care that meets both the physical and spiritual needs of patients. The George Washington School of Medicine created the George Washington Institute for Spirituality and Health which addresses these rights by stating that healthcare providers will offer a variety of

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[163] Sharon A. Cumbie, Virginia M. Conley, and Mary E. Burman, "Advanced Practice Nursing Model for Comprehensive Care with Chronic Illness," *Advances in Nursing Science* 27, no. 1 (2004): 71-72.

[164] Puchalski, 22-23.

services. Some of these include: forming collaborative partnerships with chaplains and clergy, recognizing that spirituality does play a role in the profession of medicine, including spirituality and its importance to health in medical school curriculum, increased scholarly research on the subject, and spirituality and healthcare training programs that span all disciplines.[165]

One of the changes that can be seen most easily has taken place within medical schools and their training. "By 2001, over seventy of the 125 allopathic schools of medicine in the United States offered required or elective courses in spirituality and medicine compared with just one school in 1992."[166] Loyola University Medical Center and its School of Medicine in Illinois has taken the lead in teaching other medical schools the importance of offering these courses. Students at Loyola are required to take courses in spirituality and medicine each of their four years in medical school. In addition, students spend time working in the hospice facility and assisted living so that they can learn to better understand terminal and chronic illnesses. Students take courses that discuss religious implications for medical decisions, such as end of life and reproductive issues. They also are required to make rounds with the chaplains throughout their study. The school has found that the connection and teamwork between these students and the chaplains in the hospital steadily increases in the third and fourth year of study.[167]

Medical students are learning how to be present with patients and to move beyond the desire to simply fix problems. They are realizing that personal care involves both the

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[165] Verna Benner Carson and Harold G. Koenig, *Spiritual Caregiving: Healthcare as a Ministry*, ed. Harold George Koenig (Philadelphia, PA: Templeton Foundation Press, 2004), 40-41.

[166] Sorajjakool and Lamberton, eds., 1.

[167] Copp: 24.

mind and the body. This training is difficult but schools are seeing a change in their students. Christina Puchalski writes:

> They have been trained to *act*, and not to sit still, at the bedside of a patient, particularly if the patient is terminally ill. Also, they may often have an unrealistic expectation that the patient is not going to die. When the natural event of death occurs, despite all the modern medical advances at their disposal, it can be perceived as failure on their part.[168]

Medical schools are finding that they still have much learning to do, and many physicians are still lacking in the confidence to utilize this spiritual training, however, the schools are striving to address the needs of patients. The encouragement to continue this process comes not only from patients and their families but also from the John Templeton Foundation. This foundation was started in 1995 and is directed by Christina Puchalski, a leading physician in recognizing the role spirituality plays in medicine. Competitive awards are given to medical schools and residencies that develop and implement educational courses in spirituality and health.[169]

Another way in which hospitals and physicians are striving to connect the role of spirituality with health care is through the use of spiritual assessments. "As of 2003, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandates that a spiritual assessment be completed on all patients admitted to a general hospital."[170] There are a variety of assessments currently available that have been created in conjunction with both physicians and clergy. Some popular assessments include: FICA, MERIT, and SPIRITual History. Each tool varies in the number of questions and how the

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[168] Haynes and Kelly, 140-141.

[169] Puchalski, 230.

[170] Carson and Koenig, 71.

issues are covered, yet they all offer assessment in four basic categories: does the patient use religion or spirituality to cope with illness or is this a sources of stress, are they a member of a supportive spiritual community, do they have troubling spiritual questions, and what spiritual beliefs do they have that might influence medical care.[171]

Verna Carson writes in *Spiritual Caregiving*:

> This story – unlike the information obtained in a traditional history and physical, where we focus on past health issues, the current complaint, the history of various treatments, and the patient's response to those treatments, as well as the family and social history – reveals more than factual information. We are searching for threads that weave the facts together and make them come alive. We are searching for the pattern in the person's life tapestry that allows us to see the fractured people in front of us as unique and precious with a story like no other.[172]

Those in the field of medicine have realized that spirituality and the beliefs of patients impact their recovery and the wholeness that they seek. To ignore the spiritual thoughts, questions, and concerns within the patient is to ignore an important piece of the patient's ability to encounter healing. When spirituality and medicine are combined through the knowledge gained in spiritual assessments, physicians are better able to care for those with illness.

This specialized spiritual care is often too much for physicians and nurses to add to their already complicated roles and medical schools are only in the beginning stages of offering courses in dealing with spiritual issues. To correct this issue, hospitals have realized the need for someone to step in and take the lead in this joining of faith and health and increased the role and importance of the hospital chaplain. Young and Koopsen explain:

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[171] Koenig, *Spirituality in Patient Care: Why, How, When, and What*, 22.

[172] Carson and Koenig, 88-89.

> Chaplains are professionals who represent a merger of theology and psychology. An estimated 9,000 chaplains in the United States help people with health-related transitions. Chaplains are professionally accountable to their religious faith group, the certifying chaplaincy organization, and their employing institution. They can provide spiritual care to all types of individuals, including actively religious persons who may not notify their religious community leaders of their hospitalization, other hospitalized or ill individuals who do not belong to a religious or spiritual community, and individuals who may be far from their spiritual leader when they become ill.[173]

These chaplains have gone through numerous educational and training requirements including a bachelor's and master's level degree. They also receive Board Certification after their graduate theological training of at least three years. Most are ordained and receive ecclesiastical endorsement by their denomination and complete at least 1,600 hours of supervised Clinical Pastoral Education over a minimum of one year training.[174] Thorough training gives chaplains the tools they need to be effective in their role as the bridge between spirituality and health in hospital settings.

Healthcare professionals are realizing the importance of taking a spiritual assessment and many times this gets added to the role of the chaplain. Caroline Young in *Spirituality, Health, and Healing*, describes four broad roles that pertain to chaplains in hospital settings. These responsibilities include: conducting spiritual assessments, responding to patients' religious concerns and helping with religious coping strategies, supporting the professional staff of the hospital, and functioning as a liaison with the religious communities outside the hospital.[175]

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[173] Young and Koopsen, 27.

[174] Dana E. King, *Faith, Spirituality, and Medicine* (Binghamton, NY: The Haworth Press, Inc, 2000), 73-74.

[175] Young and Koopsen, 28.

Chaplains find themselves in an increasingly difficult job as the connection between spirituality and health deepens. The task is great and they are called not only to care for patients, but their families, and the hospital staff as well. Skokan and Bader write:

> Clearly, the chaplain's role may need to be expanded beyond that of direct caregiving. Chaplains can play a significant part in training other healthcare staff and volunteers how to listen and interact with patients. As lengths of hospital stay grow shorter, much of the responsibility for care shifts from the staff to the family; chaplains can also help family caregivers deal with this new and very difficult role, as well as connect the family with needed support services.[176]

By fulfilling this role, the hospital chaplain not only cares for the patient but also becomes a valuable part of the healthcare team. Working side by side with physicians, nurses, social workers, psychologists, and others who care for those suffering with chronic illness makes the chaplain a connection to holistic care.

The use of chaplains has already shown scientific evidence in increasing recovery from illness, shortening hospital stays, and improving care for many who suffer. Dana King states:

> Experimental evidence supports chaplain use and referral. One study of open-heart surgery patients found that those randomly referred to a supplementary chaplain intervention recovered more quickly and required two fewer hospital days than control patients. Another study found that orthopedic surgery patients needed less pain medication when receiving daily chaplain visits. If collaboration between physicians and chaplains broadens the biopsychosocial model, it is welcomed by patients, and is empirically beneficial to health, then the ethics of such collaboration have much to commend it.[177]

Due to the fact that the chronically ill find themselves in the hospital at numerous times, chaplains play a significant role in helping them find hope in the midst of their illness.

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[176] Skokan and Bader: 42.

[177] King, 67.

They are yet one more example of how the church can effectively care for those dealing with chronic illness.

This chapter has shown that the connection between spirituality and health has existed since the birth of hospital care. From Basil the Great to the middle of the twentieth century, the church had a connection to hospital care. Although strained at times, this relationship allowed patients to receive care offering the hope that faith provides. Current studies show that those in the field of medicine are once again embracing the impact spirituality can play in the care of those dealing with illness. Adjustments in medical education, gathering spiritual information from patients, and incorporating the hospital chaplain into the medical team at the hospital, have all been steps in bringing health and spirituality back together. Medical professionals are realizing the significance of faith in healthcare and the next chapter will show how the local church is also responding to the importance of holistic care.

