Care with Persons Both Healthy and Unhealthy

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I am a hospital chaplain, and my primary clinical area is the medical intensive care unit. Working in this setting, I have learned of the tender bridge that is crossed when a person learns of an illness she didn't expect, a condition's development he didn't see, or the reoccurrence of a long-past disease process. That bridge leads a person from one understanding of self to another. It leads from being healthy in one moment to being unhealthy in the next. Lined with stones of sadness and surprise, relief and clarity, resolve and hope, the bridge from health to unhealth stretches from one part of existence to another. This happens in both hospitals and faith communities.

Diagnosis is a bridging moment, a series of moments perhaps, that impacts patients' views of self in a number of ways. Identity changes. Relationship to oneself changes. How one interacts with relatives may be nuanced, diminished, or modified. The tie to spiritual values turns and twists. A patient sits at the edge of health and unhealth, wellness and sickness. Prior to diagnosis, she can feel well, seem well, present well—indeed, even *be well*—while processes are at work within her to undo that wellness. To be sure, in many ways that patient *is* well. She enjoys her life. She serves in her church. She cares for her family. The entirety of her condition is not collapsed within that unexpected diagnosis. A person can hear news from the doctor and fall within the two categories of well and unwell. In other words, it is possible to be healthy and not healthy, well and unwell at the same time.

I begin with that explicit claim. The coexistence of wellness and unwellness is a claim birthed from my observations of patients who

have diagnostic information available to them but who also don't see the full picture of their physical existence. What is true in one part of the body may not represent another part of the body. One organ can be healthy while another is diseased. One system can function accordingly while another can be compromised. A diagnosis, then, serves as a partial picture and not a summary of the whole. What is true in a special sense for a patient with a diagnosis is true more generally for those who have no such diagnosis: people see a part of the health picture. In this way, every person is both healthy and unhealthy. In a very narrow way, however, the embodied experiences of persons who are living and contending with chronic conditions, long-term illnesses, or numerous co-morbidities possess rich resources for teaching local faith communities how to care well amid this paradox. These communities can include congregations as well as retirement settings, classrooms, and workplaces where believers live and thrive.

Critical reflection on the experiences of people who have been sick for lengthy periods can enrich the practice of ministry, particularly the ministry of pastoral care. These experiences of health and unhealth can teach us how to provide effective care not only for those with long-term conditions but also for people whose needs are different, who have fewer health challenges, or who have less interaction with healthcare professionals. Learning to care for one group enhances care provided to the others. Indeed, the ministry of spiritual care emerges within the context of faith communities, providing opportunities for pastors, chaplains, and non-clergy caregivers who collaborate with healthcare providers to extend ministry during and after hospitalizations.

In this paper, I begin by offering biblical foundations of pastoral care to the sick. Second, I build on this foundation using a womanist theological method, inviting caregivers to draw on an enriching theological method for care. I then provide a brief historical description of care from Swedish Covenant Hospital in Chicago to extend that summary to broader acts within communities of faith. I end with a brief discussion of strategies for regular engagement with care seekers and caregivers, suggesting specific steps for congregations seeking to become communities that are intentional in caring for those who are well and unwell.

Biblical Foundations of Care

The nature of care can change, especially as contexts change.[1] Pastoral care encompasses all the ways care has "risen to prominence amidst the changing cultural, psychological, intellectual, and religious circumstances of men and women throughout the Christian Era."[2] Seward Hiltner, in *Preface to Pastoral Theology*, has provided scholars three paradigmatic gestures—healing, sustaining, and guiding—as a basic and summative description of pastoral care and theology.[3] Healing, sustaining, and guiding were together the primary means of pastoral care throughout Christian history. As one of his three primary categories of care, healing is central to Hiltner's account.[4] He writes, "Healing implies, further, that the becoming is actually a rebecoming, a restoration of a condition once obtaining but then lost."[5] In a sense, healing is becoming whole again. It is a restoration of what was. While also providing an enduring theory for pastoral theology, Hiltner's *Preface* sketches the ways in which healing comes in people's lives as they engage with Scripture, doctrine, and the teachings of Protestant Christianity more specifically.[6] His account of healing is rooted in the Bible, and he draws from the ministry of Ichabod Spencer, a New York pastor, to show how Scripture forms the rich background from which Spencer's pastoral care emerges. Hiltner uses Spencer's experience with and application of Scripture to offer a perspective on shepherding and care.

