THE COVENANT
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August/November 2015

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Comment

Hauna Ondrey, editor, teaching fellow in church history,
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The Covenant has a rich legacy of chaplaincy. Even before the Covenant's official organization in 1885, Mission Friends supported chaplains who offered practical and spiritual care to Swedish immigrants arriving in a strange land. Currently approximately 10 percent of the Covenant Ministerium serves in chaplaincy roles in locations as diverse as military, hospitals, correctional facilities, hospice, universities, corporate workplaces, and retirement communities.

In this issue several of our chaplains reflect theologically on the distinct opportunities and challenges they experience in chaplaincy ministry. In doing so they offer practical insight to all pastoral caregivers.

Drawing from thirty years as a U.S. Navy chaplain and thirty-six as professor of Old Testament (Denver Seminary and North Park Theological Seminary), Robert L. Hubbard Jr. explores the incarnational nature of chaplaincy. He traces God's long journey toward humanity, from tabernacle, to temple and prophets, culminating in God's assuming flesh in the incarnation. Chaplains too have a ministry of incarnation, giving "skin" to God's presence in the world—*going out* to people who may never step into a church.

Tim Fretheim, chaplain at Vancouver's Forensic Psychiatric Hospital, considers the particular difficulty of providing spiritual care for those suffering from delusions of grandiosity with religious content. When a pathology manifests in religious forms, how does the chaplain nurture genuine religious experience while not inhibiting the healing of pathological experience? Fretheim offers an accessible introduction to grandiose delusion with religious content—its definition, diagnosis, and origin—and offers practical tools for the chaplain's unique role in the care of persons suffering from such delusions.

Joel Jueckstock and Kyle Vlach, both chaplains and clinical pastoral education supervisors in the Twin Cities, call pastoral caregivers beyond a passive notion of "presence" to an active use of self in providing pastoral care. They affirm the agency of caregivers in "co-creating" healing narratives with the subject of care and the Holy Spirit. Jueckstock and Vlach provide specific resources for pastoral caregivers to assume responsibility for the healthy use of self in ministry and the constant growth in self-knowledge this requires.

Finally, Amy Simpson, senior editor of *Leadership Journal,* addresses how the church body can support families struggling with mental illness, in a paper originating in North Park University and Theological Seminary's symposium, "Being Present: A Faithful Response to Mental Illness" (November 8, 2014), sponsored by the Good Shepherd Initiative and Covenant Ministries of Benevolence. Drawing from research and her own family's experience with schizophrenia, Simpson offers practical ways for the whole church to walk alongside families struggling with mental illness.

We are indebted to our chaplains for ministering to diverse communities beyond the walls of the church—and to the reflections they offer here that invite and equip the whole church to mediate Christ to those suffering physically, emotionally, and mentally in our pews and in our communities.

For more resources and discussion, join us at Forum: Dialoging with the Covenant Quarterly.

Chaplaincy: Incarnation in Action

Robert Hubbard, emeritus professor of Old Testament,
North Park Theological Seminary, Chicago, Illinois

I mark the launch of my ministry as a Navy chaplain to a brief moment on June 15, 1970, at the Los Angeles Armed Forces Induction Center. Within two hours I would receive my commission, brand-new green identification card, and orders to report to Newport, Rhode Island, two weeks later. But at the moment I stood in my undershorts in a line of about twenty young men, all of us undergoing the medical exam to confirm that we were physically qualified for service. As we turned to move on to the next station, the short, skinny eighteen-year-old next to me, obviously anxious and confused, blurted nervously, "Hey, what are we doing now?" I leaned toward him and replied softy, "Don't worry; just follow me." In that moment I briefly glimpsed the military ministry ahead of me: as a minister of the gospel, my calling was to point women and men, some confused and anxious, to find the right direction for their lives and futures. On that day, I signed on for three years of active duty and six years in the Naval Reserve, but under God's good hand I was privileged to serve four years active duty and twenty-six in the Reserve. It was a special privilege to have one ministry foot in the academy and the other in the military.

In this essay, I explore the chaplaincy ministry as I know it through the lenses of biblical theology and my own experience as a chaplain. I will argue that the theology of incarnation offers a useful model for understanding exactly what a chaplain does—and why. The model of incarnational ministry has guided me in both of my ministry fields, but I'm probably more aware of its influence when I'm wearing my chaplain hat rather than my professor mortarboard.

What Makes Chaplaincy Unique?

How does a chaplain differ from a pastor? In my view, a unique ministry setting distinguishes the chaplain from pastor. The pastor's primary setting is the local congregation—Covenant Church X, located in Y-city in Z-state. That congregation comprises a spiritual flock that the pastor shepherds in their walk with Christ and in whatever service they render their local community. Members of the flock share in common an ongoing relationship with Jesus and an agreed-upon basic set of Christian beliefs—the Apostles' Creed and the six Covenant Affirmations, for example. A chaplain's ministry setting, by contrast, is not a local congregation but an institution—a military unit, a police force, a jail or prison, a hospital, a hospice unit, a retirement village, or a college or university. Both the staff of these institutions and the public they serve are more ethnically and religiously diverse and geographically larger than the local church flock. They may share neither an ongoing relationship with God nor a set of religious beliefs, but there are often practicing Christians who work in such "secular" arenas. Some institutions may belong to specific religious denominations (e.g., hospitals, universities, retirement villages), but many belong to secular bodies like cities, towns, counties, states, or countries (e.g., police units, prisons, hospitals, universities, the military). They are not necessarily *anti*-religious (though I've occasionally encountered individuals, even some leaders, who are); it's just that their staff and their clients represent the religious pluralism of the general public more so than a local Christian congregation. In reality, their hopes, dreams, and fears are not much different from those of the average Christian congregation. But their means of managing them may differ from the approach of the latter. In short, the world of most chaplains is a secular, very diverse one. The chaplain's unique challenge is how to pastor (in the best sense of that word) individuals who span the spectrum of beliefs and non-beliefs.

To What Critical Problem Does the Incarnation Respond?

What is the critical problem that the theme of incarnation, so central in the Bible, solves? In my view, nothing captures the communication strategy of the incarnation better than two well-known biblical worship locations: the Tabernacle in the wilderness and the Temple in Jerusalem. As is well known, the central structure of both has two parts, the Holy Place and the Most Holy Place. The latter is the specific place where Yahweh was thought to reside personally; it was the location of the Ark

of the Covenant, Israel's most sacred object and the "throne" on which Yahweh invisibly "sat" as Israel's ultimate ruler. Around each of these structures spread either the tents of Israel's temporary desert encampment (the Tabernacle) or the permanent buildings and houses of Jerusalem. For my purposes, what is striking is that Yahweh chose to live right in the middle of his people; God chose not just to be "with" them (i.e., their supporter or advocate) but to "live among them" (i.e., a fellow resident in a camp or city). Theologically, God's choice presumes the divine desire for proximity to people rather than distance from them, a proximity that facilitates their access to God's presence and their receipt of God's blessings. God's expulsion of the first humans from the garden of Eden imposed an impassable distance between them and their Creator (Genesis 3:23–24), but the Tabernacle and Temple located God nearby and made God's presence accessible to their descendants.

But there's a rub. According to the Torah, that accessibility is highly regulated. The average Israelite could not simply stroll into the Most Holy Place of either worship structure whenever he or she wished. Only the high priest was allowed to enter there—and only once a year during the Day of Atonement (Leviticus 16:29–34; Hebrews 9:7). The closest an ordinary Israelite could get to the Holy of Holies was to the Burned Offering Altar that stood in the open space in front of the Tabernacle or Temple. Only priests had ongoing access to the Holy Place (but not the Most Holy Place), so while God and Israel lived as near neighbors, God still lived in a gated-community with highly regulated access. The set-up isn't exactly a return to God and humans "walking [together] in the cool of the day" back in Eden (Genesis 3:8), but it was at least a step in that direction. Let us remember, however, that that limited accessibility served a positive purpose: it aimed to protect worshipers from certain death, the fate the unfortunate Uzzah sadly met when he touched the Ark (2 Samuel 6:6–7). This protection was necessary because of qualitatively different natures of God and people: God is holy but people are unholy, and unregulated meetings of holy and unholy beings set off disastrous fireworks, as Uzzah's case confirms.

To illustrate the point, a few miles north of the Marine Corps Base at Camp Pendleton, California, the large, forbidding San Onofre Nuclear Generating Station stands between the interstate and the shoreline. High, barbed-wire fences surround the site, with a guarded front gate its only access. Blinking red lights and giant warning signs proclaim the catastrophe that awaits any intrusion inside the reactor building. The restricted

access serves to protect would-be visitors from sudden death. The same protection motive drove the limited access of Tabernacle and Temple in Israel. And my argument is that this mix of proximity and regulated access is precisely the nagging human predicament that the theology of incarnation aims to overcome. Its goal is in the direction of increased proximity and enhanced intimacy.

Were There Pre-Christian Divine Incarnations?

Incarnation is usually thought to be an exclusively New Testament idea, but I suggest that two phenomena in the Old Testament may anticipate it and illuminate a biblical understanding of incarnational ministry. In my view, both represent God's attempts to overcome the human predicament just described and speak volumes about the nature of God and the nature of chaplaincy ministry. The first example is the well-known phenomenon of prophecy. Through prophets God speaks of judgment, hope, or guidance to a human audience. Granted, the phenomenon of prophecy does not transform a human prophet into a divine being in any sense, but it does provide the means through which God's voice is heard through proclamation of God's words. Two rhetorical features of prophecy bear reminder. Typically, a prophet prefaces the message by invoking the customary messenger formula ("Thus says the LORD" or its variations), signaling that what follows are God's very own words.

The prophet also speaks in the first person, thus conveying the message almost as if God himself were present in the moment. I've often imagined the dramatic scenes that played out when Amos indicted the rampant idolatry at Bethel (Amos 5) or Jeremiah preached his "Temple sermon" to Jerusalemites passing through the Temple gate for worship (Jeremiah 7). For my purposes, I hasten to highlight the historical reality that stood behind the rhetoric and that gave their proclamations authority: the prophets were on intimate terms with Yahweh who had commissioned them to convey God's words. Some prophets even overheard or attended the deliberations of the heavenly council about Israel's future (Isaiah 6:8; Jeremiah 23:17–18). They could thus announce the disasters and rescues decreed for God's people with full authority. In sum, in prophecy God spoke divine words to humans through humans.

But we must also understand that "prophecy avenue" was in fact a two-way street. As God's messengers, the prophets brought word from Yahweh to humans, but they also mediated word from humans to Yahweh. For example, in search of his uncle's lost donkeys, Saul sought the

assistance of Samuel (1 Samuel 9), and the narrator's aside (v. 9) shows that inquiring of God through a "seer" or "prophet" was an established ancient practice. Centuries later, three times Yahweh forbids Jeremiah to intervene on behalf of Judah because the divine mind is made up to destroy Judah (Jeremiah 7:16; 11:14; 14:11). Yahweh also declares that even the most revered of mediators (i.e., Moses and Samuel) would not avail against God's decision to ravage Judah (Jeremiah 15:1). Thus, the example of Samuel, the prohibitions in Jeremiah, and the mention of fabled mediators confirm that mediation—prayers to God on behalf of humans—also formed part of a prophet's ministry portfolio.

Before proceeding, however, we would do well to understand what distinguishes prophets from priests. According to Jeremiah 18:8, the teaching of Torah is the primary province of the latter, the prophetic word that of the former. In other words, as descendants of Levi priests serve the permanent institution established by Moses to provide Israel instruction exclusively in Moses's teaching and to conduct its worship life. Prophets by contrast mark a more ad-hoc, often non-institutional, avenue for Yahweh to address Israel about current matters of concern. In my view, in today's ecclesiology the ancient priests compare to the pastor and the prophets more to the chaplain, although the analogy is admittedly imperfect.

The second Old Testament incarnation-like phenomenon is the episode in Judges 13, which has long fascinated me. It's an example of a larger group of texts featuring the intriguing figure of "the angel of God/the Lord" who interacts with human beings on God's behalf (e.g., Genesis 16:7–13; 21:17–18; Exodus 23:23; Numbers 22:22–35).[1] Compared to prophets, these messengers act in more strikingly supernatural ways, and their presence strongly implies direct divine presence on site with all the dangers at risk in divine-human contacts (cf. Genesis 32:30; Judges 13:22). This is what fascinates me in Judges 13: the narrative juxtaposes references to "the angel of the Lord" and to a human prophet (called "a man of God") as if they were the same. The story reports how a prophet informed Manoah and his wife, childless at the time, that they would have a son—the famous Samson, as it turns out. The "angel of the Lord" appears first to the wife (vv. 2–5), who describes him to Manoah as "a man of God" who "looked like an angel of God, very awesome" (v. 6, TNIV). Exactly what about the man struck the woman as "very awesome" is not

1. For scholarly discussion of this biblical character, see D.N. Freedman, et al., "*mal'ak*," TDOT 8:317–324.

explained, but her husband prays for God to send "the man of God" back again (v. 8). When "the man" reappears (v. 10), the narrator frames the ensuing dialogue as between "the angel of the LORD" and Manoah (vv. 13–18), inserting an aside that "Manoah did not realize that it was the angel of the LORD" (v. 16b, TNIV).

When Manoah burned a sacrifice to honor the visitor, the "angel" disappeared in the ascending smoke, and Manoah finally recognized the man's true identity (vv. 20–21). That recognition terrified Manoah: he thought it tantamount to seeing God, an act that doomed the couple to death (v. 22). But his wife reassured him that the sacrifice had been accepted (v. 23), and she later gave birth to Samson (v. 24). In my view, the story implies that the angel of the LORD here appeared in human form—or, at least, that was how the human couple perceived the "angel." The incarnation strategy apparently intends to introduce God's presence directly into the lives of the human pair without terrifying them.[2] It implies divine condescension—God's accommodation to the limitations inherent in the human predicament—in order to advance the larger divine salvation plan.

Incarnation in Jesus: The Climactic, Perfect Paradigm

The climactic, perfect paradigm of incarnation, the event that in my view the above examples anticipate, is of course the incarnation of God in the person of his own Son, Jesus Christ. The Tabernacle and Temple provided humans access to God but under strict regulations that promoted proximity but not the intimacy their ancestors knew in Eden. Through prophecy, humans heard God's voice, but only indirectly through messengers sent to them by God from elsewhere. In Judges 13, Yahweh's close associate, the angel of the LORD, masquerades as a human prophet to deliver good news, so Samson's parents need not fear death for having looked on God. Given this background, how stunning is John's claim that "[t]he Word became flesh and made his dwelling among us" (John 1:14, TNIV). When I quote those familiar words in public I confess that I often choke up with emotion because I know how long and hard the road back to Eden has been for humans; I understand how reticent the

2. As Freedman et al. explain, "The shift between Yahweh and *mal'ak* YHWH does not involve the substitution of an anthropomorphic portrayal of the deity by theological speculation … but rather the living portrayal of an encounter with God, which because of the dangers of an immediate theophany was also understood as having been mediated in some way" (TDOT 8:321).