# CHAPTER FIVE

## CURRENT MODELS OF CARE IN THE LOCAL CHURCH

Whether implicitly or explicitly, faith has always played a role in the care and healing of those who are ill. The church has realized, however, that "healing" comes in many forms. For some in local church ministry, "healing" has meant physical wholeness, yet the church is learning that true "healing" may come with spiritual care, support, and education. A report from the Center for Disease Control states:

> There is a faith and health movement spreading across this nation. It can be seen in the growth of congregation-based nurse programs, health ministries, and interfaith service organizations engaging in health-related activities. Through these faith-based structures, faith groups and communities are receiving benefits of health education, counseling, and a wide variety of support services and systems to advance and promote health and well-being. This work grows out of the health tenets that exist within every faith tradition.[178]

This deliberate growth has come with an awareness that the church may not always be able to physically heal or take away all illness but a caring Christian community can bring wholeness to individuals in the midst of crisis. Cheri Register writes:

> In the past five to ten years, religious institutions have begun paying more deliberate attention to the common needs of the chronically ill and the disabled rather than responding to members' illnesses as isolated crises. In part, this may be a response to the shortcomings of the health care industry, and in part the result of observing the unity of physical health and spiritual health.[179]

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[178] "Engaging Faith Communities as Partners in Improving Community Health," 1.

[179] Cheri Register, *The Chronic Illness Experience* (Center City, MN: Hazelden, 1987), 309.

## Faith Healing

Some in the church have believed and continue to believe that faith can bring physical, miraculous healing to individuals. Faith healing is defined as "improving health in body, mind or spirit by means of prayer or other extranormal states of consciousness, usually occurring apart from orthodox medicine and considered miraculous."[180] This belief that faith can miraculously heal, can be traced throughout church history and the Bible. "Phenomena associated with faith healing have a history as ancient as the human race. They are documented in every region and culture of the globe and occupy a prominent place in the Hebrew-Christian Scriptures, particularly in the ministry of Jesus."[181]

As discussed in previous chapters, many of the early church leaders held the view that suffering was due to sin or the failure to be connected deeply enough with God. Thus, if healing was to come, it also had to come through faith in God. A strong faith would break the bond of illness and bring healing. While numerous faith traditions operated with this concept and practiced various healing services and rituals, it was predominately within the Pentecostal movement that faith healing reached its highest concentration. The *Dictionary of Pastoral Care and Counseling* states:

> Pentecostalism, dating from 1906, emphasizes faith healing and charismatic healing as primary modes of ministry to the sick. Although charismatic healing was prominent from the beginning, a wave of healing revivalism burst on the American scene from 1947-52. William Branham, Kathryn Kuhlman, and Oral Roberts were among the best known healers of the period.[182]

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[180] Hunter, ed., 401.

[181] Ibid.

[182] Ibid., 402.

These miracles came as a result of the healing touch and prayer of the religious leaders, but more importantly as a response to the faith of those who were ill, their families, and their faith communities. For divine healing to occur, individuals needed to be sure of their salvation. Without this assurance, total healing might not occur. Preaching, teaching, and the laying on of hands were all necessary in this process. Nancy Hardesty writes:

> Based on this theology, most Holiness writers and preachers presented healing only within the context of deeper Christian experience. As Bainbridge cautioned, "Do not begin your quest for physical deliverance by praying to be healed." Preachers presented divine healing only after they had preached salvation and sanctification. While some people testified that they got healed at the same time they found salvation, Simpson, for example, would not lay hands on anyone until he was sure that the person was saved and preferably sanctified or at least seeking sanctification. It was important that body, soul, and spirit all be fully consecrated to God.[183]

Norman Vincent Peale concluded, after researching cases considered "successful" healings, that five factors must be present in individuals wishing to be healed. These traits include a complete willingness to surrender totally to God, a desire to let go of all sins and errors to cleanse the soul, along with a belief that there is harmony between medical science and the healing power of God. He also states that individuals have to accept God's answer, whether that includes miraculous physical healing or not without bitterness. Finally, they have to have unquestioning faith that God can heal.[184]

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[183] Nancy A. Hardesty, *Faith Cure: Divine Healing in the Holiness and Pentecostal Movements* (Peabody, Massachusetts: Hendrickson Publishers, 2003), 94.

[184] Frederic Flach, *Faith, Healing, and Miracles* (New York: Hatherleigh Press, 2000), 95.

Just as was seen throughout the ministry of Jesus, these miraculous healings occurred and physical illness was, at times, removed. Problems began to arise, however, when not every person was healed. Dee Dee Risher explains:

> There are good reasons, of course, to question miraculous healing. The most compelling is this one: Not everyone is healed. This is a great stumbling block. For most of its history, the church has linked healing and belief. The Bible often does the same. Those who believe are healed. But the nagging correlation is this: those who are not healed must not really believe.[185]

In dealing with chronic illness, the symptoms may change but the disease does not go away. Faith healers have found it difficult to make peace with this issue. Because faith was tied directly with "healing," the obvious response was to blame the individual who suffered from chronic illness for not having a strong enough faith to be free from all physical symptoms. "The first option always considered when healing did not take place was to blame the victim, to look for sin in the life of the sick person."[186]

Chronic illness became the scapegoat for unsuccessful healings. One faith healer commented, "Many good people, who are most undoubtedly saved, fall into sin through a variety of causes, and in consequence, while forgiven, are taken from the world or prostrated beneath chronic disease."[187] Because of this blame, a ministry meant to help, led those with chronic illness only to feel worse about themselves and their illness. If healing had not come, then their faith must not be strong enough. "In such a theological perspective, a 'failed' healing actually carries with it the stigma of spiritual inadequacy.

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[185] Dee Dee Risher, "The Stumbling Block of Healing," *Sojourners Magazine* 35, no. 6 (2006): 30.

[186] Hardesty, 130.

[187] Ibid., 132.

The suffering person continues to live with the condition as well as carrying an indictment of their own faith."[188]

The public perception of faith healing began to wane further not only because of the lack of healings in some individuals with chronic illness but also because some faith healers were shown to be frauds. Nancy Hardesty draws this conclusion:

> The most obvious shift is that public perception of divine healing came to be focused on individual healers. With the advent of radio and then television, healing became the province of showmen whom the general public often regarded as fakes, frauds, and con men. The fact that some became involved in public scandals and even criminal behavior further stigmatized the subject as the century progressed.[189]

Those in the Pentecostal and Holiness movements that ascribed to the tenets of faith healing continued to face challenges. These difficulties began with unsuccessful 'healings' and continued to suffer as individuals sought personal gain and attention. The obstacles, however, did not stop there.

Many faith healers encouraged discontinuing the use of medicines, which for those with chronic illness would only cause more difficulties with their disease and sometimes death. Parents who followed these healing practices began making decisions on their children's behalf. This controversial aspect of the faith healing movement not only caused issues for individuals but for the legal system as well. Hardesty continues:

> As medicine developed inoculations and vaccinations against diseases, issues among children began to surface. First there was the smallpox vaccination, then the diphtheria and tetanus inoculations. As these became more effective, common, and finally required by law, the ability of parents to make decisions about their children's care based on religious principles were increasingly challenged. Holiness and Pentecostal groups were intimidated by legal action.[190]

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[188] Risher: 30.

[189] Hardesty, 134.

[190] Ibid., 136.

As recently as the 1980s, a Holiness group in Northern Indiana which had broken from the Church of God (Anderson) tradition, faced legal prosecution because several children died due to the lack of medical care.[191]

Legal issues, a change in medical practices, attention to phony leaders, and the question of failed healings all led the church to adjust its understanding of what is true healing. While some Christian denominations still practice faith healing and while healings do, on occasion, still happen, this new understanding accepts the principle that "healing" does not mean that all symptoms of illness disappear. Healing can come through an understanding that a lack of faith or the reality of sin does not cause illness.

