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August/November 2018

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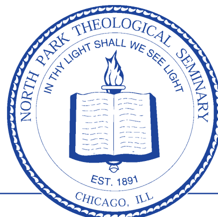

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Comment

Mary Chase-Ziolek, professor of health ministries and nursing, North Park University and Seminary, Chicago, Illinois

On November 10, 2018, the third biennial faith and health symposium, "Being Well: Connecting Church, Faith, and Health," was offered by North Park Theological Seminary and North Park University School of Nursing and Health Sciences, with sponsorship from Covenant Ministries of Benevolence, the Good Shepherd Initiative, Covenant Retirement Communities, and the Kappa Nu chapter of Sigma Theta Tau. The premise of the symposium was that, in addition to caring for the sick, the church has an important role in helping people be well that is rooted in Scripture and tradition. Claiming the church's role in health is inherently collaborative work, and thus the symposium brought together ministry and health professionals to consider what can be done together that neither group can do alone. One hundred and thirty people attended the event, while many others joined via livestreaming, including groups hosted on the campuses of Covenant Retirement Communities in Colorado, Minnesota, Michigan, and Connecticut.

The following pages offer a sampling of the richness of the symposium. This overview of the symposium is offered to set the original context within which these papers were given. The day began with a keynote address from Ruth Haley Barton,[1] president and CEO of the Transforming Center, "Honoring the Body as a Spiritual Practice," a version of which is included in this issue. Haley Barton emphasized that how we care for

[1] Information on the Transforming Center and Ruth Haley Barton's many books can be found at https://transformingcenter.org/. Video of Ruth Haley Barton's keynote address can be accessed at https://youtu.be/p8OmPTWYbvE?t=2769.

our bodies is not just a matter of maintaining health but is also central to faith, and that how we engage our bodies in spiritual practices can contribute to the experience of connecting with God.

The afternoon plenary sessions modeled the symposium's goal of interdisciplinary dialogue. Scott Stoner, an Episcopalian priest and therapist, shared the Living Compass Model of Wellness Ministries, which is being used in churches throughout the country. This faith-based model of wellness, organized around the great commandment to love God with all your heart, soul, mind, and strength (Mark 12:30), identifies eight dimensions that contribute to overall wellness. Living Compass is more than a concept, offering excellent resources for churches wanting to engage in wellness ministries.[2]

Kara Davis, physician, author, and pastor at New Zion Covenant Church in Dolton, Illinois, challenged the audience to think about restoring purpose to health ministry by recognizing that works without faith are dead. Identifying health ministry as inescapably Christian, Davis proposed going beyond the works of screening and education in the church, which can be done by anyone, to embracing the church's unique role in health through a faith model that is relational in emulating Jesus Christ, learning the stories of those in need, and seeking justice in health matters where people have been treated unfairly.[3]

Two workshop sessions provided participants opportunities to consider areas of more specific interest paired around general themes of wellness. Exploring issues of particular interest to clergy, James Bruckner, professor of Old Testament at North Park Theological Seminary, spoke on teaching and preaching on health, exploring biblical root-concepts regarding the integration of heart and mind.[4] Michael Washington,

[2] Video of Stoner's address can be accessed at https://youtu.be/p8OmPTWYbvE?t=17872. Living Compass has excellent resources for wellness ministries with adults, families, and youth, available on their website, https://www.livingcompass.org/.

[3] Video of Davis's plenary talk can be accessed at https://youtu.be/p8OmPTWYbvE?t=21404. Davis has written several books related to health, including *Spiritual Secrets to a Healthy Heart: Uncovering the Roots of America's Number One Killer* (Lake Mary, FL: Siloam, 2013) and *Timeless: Your Mind, Body, and Spirit Guide to Aging with Grace and Confidence* (Lake Mary, FL: Siloam, 2015).

[4] Video of Bruckner's workshop can be accessed at https://youtu.be/p8OmPTWYbvE?t=9379. Readers may also be interested in his book *Healthy, Human Life: A Biblical Witness* (Eugene, OR: Wipf & Stock, 2012), which provides an in-depth look at the Bible and health. https://youtu.be/p8OmPTWYbvE?t=9379.

Covenant pastor and chaplain at Northwestern Memorial Hospital, spoke on the paradox of health within illness. Washington's session was the basis for his article included in this issue, "Care with Persons Both Healthy and Unhealthy."[7]

Eating and exercise are central to wellness. These provided a second workshop theme, reflecting on the potential of churches to improve health through ministries that encourage healthy lifestyles. Tierney Frost, national director of LifeConnect with Covenant Retirement Communities, spoke on "Faith and Fitness." Francine White, pastor at Third Baptist Church in Chicago, presented on the ALIVE! program, an initiative using faith, food, and fitness to prevent premature deaths in five churches in the Metropolitan Chicago area. The origin, method, and outcomes of this innovative program are outlined in White's contribution to this issue, "ALIVE! Five African American Churches and a Medical Institution Join Together to Prevent Premature Deaths."