Old Testament is to place God and humans too close in proximity. What Hebrews 1:1–2 declares is equally stunning: "In the past God spoke to our ancestors through the prophets... but in these last days he has spoken to us by his Son..." (TNIV).

Invoking language that echoes Old Testament motifs, both statements mark the incarnation as a breath-taking, radical step forward toward improved intimacy with God. Both testify that in Jesus we have actually seen "the glory of God" (John 1:14; Hebrews 1:3), an Old Testament term that describes the aura of visible light or fire that signaled God's residence in the Tabernacle (Exodus 40:34–35) or Temple (1 Kings 8:11). Post-biblical Jewish writers would call that sight the *shekinah*. John's phrase "made his dwelling" (literally, "spread his tent") also seems to allude to God's former residence, the "tent" (i.e., the Tabernacle) that God spread amid Israel in the wilderness. It signals that Jesus's dwelling in a fleshly "tent" serves the same purpose as the former—to put God and humans in proximity. Both writers thus affirm that God himself was actually personally present in the human Jesus, not just represented at a safe distance by an angel as in Judges 13. Theologically, only Jesus bears the key title of God's "Son."

But there's more. Hebrews 1 ranks the incarnate Son as superior to any prophet when it comes to speaking for God (he speaks *as* God and not *for* God) and to any angel (v. 4) when it comes to representing God to humans (he *presents* rather than *represents* God). Finally, according to 1 John1:1, in Jesus people have not only "heard" God's voice, as they did through prophets, or "seen" or even "looked at" God, as did Manoah and his wife in Judges 13; their human hands have also "touched" him. Given the terrible fate of Uzzah noted above, this may be the most astounding claim! In sum, unlike the prophets and the angel/prophet in Judges 13, Jesus is God himself living in human form, and it is that unique distinction that vouches for God's presence living among humans.

What Does the Incarnation Teach Us about Being Chaplains?

What does the incarnation teach chaplains about their ministry? First, the incarnation reminds us of the nature of our God. Imagine a God who, having created humans and justly expelled them from his presence in Eden, now goes to great lengths to reestablish and maintain contact with them. That's the God whose desire for relationship with humans drives the provision of Tabernacle and Temple, the sending of prophets and angels, and the sending of God's own Son, Jesus. That's the God

who calls chaplains to serve and sends them into a variety of arenas where their ministries daily bridge the yawning gap between God and humans. And, as Paul put it, it is "Christ's love [that] compels us" to obey and live out that call (2 Corinthians 5:14, TNIV). Second, the incarnation shows us that God specifically tailors the pattern for such contacts. God speaks to humans through humans because, put simply, humans are comfortable with humans because they know what they're like and speak their language. Third, the incarnation also suggests what effective chaplaincy ministry today might look like. It reminds us to *be out there* where the people are.

I knew a chaplain at one base in Vietnam who would send a welcome letter to everyone who came to serve at that base inviting each one to attend chapel services. It was a kind, courteous gesture that certainly alerted new arrivals to his presence should they need assistance. But my incarnational model led me to pursue a different strategy: wherever I served, I regularly left my chapel office and made the rounds, visiting people around the base—in working spaces, lounges, flight lines, radio shacks, etc. I gladly accepted invitations to ride as a guest on aircraft, small boats, and land vehicles—anything that moved and had people on it. In offices and repair shops I never turned down a cup of coffee, the customary military sign of hospitality, although its quality and flavor varied greatly. In my day, Navy chaplains nicknamed this approach "the ministry of presence," and I loved it because my presence "out there" often opened up serious conversations with people who wanted to talk but would never have darkened the door of my office. If Jesus willingly left heaven for earth, I thought, I could certainly leave my office to walk and talk among people whom Jesus loved.

Further, the incarnation reminds us that we must be people *living in genuine communion with God.* To represent God to humans (and humans to God, too) we must know God intimately. Through that relationship, cultivated by worship, Scripture, and prayer, our understanding of who God is grows. It's the only way that we, like angels and prophets, can be on intimate terms with God. The angels knew God from sharing his presence, the prophets through receiving divine messages, and Jesus through communion with his Father. A chaplain's representing the living God effectively—demonstrating God's love and mercy, or speaking or acting on God's behalf—requires an ongoing relationship with our Lord that profoundly shapes our outlook, our attitudes, and our very personhood. Finally, a chaplain's calling is, like the angels, prophets, and Jesus himself,

to be people who *share the word and offer prayer*. Consistent with the go-between role of the prophet and the example of Jesus, it has been my practice to ask people with whom I'm dealing if they would like me to pray for them. I can't remember ever being turned down, and doing so powerfully draws the object of that prayer toward God, narrowing the gap between God and the person. Also consistent with the incarnational examples explored above, I highly commend the practice of weaving appropriate, carefully chosen Scripture quotations into ministry conversations. Hebrews 4:12 celebrates how powerful and penetrating God's word is, and Jesus invoked it in his defense against Satan's temptations (Matthew 4:1–11). So it makes sense to me to weave Scripture's words into conversations when they relate to the topic or situation at hand. In those moments, one may hear God's own words spoken to them, with the Holy Spirit quietly applying these words to their present need.

My Incarnational Ministry

Through this essay, I commend incarnational ministry as a biblical strategy for ministry today and always. In retrospect, my mind often drifts back to memorable moments in my own practice of incarnational ministry. I recall people whose life-paths have crossed mine during my three decades as a chaplain. I remember Harold,[3] a sailor in the Mekong Delta of Vietnam (1971) whom I visited late one night as he staffed a perimeter guard tower. His commanding officer was concerned that something was troubling Harold, so I went to see him. Harold shared with me his recent, strange experiences of God—dreams, striking coincidences, a heightened sense of awareness. I decided that he wasn't "crazy"—that God, indeed, was doing something in his life, although, in all candor, I didn't know what that was. So, I encouraged Harold to seek God, for God did seem to be seeking him. I prayed for him and left him to God.

I think also of my conversations with Pete, a lieutenant about my age who commanded my home base, the small repair ship anchored in mid-Mekong near the Cambodian border. That ship marked the jumping-off point from which I played "circuit-riding preacher" around the Delta. Pete was a devoted follower of novelist Ayn Rand and got me to read and reply to her well-known novel, *Atlas Shrugged*. In one conversation he listened politely as I told him my story—my relationship with Christ and what it meant to me. Later, after my transfer elsewhere, at

3. All names have been altered.

his request I had a Bible sent to him, and, to my surprise, he wrote that he'd read from Genesis into 2 Kings and hadn't found anything to which he objected! Although we eventually lost touch, I continued to pray for him for many years and wonder what seeds of faith might have grown from that Bible reading.

I also recall the Johnsons who came to my office at the shipyard at Bremerton, Washington. After six years of marriage and two kids, the husband's alcoholism drove them to divorce, but now a few years later the man was "dry" and they wanted to remarry. They were people of Christian faith, and I gladly did the small ceremony after advising them to keep Christ at the center of their marriage. Two months later they were back to see me, and shortly thereafter I baptized their school-age children. Further, I remember Tom, a Navy pilot who took me by car to the Navy airfield near San Diego where that night I was to catch a flight back to my home base near Seattle. After dinner, Tom turned the conversation to religion, asking numerous questions about God and Christian beliefs that I attempted to field. The following Christmas, I received a Christmas card telling me that our conversation had contributed significantly to his becoming a Christian. Today he's a civilian and has for many years had a Christian ministry to military personnel at nearby bases.

Finally, each June 14 my thoughts return to the sudden death of Charlie, my reserve commanding officer, of a heart attack in Denver. At the family's invitation, I conducted the memorial service and in succeeding years visited his widow every few months. I also came to know their children. When we moved to Chicago, she sent a fruit basket to congratulate me on my new position at North Park Theological Seminary, and our move back to Denver last year enabled us to reconnect. All too often, incarnational ministry requires us to walk gently with humans through the valley of the shadow of death and accompany them through their grief.

Conclusion

A story I've heard recalls a dark evening in which a parent was gently tucking a young child in bed for the night. The child was afraid to be alone in the dark—and said so forthrightly.

"Please don't leave me," the child pleaded. "Being alone in the dark scares me. I always imagine that there are angry monsters out there." Gently, the wise parent consoled the frightened child. "Don't be afraid. Remember, if something happens, Mommy and Daddy will be right next door ready to answer your cries for help."

"No, no, no!" the child objected. "Can't you stay here in the room with me so I'm not alone? Please!"

At this point, the parent drew on some good Christian theology to ease the child's anxiety. "Now, you know that God is invisible—we can't see him like we can see people—but God is also everywhere, even right here in this room. So, when you feel afraid, just remember that God is right here with you."

"No!" the child persisted, "I want somebody here with skin."

One thing chaplains do is present to people God-with-skin. They are an incarnation of God's presence and work in the world, visible with human eyes to see, ears to listen, a voice to speak, and hands to touch.

Many Will Come in My Name: Spiritual Care for Persons with a Delusion of Grandiosity with Religious Content

Tim Fretheim, spiritual care practitioner, Forensic Psychiatric Hospital, Vancouver, British Columbia

I was having morning coffee on the maximum-security ward of the Forensic Psychiatric Hospital as I normally do, in order to meet patients and engage them in friendly conversation. I noticed a patient I did not recognize looking directly at me as he walked quickly toward me. He had a crew cut, a stocky build, and was well groomed, indicating he was not off the street. When he reached me, he extended his hand with a smile, saying, "Let me cut to the chase: I think I am Jesus Christ." Though he was not the first person I had met in my ministry as a psychiatric chaplain who identified as divine, Tom's strong conviction about this identity made a lasting impression on me.[1]

I followed Tom through his hospitalization and his reintegration into society. He phoned me one day and asked to meet for coffee. At one point in the conversation, he said, "Why aren't they phoning me?"

I looked at him, puzzled. "Who isn't phoning you?"

"You know, world leaders. They know who I am. Why aren't they phoning me and asking me to solve the problems they face?" Clearly, his belief about his divine identity persisted.

A few years later I opened the newspaper to read about a man reported missing and presumed drowned. His car was found by a bridge. It was registered in Tom's name.

Tom's story is one I have encountered in my role as chaplain at the provincial facility for persons living with a mental health issue who are

1. Patient names in this article are pseudonymous.

in conflict with the law. These persons are legally termed "not criminally responsible due to a mental disorder" (NCRMD). Tom had been arrested for a criminal action directly motivated by his delusion that he was Jesus Christ. He was brought to the hospital for an assessment. The doctor was not particularly interested in the *content* of Tom's delusion (i.e., that he thought he was Jesus); the doctor's role was to determine if Tom was mentally ill at the time of his offense.

But what is the chaplain's role? Should a chaplain be interested in the fact that Tom believes he is Jesus Christ? Or does the chaplain, like the doctor, have a different role to play? Patients like Tom may turn to religion and spirituality for help in coping with stress and losses due to their illness or with their hospitalization. In this institutional setting, chaplains are the face of religion and spirituality, and they need to hone their skills in order to provide healthy spiritual care to persons, like Tom, living with a grandiose religious delusion.

A study of this type of delusion provides an excellent opportunity to explore the interface between science and religion, between psychotic behavior and authentic religious experience. In this article, I wish to highlight the chaplain's role in spiritual care provision for those experiencing mental illness and to offer some recommendations for best practice within this context. I begin with an extended discussion of the clinical definition of a delusion. Next, I explore the sources of religious delusion. Finally, I apply theory to practice by analyzing a case study. This analysis illustrates the impact of a religious delusion on a person's life and helps clarify the unique role chaplains may play in providing pastoral and professional support to both the patient and clinical team. My hope is that this study will provide chaplains and others in positions of pastoral care knowledge and skills to both affirm patients' authentic spirituality and assist them to better manage their illness.

Delusion, Dimensions, and the DSM

At its most basic level, a delusion is simply a false belief. In clinical literature, a delusion is classified by its content or themes: erotomanic, persecutory, grandiose, jealous, somatic, and referential. In the grandiose type, persons believe they possess special powers or abilities. The grandiose theme often becomes religious, leading a person to believe they are Jesus Christ or some messenger from God. Religious delusions are not uncommon. One study reported religious delusions in 24 percent of patients

hospitalized with schizophrenia.[2] Recently, in my own facility on a ward of twenty-six patients, five thought themselves divine.

Delusions are symptoms of an illness. They occur most frequently in schizophrenia and bipolar disorder, often when the person is experiencing psychosis. They are "fixed," meaning that the content of delusions is unlikely to change, though the occurrence and intensity of delusions may lessen through the use of medications that address the underlying illness. Most troubling of all, clinicians know that persons experiencing delusions are at greater risk of harming or even killing themselves or someone else.

The *Diagnostic and Statistical Manual IV* (DSM IV) defines a delusion as "a false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary."[3] The definition goes on to exempt beliefs "ordinarily accepted by other members of the person's culture or subculture." So, a delusional belief is one that is (1) false, (2) held with subjective certainty, (3) incorrigible, and (4) not an article of religious faith commonly held by a wider religious group.

The DSM's definition was adequate for clinicians to assess their patients, offering some criteria by which they could observe patients and make clinical judgments. If their patient was perhaps eccentric and hard to assess accurately, they had an exception clause that would recognize that religious groups often held beliefs that were not rational—such as the virgin birth or resurrection of Jesus—but held as tenets of the faith. However, as psychiatrist Joseph M. Pierre argues, the DSM is inadequate on this point in that diagnosis still relies on the subjective judgment of the clinician. For example, a clinician who is an atheist may assess as delusional any religious talk he or she judges irrational.[4] Clinicians therefore needed more precise criteria for diagnosing a person's religious beliefs as normal (at least culturally) or delusional (requiring medical treatment) than could be found in the *content* of the delusion, "I am Jesus Christ."

So researchers began to review the existing definition and to critique it on several points. First, it was noted that the falsity criterion was unsustainable because religious beliefs had no empirical evidence to test

2. Felicity Ng, "The Interface between Religion and Psychosis," *Australasian Psychiatry*, vol. 15, no. 1 (Feb 2007): 63.

3. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th edition (Washington, D.C.: American Psychiatric Association, 1994), 765.

4. Joseph Pierre, "Faith or Delusions? At the Crossroads of Religion and Psychosis," *Journal of Psychiatric Practice* (May 2001): 166.

for scientific validity. It might appear to be false, but this could not be proven. Second, it was pointed out that the beliefs in question were frequently held by many parts of the population not regarded as mentally ill. The television program *X Files*, for example, drew its audience from all ages and genders; many of Agent Mulder's fans agree, in the face of far-fetched paranormal claims, "the truth is out there."

This led researchers to investigate different and distinct *dimensions* of the delusion that could be measured. These dimensions were less concerned with the *content* of the delusion than they were concerned with the *experiential impact* the delusion had on the person's life. These dimensions included:

1. Conviction: the strength of the belief;
2. Preoccupation: the frequency of the delusion in a person's thoughts;
3. Emotional distress: the negative impact on a person;
4. The degree to which the delusion influenced one's action: what it causes a person to do.