This new understanding of hope and healing that is dawning in the church today reflects the learning found in Chapter Two of this dissertation. As shown there, Jesus announces in the Gospels the main purpose of delivering people from suffering and pain. His love replaces sorrow with hope. He heals the sick in an effort to show that suffering is in opposition to God's will. The theology that God causes suffering and pain is directly addressed in Jesus' mission and ministry. Instead, in the mystery of faith there is hope. Nancy Hardesty writes:

> Essentially there is no answer to the question why some are healed and others are not, why the righteous sometimes suffer and sinners live long and healthy lives. Despite the best attempts of Holiness and Pentecostal people to find the secret of divine healing, they uncovered no magic formula, no surefire cure. Medicine had and has the same problem. Some people did and do find their suffering eliminated through spiritual means. And some do not. A modern antibiotic or a particular surgery may cure many people with a specific condition, but some will experience no relief. There are no guarantees. The answer to the question is still a mystery. For religious persons, it is a mystery locked in the inscrutable mind of God.[192]

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[191] Ibid.

[192] Ibid., 133.

There are many questions that remain surrounding the issues of suffering and illness and various methods from science to faith healing have tried to find answers. Yet, the local church offers the best hope for those dealing with chronic illness by sharing the love of Christ with those caught in situations that no words can explain or take away. This hope is being realized by the local church through effective ministries.

## Addressing the Question of Healing in Today

Questions remain about how to help those suffering from chronic illness and just what exactly it means to be "healed." Yet, the church is beginning to take a more active role in caring for these individuals. Garth Ludwig writes in *Order Restored*:

> The church is discovering how much it has to say about human health and well-being. Many congregations are conducting workshops and seminars devoted to the topic of healing. It is no longer a stigma to lay on hands while praying for the sick nor even in anointing the sick with oil. Healing services, once the exclusive province of "faith healers," are being established in mainline churches. Indeed, as the church seeks to apply the theology of health to the Christian life, topics such as nutrition, exercise, and meditation have become lively points of discussion in a health-oriented church. We live in exciting times. As we share the Gospel of the kingdom, we are at the same time sharing God's gifts of healing with those who are sick and ill.[193]

One of the most active ministries leading the way in caring for those with chronic illness and other challenges is the Stephen Ministry program. Stephen Ministry was founded by Rev. Kenneth C. Haugk, PhD, a pastor and clinical psychologist in 1975. He

[193] Ludwig, 202-203.

trained nine laypersons in his congregation in St. Louis, Missouri to provide Christian care to both members in the congregation as well as those in the community.[194]

David A. Paap, who is one of the directors of the program, explains the biblical roots of the ministry in this way. "Following the biblical account of Stephen, who assisted the apostles by performing charitable tasks at the Jerusalem church, Stephen Ministries trains church leaders who in turn train members to be 'Jesus Christ incarnate to a person in need of care.'"[195] Latest records show that more than 9,000 congregations are enrolled in the program, representing over 150 Christian denominations in all 50 states as well as 10 Canadian provinces and 21 other countries. More than 50,000 individuals have been trained as leaders of the program in the local church and they in turn have trained more than 450,000 laypersons to be Stephen Ministers.[196]

As the number of individuals suffering from chronic illness continues to grow, the church must find more effective ways to respond. The need for care has grown beyond the individual ability of the local church pastor, hospital chaplain, and trained professionals to adequately care for and give the needed time to those who are ill. It is because of this need that Stephen Ministry has had such an impact. Christina Puchalski works within the healthcare system and she writes:

> Currently, the need far exceeds the supply of chaplains and other professionally trained spiritual care providers. Religious communities similarly are faced with a greater demand for services and support than they are able to handle. Thus, the role of the lay volunteer spiritual companion becomes important. The lay companion has some training but also is available to people on a more regular

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[194] *Media Fact Sheet: Stephen Ministries St. Louis*, (Stephen Ministries, 2000, accessed Aug. 28 2006); available from www.stephenministries.org.

[195] Mark Kellner, "Empowering the Laity," *Christianity Today* 39, no. 13 (1995): 82.

[196] *Media Fact Sheet: Stephen Ministries St. Louis*, (accessed).

> basis: for example, once or twice a week. In the Stephen Ministry model, companions generally do not take on more than one or two clients. Professional spiritual care providers, as well as others on the healthcare team, care for large numbers of parishioners, clients, and patients. So from a practical point of view, the lay companion is more accessible to the patient and his or her family.[197]

The Stephen Ministry Series is a complete training system for lay persons in local congregations. They initially agree to two years of service, which includes a first year of over 50 hours of training. In the second year, Stephen Ministers meet twice monthly for continuing education and peer support. Topics that are covered include: listening, assertiveness, confidentiality, and ministering to people in specific situations such as chronic and terminal illnesses. They meet with a care receiver for about one hour weekly after the initial training is completed.[198]

Dr. Haugk has stated that the belief that the local pastor is the leader of ministry, and the congregation is merely a spectator, "has been a very major stumbling block that we have had to deal with."[199] Chapter Two shows that Jesus taught His followers to reach out in care and ministry to those who were hurting. To love our neighbors shows that we love God. This understanding of all Christians in ministry was understood by theologians throughout history. Philipp Jacob Spener, John Wesley, and Mother Teresa among others, were shown in Chapter Three as reformers of the thought that only ordained clergy could care for the sick. Stephen Ministry continues to help the church, not only by caring for individuals dealing with illness, but also by encouraging all in the church to accept this role of care. David Paap states:

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[197] Puchalski, 249.

[198] *Media Fact Sheet: Stephen Ministries St. Louis*, (accessed).

[199] Kellner: 82.

> Perhaps the greatest stumbling block to providing quality Christian care is thinking the pastor needs to be the only one who provides it. The good news is that, if your congregation is like most, there are a great number of people who have gifts such as mercy, encouragement, and helping. With the right kind of training and organization, lay people can provide very high-quality Christian care for people who are hurting or suffering. That's what the Stephen Series has been doing in thousands of congregations for more than 25 years – equipping laypeople who are called Stephen Ministers to use their God-given gifts to make a significant difference in the lives of hurting people in their congregation and community.[200]

Like Stephen Ministry, parish nursing is another lay ministry that addresses the need for care of those with chronic illness in the local church. The definition of a parish nurse follows:

> A parish nurse is an experienced registered nurse with specialized training in holistic health and spiritual care. He or she has "spiritual maturity and a commitment to healing ministries." While their educational background may vary, most parish nurses receive their training in spiritual caregiving; philosophy, health assessment, and psychosocial issues; community resources; and the professional, legal, and ethical issues that are specific to their role.[201]

Parish nursing was founded in 1983 by a Lutheran minister, Reverend Granger Westberg, from Chicago, Illinois, out of a desire to offer more holistic care due to the separation between spirituality and healing found within scientific thought.[202] After reading the Gospels and understanding the ministry of Jesus that offers healing to both body and soul, he adopted this mission for parish nursing. The ministry of parish nursing desires to fill "the void left by inadequate health-care systems and helps parishioners obtain the

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[200] David A. Paap, "The Missional Value of Christian Care," (Stephen Ministries, 2005), 3.

[201] Young and Koopsen, 29.

[202] Ibid.

emotional support and practical assistance necessary to maintain well-being, prevent serious illness and survive the rigors of chronic or terminal afflictions."[203]

In 1997, parish nursing received recognition from the American Nurses Association as a specialty practice in the field of nursing, and in 1998 they helped publish standards and definitions in cooperation with the Health Ministries Association. In addition, current estimates from the International Parish Nurse Resource Center reflect that there are over 7,000 parish nurses working in the United States today. These numbers are based on those who have completed a basic training course offered at 64 institutions around the country.[204]

The ministry of a parish nurse is complex, and while some larger churches can hire someone to fill this role, most churches must rely on volunteers. Many times these nurses are members of the very congregation that they serve. Young and Koopsen write:

> Parish nurses provide holistic care to members of a specific religious congregation and they know their parishioners intimately. Parish nurses collaborate with the clergy and parish staff and strive to promote health and prevent disease. They also act as the following: integrators of faith and health; health educators; role models; personal health counselors; volunteer coordinators; advocates and facilitators; support group developers; referral agents or community liaisons; and interpreters of the relationship between faith and health.[205]

The role of the parish nursing ministry is best summed up in their mission statement developed in 2000. Deborah Patterson clarifies this mission statement:

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[203] Phyllis Hanlon, "Parish Nursing: Treating Body and Soul," *St. Anthony Messenger* 110, no. 10 (2003): 18.

[204] Teresa Malcolm, "Parish Nursing: Care for the Sick, Healing for the Community," *National Catholic Reporter* 38, no. 31 (2002): 3.

[205] Young and Koopsen, 29.