As I've learned in my years of orienting to and serving in the Covenant, finding biblical foundations for our views, for our ways of being, and for our practices in becoming God's people has always been central to Covenant identity and practice. The question becomes, what's found in

[1] In the workshop this article is based on we began by surveying the room. I invited all the participants to give their preferred name, to say something about their context of ministry, and to offer any hopes they had for the time we spent together. I suggested that names and contexts were important for the work we would do in the session as well for the works we would return to do in our unique contexts. I suggested that the brief opening exercise was mobile and could be done in their contexts to *come to terms* there. Ministries of spiritual care emerge from the contexts of that care, and each context can shape the language and terms we use about expressions of spiritual care.

[2] William A. Clebsch and Charles Jaekle, *Pastoral Care in Historical Perspective: An Essay with Exhibits* (New York: Prentice-Hall, 1964), 32.

[3] Seward Hiltner, *Preface to Pastoral Theology* (Nashville: Abingdon, 1958).

[4] Ibid., 24.

[5] Ibid., 89.

[6] A related and much-referenced resource is Clebsch and Jaekle, *Pastoral Care in Historical Perspective.*

the biblical record for the ways we are to care? Where is it written that pastoral expressions of care take shape in gestures of healing, sustaining, and guiding? How has biblical care been expressed in Covenant ministries throughout the century? These are Covenant versions of the questions that Hiltner frames through the lens of Spencer's pastoral practice. Where Hiltner uses Spencer's notes and reflections to answer these questions, Covenanters might draw upon our own reflections to answer similar queries.

There are notable stories of care throughout the Bible, as well as a record of an increasing expectation of God's love in the form of compassionate gestures, works of mercy, and pursuits of justice.[7] The trajectory of this three-sided expectation was contextualized as God's people faced bondage in Egypt, exile in Babylon, or persecution in the Roman Empire. Rather than offering a list of passages demonstrating these gestures, works, and pursuits, I want to frame my recommendations for theological reflection and practice by highlighting practices evident in Israel's enacted memory, in the disciples' holistic care, and in apostolic teaching. These three practices embody the acts of care that we ourselves have received and that we in turn transmit in our own time.

First, Israel practiced storytelling as a means of remembering the care, presence, and compassion of the Creator who sustained them in their corporate life. There are many passages describing the remembering and reenacting of Israel's story. Jacob set stones in order to mark a transitional moment for his family when he wrestled with an angel of the Lord (Genesis 35:1–3). In the setting of stones for an altar, Jacob's descendants (and the future readers of Genesis) have a concrete reminder of this episode of Israel's story. In another place, the community was exhorted to remember and tell their descendants about God's intervention throughout their history, so that God's presence would not "slip from your mind all the days of your life" (Deuteronomy 4:9). The people participated in rituals such as Passover as an embodied way to reenact and remember the events behind them, events that invoked the presence of God as a liberating agent in Jewish life and history. In addition, prophets throughout the first Testament rehearsed God's overarching story and the Jews' central place in it when they reminded the people about God's expectations,

[7] Richard J. Foster's *Streams of Living Water: Celebrating the Great Traditions of Christian Faith* (San Francisco: HarperSanFrancisco, 1998) is still a helpful resource that visits some of these themes.

gifts, and guidance toward holiness (Isaiah 1:10–17; 48:1–13; Jeremiah 2:1–21; 3:21–25; Hosea 14; Micah 6:1–8).