For example, if we ask how a person behaved while confessing Christ as "conceived by the Holy Spirit, born of the Virgin Mary," we would probably conclude that no discernible impact accompanied the confession either in emotion or action. However, if that person asked to speak in the church about the virgin birth and began to get angry about why this was not a centerpiece in the church's theology, we might become concerned.

Research has provided empirical support for the use of dimensions in diagnosing a delusional belief. British psychologist Emmanuelle Peters developed a twenty-one-question inventory called the Peters Delusions Inventory (PDI) to test whether deluded persons (hospitalized with an active psychosis) answered differently than healthy persons on questions pertaining to their spiritual beliefs.[5] The PDI asked questions such as, "Do you ever feel as if you have been chosen by God in some way?" Or, "Do you ever feel that you are especially close to God?" The results of Peters's study revealed that both healthy and deluded persons shared uncommon beliefs; what differed was *how they experienced* those beliefs. For example, comparable numbers of healthy and deluded individuals responded affirmatively to the question, "Do you ever feel as if some people are not

5. Emmanuelle Peters, Stephen Joseph, Samantha Day, and Philippa Garety, "Measuring Delusional Ideation: The 21-Item Peters et al. Delusions Inventory (PDI)," *Schizophrenia Bulletin*, vol. 30, no. 4 (2004): 1013.

what they seem to be?" However, this belief caused deluded patients far greater distress, and they spent much more time thinking about it. As Peters concludes, "whether or not one becomes overtly deluded is determined not just by the content of mental events but also by the extent to which they are believed, how much they interfere with one's life, and their emotional impact."[6]

Most people do not experience beliefs as intensely or with as much distress as delusional persons. It is this intensity of experience that can cause an individual suffering from a mental illness to act on the delusion in pathological ways. While chaplains do not assess patients using the PDI, the dimensions it outlines nevertheless provide a useful guide for learning to recognize the behaviors of clinically delusional persons. With this understanding of how delusions are defined, we can now consider the origins of grandiose religious delusions.

The Roots of a Delusion: Biology, Culture, and Anomalous Experiences

While in a treatment planning meeting at the hospital, the psychiatrist asked if I had anything to contribute. "Yes. Mr. Johnson told me that he has been called by God to reinstate full sacrificial worship in the Jerusalem Temple." Thinking I had stumbled across a great discovery, I was surprised when the doctor, without looking up from the notes he was taking, simply said, "Yes, that is Mr. Johnson's *idiosyncratic belief*." Throughout the literature, the term "idiosyncratic belief" denotes an individual patient's delusional content. One patient, for example, told me, "I have been shot through the head three times and resurrected three times. Tell me I'm not better than Jesus Christ, who only resurrected once!" This was his idiosyncratic belief, the unique content of his delusion.

Researchers are trying to determine where patients get their delusional material and why they include what they do. Because delusions are generally fixed and difficult to alter, clinicians are less concerned about the content of the delusion, unless it is threatening, than with finding an effective medication to lessen the frequency or impact of the delusion. However, the chaplain will find it helpful to understand the source of the delusion in order to effectively support the patient. Three sources are usually given: biology, culture, and anomalous beliefs.

Biology. Every person, from infancy onward, is learning how to receive and interpret data from the external world in a way that seems

6. Ibid.

to be "right." The interpretation helps us navigate our relationships and environment. When the brain's activity is disrupted, this interpretation becomes distorted and our lives can become unmanageable. This distortion is the experience of psychosis. Felicity Ng defines psychosis as "a neuropathological disorder involving aberrant reception and/or processing of information."[7] An example of psychosis, or aberrant processing, was described to me by a patient who had studied his Social Insurance Number, comprised of three groups of three digits each. The sum of the first group was his daughter's age; the sum of the second, his son's age. This was proof, he claimed, that the third group of digits, 777, confirmed his identity as Jesus Christ, seven being the number of perfection. At that time, all number combinations held significance for him. Now, under medication that lessens his delusional thinking, he describes this significance as "illogical logic."

Ng explores some theories regarding delusions and brain pathology, citing a study by Saver and Rabin that suggests religious experience can arise from pathological brain processes.[8] In particular, they observe the well-documented association of epilepsy and religious experience: a number of religious experiences occur throughout and after epileptic seizures. They note that persons like St. Paul and Joan of Arc, among others, are suggested to have had symptoms consistent with epilepsy. The question is, did St. Paul have authentic religious encounters with God, or did he experience epileptic seizures? This question—and any question trying to establish the authenticity of religious experience—is beyond the scope of science.

Ng states that researchers have tentatively identified the limbic system, which is responsible for emotion, as the part of the brain responsible for religious experiences.[9] Again, this research raises the question, does this part of the brain create the *experience* of spiritual encounter, or is it interpreting an external experience that is authentically spiritual? Ng's research offers a thoughtful answer to this theological and scientific question. Religion, she notes, is a common human theme, possibly due to its intrinsic and cultural significance to humans and our natural propensity

7. Ng, "The Interface between Religion and Psychosis," 65.

8. Jeffrey L. Saver and John Rabin, "The Neural Substrates of Religious Experience," *Journal of Neuropsychiatry and Clinical Neurosciences*, vol. 9, no. 3 (1997): 498–501. For further analysis of Saver and Rabin's hypothesis see Ng, "The Interface between Religion and Psychosis," 64.

9. Ng, "The Interface between Religion and Psychosis," 64–65.

to interpret intense or discrepant perceptual events as spiritual or paranormal.[10] At the same time, there is evidence that points to brain dysfunction (specifically temporolimbic) in the biological origins of psychosis, which may be responsible for generating the type of perceptual experiences that resemble paranormal or spiritual events. Some conclude that religious experience is therefore nothing more than brain dysfunction. Ng opposes this application, respectfully distinguishing between the essence of religious beliefs—and their validity—and the research that, among other theories, suggests that the brain can mimic religious experiences: "the challenge lies in differentiating between religious culture and pathology, and this requires a thorough assessment of the dimensions of beliefs as well as minimizing premature judgment based on ignorance of unfamiliar religions."[11] A clinical review of psychosis and religious delusions does not challenge the basic value of religious faith. Rather, it offers an opportunity to consider possible roots of delusion. The clinician—and chaplain—will need to be cognizant of these roots when working with a patient experiencing such delusions.

Culture. Culture is the medium that gives us a framework through which to look at the world and answer questions of meaning such as: Why am I here? Who am I? Pierre writes that, "Beliefs and explanations, both delusional and religious, are culled from a cultural construction of reality. The myriad of world religions in different cultures is testament to this fact. Delusions too are drawn from the language and concepts of culture."[12] Whether a person is a member of an organized religion or simply lives in a culturally religious neighborhood or nation, this culture shapes and impacts that person.

Psychiatrist Robert Clark surveyed the delusional content of five Jewish patients in a private psychiatric hospital in Philadelphia.[13] He found that some of their delusions were consistent with themes in Jewish Scripture, but others included elements from the New Testament, perhaps through the influence of a dominant culture. Clark's study was intended to demonstrate that delusionary experiences cross cultural boundaries, sometimes in surprising ways. One of his patients, for example, imagined himself with incredible knowledge that he had gained from reading Genesis 1–3.

10. Ibid., 64.
11. Ibid., 65.
12. Pierre, "Faith or Delusions?" 169.
13. Robert A. Clarke, "Religious Delusions Among Jews," *American Journal of Psychotherapy*, vol. 34, no. 1 (1980): 62–71.

His delusion was congruent with his Jewish faith and culture. Another Jewish man, however, thought he was Jesus the Messiah. He experienced tingling in his palms, a symptom he believed came from the nails in the crucifixion. This notion, which would be intolerable for many Jews, stayed with him. Delusional content can be both culturally consistent and idiosyncratic!

Kausar Suhail and Shabnam Gauri[14] studied the delusional content of Pakistani Muslims diagnosed with schizophrenia. They found that highly religious persons had grandiose delusions, self-identifying as powerful figures contextual to Islamic Pakistan: God, Wali (pious person), the Prophet Mohammad, or a king. In addition to grandiose identities, highly religious patients also professed grandiose abilities, such as the ability to control physical elements such as lightening, wind, rain, and Jinn.[15] Addressing the universality of religious delusions, A.D. Gaines writes:

> Specific beliefs may be standardized culturally regardless of how bizarre they appear to the uninitiated. … E.g., certain beliefs, such as being controlled by a dead person, are clearly and without a doubt delusional. In fact, this is a common belief among the world's cultures. … Matters become complicated for clinicians where there are many constructions of reality of how the world works and why things happen.[16]

Needless to say, a Western trained psychiatrist or chaplain would be hard pressed to know whether a patient's claim to be Wali indicated delusion or piety. In today's increasingly secular and shrinking world, chaplains need to understand the cultural and religious context from which a patient comes. This understanding will assist them both to support the patient and to provide important feedback for the treatment team with regard to accepted religious norms. Ng affirms this when she argues that clinicians need to "recognize their own limitations in theological knowledge," encouraging them to seek "education of unfamiliar religious beliefs."[17]

Anomalous Experiences. A final source of delusions is the anoma-

14. Kausar Suhail and Shabnam Gauri, "Phenomenology of Delusions and Hallucinations in Schizophrenia by Religious Convictions," *Mental Health, Religion & Culture*, vol. 13, no. 3 (2010): 245–59.

15. Ibid., 254. Jinn are supernatural creatures in Islamic mythology, capable of good or evil. They can act upon or be acted upon by humans.

16. A. D. Gaines, "Culture-Specific Delusions: Sense and Nonsense in Cultural Context," *Psychiatric Clinics of North America*, vol. 18, no. 2 (1995): 281–301.

17. Ng, "The Interface between Religion and Psychosis," 65.

lous experience. Anomalous experiences are events that the recipient perceives as paranormal, psychic, or bizarre. Such an experience cannot be explained using the conventional laws of science, and therefore the person who experiences it may explain it as a divine encounter. For example, a climber ascends a mountain and reaches the top when suddenly the clouds part to reveal the brilliance of the sun. The climber is suddenly aware of an awesome presence and exclaims, "God must be here!" Spiritually healthy persons may understand anomalous experiences as God's providential intervention.[18] But such occurrences may give the vulnerable person delusional content as they try "to make sense of discrepant perceptual events."[19]

While all psychotic experiences are processed in the brain, Ng reminds us that their explanation is likely to be as complex as our neural pathways. For this reason, any explanation of origin will need to consider culture, biology, and anomalous experiences. The origin of a delusion falls under the domain of the clinician and is not essential knowledge for the chaplain. Nevertheless, as part of a multidisciplinary care team that brings both science and religion to the table, the chaplain's role is neither to defend the validity of religious beliefs nor simply dismiss them as unhealthy, but to support the patient and perhaps clinicians by modeling the positive role that religious faith can play, even if delusionary beliefs are present.

Healthy Spiritual Care: The Chaplain's Response

Let me review the basic understanding of a grandiose delusion with religious content. It is (1) a false belief, (2) symptomatic of a diagnosis like schizophrenia or bipolar disorder, often in the psychotic phase, and (3) "fixed," usually lessened through medication. Up to this point, I have been using medical and academic language. But as I noted, a delusion is symptomatic of something greater—the very life of the person suffering from the delusion. The words of Australian psychiatrists Nicholas Keks and Russell D'Souza should alert the chaplain to the challenge this person brings to spiritual care: "Psychoses exact a terrible toll on people. In approximately half the patients there is an enduring loss of richness of personality—the so-called deficit syndrome. Many people with psychoses

18. See Mark 1:10–11 for an anomalous experience at Jesus's baptism. The heavens are "ripped open" and God "speaks to him." But for reaction to Jesus's early ministry, see Mark 3:21: "And when his family heard it, they went out to seize him, for they were saying, 'He is out of his mind.'"

19. Ng, "The Interface between Religion and Psychosis," 64.

attempt and complete suicide."[20] It may be confusing to hear a person say, "They don't understand that I am Jesus Christ, and I will punish them for putting me in here," and then have conversation continue as though nothing unusual was said. For the chaplain, however, questions arise: How do I respond to this patient? How can I offer healthy spiritual care?

I offer here two basic practices a chaplain can use to work with such a patient. First, recognize the humanity of each patient and work to de-stigmatize the effects of the delusional beliefs. Second, make a spiritual assessment of the person in order to better understand what role religious faith or practice has played in the person's life. I will model the application of these practices by analyzing a patient case history. These practices provide a reality-based framework for chaplains to use when offering care to an individual with a religious delusion, both in and out of the hospital.

Humanization and De-stigmatization. When Tom came to me on the ward and announced, "I am Jesus Christ," I responded, "Do you have any other handles?" He provided his name. Reflecting on that exchange, I realized that without thinking I had done what chaplains are called to do: recognize the humanity of the person in front of them. Shaking his hand and learning his name were simple gestures to assure Tom that he was recognized as a person first and foremost, and to remind myself that, whatever else it may mean for Tom to "be Jesus Christ," it means he is human.

In his book, *Resurrecting the Person*,[21] John Swinton addresses the stigmatization persons living with a severe mental illness face. When people heard Tom call himself Jesus Christ, their attitudes toward him changed. His friends were no longer available; a romantic date became an impossibility. The stigmatization continued in the hospital after Tom was arrested. Legal and medical terminology are an inevitable part of each person's new identity when they have been arrested. Legally, they become a "remanded patient." Medically, they may be diagnosed as "a schizophrenic." Desiring to be accepted as a professional member of the medical team, chaplains may soon speak this language as well. Janet Foggie addresses this issue clearly and personally in her role as a mental health chaplain. She urges chaplains to resist the temptation of power

20. Nicholas Keks and Russell D'Souza, "Spirituality and Psychosis," *Australasian Psychiatry*, vol. 11, no. 2 (2003): 170.

21. John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville: Abingdon, 2000).

by instead taking the side of the patient:

> In my own working life and practice I have come to the conclusion that in order to work with a patient's religious delusions I have to lose my professional identity as one of *them*, the skeptical team, and become one of *us*, the patient belief group. I also have to prove my worth to the patient, allowing them to give me their view and not to contradict it immediately, to listen and ask questions that constantly reminded the patient that it is OK, indeed normal, to have a religious faith.[22]

For the chaplain, the importance of coming alongside a patient is particularly important when the patient begins to recover. Any spiritual thoughts or behavior will be suspect and may easily be labeled "schizophrenic." Chaplains must learn how to affirm authentic spirituality while recognizing some thoughts and experiences as psychotic fragments. A patient once said to me, "God is not pleased with me. I heard the shutters rattling, and that means he is not happy with my behavior." I replied, "I don't doubt that God speaks to you and is concerned about your behavior. I think that the rattling shutters might be your schizophrenia talking, though." He smiled and accepted my comment.