> Parish nursing is the intentional integration of the practice of faith with the practice of nursing so that people can achieve wholeness in, with, and through the community of faith in which parish nurses serve. Parish nurses educate, advocate, and activate people to take positive action regarding wellness, prevention, appropriate treatment of illness, and social and spiritual connections with God, members of their congregations, and their wider communities.[206]

This ministry offers both practical care and spiritual help as individuals deal with the issues that come with chronic illness and other health related concerns. Through parish nurses, healing becomes a connection between the body and the soul and not simply the disappearance of physical symptoms.

Following in the footprint of Stephen Ministry and parish nursing, Rest Ministries, Inc. was founded in 1997 for those dealing with chronic illness. This still small ministry, largely internet-based, was founded by Lisa Copen who deals personally with the chronic illness of rheumatoid arthritis. She sums up her desire to reach out to those with chronic illness in this way. "Personally, I don't have a passion for a healing ministry, but rather for one that reaches out to people during their illness and walks alongside them. If this means that I will have to walk the walk (or someday wheel?), then I will do so, because I consider it pure joy to suffer for Christ."[207]

Rest Ministries is a non-profit service, which states as their mission:

> To serve people who live with chronic illness or pain, and their families, by providing spiritual, emotional, relational and practical support through a variety of resources. We also seek to bring awareness and a change in action throughout churches in the U.S. in regard to how people who live with chronic illness/pain are served and teach churches effective ministry tools."[208]

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[206] Deborah L. Patterson, "Parish Nursing: A Beneficial Partnership for Clergy," *The Clergy Journal* 80, no. 9 (2004): 32.

[207] Lisa J. Copen, *Why Can't I Make People Understand?* (San Diego, CA: Rest Ministries Publishers, 2005), 14.

[208] Copen, *So You Want to Start a Chronic Illness-Pain Ministry: 10 Essentials to Make It Work*, 74.

Small groups for those with chronic illness, called HopeKeepers, are being formed in a few churches in the United States. In addition they produce a magazine that is published bi-monthly.

In 2002, however, Rest Ministries, Inc. took steps to raise awareness of chronic illness by naming the last week of September, National Invisible Chronic Illness Awareness Week. Lisa Copen writes:

> This week is an opportunity for the public to be informed about those who live with invisible disabilities. Churches are encouraged to participate in ways such as (1) Having brochures available, "When a Friend Has a Chronic Illness: What to Say, How to Help"; (2) Have the pastor do a sermon on chronic pain or illness, or even suffering; (3) Volunteer to give your testimony about how God has worked through your illness to mold you into who He desires you to be; (4) Kick off your HopeKeepers meeting in September.[209]

Increasing awareness of the needs of those with chronic illness has led to the formation of other ministry groups such as: Project Vision and Balm in Gilead which care for those with specific chronic illnesses. Churches are adding small support groups, wellness centers, and health education. The Center for Disease Control desires even more connection between the local church and those suffering with illness. They write, "Partnerships between faith organizations and the health system, be it medical care or public health, are not new. These partnerships, however, are not as common as we hope them to be."[210]

This chapter has shown that the local church is trying to reach out to those with chronic illness and offer hope through various means. Some practices of the church, such as faith healing, raise questions when some are healed and others are not. Adjusting an

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[209] Ibid., 72.

[210] "Engaging Faith Communities as Partners in Improving Community Health," 1.

understanding of "healing" from total physical health, to wholeness of body and mind, offers new hope. As those with chronic illness struggle with the mystery of life, programs such as Stephen Ministry, parish nursing, and Rest Ministries, Inc., to name just a few, offer a new hope. Yet, as Jeffrey Boyd states, the church must continue to do more:

> The blunt fact is that the Christian church is facing a situation today that has not existed in the preceding millennia, namely a prolonged life expectancy, with the result that prolonged sickness looms in the forefront of our picture of life and death recedes into the background. Although we have services, ceremonies, beliefs, theology, and compassion for those who are dying, we don't quite know what to do with these sick people who languish for decades, sometimes recovering fifty percent, sometimes facing a flare-up in a seemingly endless siege. Forty-two million Americans have no health insurance. For them chronic illness is even more devastating. We need to develop services, ceremonies, beliefs, and counseling strategies that are appropriate to this new phenomenon in human history.[211]

Chapter Six begins by offering new views of ministry to those with chronic illness.

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[211] Jeffrey H. Boyd, "A Biblical Theology of Chronic Illness," *Trinity Journal* 24, no. 2 (2003): 205-206.

# CHAPTER SIX

## OFFERING HOPE

Over the course of the previous five chapters, I have shown that the local church can find the foundation of pastoral care with the chronically ill in both the Scripture as well as in the history of the Church. Currently many within the field of medicine are drawing a connection between spirituality and health. In addition, new ministries such as parish nursing and Stephen Ministry are making a difference within the local church. While all this moves the church in a more caring direction, much more can be done. John Vanderzee explains this challenge:

> Currently, the "biomedical model" of disease warfare still prominent in western medicine perpetuates the myth of body/self dichotomy that separates disease from the human experience of illness. In turn, we pastoral caregivers remain focused on an acute care-slanted medical system and a "fix-it" approach to psychosocial-spiritual care. We do not seem to know what it takes to minister faithfully to the holistic needs of the chronic sufferer.[212]

The local church, however, is best able to reverse the feelings of isolation and offer caring Christian community to those dealing with chronic illness. Helen Harris writes in *Congregational Care for the Chronically Ill, Dying, and Bereaved*:

> The congregation is uniquely equipped to minister to the chronically ill, the dying and the bereaved. The gifts of love, of people, of time, of hope, are present in abundance. We are told in the Word that we are one body of many parts. We know that what affects one part of the body has an impact on the rest of the body. We need each other. Additionally, the Scriptures tell us that we grieve, but not as those who have no hope. With every phone call and visit, with every prayer and every smile, with every casserole and pie, with every instance of reaching out, we share that hope today, tomorrow, and always.[213]

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[212] John T. Vanderzee, "When Illness Doesn't Go Away: The Pastoral Challenge of Chronic Illness," *Chaplaincy Today* 17, no. 1 (2001): 13.

[213] Harris: 42.

The local congregation is in a unique position to care for those with chronic illness. There is a familiarity and comfort in both the setting and the people. Simple actions, done by people who care, can make a difference in those who are suffering. Both the pastor and the lay people in the congregation can help bring transformation in the lives of those who are chronically ill and facing times of darkness. Jerry Sittser writes, "The defining moment can be *our response* to the loss. It is not what happens *to* us that matters as much as what happens *in* us."[214]

John Vanderzee, a Chaplain at the Indiana University Medical Center, offers pastoral care to all who are sick, but specifically to those adjusting to chronic illness. He states that pastoral care protocol for those ministering to the chronically ill must include the steps of creating relationship and community and being an advocate and prophetic voice for the religious, moral, and ethical concerns of those dealing with chronic illness. Those with chronic illness need others to speak for them in the times they are unable to speak for themselves.[215] The local church can fulfill this role.

## Creating Relationships and Community

The church can become a place of safety for those trying to find an understanding of God while persevering through pain, loss, illness, and isolation. Those who suffer, especially with chronic illness, need to know that they can come to the church with their anger and doubt towards God and not find leaders who are quick to give superficial

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[214] Sittser, 45.

[215] Vanderzee, "When Illness Doesn't Go Away: The Pastoral Challenge of Chronic Illness," 14-16.

answers. Laurie Skokan states, "Relationships are key to providing care and healing for people with chronic or life-threatening illnesses."[216] All too often, we offer quick words and preformed images of God that only cause more damage. People are told to pray more and pray harder. These "helpful" solutions create more frustration and anger for those already hurting.

New research indicates that there is an important link between caring relationships and physical health that goes beyond previous studies through the discovery of neurons in the brain that imitate the emotions of others. Daniel Goleman writes:

> The most significant finding was the discovery of "mirror neurons," a widely dispersed class of brain cells that operate like neural WiFi. Mirror neurons track the emotional flow, movement and even intentions of the person we are with, and replicate this sensed state in our own brain by stirring in our brain the same areas active in the other person.[217]

A study done at the University of Virginia concurs with these findings. Researchers explain that something as simple as holding the hand of another, especially someone with whom we have a caring relationship, makes a difference. The report states, "Both spouse and stranger hand-holding conferred a basic level of regulatory influence on the neural response to threat cues, especially with regard to structures implicated in the modulation of affect-related action and bodily arousal."[218] They conclude, "It is

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[216] Skokan and Bader: 41.