Second, at critical points Jesus instructed his disciples to feed the people surrounding them, and he expected his followers to be engaged in the same caring ministries that he himself engaged in—serving others, preaching, and healing.[8] It is important to view the ministry of Jesus and that of his disciples as ministry of care for the physical, emotional, and mental needs of persons. Without that recognition, Jesus's ministry takes on an exclusively *spiritual* form, where spiritual connotes a kind of disembodied existence. Being from the black tradition and the black experience, I challenge that view of spirituality. I see in Jesus a ministry that is always inclusive of the physical and that does not divide the human person. This comment derives both from Jesus's Jewish identity—he would see persons as whole beings rather than divide them into the spiritual and material—and because of African influences on me as a practitioner. In African traditional religions (and in black religiously influenced traditions broadly), there is an integrity to the seen and unseen, a holding together of the physical and the non-physical.[9] This view sees Jesus's ministry and that of his followers as addressing all the needs of those they served—physical, mental, and emotional.

Third, the apostolic record affirms the church's call to be a people of care, a people of explicit burden sharing, and a people of deepening generosity. A survey of the New Testament pastoral epistles in particular unearths a number of clear messages of care. Across all the epistles, though, listeners are invited to bear one another's burdens (Galatians 6), to pray without end (1 Thessalonians 5), and to love when love goes unreturned (1 Corinthians 13). While the writers of our sacred texts are not only addressing behaviors toward the sick, their admonitions, prayers, and direction apply to ethics toward the infirmed. Are we only to love without remuneration those persons in our families? Are Christians called to bear the burdens of a selected few in their local assemblies and not more, should additional needs emerge? Are followers of Jesus only to love the healthy? It seems that opportunities to be compassionate,

[8] See examples of Jesus's instructions in Matthew 17:14–21; 20:26–27; 28:18–20; Mark 6:7; Luke 9:1–2; 10:1; 22:26–27.

[9] See Barbara A. Holmes, *Joy Unspeakable: Contemplative Practices of the Black Church,* 2nd ed. (Minneapolis: Fortress, 2017) and Emilie M. Townes, *In a Blaze of Glory: Womanist Spirituality as Social Witness* (Nashville: Abingdon, 1995).

ethical, and responsive believers have less to do with scarcity and more to do with faithfulness to the generous ways Christians engage each other.

Consider how these biblical themes relate to your particular context, to the named persons there, and how that context would state its own hopes in biblical terms. How does this section relate to your sphere of ministry? Given the role biblical reflection has in pastoral theology and pastoral care historically, seeing connections between biblical reflection and care for the well and unwell can enrich and strengthen the way you conceptualize your care. Having offered these ways of engaging the biblical record, I want to illuminate a particular theological method that can be useful in appropriating the various expressions of care within Scripture—womanist theological method.

Womanist Theology and Method

In noting Hiltner's use of Spencer above, I am also pointing to a primary aspect of method within womanist theology, namely the use of particular life experiences as the starting point and source of theological meaning. This is a tradition that draws upon the experiential beliefs of black people, primarily black women, to theologize on themes of God and race, class, gender, and sexuality.[10] For Cheryl Kirk-Duggan,

> Womanist thought has five elements: it works against oppression, for liberation; is vernacular or of everyday realities; is nonideological, abhorring rigid lines of demarcation toward decentralization; is communitarian, where collective well-being is the goal of social change; and is spiritualized: it acknowledges a spiritual/transcendental realm where humanity, creation, and matter interconnect.[11]

Womanist theology was a critical response to feminist theology for its dismissal of race, and it was a critical response to black theology for its sexism against black women. Feminist theology was a response to white, patriarchal theological systems, and black theology was a critical response

[10] Cheryl Kirk-Duggan offers a thorough article summarizing how womanist theology serves as a "corrective discipline" in theological studies. She gives brief reviews of the movements or moments in womanist work and lifts many of the key voices in this wise collective. See Cheryl Kirk-Duggan, "Womanist Theology as a Corrective to African American Theology" in *The Oxford Handbook of African American Theology*, ed. Anthony B. Pinn and Katie G. Cannon (Oxford: Oxford University Press, 2014), 267–79.