Assessment. One of the best tools a chaplain can use is a spiritual assessment. There is a growing body of literature that recognizes the importance of assessing a patient for their spiritual beliefs and practices.[23] The HOPE Assessment tool[24] was designed by two medical doctors for use in their daily practice, using the word "hope" as an acrostic checklist:

> H: sources of hope, strength, comfort, meaning, peace, love, and connection
> O: the role of organized religion in the patient's faith
> P: personal spirituality and practices
> E: effects of religious beliefs on medical care and end-of-life decisions

22. Janet Foggie, "Orthodoxy or Heresy? A New Way of Looking at Spiritual Care for People with Delusional Beliefs," *Scottish Journal of Healthcare Chaplaincy*, vol. 10, no. 1 (2007): 25.

23. See, for example, George Fitchett, *Assessing Spiritual Need: A Guide for Caregivers* (Minneapolis: Augsburg/Fortress, 1993).

24. Gowri Anandarajah and Ellen Hight, "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment," *American Family Physician*, vol. 63, no. 1 (2001): 81–89.

Using these categories, the assessor simply asks the patient: What are your sources of hope? What is the role of organized religion in your faith? And so on. Administering a spiritual assessment is a learned skill. One needs to be familiar with the questions in order to probe for more nuanced answers. These questions equip the chaplain with doorways for conversation and are useful in discerning and encouraging healthy spirituality in patients.

Practice. Case studies are used to illustrate the nature of the patient's illness and the clinician's treatment of that patient. In order to offer an extended example of this practice, I offer here my reflections on a case study provided by Keks and D'Souza.[25] I have divided the case study into four sections, following each with my commentary, drawing from my clinical and pastoral experience to demonstrate both the impact the delusion has on the person and what healthy spiritual care may look like. I begin with the title given by Keks and D'Souza:

"Case 2: The Anti-abortion Campaigner"

This title unwittingly stigmatizes Bill by connecting his mentally ill behavior with an unpopular moral issue. Bill's religious background is Roman Catholic—a tradition that is unabashedly pro-life, in which it is not uncommon to demonstrate publicly at women's health clinics. Since Bill's campaigning occurs during his elevated (manic) moods, the moniker might seem to be appropriate, at least in the doctor's mind. But why identify Bill in this way? When his mood regulates, the campaigning stops. Then what is he? As I wrote earlier, recognizing the humanity of a person with mental illness and avoiding stigmatization is an important challenge for the chaplain.

> A 44-year-old single, unemployed man was living alone. . . . He had an 18-year history of schizoaffective disorder with no hospitalizations for some time, but continued to experience marked mood fluctuations and chronic underlying psychosis with persecutory delusional themes.[26]

This first paragraph gives us a snapshot of Bill's medical history and current situation. We learn that his diagnosis is schizoaffective. As the chaplain, I would need to understand what this diagnosis means. Schizo-

25. Keks and D'Souza, "Spirituality and Psychosis," 170–71.
26. Ibid.

phrenia is a breakdown in the relation between thought, emotion, and behavior, leading to faulty perceptions of the world. It often involves a group of disorders: in this case, the word "affective" means how moods and emotions are expressed. So Bill is diagnosed as a person with schizophrenia who has a noticeable shift in his mood swings. The recognition that he has chronic underlying psychosis with persecutory delusional themes means he thinks people are out to get him. Bill's current situation is this: single, unemployed, living alone, with an eighteen-year history of illness with hospitalization. This could fit many persons living with a mental illness like schizophrenia. It is a disabling disease that isolates one from community, prevents regular employment, and periodically flares up into hospitalization, so that one's life may take an abrupt turn for weeks. One other aspect that many patients have is an addiction to street drugs, alcohol, and/or tobacco.

> During episodes of psychotic depression, the patient had been in torment over his "sins," particularly masturbation. He would react violently if it was suggested that masturbation was normal. When his mood was elevated, he would pursue anti-abortion activities, occasionally becoming violent. He had delusions of grandeur relating to themes of God. . . . He demanded to know if his psychiatrist was an abortionist. . . . He had been banned by radio stations for making nuisance calls. . . . When mildly depressed, he would be most in touch with reality and would become aware of his losses. The therapeutic relationship tended to fluctuate and trust was highly variable.[27]

The second paragraph describes Bill's moods. With regard to the experiential dimensions of delusion, outlined previously, we can see clear evidence of the "emotional affect" (negative effect) and "impact on your life." First, the emotional impact is indicated by the words used to describe his feelings: "depression," "torment," "reacts violently." The word "torment" suggests great pain due to his psychotic depression. Notice the strength of his feelings: there is a great deal of anger expressed, perhaps due in part to his delusions of grandeur relating to themes of God. He suddenly feels powerful enough to take on the abortion clinics and do so in the name of God. He "demands to know" if his psychiatrist is an

27. Ibid.

abortionist. Bill goes from torment to anger. This emotional roller coaster can be exhausting.

The "impact on your life" is described next: "pursue anti-abortion campaign activities, occasionally becoming violent. . . . banned by the radio station for making nuisance calls." This is manic behavior that can lead to negative consequences. Bill's nuisance phone calls would alarm me because it suggests he is acting on his feelings of power and righteousness. His anti-abortion campaigning can become violent—that suggests possible legal consequences. Either behavior could return him to a forensic psychiatric hospital.

When Bill's mood levels off and he is slightly depressed, he is able to become aware of the losses in his life and is able to experience the sadness and loneliness that are the realities of his life. This is the most telling sentence in the case study. Even though he has lived with his illness for eighteen years, is it a stretch to think that one of those times he might attempt suicide?

> Part of the therapeutic contract was to avoid direct action in anti-abortion activism for reasons to do with his personal safety. He agreed to the therapist's suggestion of constructive use of religious outlets at times of crisis. The patient appreciated opportunities to educate his psychiatrist about Catholicism.[28]

The third paragraph is a summary of the work of Bill's therapist, but also highlights the place where the chaplain could play a role as his religious friend. The therapist has created a therapeutic alliance with Bill. This allows him to suggest alternate behaviors for Bill when his mood is elevated. The therapist wisely found a *religious* alternative outlet during the times of crisis. Here is where it is helpful to know if Bill's support network includes the priest. That kind of information can be gleaned from a spiritual assessment.

It is surprising to me that the man's religious life is being recognized and affirmed by the medical professionals; often this is not the case. Apparently the therapist has recognized the important role spirituality plays in Bill's life, and the psychiatrist's willingness to allow his patient to instruct him in Catholicism is encouraging. The professional respect the team demonstrates for Bill's spirituality would be a wonderful entry point for the chaplain, who could build on the team's respect and encourage

28. Ibid.

Bill by attending Mass with him or by spending time with him when he lives out his pro-life values.

A case study like this is a snapshot of the care of a person in treatment and can be a teaching tool for chaplains who want to learn how to care for a person diagnosed with a religious delusion. The chaplain might also want to present a case study outlining the differences between genuine spiritual experience and psychotic experience, as well as highlighting commonly held Catholic beliefs. The chaplain can be an important resource for the rest of the treatment team in this regard.

Conclusion: The Challenge

In a revealing study, Sylvia Mohr et al. compared patients with delusions with religious content to patients with delusions without religious content to see if one group fared better than the other.[29] Earlier studies had suggested that persons with delusions with religious content had a poorer prognosis in schizophrenia; the same studies showed that positive religious coping is frequent among this group. What the researchers found was that, "Patients who have persistent delusions with religious content…frequently feature antagonism with psychiatric care and get less support from their religious *communities*."[30] Mohr explains the difficulty: "Delusions with religious content were an obstacle to participation in religious activities with other people and support from a religious community…due to the dysfunctional behaviors related to their delusions." As a result, these patients "kept their distance from both psychiatric care and religious communities."[31]

The challenge for chaplains is to learn how to reach out to people that have delusions with religious content, both in the hospital and in the community. These persons can be behaviorally difficult and disruptive. They may require a great deal of time from the pastor. A congregation might be apprehensive and fearful about such a person. Thoughtful preparation will need to be given to ministering to a person with these needs. But the studies mentioned above indicate that positive spiritual coping benefits these people and allows them to live a richer life.

29. Sylvia Mohr, Laurence Borras, Carine Betrisey, Brandt Pierre-Yves, Christiane Gillieron, and Philippe Hugueler, "Delusions with Religious Content in Patients with Psychosis: How They Interact with Spiritual Coping," *Psychiatry*, vol. 73, no. 2 (2010): 158–72.

30. Ibid., 167, my emphasis.

31. Ibid., 167–68.

Tom had been living in the community for several years when he phoned me about a church he wanted to attend. I suggested that he not reveal his "identity" too quickly. Of course, that was the first comment he made when he entered the church! But the greeter simply escorted him to a seat. I met with the pastor several times to talk about Tom's participation in the church. It was bumpy. At times, Tom refused any counsel from the pastor, while at other times he received it. After two years, Tom left the church and tried a few others. That lasted only for a short time.

For the chaplain or congregation that is willing to invest the time and effort it takes to create and sustain a relationship with persons like Bill or Tom, the experience can be rewarding. You may learn how to survive living under a bridge, as I learned from Raymond. Or, they may show you the best places to go dumpster diving. They will introduce you to a world you would not normally frequent—and do it all on a limited disability pension. God's bias for the poor and marginalized is clear biblically—and this includes persons with mental illness. Spiritually, persons living with a chronic mental illness and who carry all their earthly possessions in a shopping cart challenge our materialistic values. Pastorally, the weak give the strong an opportunity to practice humble foot washing. And in so doing you will truly meet Jesus Christ: "For I was hungry and you gave me food, I was thirsty, and you give me drink. I was a stranger and you welcomed me. I was naked and you clothed me. I was sick and you visited me. I was in prison and you came to me… inasmuch as you did it to one of the least of these my brothers or sisters, you did it to me" (Matthew 25:35–36, 40b).

Claiming a Substantive View of Presence: The Significance of the Pastor's Self

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The disciplines of pastoral care and counseling have witnessed growing attention to "presence" or a "ministry of presence."[1] Certainly prayerful being, or presence, ought to be the starting point for all pastoral ministry. However, the emphasis on presence has the potential to minimize the significance of active pastoral caregiving, especially when one *only* defers to being a supportive presence. In this paper we argue for an expanded view of pastoral presence that calls pastoral caregivers to exercise their agency and assume a more active, engaged posture when providing care. Such an expanded notion of presence requires the caregiver's ongoing development of self-awareness and development of capacities to elicit narrative and facilitate mutual attunement to the Holy Spirit. These capacities enable the caregiver to co-create transformative moments that may provide strength in weakness, hope in despair, and peace in unrest.

Claiming Presence: The Use of Self in Pastoral Care

While the notion of presence has received much attention in theologies of pastoral care, it is important to recognize this as a twentieth-century

1. Rob O'Lynn, *Practicing Presence: Theory and Practice of Pastoral Care* (Bloomington, IN: WestBow Press, 2015); Steve Nolan, *Spiritual Care at the End of Life: The Chaplain as a "Hopeful Presence"* (Philadelphia: Jessica Kingsley Publishers, 2011); Ewan Kelly, *Personhood and Presence: Self as a Resource of Spiritual and Pastoral Care* (New York: T&T Clark, 2012).

trend. This is significant. Even a brief survey of the history of pastoral care and counseling reveals that active, engaged presence characterized by authority and expertise has been at the core of pastoral care for centuries. For example, William Clebsh and Charles Jaekle's *Pastoral Care in a Historical Perspective*[2] convincingly demonstrates that prior to the twentieth century, the key qualities of the pastor in caring relationships were an authoritative sense of purpose, theological expertise, and clarity of vision. To draw a single example from the early church, Gregory of Nazianzus (d. 390) famously conceptualized the pastor as a "physician of souls" and as a "ruler" who engages in the "guidance of souls."[3] According to Gregory, "In the same way the soul perfects the body, so does the pastor perfect the church."[4] Influenced by Nazianzus, Gregory the Great (d. 604) expanded the metaphor, attributing to pastor-as-physician the responsibility of curing not only soul but body as well. These two towering figures influenced pastoral practice for nearly a millennium.

Whereas prior eras generally esteemed the pastoral role, taking for granted the pastor's expertise, today's post-Christian culture often places on pastors the added burden of demonstrating the need for and benefits of pastoral care. This is particularly true of chaplains serving within institutional contexts.[5] For this reason, pastors must demonstrate a strong sense of pastoral authority and expertise in relationally connected ways.

Authority and expertise can be difficult concepts to grasp within the context of pastoral ministry. Our CPE (clinical pastoral education) students often struggle to name and own their expertise, as many assume such authority creates power imbalances that prevent pastoral relationships from flourishing. However, amid the diversity of contemporary life, it is essential to extend one's pastoral identity beyond being an expert in *content*, toward being a specialist in the *process* of facilitating meaning-making and healing conversations. This is a shift from the *objective* treatment of particular issues to facilitating a healing process for the *subjects*

2. William A. Clebsh and Charles R. Jaekle, *Pastoral Care in a Historical Perspective* (New York: Jason Aronson Inc., 1994). See also, Andrew Purves, *Pastoral Theology in the Classical Tradition* (Louisville: Westminster John Knox, 2001).

3. Gregory of Nazianzus, "Orations," in *The Fathers of the Church: St. Gregory of Nazianzus Select Orations* (Washington, D.C.: Catholic University of America Press, 2003). See also, Andrew Purves, *Pastoral Theology in the Classical Tradition*, 17–20.

4. Ibid., 18.

5. This is best evidenced by a recent study demonstrating the relationship between chaplains' care to patient satisfaction scores in health-care settings. See Deborah B. Marin et al., "Relationship between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy,* vol. 21, no. 1 (2015): 14–24.

of our care. Our students can often assent to this vision in good faith, as it calls forth their training and resources while honoring the agency and expertise of the subject in an I-Thou relationship.[6] Reframing expertise allows pastoral caregivers to build on a history of expertise in ways that resonate with the current context.

Honoring the agency of the pastor is foundational to pastoral care characterized by authority and expertise. The incarnation provides a helpful analogy for conceptualizing the interplay of divine and human agency in pastoral care. The Third Council of Constantinople (680/681 CE) stated that Christ had two wills corresponding to his divine and human natures, his human will always in obedient submission to the divine will. While pastoral caregivers do not embody divine agency as Jesus does, a substantive view of presence recognizes a dynamic relationship between divine and human action. Effective pastoral care requires that the caregiver recognize not *only* the priority of divine agency but also one's own agency, seeking to align oneself with God's work. The task of reimagining a ministry of active presence is not necessarily concerned with the "what" of incarnational ministry[7] but with the "how," specifically the ways in which the pastor's agency can be best aligned with God. Charles Gerkin has alluded to this by framing pastoral care as an incarnational style of tending to present life experiences.[8] In other words, the pastor's identity is undergirded by the presence of God, yet style and approach are dependent upon the individual. If the pastor is without a sense of agency, self-awareness, and capacities for ministry, his or her potential will not be fully actualized. Pastors may better partner with the ministry of the Triune God through increased awareness of the self in ministry.