Mental health is a dimension of wellness that significantly influences the church and was the theme of North Park's first faith and health symposium in 2014.[6] Two workshops in the 2018 symposium addressed what the church can do to promote mental wellbeing. Focusing on individuals, Daisy Santiago-Altiery, director of counseling support services at North Park University and a pastor at New Life Covenant Church (Chicago), presented on "Spirituality, Mental Health, and the Church." Recognizing the important role that families play in mental wellbeing, Scott Stoner led a workshop on "Family Resilience and Wellness." Resilience is the quality of responding to challenges and is a dimension of mental wellbeing to which the church has much to contribute.

The role of communities in wellness was the fourth and final workshop theme. Health is influenced not only by individual behavior but also by the conditions of places people live, learn, work, and play. Recognizing that not all communities provide the same opportunities to be well, a workshop on the church's role in promoting health in under-resourced

[5] Video of Washington's workshop can be accessed at https://www.youtube.com/watch?v=p8OmPTWYbvE&feature=youtu.be&t=26229.

[6] The inaugural faith and health symposium in 2014 was "Being Present: A Faithful Response to Mental Illness." The keynote address, "A Faithful Response to Mental Illness," was delivered by John Swinton, professor in practical pheology and pastoral care at the School of Divinity, Religious Studies, and Philosophy at the University of Aberdeen. It can be accessed at https://vimeo.com/113926192. The password is "npts."

communities was led by Jasmine Zapata,[7] pediatrician and preventive medicine/public health physician and member of Fountain of Life Covenant Church in Madison, Wisconsin. Traumatic life events also influence well-being. Recognizing that not all adversity can be avoided, Stan Sonu, pediatrician and preventive medicine/public health physician and former member of Ninth Hour Covenant Church in Chicago, led a workshop on promoting wellness after adversity. Sonu discussed the concept of Adverse Childhood Experiences (ACEs) and how they influence health in later years and explored how the church can contribute to nurturing resilience after adversity.

Service to the church was the ultimate purpose of this interdisciplinary continuing education event. To this end, Eric Hillabrant, Covenant pastor and chaplain at Swedish Covenant Hospital, provided closing reflections on what the day's content might mean for the church. His "Pastoral Reflections on Being Well: Connecting Church, Faith, and Health," concludes this issue.

The Being Well symposium built on decades of work in faith and health at North Park. A narrative of this rich history is offered in my own article that begins the issue, "Twenty Years of Faith and Health at North Park Theological Seminary (1998-2018)." The church has much to contribute to helping people be well and flourish, through both our institutions and our congregations.[8] We hope this issue gives you much to consider regarding the connections between faith and health for your personal and congregational life.

[7] More information on Zapata's work can be found on her website, https://www.drjasminezapata.com/.

[8] An interesting reflection of the institutional role within the Evangelical Covenant Church is found in the recent name change of "Swedish Covenant Hospital" to "Swedish Covenant Health." See https://swedishcovenant.org/.

Twenty Years of Faith and Health at North Park Theological Seminary (1998–2018)

Mary Chase-Ziolek, professor of health ministries and nursing, North Park University and Theological Seminary, Chicago, Illinois

The 2018 faith and health symposium, "Being Well: Connecting Church, Faith and Health,"[1] marked twenty years since the first interdisciplinary course in faith and health was offered at North Park Theological Seminary (NPTS). This anniversary presents a fitting opportunity to provide a retrospective on the journey from that first class to the recent symposium. This twenty-year period also coincides with my own career at NPTS. I was appointed director of health ministry programs in August 1999 and now serve as professor of health ministries and nursing. The trajectory of my own professional development has simultaneously contributed to the shaping of the events narrated and been shaped by them in turn. I offer this retrospective, drawn from program documents[2] and two decades of firsthand experience, hoping that it may both illuminate the first twenty years of faith and health initiatives at NPTS and shine light on the way forward.

Laying the Foundation (1886–1998)

Substantial prior groundwork paved the way for NPTS's innovative faith and health programming. While 1998 marks the beginning of faith

[1] See notes 41 and 42 below for more information on this event.