[11] Ibid., 268.

to white theology for its exclusive ways of keeping black persons outside of theological discourse. Womanist thinkers began to shape a decentralized theology in response to the very central and pronounced rigidities of whiteness or maleness or racism. One way to frame womanist work, then, is to situate it along the continuum of theological expressions that are in pursuit of developing good theology while also expanding who does that theology. Over the centuries, theology has been done predominantly by white men, while other voices have been absent or marginalized. Womanist work invites the continued inclusion and celebration of theology from black women whose experiences of class, gender, sexuality, and race have been excluded from white theology.

Inclusion from a womanist perspective focuses on the experiences of black folk. For Kelly Brown Douglas, theology pairs historical inquiry with contemporary experiences:

> Womanist understandings of Christ emerge out of the Black Christian tradition. This is a tradition in which Black women and men confessed Jesus as Christ because of what he did during his time as well as in their own lives. They did not make this confession because of his metaphysical make-up. Those in the slave community, for instance, were most likely unaware of the Nicene/Chalcedonian tradition.…[12]

Rather than Christ's two natures in one person (his "metaphysical make-up"), confession in the black Christian tradition was rooted in Christ's participation in the *experience of blackness*. It was the experience of Jesus in and through the embodied lives of black persons that enabled them to come to Jesus and to accept Jesus. For womanist theologians, experience includes several categories. Theologian and anthropologist Linda Thomas writes, "The categories of life which black women deal with daily (that is, race, womanhood, and political economy) are intricately woven into the religious space that African American women occupy."[13]

What is true for black women can inform, influence, and shape the experiences of others as we do theological work, engage in ethical

[12] Kelly Brown Douglas, *The Black Christ* (New York: Orbis, 1993), 111.

[13] Linda E. Thomas, "Womanist Theology, Epistemology, and a New Anthropological Paradigm," *CrossCurrents* 48, no. 4 (1998/99): 489. Full text of this article is available at http://crosscurrents.org/thomas.htm.

responses to suffering, and give care to those contending with the paradox of being healthy and unhealthy. In other words, I as a black man can use the method within womanist theology as I employ the various sources that engage the people I serve. If I'm attending to their beliefs and traditions, if I'm increasingly attentive to their experiences of class and economics, if I'm aware of his or her gender, sexuality, and body as a man or woman—*these* elements enable me to put to use a womanist method for pastoral care.

Thomas is clear that womanist theology "engages the macro-structural and micro-structural issues that affect black women's lives and, since it is a theology of complete inclusivity, the lives of all black people."[14] Thomas points to the inclusive nature of womanist approaches, methodologically speaking. What includes black women—the most *un-included* people in most settings—has a way of including everyone. Delores Williams, another founding voice in womanist theology, writes that womanist theology is "mindful of global coalition work."[15] A part of that mindfulness of black women's voices means celebrating and listening, as women "from various cultures and countries will develop theologies consistent with their own experiences and cultural heritages."[16]

I suggest that by drawing on womanist theological method, theologians, ministers, and caregivers can, in a more inclusive way, "retrieve sources from the past, sort and evaluate materials, and thereby construct new"[17] ways of knowing relative to compassion, care, and health. This can happen by listening to the voices of the most unheard within particular contexts and by attending to the immediate experiences of persons who are healthy and unhealthy. Working to inscribe the impact of class, race, and embodied existence is womanist work, even when that work is done by a man, a white theologian, or a pastoral leader who is not a black woman. Womanist approaches to ethics and care inform how a faith community can respond to situations where people are experiencing health challenges, chronic diseases, and the ups and downs of recovery, new diagnosis, treatment, treatment failure, and the emotional currents within

[14] Ibid.

[15] Delores Williams, "Black Theology and Womanist Theology," pages 58–72 in *The Cambridge Companion to Black Theology*, ed., Dwight N. Hopkins and Edward P. Antonio (Cambridge University Press, 2012), 70.