Providing incarnational pastoral care necessitates being a faithful presence who is actively attuned to one's own spirit, to the spirit of recipient of care, and, of course, to the Spirit of God. This type of listening—spirit-to-spirit-to-Spirit listening—allows the pastor to hear the messages embedded within the stories of the person they are caring for and to be aware of the state of the other's spirit. This happens when the pastor checks his or her own presuppositions and judgments. At its

6. See Martin Buber, *I and Thou*, trans., Walter Kaufman (New York: Touchstone, 1996).

7. I.e., the Spirit of Christ dwelling within the caregiver, re-presenting Christ to recipients of care, etc.

8. Charles V. Gerkin, "Incarnational Theology and Pastoral Care (Protestantism)," in *Dictionary of Pastoral Care and Counseling*, ed., Rodney J. Hunter, et. al. (Nashville: Abingdon, 1990), 573.

best, spirit-to-spirit-to Spirit listening results in a dynamic, co-creative partnership between all three parties that reveals processes that can be replaced, revised, or blessed so that the individual being cared for may live into a narrative characterized by healing, sustenance, justice, and/or reconciliation. In this partnership, the pastor, subject(s) of care, and Spirit of God co-create a transforming narrative in the space within and between the pastor, God, and subject(s).[9]

Growing Pastoral Capacity

Constricted self-awareness and capacity limit pastoral effectiveness. "Capacity" is a helpful metaphor for the work of pastoral formation, including the CPE experience. A mechanically minded CPE student once likened pastoral capacity to a speed limiter (or governor) on a car. While an engine may have the capacity to reach great speeds, the governor caps its potential at a set point. Left unrestricted the needle may reach one hundred miles per hour; governed, it may only reach seventy-five miles per hour. The degree to which a pastor has unexplored and disintegrated soul material is the extent to which the pastor is limited or "governed" by it. The range between the pastor's ultimate capacity and current development level is the zone he or she may cease to provide patients or parishioners an effective pastoral presence.

Learning to facilitate meaning-making and healing conversations requires tremendous soul work. Parker Palmer speaks to the wild, tenacious, savvy, and yet shy qualities of the soul.[10] Like a wild animal the soul resides in the thickets, listening and looking for the conditions in which it will emerge. Acknowledging both the lively and wary realities of the soul can help the pastor create conditions that are safe enough for souls to come forward with curiosity, and perhaps even trust. These conditions apply to the pastor's soul no less than the patient's or parishioner's. The soul grows distrustful and wary if repeatedly forced from its safe place. Often parts of us are hyper-driven and a bit tyrannical. They are out of tune with our vulnerability, and so can rush into the forest and spook our soul into hiding. Part of the task of pastoral formation

9. Ruthelle Josselson, *The Space between Us: Exploring the Dimensions of Human Relationships* (Thousand Oaks, CA: Sage Publications, 1996). See also the concept of "transition space" in Ann Belford Ulanov, *Finding Space: Winnicott, God, and Pscyhic Reality* (Louisville: Westminster John Knox, 2001).

10. Parker Palmer, *A Hidden Wholeness: The Journey toward an Undivided Life* (San Francisco: Josey-Bass, 2004), 58–59.

is learning the subtle intentions and energy of our various parts so they can find new ways of relating with less polarity and antagonism. Thus, creating a safe and respectful inner space for ourselves is prerequisite to creating a safe place for others.

There is some truth to the adage, "We can't expect people to go where we haven't gone ourselves." The needs of those in our care are profound. In order to meet these needs the pastor must build the capacity to go toward and remain in the depths of the human encounter. It is precisely this capacity clinical pastoral education seeks to build. Palmer expresses this principle well:

> Why must we go in and down? Because as we do so, we will meet the darkness that we carry within ourselves—the ultimate source of the shadows that we project onto other people. . . . if we ride those monsters all the way down, we break through to something precious—to . . . the community we share beneath the broken surface of our lives. Good leadership comes from people who penetrated their own inner darkness and arrived at the place where we are at one with one another, people who can lead the rest of us to a place of "hidden wholeness" because they have been there and know the way.[11]

In this quote, Palmer illustrates the necessity of the type of soul work students and pastors ought to engage in on a regular basis. Doing so requires not only self-awareness, but also willingness to explore the depths of one's innermost being at various points of need.

The Use of Self in Pastoral Ministry: Tools for a Robust Presence

Translating self-knowledge into the use of self in pastoral ministry can be a complex challenge. For this reason we suggest two practical tools for growing pastoral capacity and using one's self in ministry. Both seek to expand the inner space of the caregiver—to create room for deep, abiding, and playful curiosity within and outside of one's self. Jaco Hamman's six capacities for pastoral leadership[12] explicitly address the developmental process of the pastor. Richard Schwartz's internal family systems (IFS)

11. Parker Palmer, *Let Your Life Speak: Listening for the Voice of Vocation* (San Francisco: Jossey-Bass, 2000), 80–81.

12. Jaco J. Hamman, *Becoming a Pastor: Forming Self and Soul for Ministry* (Cleveland: Pilgrim Press, 2007).

theory[13] is an integrative model used more broadly in therapy, self-supervision, and spiritual practices.

Six Capacities. Hamman's concept of "capacity" speaks both to the need for inner spaciousness (being) as well as the ability to engage in effective pastoral relationships (doing). Hamman likens pastoral formation to human development, drawing from twentieth-century pediatrician and psychoanalyst D.W. Winnicott. Hamman understands development as a "gradual formation of the self, capable of an experience that is real," and connects a life in pursuit of such reality with the abundant life described in John 10:10.[14] Hamman adopts Winnicott's "true self" and "false self," identifying the true self as the innate, spontaneous self that holds the uniqueness and vital energy of the person. The false self is the self that develops to manage the outside world.

The six capacities Hamman advocates are capacities (1) to believe, (2) to imagine, (3) for concern, (4) to be alone, (5) to use others and be used, and (6) to play. These capacities unfold in the process of becoming. By contrast he argues that pastors are "un-becoming" when they stagnate or operate with diminished capacity. Hamman's description of the "un-becoming" leader offers a helpful guide for self-appraisal. The notion of developing capacity, therefore, pertains to an exploration of one's own soul in order to experience relating to self and others with a growing sense of freedom, characterized by each of Hamman's six capacities.

Each of Hamman's six capacities calls the pastor to ever-deepening engagement with self, others, and God. This deepening requires an expansion of the true self that, to varying degrees, has been obscured by the "socially compliant" false self. This true self serves as the secure base to which other capacities are held and from which we can provide a holding space in the pastoral moment. The true self is in touch with soul, God, and reality, and is therefore the starting point for attuned, courageous ministry. Hamman calls this foundational capacity the capacity to believe. He summarizes, "To become a pastor is to be someone. . . . If the only relationship parishioners have with you is with the pastor-as-actor . . . in the absence of a real self to engage, spiritual growth and maturity will remain elusive."[15] Without a critical mass of selfhood in place, the pastor will struggle to access imagination, care deeply, tolerate solitude (even in

13. Richard C. Schwartz, *Internal Family Systems Therapy* (New York: Guilford Press, 1995). See also Jay Earley, *Self-Therapy* (Larkspur, CA: Pattern System Books, 2009).

14. Hamman, *Becoming a Pastor*, 8–9.

15. Ibid., 39.

the midst of others), use and be used well, or be playful.

Hamman's capacities are a useful tool in exploring the roominess of our pastoral soul. The qualities of Jesus's deep-seeded security, even while carrying such a heavy cup, are a model of deep dependence on the ultimate secure Self, the "I Am" who is God.[16] Walking with people into their pain, despair, and ultimately death is profoundly challenging. Along the way we encounter our own mortality, disappointment, longing, agnosticism, and shame from our perceived inadequacy. If we listen closely, the self is there, and it is a great resource as we seek to meet others in the depth of their experience. Holding others' pain and our own, not knowing exactly what to do or what lies ahead, requires great capacity.

Internal Family Systems. In the work of pastoral development we sometimes experience our soul as a cacophony of competing voices, emotions, and desires. We can employ a variety of "strategies of disconnection" to keep pain at bay.[17] The model of internal family systems (IFS) provides new ways to relate to our complex inner world, fostering peace and embrace rather than hostility and exclusion.[18] IFS emerged from the language of eating disorder therapy clients that referenced disparate internal experiences. They spoke of "part of me" on the one hand, "while part of me" on the other.[19] IFS takes for granted the notion that human beings exist with internal multiplicity. For instance, one can hold seemingly opposite points of view, such as a tremendous depth of grace and compassion for others while being highly critical and negative towards oneself. IFS contends that we are not unified selves, but that in fact we experience life from a variety of perspectives.

The pastor too lives with multiplicity. Part of us is moved to compassion as we hear grief borne by a parishioner, while another part may feel fatigued and caught up in our own losses. Some parts of us are more "popular" with other parts. For example, the people pleasing high functioning parts do a lot of good for advancing our ministry and getting us

16. Ibid., 31.

17. Linda M. Hartling et al., "Shame and Humiliation: From Isolation," in *The Complexity of Connection: Writings from the Stone Center's Jean Baker Miller Training Institute*, ed. Judith V. Jordan, Maureen Walker, and Linda M. Hartling (New York: Guilford Press, 2004), 109–10. Here the authors describe three strategies of disconnection people employ when they are caught in shame and struggling to feel worthy of community or to trust the intentions of another. The strategies are moving away, moving toward, and moving against. Each strategy has its own logic and intention, but all limit the person's ability to be in genuine relationship with others. The authors are writing primarily about interpersonal relationships, but IFS applies these types of external relational dynamics to

through hard days. Other parts are less popular and can even be abused and exiled by parts with more access to power.[20] According to IFS theory, the parts that connect us to our vulnerability and complexity are often seen as trouble-makers and unqualified for leadership or presentation to the world—thus they are sidelined and replaced with more elaborate personas. To the extent to which we collude with this prejudice, we are cut off from important wisdom from our humanity. Instead of quarantining and splitting off parts that are perceived to be problematic, the work of IFS brings parts out into a spacious common space where they can all relate in the light of the self and the Spirit.

IFS calls us to access what it terms the "self" as the compassionate, curious, secure mediator of all the parts' concerns, burdens, and extreme beliefs. The self is the place where we commune most purely with God, the centered location of wisdom and leadership. We can imagine Jesus's self, the still center that was most attuned to God, pastoring his hurting and confused parts in the garden, so they could find authentic expression. Jesus's ministry was one of inclusion and breaking down of walls; we can only imagine how he practiced this peace-making within himself. Voices of perfectionism, shame, and despair linger in us all—how might Jesus have related to these experiences in himself? How might we take on Jesus's easy yoke as we seek peace within ourselves and hope to facilitate similar wholeness in others?

Employing the Use of Self: A Vignette

There is perhaps no better way to integrate the concepts of pastoral presence, use of self in ministry, growing pastoral capacity, and internal family systems than by concluding with a brief vignette. Drawn from Joel's ministry, it illustrates how his pastoral formation and internal processes were used to support the process of others.

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the internal world of the individual, where parts (or sub-personalities) struggle to relate with harmony and trust.

18. For meta-discussions of the theological concepts we see as undergirding IFS, specifically "exclusion and embrace," and rivalry and scapegoating, see Miroslav Volf, *Exclusion and Embrace: A Theological Exploration of Identity, Otherness, and Reconciliation* (Nashville: Abingdon, 1996). See also, René Girard, *I See Satan Fall Like Lightning* (Maryknoll, NY: Orbis Books, 2001), 11–17, 31–32.

19. See discussions on multiplicity in Schwartz, *Internal Family Systems Therapy*, 11–17, 31–32.

20. Ibid., 17–21. Here, a key assumption about IFS is explained well. The assumption is that the dynamics that play out between internal "parts" in IFS mirror the long established dynamics in traditional family systems theory. For example, power differen-

After several days in the pediatric intensive care unit, Jill, Greg, and Andrea's physician made the difficult decision to stop providing aggressive, life-sustaining care, as Andrea had experienced brain death secondary to meningitis.[21] A normally healthy seven-year-old, Andrea had contracted a very rare virus from lake water at her family's cabin. No one expected something so routine and benign to the naked eye would lead to death, especially over the course of a few short days. Jill and Greg's worst nightmare was a reality.

As a chaplain I was present to support Andrea's family in the final moments of her life, and my heart broke with theirs. Prior to the extubation, however, it became abundantly clear that this large family—parents, siblings, and a host of grandparents, uncles, aunts, and cousins—needed something more, as this was the onset of a very unique kind of grief. Rather than attempting to treat the family's grief from a distant, objective point of view by mustering up words to appease my own anxiety, I dove into the depths of my soul and experienced several parts of myself that were seemingly at odds with each other.

My internal processes were characterized by multiplicity. One part of me was acutely aware of the magnitude of the situation and my own assumption that I would not be able to support the family in meaningful ways. "What do I know about the death of a child?" I asked myself, calling into question my pastoral authority and expertise. Simultaneously, I noticed a confidence and peace about my *being* with the family in a difficult moment while yet another part of me was attuned to the ways in which the family's grief was generating an anxious uncertainty about what to *do* next. In moments like these, a natural tendency for me is to perform by sharing my theological knowledge of suffering and grief and then pray for the family. However, an honest part of me recognized this as an attempt to seek relief from the anxiety of uncertainty. In each of these ways I explored a variety of difficult feelings. The processes of becoming self-aware in the moment gave me insight into how to be present, use myself as a resource for ministry, and generate a pragmatic way to proceed.

The definitive moment arrived when I recognized once again that ministry is not about me and that I should refrain from taking myself too seriously. I then shifted internally and presented the family with an

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tials, triangulation, valuing of homeostasis, and pathologizing of those who challenge it.

21. All names are pseudonymous.

opportunity to be active participants in the meaning-making process by sharing a memory of Andrea. By inviting the family to engage actively, I was fully immersed in spirit-to-spirit-to-Spirit listening and attuned to the parts of myself and to the moment at hand. In trusting my authority and expertise I was freeing myself from a need to control the outcome of the dialogue. Grandpa started the dialogue without hesitation, and everyone followed his lead, even the young children. They spoke beautifully of Andrea's joyful smile, generous heart, love, and care for others and the many fun times they shared together. The family shed tears, released bursts of laughter, and everything in between.

This experience was deeply painful for all, including the parts of me that grieved with the family and remained acutely aware of the fragility of life. Yet this opportunity to gather at the bedside and remember Andrea is one I will never forget. Andrea was remembered well that night, and the memories shared validated Jill and Greg's inklings that Andrea would not be forgotten and the family would manage to continue living well despite tragedy. This outcome emerged from the stories the family shared and the collective process of meaning-making.

Supporting Families Living with Mental Illness

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Though gray and rainy, the day I graduated college was bright with possibilities. My friends and I smiled in our bright blue caps and gowns, our tassels blowing in the wind as we posed for pictures and looked toward what we were sure was a bright future. Because of the rain, colorful umbrellas bobbed like party balloons through a crowd of family, friends, and faculty, boosting the festive atmosphere.

No more school, I kept realizing. I really had done it. No more tests, grades, papers, or homework. I had earned my college degree, and I was ready to do something with it. I had a job lined up; I was a newlywed; I was already settled in the apartment my husband and I had moved into after our wedding a few months earlier. The future felt like a wide-open door to a promising new land.