[217] Daniel Goleman, "Friends for Life: An Emerging Biology of Emotional Healing," *The New York Times*, October 12 2006.

[218] James A. Coan, Hillary S. Schaefer, and Richard J. Davidson, "Lending a Hand: Social Regulation of the Neural Response to Threat," *Psychological Science* 17, no. 12 (2006): 1037.

already well known that social isolation is a major health risk, and that high-quality attachment relationships mitigate the effects of stress, injury, and infection."[219]

Other scholars are noting that the connection between the social and emotional aspects of our brain and body are also represented in our language. Separating the emotional from the physical causes a disconnect. Matthew Lieberman and Naomi Eisenberger write, "We describe social pain with phrases such as, 'She broke my heart,' and 'He hurt my feelings.' Indeed, it is difficult to describe social pain without reference to physical pain terminology. In fact, English speakers have no other way to describe the feelings associated with social pain."[220] This phenomenon is not just in English speaking countries. Continued studies show that of the fifteen European and non-European countries evaluated, all made this same linguistic connection. This suggests that, "social and physical pain may be universally linked in the mental lexica of humans around the world."[221]

Humans connect with each other through language and social contact. The church can make a connection through caring relationships that will affect both the physical and emotional aspects of living with chronic disease. When those that have a healthy relationship with Christ reach out to those that are struggling with chronic illness, holistic healing can take place. This connection can bring an end to isolation. Daniel Goleman explains:

We can no longer see our minds as so independent, separate and isolated, but

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[219] Ibid.: 1038.

[220] John T. Cacioppo, Penny S. Visser, and Cynthia L. Pickett, eds., *Social Neuroscience* (Cambridge, MA: MIT Press, 2006), 168.

[221] Ibid., 169.

> instead we must view them as "permeable," continually interacting as though joined by an invisible link. At an unconscious level, we are in constant dialogue with anyone we interact with, our every feeling and very way of moving attuned to theirs. At least for the moment our mental life is cocreated, in an interconnected two-person matrix.[222]

This understanding of connection and relationship is vitally important for those trying to find both physical and emotional wholeness in their experience with chronic illness. As Chapter One stated, even the Center for Disease Control agrees that faith communities offer the best hope for achieving wholeness. "Chronically ill persons are continually tempted to withdraw from society, trying to protect themselves from the intolerance and hurtful reactions of others. Yet they need from the community the same support, encouragement, and acceptance that we all need for self-fulfillment."[223] Relationships filled with care and empathy, offered through the church, can make a difference.

John Vanderzee explains that to get this close in relationship involves risk and uneasiness, yet, the church must accept this risk. He writes, "What chronically ill and disabled persons are asking of their faith communities is that we get close enough to them to be willing to risk the discomfort that proximity generates."[224] Stephen Schmidt, who suffers from chronic illness, describes it in this way:

> Perhaps most importantly, living with limitations means that we must do so in community. Folks make it with chronic illness to the extent they are in community; we never make it alone. When we are ill, it is almost necessary that we are supported over a long time by a dedicated community. That is most difficult. For disease and long-term suffering do not naturally pull people

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[222] Daniel Goleman, *Social Intelligence* (New York: Bantam Books, 2006), 43.

[223] Vanderzee, *Ministry to Persons with Chronic Illness: A Guide to Empowerment through Negotiation*, 26.

[224] Ibid., 80.

> together. There are ample statistics that indicate that folks who are suffering from long-term disease have great problems with community. Sick people are not easy company. Divorces happen. Families break under stress. Limits imposed by personal illness, absolutely inescapable for the one suffering, are not so for family and friends. So it is critical that the ill person place great priority on building relationships with those closest.[225]

Establishing this connection requires the sacrifice of time, effort, and training for caregivers within the church. It is in this connection, however, that meeting the needs of others can take place. "Spiritual care occurs when the caregiver takes the initiative to enter another's world for the purpose of discerning current needs."[226] The brokenness and isolation that takes place within chronic illness and suffering, in general, can be cared for when the church takes the time to be God's tangible love to a broken and hurting world. "Spiritual care is not standing at the end of a bed with a Bible like a televangelist, attempting to influence the patient into making a decision. Spiritual care is coming close to the heart of patients so we become aware of their burdens, both above and below the surface."[227]

Although this understanding of connection may seem new and frightening at times, it is necessary if the local church is truly to be in ministry and offering pastoral care to those who are suffering. By entering into this community and fellowship, those who are feeling isolated can find hope and those giving pastoral care can offer peace. Jerry Sittser states, "Loss does not have to isolate us or make us feel lonely. Though it is a solitary experience we must face alone, loss is also a common experience that can lead

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[225] Stephen A. Schmidt, *Living with Chronic Illness: The Challenge of Adjustment* (Minneapolis: Augsburg Fortress, 1989), 44-45.

[226] Sorajjakool and Lamberton, eds., 98.

[227] Ibid., 105.

us to community. It can create a community of brokenness. We must enter the darkness alone, but once there we will find others with whom we can share life together."[228]

## Formation of Support Groups

One way these relationships can form within the local church is through the ministry of small support groups. Creating community among a few, is not a new concept for the church. In fact, Lisa Copen concludes in her research, "Support groups have become a place of refuge for people in the last fifteen years, and churches have recognized that people have a deep desire to share not only their emotional struggles, but also the spiritual struggles they have along their journey of recovery."[229] Small groups provide support, education, and action for both those who are ill as well as their families. Resources can be shared and a level of trust gained. The creation of these groups can seem overwhelming for those in the local church, yet by working with area hospitals and health centers that can provide facilitators, these groups can be formed within the local congregation.[230]

This time to share with others walking similar journeys of life, offers a means for coping with illness. A study done in 2000 emphasizes the important role that the church can play in the formation of these small support groups. Aru Narayanasamy explains:

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[228] Sittser, 171.

[229] Copen, *So You Want to Start a Chronic Illness-Pain Ministry: 10 Essentials to Make It Work*, 11-12.

[230] Vanderzee, *Ministry to Persons with Chronic Illness: A Guide to Empowerment through Negotiation*, 83.

> The significance of this study is that it reveals that the lived experience of connectedness with God and others, and the search of meaning and purpose appear to be important spiritual coping mechanisms during chronic illness. Being connected to God and others appears to help sufferers through the crisis brought on by the illness.[231]

While many hospitals and other secular venues offer support groups for various illnesses, the local church is able to address needs that only a religious organization can answer. Lisa Copen explains this difference:

> Whether a person is seeking to express his anger at God or seeking for the support of God, he is oftentimes discouraged from expressing these thoughts at secular group meetings. It is common to leave the meetings feeling as though something is missing. Oftentimes, these meetings focus on the education of one's illness and how to live a productive life despite the limitations. The facilitators try to come up with positive agendas for the meetings, but ultimately, the only hope that is given is hope for a cure or a more effective drug.[232]

In Chapter One, I discussed that every individual burdened with chronic illness, whether churched or unchurched, at some level asks "big picture" questions about God and the workings of this world, while at the same time feels a need to find comfort. While all individuals find themselves in different places regarding spirituality, chronic illness brings out needs that the secular world cannot address with authority. The local church, however, can meet these needs.

Those experiencing the feeling of isolation due to chronic illness, find a hope for their fears within these support groups. A safe refuge is discovered where people can honestly share their feelings and know that others will have a common experience all the

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[231] Aru Narayanasamy, "Spiritual Coping Mechanisms in Chronic Illness: A Qualitative Study," *Journal of Clinical Nursing* 13 (2004): 116.

[232] Copen, *So You Want to Start a Chronic Illness-Pain Ministry: 10 Essentials to Make It Work*, 15-16.

while connecting to a greater power beyond themselves. Together, this group can move towards healing. Lisa Copen asserts:

> A small group or support group for people who live with chronic illness or pain is an excellent place to start. You may be surprised at the response you will get when you announce that a chronic illness/pain support group is forming. People will sign up who you never realized dealt with pain. There is an undeniable need in all of us to have the support of friends, and for those of us who live with chronic illness, the need to have people who understand what we are going through is even greater.[233]

In addition to the formation of support groups, the use of humor can also build relationships. Humor can lift those who are ill above the embarrassment that is often associated with chronic illness. This phenomenon has been proven through research. "Laughter produces positive psychological and physiological benefits. Various studies have shown that laughter lessens depression, induces relaxation, strengthens our immune system, and stimulates the release of endorphins, the brain's natural painkillers. People who laugh feel less alienated and more in control of their lives."[234]

This feeling of being in control is much needed for those dealing with chronic illness. Often, those who are ill feel that they are merely victims in some horrible plot. Humor can break down barriers and build bridges toward better living. George Harper Lea concludes, "At a time when we feel most powerless, if we can laugh at our disease, or our treatment, or our appearance, then we in some measure control it. Laughter may become the *bridge* from tears to renewal and hope. It can empower us when we feel like pawns of disease and circumstance."[235]

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[233] Ibid., 32.