[16] Ibid., 71.

[17] Ibid.

each of these. Certainly womanist method would call for an attentiveness to the experiences of black women, but it would also enable a thorough appraisal of the experiences of others who are mistreated, underserved, and subjugated to oppression in numerous settings.

Mitzi Smith describes womanist theology as a political project that commits to black women's consciousness and to their needs for love, care, and liberation. The liberation within womanism is not tied to women alone but extends to entire communities of color and to global neighbors.[18] On the path of articulating her project's aims, Smith positions elements of her own life inside the work. For example, as she developed her book, she was attempting to adopt a child, an adoption that, she writes, "did not work out," and one that echoes in her introduction as Smith imagines how trauma and suffering impact persons and how God gets involved, (mis)understood, and known during the suffering.[19] There is a sense of the political, the social, and the personal. There is an intersectional quality to the work that runs over those words: political, social, personal. Can you see them in relation to those with health challenges, those who meet barriers in their social worlds, and those whose personal resources tap out before their needs are met? As pastoral theologian Phillis Sheppard says of black women's experience, we can hear echoes of the experiences of persons suffering within the paradox of health and unhealth. Sheppard states, "A single-issue analysis essentially renders some aspects of black women's experience invisible."[20] The lives of many people can be invisible, and womanist theology can push care providers to notice them.

Finally, Emilie Townes's work puts forward an ethical response from a womanist approach. An ethicist, Townes works to "explore models of healing that are sensitive to social location and cultural context."[21] She grapples with ethical, theological, historical, and economic issues that impinge on the pursuit of health within black communities. Discussing the unique issues associated with HIV/AIDS, insurance and economics,

[18] Mitzi J. Smith, *Womanist Sass and Talk Back: Social (In)Justice, Intersectionality, and Biblical Interpretation* (Eugene, OR: Cascade Books, 2018), 2–3.

[19] Ibid., 1–6.

[20] Phillis Isabella Sheppard, "Womanist Pastoral Theology and Black Women's Experience of Gender, Religion, and Sexuality," in *Pastoral Theology and Care: Critical Trajectories in Theory and Practice,* ed. Nancy J. Ramsay (Oxford: Wiley Blackwell, 2018), 126.

[21] Emilie M. Townes, *Breaking the Fine Rain* (Eugene, OR: Wipf & Stock, 2006), 2.

and the historical abuses of scientific research within the black community, Townes gives a broad reading of health and care in the black experience. She explores the "primary sites for black health care,"[22] facilitates the practice of communal lament in the historical context of pronounced health disparities,[23] and delves into several specific ways black people have lived into the spiritual and theological work of creating and reproducing health.[24] Womanist theological method is not only an approach to speak about God, but it is also an approach toward the ethical practices of God's people. It provides guidance in developing ways to hear from the most unheard while learning how to care from them and with them. Those who are both well and unwell often go unheard. Their specific needs may be chronic rather than acute. Their experiences, then, may be largely unseen. This theological method starts and ends with their experiences, not the experience of caregivers. It enables leaders to think through the embodied matters of the other. This method also illuminates ways to equip faith communities with tools to interrogate practices that impact people's bodies and to lament together when those bodies are negatively impacted.

As we saw above, the Bible provides a background and context for pastoral caregivers. Womanist theological method seeks to infuse with that biblical background the contemporary experiences of the persons to whom we offer care. If the biblical record offers resources for pastoral theology and care, a womanist theological approach will raise the experiences of persons as additional needed sources of that theology and care.