My husband was with me that day, and he cheered me on as I had cheered for him at his graduation ceremony two years earlier. My best friends were there, most of them also graduating and making their own plans. My parents had driven five hundred miles to see me walk across the stage, to celebrate with us, and to show their pride in another college graduate in the family. In spite of the rain, we all smiled and enjoyed the celebration.

But beneath my smile that day, I was troubled. I tried to ignore it, but I couldn't overlook the familiar faraway look I saw in my mother's eyes, the stiff and half-unaware look on her face. Although I had spent my teenage years trying, I had never been able to escape the emotional devastation that came with seeing that expression on my mom's face. I knew what it meant. I suspected that sometime soon, perhaps very soon, we would lose her again.

I was right.

The next morning, after a night out to celebrate with friends, my husband and I got out of bed, planning to spend some time with my parents before they left our apartment for home. Instead of well-rested guests, we found Dad hovering over Mom, trying to rouse her. She lay where she had slept, awake but catatonic. Again.

After about an hour of gentle and persistent work, she began responding to our insistence that she engage with reality. We walked her through the basics: *Open your eyes. Move your arms. Move your legs. Sit up.* Slowly, step by step, she revived and eventually shuffled her way to the car. My parents drove home, and a day or two later Dad called to say Mom was back in the hospital. We weren't surprised, but we grieved as we had so many times before—and as we would do many times again.

Once again my mom's schizophrenia had stolen the precious person who had gently cared for me when I was sick, held me when I was sad, and taught me about Jesus. Year after year, her symptoms came in cycles and waves, and this new wave crashed right over a happy new stage in my life. Flush with the joy of getting married, graduating from college, and landing my first career job—a successful process of leaving home—I realized I couldn't really leave the heartache and grief that came with repeatedly losing my mother to delusions, paranoia, and other symptoms of serious mental illness.

Mom's illness began before I was born, but it wasn't until I was fourteen that it turned our lives upside down. That was the year Mom had a psychotic episode that was impossible to hide; she lost all connection with reality and was incapacitated. Our family had been through a period of extraordinary stress—a major move, unemployment, culture shock, financial hardship, marital strain, the first high-school graduation, and the conflict inherent in three teenage girls sharing a small bedroom. Mom's fragile mental health made her unable to navigate all this stress, and her disorder grew increasingly severe until she lost the ability to discern and understand reality. Although we needed years to really understand what had happened, life would never be the same after this time.

Mom was hospitalized multiple times through my high-school years, and each time she came home with bottles of pills that helped control most of her symptoms but made her miserable with side effects. She sat on the couch, staring into space. Eventually she would start to feel better and shuffle around the house, doing what she could to care for her family. And when she started feeling well enough, eventually she decided

she didn't need to take those pills anymore. So the cycle would repeat itself, and we learned to live without her. When she was home, we cared for her and let her care for us the best she could, because some kind of normalcy was important to all of us. But we couldn't really afford the luxury of needing her—so we didn't.

Neither did we feel we had the luxury of finding sympathy or support in the people around us. We knew we weren't supposed to talk about mental illness. No one else ever did, except to joke or dismiss people. We got the message that we were alone, worthy of shame, and supposed to pretend everything was fine and somehow keep it all under control. So that's what we tried to do. Even at church. For the most part, our church seemed content with this arrangement. They were quiet too.

I had spent my whole life deeply involved in churches, and I had never heard a sermon that mentioned mental illness. No one had addressed it in Sunday school or youth group, and I had the distinct impression the church was afraid of the questions I needed to ask—questions about what was happening to Mom, why my "good Christian family" was suffering, and why God didn't fix it.

As time marched forward, my family kept coping in the best way we knew how. Decade after decade, we walked with Mom through some of the worst that severe mental illness can visit on a person: delusions, paranoia, religious confusion, panic, hospital after hospital, homelessness, criminal conviction, prison. And so often, like so many families, our family was left out of the loop of information, out of the circle of care, floundering as we tried to figure out how to help Mom, how to deal with our own overwhelming emotions, and how to carry on with our lives at the same time.

Like most churches, ours was full of well-intentioned people who let fear, misunderstanding, and stigma keep them from ministering to a suffering family. Unfortunately, in that sense our story is not unique. But we do not have to keep making this mistake. We can start by recognizing that behind every person with mental illness is a family that has been impacted—perhaps even devastated—by that illness. The effects of mental illness go far beyond the individual.

In this article, I argue that supporting families who live with mental illness is a job for everyone in the church. I demonstrate the effects of mental illness on families, consider why the church is uniquely positioned to help, and offer ideas for specific ways we can offer support.

Families in Crisis

Mental illness is extremely hard on families. For starters, individuals with mental illness live with difficult symptoms. They may be overwhelmed by depression, anxiety, fear or even terror, compulsions that control their lives, voices or visual hallucinations that redefine reality, thoughts of suicide, or an inability to cope with everyday life. These symptoms are hard to live with—and not only for those who have them. They also make life difficult for people who love those suffering from mental illness.

But there's more trouble that affects families. They can be thrown into crisis, even with a relatively short-term and mild mental illness. The person with the illness necessarily tends to monopolize the family's resources, may be incapable of earning a living, may seem selfish and demanding at times, and may appear unmotivated or unwilling to do anything productive. The person may behave erratically; a small number become violent. These struggles can be extremely difficult for loved ones to live with them and even for family members who do not share a living space with them. Mental illness causes financial burdens and hardships. Families may be hit by lost workdays, unemployment, expensive medications, hospitalizations, residential care, or alternative schooling. These financial demands can bankrupt a family.

Many people who haven't had to experience it don't realize our mental health care system is badly broken and hard to navigate, for both individuals and families. It can be hard to access care: we have a shortage of mental health professionals, especially psychiatrists. What is a person to do when he or she needs an adjustment in medication and the psychiatrist is booked for the next six weeks? Many people try to wait it out, and they suffer for it, as does the rest of our society. Others turn to alcohol or illegal drugs to self-medicate and relieve their symptoms, a strategy that always backfires. Others go to emergency rooms, where some find the care they need and many more do not. In 1955, there was one bed in a psychiatric ward for every three hundred Americans; today there is one for every three thousand Americans.[1]

As with other forms of health care, the mental health care system places the burden for managing care solely on the person with the illness, though that person may or may not be able to shoulder this burden.

1. National Sheriffs' Association and Treatment Advocacy Center, "More Mentally Ill Persons Are in Jails and Prisons than in Hospitals: A Survey of the States," (May 2010), 1, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

Unless the person with the illness takes the initiative to sign paperwork granting loved ones access, family members and friends are outside the circle of care. Often they are left with no understanding of the disorder affecting the person they love or the best ways they can offer support and facilitate healing.

Doctors can be reluctant to offer solid diagnoses because they fear their patients will be stigmatized and insurance companies will discriminate in following through with benefits. Lack of clear diagnoses and treatment plans leaves patients and their loved ones floundering, not equipped to manage symptoms or pursue health. Insurance companies sometimes actively pressure doctors and hospitals to shorten treatment for psychiatric patients or deny necessary coverage altogether.[2] These short hospitalizations focus on stabilization, not on setting people up for long-term success. The average length of a hospital stay for psychiatric care in the United States is about seven days.[3] The average length of time required for psychiatric medications to work is two to six weeks. People are routinely released from inpatient care with no idea whether their treatments will work, and they are immediately transferred to the care of new doctors, new therapists, and new peer groups with whom they must start from the beginning in forming relationships. When a hospital discharge takes place, again the focus is on the patient; families are not routinely educated or offered support. It is no surprise, then, that up to 13 percent of psychiatric patients find themselves re-admitted shortly after leaving the hospital;[4] they lack the necessary support systems to make a successful transition and work toward greater health.

When people do not receive the care they need—and only about 50 percent of people with severe mental illness do receive treatment[5]—the consequences can be serious for individuals, families, and society as a whole. People with serious, untreated mental illness are at high risk for homelessness. Determining demographics of the homeless population is

2. Scott Pelley, "Denied," CBS News (December 14, 2014), http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes.

3. "Mental Health," Centers for Disease Control and Prevention, http://www.cdc.gov/nchs/fastats/mental.htm.

4. S.N. Vigod, P.A. Kurdyak , C.L. Dennis, T. Leszcz, V.H. Taylor, D.M. Blumberger, D.P. Seitz, "Transitional Interventions to Reduce Early Psychiatric Readmissions in Adults: Systematic Review," *The British Journal of Psychiatry* (March 2013), http://www.ncbi.nlm.nih.gov/pubmed/23457182.

5. "About 50 Percent of Individuals with Severe Psychiatric Disorders (3.5 Million People) Are Receiving No Treatment," Mental Illness Policy Org, http://mentalillnesspolicy.org/consequences/percentage-mentally-ill-untreated.html.

difficult for obvious reasons. Most reliable sources report that about 40 percent of homeless people have some kind of mental health problem and that 20 to 25 percent have a serious mental illness. This compares to just 6 percent of the general population affected by mental illness.[6]

Because only law enforcement officers and judges possess the power to force the receipt of care (and even their power is limited to intervention in specific situations), police officers, often ill-equipped, have become front-line mental health workers by default. And because our communities are not equipped or committed to offer the care people need before they reach the point where our criminal justice system intervenes, that very system has become the largest and most effective response to mental illness our society offers. Tragically, the three largest mental health providers in the United States are Cook County Jail in Chicago, Los Angeles County Jail, and Rikers Island in New York City.[7]

The Department of Justice estimates that more than half of U.S. inmates have symptoms of serious mental illness, ranging from 45 percent of inmates in federal prisons to 56 percent in state prisons and 64 percent in local jails.[8] Almost three-quarters of female inmates have a mental disorder. More than three times as many mentally ill people are housed in prisons and jails than in hospitals, and while incarcerated they are regularly preyed upon and injured by other inmates. Some 40 percent of people with serious mental illnesses have been arrested at some point in their lives.[9] For some people, breaking the law is the only way to get the help they need.

When our society refuses to pay directly for mental health care, we pay indirectly, both economically and socially, far more than offering appropriate, widely accessible care. The cost of allowing incarceration to serve as an alternative to community-based care is staggering. A ninety-day

6. These statistics are taken from a number of sources; however, a nice summary can be found at "Facts and Figures: The Homeless," PBS (June 2009), http://www.pbs.org/now/shows/526/homeless-facts.html.

7. Michael Arceneaux, "Why Are the Three Largest Mental Health Providers Jails?" *NewsOne* (October 24, 2013), http://newsone.com/2744141/prisons-mental-health-providers. See also the *New York Times* article, "Rikers: Where Mental Illness Meets Brutality in Jail," July 14, 2014, http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html

8. Doris J. James and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," *Bureau of Justice Statistics Special Report* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 2006)

9. Nicholas Kristof, "Inside a Mental Hospital Called Jail," *New York Times* (February 8, 2014), http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html.

incarceration of one person costs roughly the same amount ($30,000) as an entire year of subsidized housing, disability income, and outpatient mental health services.[10] Untreated mental illness costs the U.S. economy more than one hundred billion dollars each year.[11] Moreover, the human cost is incalculable: lives lost to suicide, people locked up for choices they would not have made when healthy, and the societal consequences of self-medication with drugs and alcohol.

Individuals and families affected by mental illness need help and support. They routinely find themselves on their own in the dark, unsure of how to get the help they need. Many often find themselves in crisis, and when they do reach out for help, they run into stigma and fear that alienate others from getting involved. Many people believe there is nothing churches can do to help. They are wrong.

The Church's Role

Whether they know it or not, churches are on the front lines of mental health care. A 2003 study by the National Institute of Mental Health found that 25 percent of people who sought help for mental illness first went to clergy.[12] This is a ministry opportunity the church cannot afford to ignore. Unfortunately, many church leaders are ill-equipped to help those suffering from mental illness get the care they need.

Churches leaders are not in an easy position. Many feel they are in over their heads. Like most people, clergy have a limited understanding of mental illness. They regularly interact with people who have mental-health problems but who fail to mention or simply deny those problems because they are afraid of stigma or silenced by their own shame. Church leaders wonder how to deal with people in their congregations who behave inappropriately or those who consume all their time yet still demand more. Pastors try to minister to people who are spiritually confused because of thought disorders and symptoms of other mental health problems. Although regularly faced with these challenges, most

10. Liz Szabo, "Cost of Not Caring: Nowhere to Go," *USA Today*, http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535.

11. "What Is Mental Illness: Mental Illness Facts," National Alliance on Mental Illness, available at http://www.nami.org/template.cfm?section=about_mental_illness.

12. Philip S. Wang, Patricia A. Berglund, and Ronald C. Kessler, "Patterns and Correlates of Contacting Clergy for Mental Disorders in the United States," Health Research and Education Trust, 2003, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360908.

church leaders do not realize that they are first responders for mental health problems. From this position on the front lines, pastors and congregations can provide people with mental illness with friendship, love, and hope in Christ. Are they?

In 2010 I conducted a survey among five hundred readers of *Leadership Journal* and other publications for church leaders published by Christianity Today. I asked about their experiences with mental illness among members of their congregations, in their families, and personally. I also asked what their churches believe about mental illness, how they treat people with mental illness, how frequently they mention mental illness in sermons, and other revealing questions about this sensitive topic. I published the results of this survey in *Troubled Minds: Mental Illness in the Church's Mission.*[13] My 2014 survey update yielded few changes.

Among the five hundred church leaders who responded to my 2010 survey, 98 percent indicated they had seen some type of mental illness in their congregation. Nearly half (44.5 percent) said they are approached two to five times per year for help in dealing with mental illness. Almost 33 percent (32.8) are approached more frequently, from six to more than twelve times per year. Twenty-nine percent said that on average mental illness is never mentioned in sermons at their church, 20 percent said mental illness is mentioned once a year, and 29.4 percent said two to three times per year. It is important to place this statistic within the context of another. Mental illness affects 20 to 25 percent of the adult population of the United States in any given year,[14] and over the course of a lifetime, nearly 50 percent of us will experience a mental health problem.[15] People who are suffering often come to the church first. Yet this kind of hardship is barely mentioned in our pulpits.

The gaps do not end there. Only 56 percent of church leaders said they have reached out and ministered to the family of someone with mental illness within their congregation. And although 80 percent of church leaders said they believe mental illness is "a real, treatable, and manageable illness caused by genetic, biological, or environmental fac-

13. Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: InterVarsity, 2013).

14. Various sources report statistics in this range. See Victoria Bekiempis "Nearly 1 in 5 Americans Suffers from Mental Illness Each Year," *Newsweek* (February 28, 2014), http://www.newsweek.com/nearly-1-5-americans-suffer-mental-illness-each-year-230608, and "Mental Illness: Facts and Numbers," National Alliance on Mental Illness, http://www.nami.org/factsheets/mentalillness_factsheet.pdf.

15. "Data on Behavioral Health in the United States," American Psychological Association, http://www.apa.org/helpcenter/data-behavioral-health.aspx.

tors," only 12.5 percent said mental illness is openly discussed in a healthy way in their church.