[234] Wells, 117.

[235] George Harper Lea, *Living with Dying: Finding Meaning in Chronic Illness* (Grand Rapids, Mich.: Eerdmans, 1992), 76-77.

Sharing a humorous story or funny anecdote can be helpful in ministering to those with chronic illness.[236] The ability to laugh reduces stress and becomes a tool to deal with frustration. For both the caregiver and the victim of chronic illness, this opportunity creates a connection and bond that can lead to deeper relationships. Jeffery Boyd summarizes the use of humor in this way:

> When sick people can laugh, it means that the human spirit triumphs over the mean-spirited destructive powers of disease. Humor reflects the joy of resurrection, whereas disease is more akin to crucifixion. Humor dethrones disease – which has a way of controlling a person's life – and places the person in control. It converts that which is dull and gruesome into something dazzling, imaginative, and outrageous. It ridicules the emperor named "disease" for having no clothes and therefore restores dignity to those crushed by that emperor.[237]

## Sharing Narratives

Reaching out in caring Christian community is vital in ministry to the chronically ill. While support groups and laughter help, those within the local church must be willing to take the time to listen to the stories of those who are hurting. To be in relationship does not mean, however, that we must always be talking. In fact, we learn from Chapter Two, and the story of Job's friends, that there are times when it is best just to sit in silence and be a presence. Each and every person, ill or healthy, has a story to tell. For those suffering with chronic illness sharing the narrative of life and disease can have incredible power. Paul Donoghue states:

> The story that you live needs to be brought into consciousness. It has enormous power in giving your life direction and meaning. It defines your values and shapes

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[236] Carson and Koenig, 120.

[237] Boyd, *Being Sick Well: Joyful Living Despite Chronic Illness*, 69.

> your view of yourself and of your world. Being aware of your story can help to free you from any limitations that it imposes and any untruths that it inflicts. Consciousness of your story can free you to understand yourself more deeply and to change in directions that make your life more livable.[238]

Research has shown that storytelling serves various functions for those who both suffer from chronic illness and those who care for them. Creating a narrative through health and illness, helps patients reflect on life and make sense of all that has happened. In addition, for those who are already feeling isolated, sharing a personal story with another person helps create a sense of connection and intimacy. Reflecting on the journey of life also helps the person to bridge the span between spirituality and wholeness.[239]

While telling our stories builds relationships, it has also been found to be therapeutic due to the fact that the patient is venting the feelings that are held deep inside. This is affirmed by David Spero:

> How do we get in touch with the sources of meaning in our lives? One valuable way is to tell our stories. Tell them verbally to others, put them on tape, or write them down in a journal. Get someone else, maybe of a younger generation, to help you make a video of yourself talking about life. Think about where you came from, the times you've lived in, how they've influenced you, and you them. Remember the highs and lows, what you learned, whom you helped, and who helped you. You may find some real sources of strength, some reasons to value yourself, to care for yourself, to get well. Don't think, "Nobody's interested." Most people are nosy. But even if nobody else hears your story, it is good to tell it for our own benefit.[240]

The story can be verbal or written, done in artwork or video, shared with others or simply for the benefit of the one who is ill. Regardless of how the story is shared, the act of telling it can help those with chronic illness find their way to wholeness.

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[238] Paul J. Donoghue and Mary E. Siegel, *Sick and Tired of Feeling Sick and Tired* (New York: W.W. Norton and Co., 2000), 152.

[239] Skokan and Bader: 41.

[240] David Spero, *The Art of Getting Well* (Alameda, CA: Hunter House Publishers, 2002), 77.

This narrative pastoral care creates a climate of caring and can easily be accomplished within the local church family. Pastors and lay people can help make connections between the individual stories and Scripture and this very practical means of pastoral care helps individuals find a living expression of faith. This practice of pastoral care is explained by Charles Gerkin:

> Practical theology becomes the task of maintaining the connections between the varied stories of life and the grounding story of the Christian community. Pastoral care becomes the community of faith's living expression of that grounding story. Locating pastoral care in the center of the dialogue between the Christian story and life stories suggests that its most fundamental caring purpose is to facilitate the process of connecting life stories to the Christian story and vice versa. I have already asserted that this is the most elementary form of care that the Christian community has to offer. Fostering and facilitating that dialogical connection is therefore central to the work of pastoral care.[241]

Pastoral care that focuses on the sharing of narrative does not mean that we must have all the "right" answers to difficult questions or "fix" every problem. Pastoral care that truly reaches to the chronically ill is simply a desire to walk with another.

Richard Rohr discusses this in *Job and the Mystery of Suffering*:

> Most of us are not trained in redemptive listening. We're trained to give answers. In the counseling context, this listening mode is often called nondirective counseling. It is based on the premise that one can't ultimately provide the answers for others. All one can do is walk with the other and help others rightly to hear themselves. What people long to have happen is to be somehow received, understood. When they are heard, it seems, they can begin to hear. The most redemptive thing one can do for another is just to understand.[242]

Active listening does not require a seminary degree or special training. As Chapter Two and Three of this dissertation reflect, both the Bible and leaders throughout Church history, from Gregory the Great to Mother Teresa, have shown that all people

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[241] Gerkin, 111-112.

[242] Richard Rohr, *Job and the Mystery of Suffering: Spiritual Reflections* (New York: Crossroad, 1996), 64.

have the ability to offer this care. Dietrich Bonhoeffer calls this the first service of fellowship. He writes in *Life Together*:

> The first service that one owes to others in the fellowship consists in listening to them. Just as love to God begins with listening to His Word, so the beginning of love for the brethren is learning to listen to them. It is God's love for us that He not only gives us His Word but also lends us His ear. So it is His work that we do for our brother when we learn to listen to him. Christians, especially ministers, so often think they must always contribute something when they are in the company of others, that this is the one service they have to render. They forget that listening can be a greater service than speaking.[243]

This type of listening is exactly what Job's friends did for him in those first days and nights of their visit. At that time, they were faithful friends who sat in the midst of loss and pain. No words were spoken. No words needed to be spoken. They realized as Richard Rohr states, "All words fall short. Often, all we can offer is our presence, just being there. But strength is communicated, caring is communicated."[244]

Caring for those who are chronically ill can often be done best by simply being an available presence and having a willingness to sit and listen. A recent study of women with chronic illness done by Jenaneta Hampton showed that offering a safe place for victims to ask spiritual questions and simply listening to their thoughts provides a valuable tool for coping. She states, "The telling of their spiritual experiences confirmed what researchers have found – that the connectedness and support that one feels through a relationship with a higher power can be an extremely helpful and powerful coping mechanism that can be used in managing the stressors of a chronic illness."[245] We need to

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[243] Dietrich Bonhoeffer, *Life Together* (New York: HarperCollins Publishers, 1954), 97.

[244] Rohr, 52.

[245] Jenaneta S. Hampton, "An Exploration of Spirituality in Rural Women with Chronic Illness," *Holistic Nursing Practice* 20, no. 1 (2006): 32.

learn that the best pastoral care in these situations simply involves knowing when to be still. Christina Puchalski notes in *A Time for Listening and Caring*:

> There simply are no answers to these types of questions. Part of spiritual care is recognizing when to simply sit in silence as the person grapples with his or her quest for meaning. Honoring the mystery is sitting in silence, being present to another's as well as our own grief and sadness while surrounded by unanswerable questions. Life and death become more precious when we unlearn our need to fix and control and simply learn to be present to another, to ourselves, and to the mystery.[246]

The role of active listening and caring is vitally important, but there is also a role that the church must play as advocate and prophetic voice for the chronically ill.