Homes of Mercy

I now consider how Scripture and the embodied experiences of persons have served as a starting point for working with persons undergoing treatment and contending with health concerns in our denominational history. The Bible has been integrated in the lives of Covenant people. What Scripture says has been taken into the acts and gestures of persons who have lived their theology. Persons within what came to be the Evangelical Covenant Church responded early to the healthcare needs of immigrants arriving in the United States from Sweden. Immigrants were disproportionately plagued with cholera in Chicago. In 1854, two-thirds

[22] Ibid., 85.
[23] Ibid., 23–25.
[24] Ibid., 147–86.

of Swedish immigrants that came to Chicago suffered from cholera[25]; in 1849 a full third of those who died of the disease in Chicago were Swedish immigrants.[26] Like other diseases at the time, no treatment existed for cholera. Men, women, and children were cast aside and thrown to the streets because their deaths seemed unavoidable. Among the Covenant's responses was the establishment of the Home of Mercy, which eventually became Swedish Covenant Hospital. The hospital, like other homes established at the time, was intended to be a place for the distressed, something "certainly true of the hospitals designed by and for immigrants," according to Covenant historian Karl Olsson.[27]

The Home was established by Mission Friends and served by city missionaries like Henry Palmblad, nurses like Anna Anderson, and physicians like Claes Johnson.[28] But on the way to establishing the Home, pastors opened their homes, cared for the sick, and invited others to care in the same way. Missionaries invited other Covenant people to take in the sick when the city cast them out. From children who migrated alone to women and men who slowly succumbed to the ravages of cholera, these immigrants were served by Covenanters who risked their lives to be hospitable and to offer compassion. With the establishment of the Home, the church *would do* what the people of the church already *had been doing*. The establishment of the Home of Mercy was a symbol of what so many individuals and families had established in their own homes.

Of course Mission Friends were not the first Christians to launch ministries of benevolence, compassion, and health. While the New Testament shows apostolic encouragement for compassionate living, post-biblical materials can also be found. One fairly accessible sociological study is worth noting, both because it is not written from the disciplinary perspective of Christian history and because of sociology's unique emphasis on impact on persons. Sociologist Rodney Stark has written that first-century Christians engaged in benevolent ministry like the Covenant ministries centuries later.[29] At a time when "the entire world lacked social services,"

[25] Karl A. Olsson, *Quality of Mercy: Swedish Covenant Hospital and Covenant Home; Seventy-fifth Anniversary 1886–1961* (Chicago: Swedish Covenant, 1961), 4.

[26] Ibid., 3.

[27] Ibid., 7.

[28] Ibid., 9–12.

[29] Readers unfamiliar with Stark's work may begin appreciating his scholarship and point of view through *The Rise of Christianity: How the Obscure, Marginal Jesus Move-*

Christians spent themselves supporting the dying, tending to the sick, and accompanying the infirmed, the old, and the abandoned.[30] According to Stark, Christians responded with care and compassion during brutal plagues in the first and second centuries. Stark asserts, "Pagans tried to avoid all contact with the afflicted, often casting the still living in gutters. Christians nursed the sick, even though some believers died doing so."[31] This same behavior would extend throughout the centuries as monks provided care to the sick through infirmaries, developing ministries after the models of shelters in urban areas by Byzantine people of faith.[32] According to historian and internist Guenther Risse, the monks' purpose was to create places of rest, hospitality, and nourishment. Those places would transition into the professional services of municipal and state-supported hospitals, "retaining the traditional services of shelter" and working toward "physical recovery" and "mending bodies."[33] Risse describes medieval and modern hospitals as "houses of recovery."[34]

This short section seeks to highlight Christians who involved themselves in building homes of medicine, recovery, mercy. These were theological choices informed by a people's understanding of biblical values and the lived experiences of infirmed persons. For the Covenant people who established the Home of Mercy in Chicago's Bowmanville neighborhood (bordering on what is now Albany Park), recovery and mercy belonged together, bringing the biblical witness in relationship to the embodied experiences of others. This brief survey is important for grounding us in both a biblical and historical stream of care. While the focus of this article is not hospitality to the terminally ill or ministry to dying persons, the connections between ministries of compassion to those with chronic conditions today extend back to Covenant people in Chicago during the late nineteenth century, back further to Christians of the first century, and to many grace-filled, compassionate persons in between. What

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ment Became the Dominant Religious Force in the Western World in a Few Centuries (San Francisco: HarperSanFrancisco, 1997) and *The Triumph of Christianity: How the Jesus Movement Became the World's Largest Religion* (New York: HarperOne, 2011).