For church leaders, part of the problem may be a feeling of incompetence, just as it is for many of us when we think of mental illness. In my survey 53 percent of respondents indicated they feel "somewhat equipped" to minister to people suffering from mental illness. Only 27 percent felt "competent" or "confident," and 3 percent considered themselves "expert." Sixteen percent felt "not equipped at all" to minister to people with mental illness. My study revealed that, in general, church leaders who themselves have suffered from some type of mental illness feel more competent to minister to others who are suffering. Church leaders' own experiences seemed to affect their responses in other ways as well. For example, church leaders who had suffered from mental illness were less likely to feel that their church discusses mental illness openly and in a healthy way (9.5 percent). Among those who had not suffered, 16 percent believed mental illness was openly talked about in a healthy way in their church.

Some Christian traditions mistrust psychiatric medicine. Believing all ailments can and should be handled within the church, some pastors discourage people from receiving the treatment they need. On the other hand, many church leaders assume that addressing mental health is the task of mental-health professionals exclusively. While it is often wise to refer a congregant to counseling or other treatment outside the church, the church should avoid the misconception that having made the referral their job is done. Even after those suffering from mental illness have received needed mental-health care, there is a distinct role to be played by the church. The front lines are populated with well-meaning people who often lack the confidence and tools they need. But we must respond. Helping people affected by mental illness is part of the church's mission and calling. This is true not only for church leaders, but also for every Christian. We are responsible for our response to people in need.

We All Can Help

The good news is there is plenty of opportunity to help and improve support for families affected by mental illness. In most churches, one small step can make a big difference. And it is not necessarily up to the pastor to do the work. The most passionate, most well-equipped people for this kind of ministry are those who have their own story to offer—a story of living with mental illness, a story of loving someone through this

struggle. Some are called to do something requiring a big investment. Others simply are required to love others in small ways. Here are some ways, big and small, that we in the church can help families affected by mental illness.

1. Start by humbly acknowledging your own problems. Whether or not you have your own struggle with mental health, we are all flawed and scarred. We all have parts of ourselves that do not work as they were designed to work. Those who truly are effective in ministering to those impacted with mental illness are the ones who are aware of their own weakness.

2. What does your church teach about suffering, explicitly or implicitly? Be sure your church is teaching clearly that we should not expect a pain-free life on this earth. Christian theology teaches that our world is an imperfect place, polluted by our rebellion against God. Our bodies are affected by sickness and decay. There is no reason for us to believe that people who believe in God, go to church, repent of their sin, and follow Jesus are immune to the trouble that is part of the human experience on this earth. A prevalent assumption in our culture is that life should be easy and "happy." Many Christians adopt this idea within their theology, and churches must actively correct it.

3. Recognize the person before you see the illness. Sometimes people with mental illness feel as if others see them as walking problems. But they are people like the rest of us. Make eye contact, smile, say hello. Don't pretend they're not there, and don't allow irrational fear to overwhelm you. So often our first reaction to mental illness is fear. If someone is dangerous to self or others, call the police. Otherwise, your fear probably is irrational. Try to look past it and recognize the real person in front of you, with the same human needs you have.

4. Be a friend. We often believe we are not qualified to help people struggling with mental illness if we are not qualified to treat their disorder. We do not have this same reaction when people are suffering from other types of illness. Most of us can't treat cancer, but we know we can offer friendship and practical support to people who have cancer. Most of us can't set broken bones, but we don't keep our distance from people who have them. You may not be qualified to treat mental illness, but everyone is qualified to be a friend. Do what you would do for other suffering people. You already know how to respond when someone needs help because of illness, injury, or family crisis. You bring meals, give rides, take them to the doctor, ask how they're doing, help them with expenses,

and visit them in the hospital. You can offer this same practical help to families affected by mental health crises.

5. **Encourage open talk about mental illness** in sermons, classes, Bible studies, and public prayers. In most churches, this step alone has the potential to transform the culture of the church, keep people plugged into the community, keep hearts open to God, and even save lives. One of the great tragedies of the stigma that surrounds mental illness is that it keeps people silent about their struggles when they desperately need to connect with others who will understand. Although mental illness is about as common in the United States as diabetes, cancer, heart disease, HIV, and AIDS combined,[16] this silence means many people feel desperately alone and marginalized by their experience. Talking about struggles with mental illness normalizes them. And talking about them in the context of the church, informed by Christian theology and the gracious love of Christ, can transform them.

6. **Refer people to counselors, support groups, and other types of care.** Make sure your church builds a network of local professionals, creates a list of contact information, and makes it freely available to everyone. Include resources for people with illness and their families. It can be difficult and overwhelming for them to find appropriate help, especially in a time of immediate crisis. This is a hugely helpful resource churches can provide.

7. **Don't abandon people** once you've connected them to professional mental health care. Your job is not over, and a mental health professional will not provide what you can provide. Through God's grace, refuse to be fearful or put off by families in crisis. Assure them of God's love and that God has not abandoned them (Romans 8:35–38).

8. **Start or advocate for a support group or ministry** within your church or community. Perhaps this is a ministry you can start in partnership with other churches. Perhaps someone in your church already has the necessary expertise for this. In *Troubled Minds: Mental Illness and the Church's Mission*, I profiled four churches that have thriving ministries to people affected by mental illness.[17] None of these ministries was started or is led by a pastor; all four are led by someone who lives well with mental illness or has an immediate family member whose life was changed by a struggle with mental health. This does not have to be one more job for the pastor!

16. Simpson, *Troubled Minds*, 37.
17. Simpson, *Troubled Minds*, 166–79.

Improving the response to mental illness is not just a job for mental health professionals. In fact, we are all on the front lines in this fight. All of us are called to help people with mental illness and their families. Those who have mental illness must speak up about what they need. And people like me, who have watched loved ones suffer, must advocate for them.

Conclusion: Support Makes a Difference

A couple of years ago I received a package from my mom. Inside were special outfits she had sewn for my kids. They were custom-made to my children's specifications, and they were beautifully and lovingly crafted. There was a long stretch of years leading up to that time when I would not have believed Mom would ever have the capacity to do such a project, but by the grace of God she had surprised me. She was stabilized on the medication she needed, making healthy choices for herself, and doing kind things for her grandchildren. She was the person we knew her to be and had missed for many years. She was functioning well.

Then, after three years of relative stability and health, a few months after I had released a book that included painful portions of my family's story, Mom once again stopped taking the full strength of medication she needed and lost touch with reality. My family was in crisis again. But something was different this time, and we discovered the power of having our story known. Because we had told our story, we had people praying for us and helping us, and we knew where we could go for support. We had had conversations with one another and done individual work that made us a healthier family. And this made a huge difference. Because of that, we were able to handle the crisis quickly. Within a few weeks Mom was living in a safe place and getting the care she needed, and a few months later she was psychologically stable.

Mom's schizophrenia isn't gone. I can't say she will never have another psychotic episode, but I can say she is a picture of the hope all people with mental illness can have. Modern medicine offers great hope for treatment, and loving, consistent friendships are the best context for encouraging people to get and maintain needed treatment. For the family, having support makes all the difference. And even more powerful, no one is ever beyond the reach of God's love, grace, and redemption. Both now and in eternity, the church has a message of hope that people affected by mental illness need.

A passage from *Troubled Minds* speaks to this kind of hope and its

source: “We are all in this together, and we all have hope in the current redemptive work of Christ and the future and eternal fulfillment of his promise of life without the burden of sin.”[18] I can’t emphasize redemption enough. For we can offer hope based in medical and psychological treatments, loving relationships, the good things in life, and all the reasons we have for living well in the here and now. Yet ultimately this kind of hope pales in comparison to the hope we find in looking toward our eternal future and the coming redemption. We find hope 2 Corinthians 4:17–18 (NLT) speaks of this hope: “Our present troubles are small and won’t last very long. Yet they produce for us a glory that vastly outweighs them and will last forever! So we don’t look at the troubles we can see now; rather, we fix our gaze on things that cannot be seen. For the things we see now will soon be gone, but the things we cannot see will last forever.”

But God’s grace doesn’t stop there. God lovingly shows us glimpses of what is coming our way. He refuses to leave us as we are, never giving up on us. He takes the ugliest parts of life and uses them to grow something beautiful. We have hope now not only because of what is coming but also because of Jesus’s present work in and through us. It’s the work of redemption. Sometimes it simply serves to heal what was broken. Sometimes it brings us a new understanding as we walk through suffering. Sometimes it sets us free from prisons we never could have left on our own. As I wrote in *Troubled Minds*,

> What’s remarkable about this life is not that we have pain, that we suffer, that life gets so ugly we can’t even look at it. The remarkable thing is that we have anything but suffering. That there is a large supply of goodness in this world. That despite our best efforts at self-destruction, grace still shines on us and the sun rises. That we are surrounded by beauty. That we know how to laugh. That we can laugh and cry at the same time. And—most remarkable—that our suffering and pain themselves become the media for some of God’s most beautiful work. It’s called redemption, and we overlook it every day.[19]

Let us join in this work of redemption. Let us be the instruments God uses to do beautiful work in and through people with mental illness.

18. Ibid., 200.
19. Ibid., 201.

We are the church, and it is our responsibility to do something—all of us. We can all start simply by extending grace to each other and taking some risks in relationship. This is the best way for us to participate in the beautiful redemptive work God is constantly doing in our world. And ultimately, the true hope we can offer lies in that redemption.

I conclude this article as I did *Troubled Minds*, with a blessing for the body of Christ, the representative of his love and compassion on earth:

> A Blessing for the Church
>
> There is hope! Let us, the church, proclaim that hope in what we say and do.
>
> May your heart be open.
>
> May you understand your own suffering as an opportunity to witness God's redemption.
>
> May you see the suffering within your church and outside your walls and respond with sacrificial compassion.
>
> May God's redemptive work cause the struggles of people in your church to blossom into loving ministry toward the suffering.
>
> May you invest what God has given you in things that will last forever.[20]

"Three things will last forever—faith, hope, and love—and the greatest of these is love" (1 Corinthians 13:13, NLT).

20. Ibid., 210.

Book Reviews

Jesse Slimak, pastor, Evangelical Covenant Church of LeRoy, Michigan

Jim Swanson, retired Covenant pastor and chaplain,
New Smyrna Beach, Florida

Michelle Clifton-Soderstrom, professor of theology and ethics, North Park Theological Seminary, Chicago, Illinois

Eric Sorenson, pastor of Christian formation,
Community Covenant Church, Santa Barbara, California

Benjamin H. Kim, youth and children's pastor, Lighthouse Covenant Church, West Sacramento, California

Paul Koptak, Paul and Bernice Brandel professor of communication and biblical interpretation, North Park Theological Seminary,
Chicago, Illinois

Brian Brock and John Swinton, eds., *Disability in the Christian Tradition: A Reader* (Eerdmans, 2012), 564 pages, $45.

Recent decades have seen notable theological engagement with disability. Stanley Hauerwas and Jean Vanier offer two well-known examples. Absent has been a "serious or systematic effort to ask what Christians of other ages might bring to this inquiry" (p. 4). This reader represents the editors' deliberate attempt to fill this gap. The readings compiled within this volume span Christian history, from the patristic era (e.g., Cappadocians), through the Middle Ages (e.g., Julian of Norwich) and Reformation (e.g., Luther and Calvin), to the present (e.g., Hauerwas).

Each historical text is prefaced with an introductory essay that seeks to contextualize the author's thought in order to prevent anachronistic evaluations. To this end, the editors asked contributors to undertake a "searching investigation of the sources to discover the conditions *they* [the historical authors] considered disabling" (p. 10, emphasis original). Seeking to enter the worldview of historical thinkers, each contributor addresses the following questions: What does each thinker directly say about disabling conditions? What is problematic about their accounts? What can we learn from such accounts? (p. 11). These introductory essays vary in quality, but most are quite helpful in contextualizing what might otherwise be strange to the contemporary reader.

One theme underlying this broad range of historical inquiry is the tension between challenging cultural assumptions about disability while also remaining bound to them. The patristic thinkers, for example, objected strongly to the common practice of exposing infants with disability. They advocated for more humane treatment of those with disabilities, as being equally divine image bearers (pp. 24–64). At the same time they could be paternalistic toward the disabled, clearly viewing them as objects of ministry rather than agents of ministry. This tension is highlighted throughout the writings and invites us to consider what assumptions limit our own ability to transcend contemporary views on disability.

This volume also suggests new avenues for Christian engagement with disability. One provocative example is Jana Bennett's contribution, "Women, Disabled." Bennett mines feminist theology for resources for a theology of disability. She highlights points of intersection between interpretations of disabling conditions and how women have been regarded throughout Christian history: women's bodies have been considered inferior deviations from normative male bodies; women have been more specifically linked to sin; women have been seen to possess an inferior capacity for reason—the essence of the *imago Dei* for much of Christian history. All of these judgments have been made of those with disabilities, yet feminist and disability theologies have rarely engaged one another.

However, the attempt to draw profitably from some of the thinkers struck me as a bit of a stretch. Martin Wendt himself admits that Hegel's perspective on those with cognitive impairments is not redemptive. Nevertheless Wendt suggests we "read Hegel against Hegel" (p. 251) by applying Hegel's development of Spirit to those he considers intellectually incapable of doing so. But is it really necessary that all Christian thinkers make a positive contribution to disability studies?

Why not judge certain forms of thought harmful and allow the reader to learn from these mistaken presuppositions?

Aside from this critique, this book is an excellent source of primary readings on disability from the breadth of the Christian tradition, introduced by mostly excellent essays that helpfully demonstrate each original author's contribution. I highly recommend this collection for those who are familiar with disability studies, those wishing to start studying this area, and even those interested in reading original sources of historical theology.

JESSE SLIMAK

Jeffrey M. Gallagher, *Wilderness Blessings: How Down Syndrome Reconstructed Our Life and Our Faith* (Chalice Press, 2013), 206 pages, $18.99

At first scan this book appeared to be personal rather than academic or particularly theological. It is personal, as the author is relating his own experiences of dealing with the medical and developmental challenges of a son born with Down syndrome. But Gallagher also offers a wealth of theological reflections that pastors, chaplains, and counselors will find insightful and helpful. Further, Gallagher's bibliography provides a rich reading trail to follow.

The "wilderness" the title references is that of walking through unknown territory as we encounter situations in life outside of our usual experience or expectations. The "blessings" are discoveries along the way that turn out to be beneficial, even though our lives have been shaken by events we would not have anticipated or chosen. Gallagher is not being simplistic but looks honestly through the eyes of his Christian faith. He is honest about doubts, challenges, and struggles, but accepting of his son and his son's syndrome, while trusting with a positive faith in God throughout.

Jeff Gallagher begins with affirming that all are created, uniquely, in the image of God, including those of differing abilities. He was not looking for changes in his son's diagnosis but for help and guidance for doing the best possible for him and for insight into how to receive and allow for development of the gifts his son had to offer. Blessings Gallagher and his wife received were the caring and loving way difficult medical news was delivered to them and the subsequent care they received.