[2] Cited program reports, newsletters, and other documents are in the author's possession and can be made available to anyone wishing to pursue further study.

and health work at the seminary, within the School of Nursing at North Park University (NPU), the connection between faith and the healing ministry of nursing goes back to 1968, when the first baccalaureate class graduated. The strong connection between nursing and the Christian faith is articulated in the philosophy of the School of Nursing.[3]

NPU's nursing program in turn builds on a deep tradition of care reflected in the ministry of Swedish Covenant Hospital. The very first denominational initiative of the Covenant Church after its organization in 1885 was to create the Home of Mercy in Chicago. Approved at the Covenant's first Annual Meeting in 1886, the Home of Mercy cared for the aged, orphaned, ill, and destitute. Due to the pressing need for healthcare, the Home soon expanded to a hospital in 1903 and reorganized to become Swedish Covenant Hospital in 1921.[4] This ministry of care evolved into Covenant Ministries of Benevolence, which in 2010 included two hospitals, fourteen retirement communities, seven enabling residences for adults with disabilities, and other initiatives to serve those in need.[5]

With this strong tradition of care, when issues of access to healthcare became centered in national dialogue in the 1980s and 1990s, the church brought its voice to the conversation. Many denominations, including the Evangelical Covenant Church (ECC) began addressing issues of health and access to healthcare.[6] The 1984 Covenant Annual Meeting passed a resolution on "Access to Adequate Health Care." This resolution affirmed the ministries of healing and health care as central to the ECC from its inception and offered six ethical principles, addressing both individual obligation and social responsibility to ensuring equitable healthcare for

[3] North Park University School of Nursing and Health Sciences, Mission, Vision, and Philosophy, dated August 2014, is available at http://www.northpark.edu/wp-content/uploads/SON_Mission.pdf. Accessed January 28, 2019.

[4] For the history of the Home of Mercy and its transition to Swedish Covenant Hospital, see Karl A. Olsson, *Quality of Mercy: Swedish Covenant Hospital and Covenant Home; Seventy-fifth Anniversary 1886–1961* (Chicago: Swedish Covenant, 1961), and the timeline provided by Swedish Covenant Health, https://swedishcovenant.org/docs/default-source/default-document-library/schealth-timeline-final.pdf?sfvrsn=bf7ad2c8_4.

[5] "Resource for Health Care Reflection," *Covenant Companion* (January 4, 2010), available at https://covenantcompanion.com/2010/01/04/7478n/.

[6] Faithful Reform in Healthcare has compiled many denominational statements on healthcare, past and present. See http://faithfulreform.org/, accessed January 23, 2019.

all.[7] This resolution was reaffirmed in 1992 and followed by a 1993 resolution on "Health Care."[8]

The 1993 resolution provides the most significant groundwork for faith and health at NPTS. It claims that concerns about health are central to Christianity generally and to the Evangelical Covenant Church specifically. It challenges the church to extend its care for the sick to the promotion health and wellness in congregations and neighborhoods, working to ensure that all have access to adequate healthcare. Finally, the resolution suggests congregational responses in the forms of parish nurse programs, health and wellness programs for congregations and neighborhoods, and the practice of letter writing to encourage political representatives working on health-care reforms.

In addition to passing resolutions, the ECC created resources for the church. In 1989 an ad hoc Committee on Health Care Curriculum prepared *Health Care and Caring*, an adult education curriculum, with the partnership of the Department of Christian Education and Discipleship and the Covenant Resource Center. The health ministries of the Evangelical Covenant Church grew in 1991 when Covenant Ministries of Benevolence added wellness to their services with the formation of Galter Life Center.[9] In addition to serving the local community in Chicago, for many years Galter Life Center has provided health screenings for clergy at Midwinter Conferences and Annual Meetings.

During this same time period (1984–1993), parish nursing emerged on the national scene. Parish nursing was pioneered by Lutheran chaplain Granger Westberg as a model in which nurses lived out the connection between faith and health, serving as educator, counselor, referral agent, advocate, and facilitator within specific faith communities.[10] Within the ECC, the ministry of parish nursing developed most significantly in the Northwest Conference, initially under the leadership of Joan Erickson. In 1997 the Northwest Conference developed a parish nurse task force, which became a commission in 2000, to support nurses serving in par-

[7] *Covenant Yearbook 1984*, 270–71.

[8] Available at https://covchurch.org/resolutions/1993-health-care/, accessed January 23, 2019.

[9] See https://swedishcovenant.org/docs/default-source/default-document-library/schealth-timeline-final.pdf?sfvrsn=bf7ad2c8_4.