[30] Rodney Stark, "The Early Church's Health Plan: Christians Practice neither Abortion nor Infanticide and Thus Attracted Women," *Christianity Today* 42, no. 7 (1998): 54.

[31] Ibid.

[32] See Guenther B. Risse, "Health Care in Hospitals: The Past 1000 Years," *The Lancet* 354 (December 1999): SIV25.

[33] Ibid.

[34] Ibid. Risse also called hospitals "houses of healing," an important and inspiring note.

those believers lived, they passed on to us. What they practiced became a portion of the theological method we can draw upon while seeking to love those who are healthy and unhealthy. As with African-informed approaches to care, those who have come before us provided a way to respond to the paradoxical conditions of being both healthy and not.

Communities Providing Spiritual Care

Faith communities, congregations, and workplaces are important contexts for spiritual care, as are hospitals. In addition to giving medical care, practitioners of medicine, caregivers, and healthcare providers can also attend to the mending, sustaining, and uplifting of the spirit. Each person can be a spiritual caregiver. Each place can be what pastoral theologian Archie Smith calls an intentional community, "groups that have emerged from historical struggle, that seek to remain faithful to the imperatives of social justice and to the continued need for transformation of sinful social structures."[35] Communities interpret their practices in view of their values, social histories, and desires for liberation. Intentional communities also develop "reflexive and imaginative capacity" in order for "relational or mutual recognition" to occur.[36] They see themselves and their structures surrounding them while also imagining the future they seek for their relationships. Reflective and imaginative capacity helps spiritual leaders instill the imaginations of the community, including those living the paradoxical life of being healthy and unhealthy. A community's imagination is enriched by their leaders' imaginations.

Taking into consideration the biblical background, womanist theological method, and Covenant history, faith community leaders and caregivers may locate strategies to do some of the following while giving care and expanding their "imaginative capacity."

Have something to say. How does your tradition think about spiritual care? The medical centers and hospitals of the world create their own descriptions; perhaps churches and other intentional communities should offer descriptions of health and unhealth as a way to judge and discern their own ministries. Who decides what health is in your setting? How involved are persons in naming what it means to flourish? Those who are

[35] Archie Smith, *The Relational Self: Ethics and Therapy from a Black Church Perspective* (Nashville: Abingdon, 1982), 87.

[36] Ibid., 93.

unwell and well will offer what they need based on their experiences and challenges. Your role as a caregiver is to hear them and to offer responses from your tradition and its resources.

Provide specific rituals. Important moments require acknowledgment, and the matter of health is no different, especially when health crises are protracted or, seemingly, unending. The church, congregation, or faith community is great at gathering, celebrating, lamenting, and remembering—at least we should be. Rituals can advance those behaviors. As in the history of Israel, rituals can enable us to reenact what God has been doing as liberating agent in the life of a faith community.

Offer pastoral prayers. Prayers emerge "from the contexts where people live and move and find themselves."[37] Weekly prayers offered in worship, small groups, Bible studies, and homes have "the potential to expand people's honesty and awareness and enrich relationships."[38] Many traditions include pastoral prayers, prayers of the people, and altar calls. These liturgical conversations can reflect the needs of persons struggling with health issues, show pastoral sensitivity and concern, and deepen authenticity between those praying. They also invite God into the regular, even mundane moments of living a paradoxical life.

Create healing spaces or healing environments.[39] Scholars have noted that environments impact healing. There are internal, interpersonal, behavioral, and external environments related to a person's and a community's health. Your faith community might focus on one of these categories during one liturgical season and another in during a different season. For instance, perhaps you work in the behavioral category during the beginning of the year, offering classes around spiritual practices that impact relaxation, stress, or discernment. In another season, your community might turn toward the interpersonal and study Scripture related to developing friendships.