The author's affirmation of blessings received in his wilderness is

encapsulated in his conclusion that "without Down syndrome Jacob is not Jacob. Without Down syndrome, I am not who I am. Without Down syndrome, Jacob would not have blessed us as richly as he has. Without Down syndrome, Jacob would not bless the world as richly as I believe he will. Without Down syndrome, the world will be a sadder place. And that's not a world I'm eager to live in."

Gallagher affirms in several places that God is present, walking with us, and supporting us in the various difficulties and situations we face in life. He affirms the value of intercessory prayer. He affirms that God is at work—not causing challenging situations but teaching us valuable lessons in the midst of them, including changing and deepening our understanding of people, the world, and God.

The author uses these lessons even in premarital counseling, helping those about to be married think ahead about how they would face challenging situations, especially the possibility of having a child with Down syndrome. And he uses—and shares—these lessons in the writing of this book.

JIM SWANSON

Mae Elise Cannon, Lisa Sharon Harper, Troy Jackson, and Soong-Chan Rah, *Forgive Us: Confessions of a Compromised Faith* (Zondervan, 2014), 240 pages, $15.

Forgive Us: Confessions of a Compromised Faith offers the church a much needed memory check. Written from an evangelical perspective, the book addresses sins against creation, indigenous people, African Americans and people of color, women, the LGBTQ community, immigrants, and Jews and Muslims. This is quite a list and, not surprisingly, there is a lot of history and specifics that the authors simply could not cover. Nevertheless, the topics they tackle reveal problematic beliefs that U.S. evangelical groups have held historically, and the authors aptly call evangelical Christians to confess their sins and transform their witness.

Each chapter includes sections on historical reflection, theological reflection, signs of hope, and a prayer of confession and lament. The primary audience is evangelicals in the United States. Given that each of the authors identifies as evangelical, the book reads as a genuine call to repentance. Evangelical Christians often hesitate to tie social issues to worship, so the inclusion of psalms, prayers, confessions, and hope that conclude each chapter is a fitting challenge.

Given the extensive reach of *Forgive Us*, the authors might have covered two other very important groups against whom evangelicals have sinned: children and the poor. The topics chosen align politically with "left" issues, which is not necessarily problematic. However, by neglecting to discuss children in particular, the authors lost a chance to bring in more conservative evangelicals who care deeply about the family. There is much to critique in evangelical views of family, and an added chapter would have completed the list of key topics.

More analysis of subtle and ongoing abuses in the church itself would have given readers more to chew on—especially those who already have some awareness of problematic attitudes towards the groups discussed. Many readers might readily agree with the authors and not find themselves implicated deeply enough in these truthful narratives, thus missing out on the opportunity for deeper examination. For example, in the chapter on women, many evangelicals would agree with the abuses named and gloss over the more subtle—yet no less hurtful—attitudes that continue to marginalize women. The same may be true for those who acknowledge historical abuses toward indigenous peoples and creation. If the authors were to publish a sequel, they would do well to include richer analyses of patriarchy, heterosexism, wealth, nationalism, and white privilege—abuses that remain entrenched in evangelicalism.

While the book was consistently prophetic, the chapter on sins against the LGBTQ community fell slightly short. It correctly argues that many Christians identify homosexuality as a sin, even while they make clear that this debate is not the purpose of the chapter. This in itself is not problematic. Yet no other chapter mentions what Christians identify as sin—even, for example, the chapters on immigration and other faiths, both of which some Christians would argue are sinful in some cases. This lack of balance negates some of the good work the authors are attempting in challenging evangelical views on sexuality.

All in all, the book succeeds in tracing critical historical abuses in evangelical Christianity and calling Christians to greater awareness. In this way, the book is not only for evangelicals, but for all Christians who desire to enact God's justice in the world. *Forgive Us* tells the truth, and it offers hope. It ends with prayer and liturgy, acknowledging whence the power for renewal comes. For these reasons and many more the book is to be celebrated.

MICHELLE CLIFTON-SODERSTROM

Jamin Goggin and Kyle Strobel, eds., *Reading the Christian Spiritual Classics: A Guide for Evangelicals* (IVP Academic, 2013), 337 pages, $24.

Attendant to the surge of interest in Christian spirituality is renewed attention to classic spiritual literature. Unfortunately, those attracted to such literature often encounter unfamiliar terms, bewildering theology, and an alien historical context. Thus, used bookstores are lined with Christian spiritual classics, the opening pages of which show wear, while the remainder looks as fresh as the day they were printed.

Jamin Goggin and Kyle Strobel, both associated with Talbot Seminary's Institute for Spiritual Formation, have collected a series of essays to ease the evangelical reader's entry into this formidable, but rich, literature. Their purpose is clear: to provide readers with an informed, spiritual, and evangelical reading of the classics. In short, their goal is to offer a hermeneutic that will equip readers with the wisdom necessary to discern their way through the sometimes dense thicket of these classical texts. The approach they take is as user-friendly as they hope the spiritual classics will become for those who follow their advice.

The volume begins with three essays that address the overall approach one should take in engaging this literature, followed by three essays that describe the basic schools of Christian spirituality. The third section turns more practical, as advice is given about how evangelicals can understand and appreciate Catholic and Orthodox spiritual literature. The fourth and final section provides specific guidance for reading the spiritual literature in its various historical periods, such as the Desert Fathers and the medieval writers. The editors' intended audience is indicated in the book's subtitle: theirs is a guide for *evangelical* readers of the spiritual classics.

That this volume is aimed at the evangelical reader is a key factor in the design, approach, and even feel of the book. It is also immediately clear that Goggin and Strobel have the more conservative side of the evangelical spectrum in mind, since early in the introduction, the editors take the space to address certain evangelicals who may not read the classics at all because they believe only the Bible should be read for spiritual nourishment. In that vein, Steve Porter's opening chapter is an apologetic, aimed at convincing evangelicals to actually read the spiritual classics. In short, he takes the entire chapter to persuade readers that it is biblically permissible to do so. This is not to deny that some evangelicals really do need to be convinced; however, since most Covenanters do not fit that

mold, the opening chapter may make one feel like this book is designed for someone else, which is not the case.

The remainder of the volume is helpful to anyone wanting assistance in reading and appropriating the Christian spiritual classics, but it is especially useful for Protestants, and evangelicals in particular. The contributors are right in reminding us that as Protestants we are a Scripture-first people (and, I would add, as Covenanters: "Where is it written?"). Thus, the volume is undoubtedly correct in stating that we must always read these classics with discernment. In this light, Bruce Demerest's contribution in chapter 7 is especially useful for evangelicals seeking to understand, appreciate, and appropriate Catholic spirituality. Even more confusing to most evangelicals, and thus even more beneficial, is James Payton's excellent orientation to reading the Eastern Orthodox classics. Finally, all of section four offers very insightful and practical reading assistance, as the authors introduce and explain Christian spiritual literature from various historical periods. Gerald Sittser's chapter on the Desert Fathers is a particularly valuable piece. Covenanters will also be attracted to Tom Schwanda's chapter on the Puritan and Pietistic traditions.

As is the case with any edited volume, there is overlap, as one writer treats a particular historical figure that fits into more than one category; and, of course, some of the chapters are more significant than others. Still, what lies within the pages of this interesting volume is some very useful material, not only for evangelicals who are tentative in reading the spiritual classics, but for all those who welcome them and want more from them.

ERIC SORENSON

Andrew Root, *Bonhoeffer as Youth Worker: A Theological Vision for Discipleship and Life Together* (Baker Academic, 2014), 224 pages, $20.

As he states in the introduction to his book, Andrew Root's primary audience is the youth worker. In service to this audience, Root explores Dietrich Bonhoeffer's lesser-known ministry with children and youth. The book is structured in two parts. The first part offers a historical analysis of Bonhoeffer's youth work in relation to his theology; the second part presents a theological analysis of Bonhoeffer's *Discipleship* and *Life Together* in application to today's youth ministry and ministers.

Root identifies two approaches to youth ministry, the "technological"

and the "theological." He ties the birth of modern American youth ministry to this technological mindset in which its purpose was to "achieve or solve some problem," resulting in "increased capital" (p. 5). Within this framework, successful youth ministry is determined by the numerical growth of youth groups or by the modification of behaviors deemed immoral among students. In Bonhoeffer, by contrast, Root sees the beginnings of a theological turn, in which the orientation of ministry practice moves from results-based toward one that "seeks to share in the concrete and lived experience of young people as the very place to share in the act and being of God" (p. 7). Root uses the category "theological" to intend not the conceptual and doctrinal, but the lived and experienced reality of Christ-in-community.

If one of the Root's goals was to connect Bonhoeffer's theological writings and his ministry experience, he was successful. It is well known that both *Discipleship* and *Life Together* stem from Bonhoeffer's experience of sharing life with his students at Finkenwalde. Less obvious is the impact of his experience working with youth on *Sanctorum Communio*, his initial ecclesiological work. Originally published as his first doctoral dissertation, *Sanctorum Communio* (*The Communion of Saints*) is considered Bonhoeffer's induction into academic significance. Root draws connections between this text and Bonhoeffer's lived experiences as a youth worker early in his ministry. Herein also lies a clear example of Bonhoeffer's turn to the theological over the technological. It was through concrete, lived experiences ministering to youth and children that Bonhoeffer was able to develop his theology of the body of Christ. Likewise, his theology of obedience and discipleship grew out of his experience teaching at the seminary in Finkenwalde, and his ethic of responsibility stemmed from his lived reality during Nazi control of Germany. In this way, Bonhoeffer was in every aspect a practical theologian whose life experiences informed his theology of Christ-in-community.

Root offers an alternative perspective to approaching youth ministry for youth workers today. He writes, "Youth ministry's job is *not* to get youth to believe an idea, fighting to convince young people why the idea of Christianity is better than other ideas. Rather, youth ministry seeks… to invite young people to join the ministry of Jesus's own person, to follow Jesus out into the world, to minister to the world as Jesus does, through the personal act of place-sharing" (p. 186). Derived from Bonhoeffer's christocentric perspective of the church, Root's book is a necessary reminder for church leaders and youth workers to re-examine

their ministry practices to discern whether they have been technologically driven to achieve results or whether they too are willing to take the theological turn to follow Jesus Christ with costly obedience. This book is recommended not just to youth workers but to anyone in leadership, as it challenges readers to re-evaluate their approach to youth ministry programs with a theological lens.

BENJAMIN H. KIM

Bruce Cockburn with Greg King, *Rumours of Glory* (Harper One, 2014), 530 pages, $36; Brian J. Walsh, *Kicking at the Darkness: Bruce Cockburn and the Christian Imagination* (Brazos Press, 2011), 217 pages, $19.

Bono called him a psalmist. In 2002 he was promoted to Officer in the Order of Canada, and in 2011 his face appeared on a Canadian postage stamp. In April 2015 Bruce Cockburn received the Denise Levertov Award and celebrated his seventieth birthday the following month. He's now taking a look back with a nine-CD retrospective box set and this memoir that traces his life up to 2004.

For Christian fans from the 1970s on, Cockburn's perceptive and honest lyrics about his Christian faith offered an alternative to the sentimental tone of what was then contemporary Christian music. Cockburn now identifies himself as more of a mystic, a God-seeker: "I have tried to keep Jesus the compassionate activist close to my heart, along with Jesus as portal to the cosmos, but I have long been leery of the dogma and doctrine that so many have attached to Christianity as well as to most other religions" (p. 2).

Long-time fans will find enigmatic references explained, as stories behind the songs are told and lyrics are quoted in full. Cockburn says that his songwriting has been inspired by reading and travel that are "joined at the hip" in a "less-than systematic mind" and by "whatever is in front of me, filtered through feeling and imagination. I went looking for humanity in all its guises.... That's why I don't think of the things I write as 'protest' songs. They reflect what I see and how I feel about it" (p. 280–82).

The imagery of light and darkness runs throughout Cockburn's life and work. He associates one early song with his commitment to follow Jesus: "All the diamonds in this world that mean anything to me are conjured up by wind and sunlight sparkling on the sea" (p. 133). Another, "Lord of the Starfields," marked his move "beyond fundamentalism toward

mystery" (p. 150). His first marriage had become increasingly troubled during that time and ended a few years later. As he started reaching out to all sorts of people beyond the walls of the church, Cockburn found that "Something is shining / Like gold but better / Rumours of Glory" (p. 193).

His look outward in the 1980s used more urban imagery, the light coming from neon rather than the night sky. Along with some other musicians, Cockburn was invited to travel to Central America as a war observer. When he learned of the Guatemalan government's violence against its own citizens (rebels don't have helicopters, he was told), his anger prompted the song for which he is best known, "If I Had a Rocket Launcher." Over the years similar visits to Chile, Honduras, Mozambique, Nepal, and Vietnam (to name a few) changed him. Now claiming to follow the social teachings of Jesus more than other aspects of Christian doctrine, he still writes about that light: "Come all you stumblers who believe love rules / Stand up and let it shine" (lyrics, "Mystery," p. 515).

The title of theologian Brian Walsh's book, *Kicking at the Darkness*, cites another famous Cockburn lyric, from "Lovers in a Dangerous Time." (The whole line was quoted in a U2 song: "heard a singer on the radio late last night says he's gonna kick the darkness till it bleeds daylight.") Having assured readers that he will not try to define or explain Cockburn's worldview, Walsh does ask that we follow along as he listens to Cockburn's songs and asks four questions: "First, Where are we? What is the nature of the world in which we find ourselves? Second, Who are we? What does it mean to be human? Third, What's wrong? What is the source of brokenness, violence, hatred, and evil in life? Fourth, What's the remedy? How do we find a path through this brokenness to healing? What is the resolution to the evil in which we find ourselves?" (Walsh, p. 21).

To focus on a few important examples, chapters on "Where are we?" bring together creation imagery with the human longing for home. Walsh includes sermons that juxtapose Cockburn's lyrics with biblical texts: one brings "Creation Dream" from *Dancing in the Dragon's Jaws* to the world birthed in Genesis and made desolate in Jeremiah. "Who are we?" begins with that image of creation as divine dance, concluding that bearers of the divine image dance sacramentally and faithfully, nurturing life. In perhaps the book's best chapter, that joyful *Dancing* is compared with the lament of Cockburn's next recording, *Humans*, identifying that album's various expressions of disorientation, entrenchment, and reorientation. *Humans* not only voices Cockburn's cry; it also portrays a man wrestling

with God, hanging on for dear life.

In both books, the songwriter and theologian have to come to terms with the evolution of Cockburn's faith: the singer is honest enough to say that he took hold of Jesus's hand, only to let it go later. Walsh, writing before the memoir was published, seems appreciative but puzzled. Is he concerned that he has to reach back to the Jesus songs of the seventies to get the material for his sermons and final chapters? In doing so, is he quoting Cockburn against himself? It is likely that the artist himself would not reject the Christian imagery of the early songs; he quoted one at his own book's end. In a recent interview, he spoke of a hope that he can keep his own static down as he tries to listen to the divine voice. Like Walsh, I'll keep listening along as Cockburn shares what he hears.

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