[10] Peggy S. Matteson, "Parish Nursing—A New, Yet Old Model of Care," *Massachusetts Nurse* 69, no. 3 (199): 5.

ish ministry[11] and continues to be active today. While many Covenant churches are involved in ministries that promote health, the Northwest Conference is unique in having a conference-level commission to support this work.

One of the logical questions to emerge from this increasing denominational attention to health ministry and community health was the education needed to prepare people to promote access to healthcare and healing within congregations. Joan Zetterlund, professor of nursing and former director of nursing at NPU and an ardent supporter of the integration of faith and health, was central to this project, as was Judy Shelly, then serving as director of Nurses Christian Fellowship. Shelly had completed her doctor of ministry degree at Lutheran Theological Seminary in 1997 and was looking for a place to pilot the dual-degree curriculum she developed as her doctoral project.[12] Thus was Theology of Caring and Health, the first course in faith and health, offered in the summer of 1998 by Zetterlund, Shelly, and John Weborg, seminary professor of theology who had a long-standing interest in health. Weborg contributed thoughtful theological reflection, personal experience, and love of medicine, while Zetterlund brought her work in Scandinavian caring sciences and commitment to interdisciplinary education in faith and health. The inaugural class was comprised of fourteen seminary and nursing students. This course continued to be taught regularly until 2009.

Zetterlund's enthusiasm captured the interest of then seminary dean of faculty Stephen Graham as well as professor John Weborg. This led to conversations with Paul Peterson, head of Covenant Ministries of Benevolence (CMB). An agreement was made whereby CMB provided seed funding for a new seminary/church initiative that would provide educational programs in faith and health and resource congregations interested in ministries of health. Beginning in 1999, the initiative received initial funding of $140,000 over a two-year period, which was then extended at a declining rate of support through 2004, thus helping establish the

[11] Eleanor Edman, "Out of the Clinic," *Covenant Companion* (April 2009): 6–9. Parish nursing was later renamed "faith community nursing," in the American Nurses Association standards of practice to better reflect the diverse religious traditions involved in this type of nursing.

[12] Judith Allen Shelly, "Health Ministries: A Dual Degree Program for Graduate Nursing" (DMin diss., Lutheran Theological Seminary at Philadelphia 1997).

Health Ministry Programs.[13] The foundation was now established for integrating health ministry into seminary education and church life.

Beginning of Health Ministry Programs (1999–2008)

Interdisciplinary Education. In August 1999 I joined the NPTS faculty as assistant professor of health ministries and director of health ministry programs. The twofold charge of this new position was to develop a curriculum that would provide interdisciplinary education in faith and health, including supporting a newly created dual degree, master in nursing and master in theology,[14] and to resource the growing interest in health ministry within the ECC. The curriculum expanded with a second course, Ethics of Caring and Health, co-taught in 1999 by F. Burton Nelson, professor of theology and ethics, and Dan Dugan, ethicist for Swedish Covenant Hospital. Recognizing the need to make these courses accessible to those living outside of Chicago, the courses were most often taught online or as a one-week summer intensive.

Developing Congregationally Based Health Ministries was the first course taught online in the fall of 2000 with five students, three of whom were members of Covenant churches. This class considered the conceptual and practical frameworks for developing health ministries in a way that fit a congregational culture. It continues to be taught today as Engaging Congregations in Ministries of Health, renamed to reflect the mutuality of the process. It was clear that engaging congregations in promoting health was inherently interdisciplinary and needed to use language that prioritized what was most important. This led to a shift in thinking and terminology from "health ministry" to "ministries of health."[15] The content of this course provided the basis for *Health, Healing and Wholeness*, published in 2005.[16]

As the faith and health curriculum continued to expand, a class on the Bible and health was considered essential. James Bruckner, professor of Old Testament, agreed to develop a course, and thus Biblical Perspectives

[13] A memo from Stephen Graham to the Board of Benevolence, dated April 15, 2004, summarizes this process.

[14] This dual degree stimulated interest, but no one graduated from the program, and it was discontinued.

[15] Mary Chase-Ziolek, "Rethinking Our Terms: Health Ministry or Ministry of Health?" *Journal of Christian Nursing* 20, no. 2 (2003): 21–22.