## Being an Advocate and Prophetic Voice

To be in ministry with the chronically ill requires being an advocate and prophetic voice for religious, moral, and ethical concerns. This role involves taking an active stand when those suffering with chronic illness are unable to do so themselves because of the symptoms of their illness. Ilene Lubkin expresses the importance of this role in the book *Chronic Illness: Impact and Interventions*. She claims:

> Clients with chronic illnesses and their families often need information, understanding, and competent intervention to help them reformulate their lives, assimilate their losses, and adjust to the changes brought about by their illnesses. These individuals are at risk if they are unable to represent their needs, wishes, values, and choices. Under these circumstances, others must advocate on their behalf.[247]

The chronically ill need to know that the church will be their voice if they are unable to speak on their own. John Vanderzee explains further:

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[246] Puchalski, 49.

[247] Lubkin and Larsen, 359.

> Embracing people who are chronically ill and disabled in the life of the faith community, however, involves commitment on an even broader scale. Visitation in the hospital, nursing facility, and the home is important, but it is not enough. Care, support, and nurture will flourish when transformed by strategies of empowerment in all levels of the church structure. Religious education, stewardship of money and talents, long-range planning, facilities management, preaching – each of these has a role in creating an environment that will give the chronic sufferer hope, support, and a sense of belonging.[248]

Each person within the local church needs to be an advocate for the concerns of the chronically ill due to the staggering statistics of physical disabilities related to these illnesses. No single person can address this need alone.

Chronic disease is the leading cause of disability in our country with current statistics reflecting that 43.2 million Americans with chronic conditions also have a physical disability.[249] Further studies show, that of those with disabilities, only 47 percent attend religious services at least once a month compared to 65 percent of those without disabilities. People with physical disabilities, however, are more likely to desire pastoral counseling.[250] The desire to be involved in the local church is present, yet something is keeping these individuals away. Joni Eareckson Tada addresses this question on her website. She states, "The National Organization on Disability points out that approximately 65 percent of people with and without disabilities consider their religious faith very important to them. Therefore something else – likely a barrier of architecture or attitude – is holding people with disabilities back from attending services."[251]

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[248] Vanderzee, *Ministry to Persons with Chronic Illness: A Guide to Empowerment through Negotiation*, 81.

[249] Kane, Priester, and Totten, 19.

[250] Albert A. Herzog, "Spires, Wheelchairs and Committees: Organizing for Disability Advocacy at the Judicatory Level," *Review of Religious Research* 45, no. 4 (2004): 350.

[251] Joni Eareckson Tada, *Disability Information and Statistics*(accessed Dec. 18 2007); available from www.joniandfriends.org/disability_stats.php.

Chaplain John Vanderzee explains the discrepancy:

> Despite the impact of the Americans with Disabilities Act, many public and private facilities do not accommodate those persons whose chronic illness or disability may be less obvious. To address this concern, I may do what I can to help point out the persistent problem of limited access to people with special needs in our churches.[252]

This problem within the local church dates back to the introduction of the Americans with Disabilities Act in 1990. "Unfortunately, the percentage of churches actively engaged on the issue is extremely low. In 1990, the Americans with Disabilities Act was enacted. Existing church buildings were exempt from many ADA mandates regarding accessibility."[253] Because change was not required, it was ignored by many.

Adding to the complexity of church accessibility, is a decline among mainline denominational funding for disability building and programmatic change. Becoming handicap accessible can be expensive and this financial stress becomes a burden for the local church without outside funding. Albert A. Herzog states:

> In the late 1980's and early 1990's, as national denominational organizations experienced a decline in financial support, several denominations including the Episcopal Church, the Evangelical Lutheran Church in America, the Presbyterian Church, U.S.A., and the United Church of Christ either downsized or eliminated altogether their national offices which coordinated disability work. Even among those denominations where the offices were not closed (such as the United Methodist Church), already limited funds were reduced for programming and staff portfolios were merged with other denominational programs. In most cases, national task forces and committees have been maintained, but with fewer resources to implement programs at the regional and local level.[254]

Churches have not been able to address the needs of the chronically ill and disabled at either the local church or denominational level. Without required action from our

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[252] Vanderzee, "When Illness Doesn't Go Away: The Pastoral Challenge of Chronic Illness," 16.

[253] "Fear Not the Disabled," *Christianity Today* 49, no. 11 (2005): 28.

[254] Herzog: 353.

country's legal system or from denominational leaders, many churches have not begun to address the issue of accessibility in the local church.

Churches need to be handicapped accessible, with wheelchair ramps and automatic door openers. The question of whether there are those who need large print Bibles and interpretation for the deaf needs to be asked. Many churches do not have enough handicapped parking spaces, assistance for hypoglycemic reactions, room in their sanctuaries for walkers and wheelchairs, or bathrooms that are usable for those with these types of disabilities. This reflects only the beginning of necessary physical change. It takes all people within the church who are aware of these needs and actively making necessary changes, for the church to truly be in ministry to all people and not excluding some because of physical disabilities. The role of advocate is large enough for all within the church.[255]

The unfortunate outcome from this lack of change is that innocent people who suffer with chronic illness cannot find comfort and hope within the local church. One study done to evaluate the number of churches addressing the issue of handicap accessibility offered many disconcerting stories. Albert Herzog explains this attitude as he writes, "Some informants expressed frustration at how the church, in general, responds to and/or avoids disability issues. One informant told of a congregation that indicated that disability issues 'had nothing to do with the Gospel of Jesus Christ.' They suggested that she 'stop this nonsense.'"[256]

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[255] Wiegand, 141-142.

[256] Herzog: 360.

Those who face the struggles of chronic illness need the local church to be an advocate when it comes to full accessibility in our congregations. Life is already filled with problems and complications; physical change to church buildings is an area where the church can be more active. The chronically ill also need individuals, however, to stand up against a medical system that does not provide adequate healthcare coverage and insurance companies that continue to raise medical costs. Daniel Sulmasy clarifies this problem:

> There is another reason that sick people and caregivers might consider taking charge, namely that the medical system is flawed, at least in the United States. Many people get excellent care, some get poor care, and for many the care is uncoordinated or nonexistent. Forty-three million Americans have no health insurance at all. The U.S. Supreme Court endorses the rationing of health resources. Our medical system is not designed to treat chronic illnesses. It is designed to treat short-term "episodes of care." Only now are our computer systems in healthcare shifting from being focused on "episodes of care" to being focused on "patients." In other words, the people who consume most of the healthcare resources – the chronically ill – are not the ones the system is designed to treat.[257]

Not only does he conclude that inadequate coverage for those with chronic illness exists but also the rising costs of insurance fall on the chronically ill. He adds:

> The reimbursement system (the insurance companies and the government) do not structure their payments so as to encourage any change in the system. We are locked into a system, now costing Americans 1.7 trillion dollars a year, that is not good at responding to the needs of the majority of patients – those with chronic illnesses.[258]

The local church is called to care for the poor and the "least of these." We must accept this role of advocate for the chronically ill.

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[257] Sulmasy, 170.

[258] Ibid., 98.

The Robert Wood Foundation recognizes the special role of the local church and offers grants for those organizations willing to step forward and take on the role of advocate. The Center for Disease Control explains:

> Recognizing the unique capacities of congregations, beginning in 1983 the Robert Wood Foundation has provided matching, start-up grants of $25,000 (now totaling over $38 million) to 1,100 interfaith coalitions that develop networks of volunteer caregiving services. Through the Faith in Action initiative, volunteers are trained to help people in need: the elderly person living alone; the physically or mentally disabled; the terminally ill; and the family caregiver needing relief.[259]

Millions of people feel the effects of chronic illness and are waiting for someone to stand with them in their fight for understanding and care. As Stephen Sapp summarizes, the church can do much more than it is currently doing. He writes in *Living with Chronic Illness*, "In the absence of adequate public response, this is an area where the nation's religious institutions could play a much more active role, not only in advocacy for appropriate governmental solutions to chronic care problems but also in mobilization of their members, facilities, and financial resources."[260]

## Advocacy for Inclusion in Religious Rituals

While change must happen in our nation's medical system and in the physical structure of our buildings, advocates must also come forward to create change in the way the church includes those with chronic illness in the religious ritual and practices of the church. For far too long the church has used whatever tools were available, especially

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[259] "Engaging Faith Communities as Partners in Improving Community Health," 7.

[260] Stephen Sapp, "Living with Chronic Illness: A Family Perspective," *The Catholic World* 235, no. 1409 (1992): 224.