Enlist people in recovery. Include the un-included, both persons who are recovering from a condition and people who will be in the future. Ideally there is a broadness to who participates in the ministry of a faith community. Participation in ministry is communal, not individual. I

[37] Archie Smith, "Thoughts Concerning the Pastoral Prayer," *Pastoral Psychology* 67, no. 1 (2018): 90.

[38] Ibid.

[39] See B. Sakallaris et al., "Optimal Healing Environments," *Global Advances in Health and Medicine* 4, no. 3 (2015): 40–45.

use recovery to point to the process of discovery, of uncovering what is present, and of exploring the spirit.

Focus on people's transitions as they pursue wellness. Adams and Spencer discuss seven transitional stages that capture the unique needs of persons with chronic health challenges: (1) destabilizing and losing focus, (2) minimizing the impact, (3) questioning self-worth, (4) letting go of the past, (5) testing the new situation, (6) searching for meaning, and (7) integrating the experience.[40] These stages can be used to understand how a person struggling with a condition may take a while to "let go of the past" (stage 4) or may spend a long time "searching for meaning" (stage 6). Pastoral acts and congregational supports across the transitional stages will call for the use of diverse gifts within a church. On the other hand, a congregation may own a select number of the stages and limit its focus in the direction of, say, accompanying persons "questioning self-worth" (stage 3) and being Christ to those persons.

Stay connected. The New Testament uses the metaphor of the body to describe the church. Tissues and muscles and nerves are housed in the human body. Generally speaking, bodies stay intact. How might this metaphor inform your approach as a leader who serves? How might it give you a way to encourage yourself and others in the ministry of keeping together the health of your body? It can certainly give you a vision for being together and for ensuring that the community takes seriously the health of those present.

Consider Clinical Pastoral Education (CPE). CPE is a process-oriented learning experience where students—traditionally seminarians or persons involved in various kinds of pastoral ministry—serve in medical, prison, or social service contexts in order to learn, apply, and grow clinical skills and to participate in structured reflection on the practice of ministry. It is both an individual and group experience.[41] Most people learn about CPE through their seminary program requirements. However, CPE is becoming more common among persons who are not interested

[40] We discussed these at length during the workshop. See John Adams and Sabina A. Spencer, "People in Transition," *Training and Development Journal* 42, no. 10 (1988): 61–63.

[41] Individual students participate in group learning seminars, conduct presentations on their clinical ministry through verbatim seminars, and consult with their peers and supervisor on their approach to assessment of another's needs and resources, the student's interventions, and so on.

in traditional ministry roles.[42] Congregations might engage a clinical pastoral educator to offer a unit of CPE for those active in congregational ministries or support the learning of lay persons who have expressed particular interest in serving, leading, or facilitating pastoral care.

Conclusion

I began this article by noting that the experiences of persons living with chronic conditions, long-term illnesses, and various co-morbidities provide faith communities rich materials for strengthening their practice of ministry. Those relatives in the faith know something about the paradox of being both healthy and unhealthy. Persons with chronic health concerns live in the long line of saints who, from the first century to the present moment, have served and been served by a hospitable, courageous family of Christians who knew how to attend to well-being in the midst of sickness. Black women's liberating, womanist theological method offers an increasingly generous approach to hearing the stories of persons often unheard, to engaging those stories, and to letting those narratives teach us about theology and faith as meaningful, embodied care. Those persons are worth hearing.

[42] CPE was available to seminarians, to students of pastoral counseling programs, and to persons within the healthcare setting such as nurses. It is true that these avenues continue to bring students into CPE, especially graduate theological education. Whereas, years before, persons would identify ministry programs as ending in pastoral appointments or roles in education or formation, today individuals are increasingly coming to the ministry of chaplaincy directly and doing so from a number of spiritual traditions. Students thus bypass the roles of pastor and follow direct paths into chaplaincy. CPE is the standard education for such persons.