Scripture and doctrine, to build walls between people. For the church to be a credible witness to the hurting in the world today, we must recognize our differences and start focusing on the gift of diversity. Instead of trying to find all the right words to speak our theology, we must begin to find ways to let our actions speak for us. Robert Greer describes this in his book, *Mapping Postmodernism*, "To the degree that the followers of Jesus do not reflect the love of God and his reconciliation in their relationships inside the church, they diminish the credibility of the gospel that they are proclaiming to those outside the church."[261]

The process of healing can begin when caregivers from within the local congregation reflect the love of God not solely in their words but in the inclusion of those with chronic illness as well. By doing so, these caregivers become advocates and prophets to those who need to sense God's presence in the midst of their suffering. Stanley Grenz writes, "God's goal for humankind, in turn, is that we represent God by reflecting the divine nature (love) and thereby be the *imago dei*, which is our divinely intended destiny."[262]

Studies explained by Caroline Young in her book, *Spirituality, Health, and Healing*, show that participation in "regular prayer, Scripture reading, or study has provided health benefits."[263] A five-year study of chronically ill patients found that those who practiced meditation felt a much greater intimacy with God and had better health and

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[261] Greer, 49.

[262] Stanley J. Grenz, *Beyond Foundationalism* (Louisville, KY: Westminster John Knox Press, 2001), 201.

[263] Young and Koopsen, 45.

recovery from symptoms.[264] Ilene Lubkin expresses in the book, *Chronic Illness*, that research shows that pastors and churches, however, tend to wait for the chronically ill to express a desire to be more involved instead of inviting them directly.[265]

A statement prepared by a committee within the World Council of Churches addresses this need for change within congregations. They write:

> To truly feel welcome in the church, people with disabilities need to see people like themselves in leadership roles. For people with disabilities to play a larger role, a faith community may need to rethink its policies about who is and who is not allowed to offer a welcome, usher, or participate as banner-bearer, to sing in the choir, to read the lessons and lead the prayers of the people. Is the altar area accessible to someone who uses a wheelchair or walker? Can the microphone be adjusted to different heights? Inclusion requires the conviction of the disabled person that he/she has access to leadership according to his/her abilities, attitudes, and vocations, setting aside his/her complexes and frustrations.[266]

As caregivers, the church must do everything within its power to offer inclusion in religious ritual to those suffering with chronic illness. Isolation is already problematic for these individuals and inclusion in worship and religious practices are vitally important. Pastors and laity must strive to include the chronically ill in the practices of the faith. In worship, it must be understood that all sitting in the pews, regardless of chronic illness or health, have much to offer.

Carrie Doehring writes, "These aspects of spiritual and religious life can help the careseeker fully experience and explore the meanings of his or her suffering, experience a sense of God and the sacred in this process, and become more deeply embedded in a web

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[264] Wallis: 64.

[265] Lubkin and Larsen, 246-247.

[266] "A Church of All and for All: An Interim Statement," *Ecumenical Disabilities Advocate Network* 93, no. 370/371 (2004): 523.

of being."[267] While this inclusion can bring strength to the weak, it can also benefit others participating in worship. John Vanderzee writes:

> The inclusion of marginalized persons in the congregation enriches the faith life of the entire community. When the one who chronically suffers is able to portray his or her pain and passion without shame or embarrassment, others become freer to share their own anguish. When the sufferer is allowed to cry "Hallelujah anyway," the rest of the faithful discern the integrity of praise in the midst of pain.[268]

Offering caring relationships and community, along with effective advocacy and prophetic voice for the chronically ill, is a necessity for the local church. We have much work to do as the church in the world today. For the local church to be its very best, relationships and inclusion must be offered to all. John Vanderzee summarizes this mission:

> The mission of the faith community is to demonstrate through word and deed God's love and compassion for all God's creation. Each member of the community has a unique role in the realization of this mission. If any one member's capacity to minister or be ministered to is disregarded, the whole community is diminished. Conversely the ongoing life and mission of the faith community will flourish when we transcend physical and emotional barriers to wholeness.[269]

The local church is well situated to offer hope and healing as they stand up for those unable to stand for themselves.

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[267] Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2006), 139.

[268] Vanderzee, *Ministry to Persons with Chronic Illness: A Guide to Empowerment through Negotiation*, 81.

[269] Ibid., 79.

## Summary of Findings

This dissertation has addressed the need for effective pastoral care to those who suffer from chronic illness. The number of individuals dealing with the brokenness of chronic illness continues to grow each day and as the church we must make a theological commitment to be channels of God's grace. The local congregation is in a unique position to care for those with chronic illness and is best able to reverse the feelings of isolation and offer caring Christian community to those dealing with chronic illness.

Chapter Two traced the issue of suffering, pain, and illness through Scripture. The basic understanding of the Hebrew Scriptures was that suffering was a direct consequence of sin. This was especially understood due to the interpretation of Job. Yet, throughout the Scriptures, and even in the book of Job, it was shown that God desires individuals to remain strong in the trials of life and to seek God's presence in the midst of loss. Looking deeper into the Scriptures, it was seen that suffering and evil were not God's intention for this world and while God does not always take away this pain, God is present in the midst of it.

By looking through church history in Chapter Three, it was suggested that the local church can be a place that connects emotional and physical experiences for those dealing with chronic illness. Numerous leaders from ancient to modern times reflect that care does happen in the context of church. In addition, it was shown that the teachings of the church have long taught that healing is not just a physical event but a spiritual one as well. It is the goal of the church to use this knowledge as a springboard for effective ministry today.

The church has been active in healthcare since the early beginnings of hospitals. From Basil the Great on to modernity, the church has offered a connection between health and spirituality. While this relationship has been strained at times, Chapter Four showed that once again the field of medicine is learning to embrace the impact of faith and spirituality in the care of those with chronic illness. There are still some who question this connection, yet research is showing that the medical field is more effective when it is balanced with the best of the church and ministry.

Chapter Five showed that the local church is trying to reach out to those with chronic illness. The road has been filled with obstacles, from the misunderstanding of faith healers, to the difficulty of bringing this ministry to the local church level. There are programs, however, that are making this goal become reality. Stephen Ministry, parish nursing, Rest Ministry, Inc., are all programs that model this outreach. With a clearer definition for "healing," the church is beginning to make strides in the care of those with chronic illness.

While physical healing may by sparse for those who suffer, healing can come through the means of God's grace. "It is possible to be healed but not cured. Getting to the point where being in touch with our spiritual strength allows us to face the future with courage and intention is a worthy goal. To live each day as a gift, focusing not on the disease but on the gift of life is an important kind of healing."[270]

Chronic illness can cause suffering and isolation that is incredibly difficult. Yet, there is hope. This hope comes in the Body of Christ known as the church in the world. While healing may not mean taking away the illness, healing can come through the love

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[270] Sorajjakool and Lamberton, eds., 110.

and relationships found in local congregations. Perhaps our prayer can be found in the words of one who suffers from chronic illness:

> Finally I have come to know that this God who lives and moves and has being within my being is quite capable to enter into my fight for life. This God *invites* the struggle. The God who wrestled with Jacob for the night and left only after wounding him still enjoys the conflict of intimacy (Gen. 33:22-32). God doesn't shrink from our little war with God. And I have come to know that all the forces of my energies (my frustration, hostility, sadness, anger, and all the other parts of my armament) are no match for God's. I can muster the best of my forces and know full well that God can handle the attack. And wounded I will surely be, but with the sure knowledge that I have fought with God and wrestled the blessing. "Lo, I am with you always..."[271]

This dissertation shows that by offering a theology of healing the local church can connect those with chronic illness to the grace and love of God and bring an end to their isolation. Studies explored within have shown that chronic illness affects a huge percentage of our population and causes its victims to suffer in isolation and despair. The church has failed to meet their needs and changes must happen. Scripture explored has made known God's presence in the midst of suffering and offered a new understanding of the experience of loss. Church history has given a model for effective pastoral care. Despite all the changes that have been made there is much more to be done. The church can make the necessary adjustments and offer a new paradigm of holistic care. As Gerald May writes, this is hope:

> So in the end I am left only with hope. I hope the nights really are transformative. I hope every dawn brings deeper love, for each of us individually and for the world as a whole. I hope that John of the Cross was right when he said the intellect is transformed into faith, and the will into love, and the memory into... hope.[272]

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[271] Schmidt, 57.

[272] May, 191.

When the real love of Christ meets the real needs of the chronically ill, the hope of the eternal God is manifested in the hearts of all.

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