[16] Mary Chase-Ziolek, *Health, Healing and Wholeness: Engaging Congregations in Ministries of Health* (Cleveland: Pilgrim Press, 2005).

on Health and Healing was taught in the summer of 2000 by Bruckner and John E. (Jay) Phelan, then seminary president and professor of New Testament. Eventually this course was taught online and became the foundation for Bruckner's book *Healthy Human Life: A Biblical Witness.*[17]

Acknowledging the importance of clergy connecting faith and health in their own lives led to a spiritual formation course in spring 2001, Spirituality and Health. This course was later integrated into Embodiment, a course required for all master of divinity students from 2002 until 2015.[18] Later renamed Being Well, the course provided an opportunity to think about health and wholeness for individuals with a particular lens toward those preparing to go into ministry. Clergy who experience the connection between faith and health in their own lives are better equipped to flourish in ministry and may also be more likely to see health as an appropriate ministry for the church.[19]

Finally, while promoting health and wellness are important, the recognition that illness does happen led to the development of Spiritual Issues in Chronic Illness and Disability, taught by Mary Chase-Ziolek, John Weborg, and Phillis Sheppard, assistant professor of pastoral care and counseling. A unique feature of this class inspired by Sheppard was bringing in the arts to reflect the experience of living with a chronic illness or disability.[20]

With this full complement of faith and health courses, a certificate in faith and health was created that could be taken in a combination of online and intensive courses. This certificate also became part of a concentration for the master of arts in Christian ministry. The table below provides a timeline of the development of faith and health courses over

[17] James Bruckner, *Healthy Human Life: A Biblical Witness* (Eugene, OR: Wipf & Stock, 2012).

[18] Richard Carlson, professor of ministry, was a valued colleague with whom I taught Embodiment. Work from this course is articulated in Richard Carlson and Mary Chase-Ziolek, "Wholeness: Rhythms of Intimacy and Health," pages 274–91 in Philip J. Anderson and Michelle A. Clifton-Soderstrom, eds., *In Spirit and in Truth: Essays on Theology, Spirituality, and Embodiment in Honor of C. John Weborg* (Chicago: Covenant Publications, 2006).

[19] Mary Chase-Ziolek, "Honoring the Body: Nurturing Wellness through Seminary Curriculum and Community Life," *Theological Education*, 46, no. 1 (2010): 67–78. I explored further the relationship between spiritual practices and wellbeing through completing NPTS's certificate in spiritual direction in 2018. Cf. Mary Chase-Ziolek, "The Gift of Spiritual Direction," *Church Health Reader* 7 (2017): 18–21.

[20] Mary Chase-Ziolek, "The Arts as a Lens for Understanding Spiritual Issues in Chronic Illness and Disability," *Teaching Theology and Religion*, 12, no. 4 (2009): 348.

the past twenty years. Course offerings altered over the years, reflecting faculty changes and curriculum revisions. The table demonstrates the variety of course created, engaging diverse disciplines including ministry, pastoral care, Bible, theology, and nursing. Moreover, the many individuals involved in creating these courses indicates clearly that this work came from a team, doing together what could not be done by any single individual. Between 2000 and 2008 especially it was quite common to team teach courses in the seminary, providing rich opportunities to collaborate and learn from colleagues and enabling students to learn simultaneously from professors with different perspectives. Eight of these twenty courses are still taught regularly.[21]

Faith and Health Course Development, 1998–2018

Course	**Instructor(s)**	**First Taught**
Theology of Caring and Health	John Weborg, Judy Shelly, and Joan Zetterlund	Summer 1998
Ethics of Caring and Health	F. Burton Nelson and Dan Dugan	Summer 1999
Developing Congregationally Based Health Ministries (later renamed Engaging Congregations in Ministries of Health)	Mary Chase-Ziolek	Fall 2000
Spirituality and Health	Chase-Ziolek	Fall 2001
Reflections on Health Ministry Practice	Chase-Ziolek	Fall 2001
Experiences of the Body in Pastoral Ministry	Phillis Sheppard	Fall 2002
Embodiment	Chase-Ziolek and Richard Carlson	Spring 2003
Christian Spirituality and Health (later renamed Being Well)	Chase-Ziolek	Spring 2004
Faith, Health and Community Development	Chase-Ziolek and Bob Hoey	Summer 2005

[21] Three were connected to particular events (e.g., a symposium or trip) and therefore intended to be taught only once; one was integrated into another course.

Symposium on the Theological Interpretation of Scripture—Health and Healing	Chase-Ziolek and Michelle Clifton-Soderstrom	Fall 2005
Living Responsibly in the Realm of God	Carlson, Chase-Ziolek, and Kazi Joshua	Spring 2006
Connecting Faith and Health in the Congregation	Carlson, Chase-Ziolek, and Joshua	Spring 2006
Religion, Spirituality, and Health	Chase-Ziolek	Fall 2006
Missions and Ministry in Africa—with an Emphasis on Community Health	Chase-Ziolek and Paul de Neui	Fall 2007
Health and Justice	Clifton-Soderstrom	Fall 2008
Stewarding Creation: Justice, Food, and Health	Chase-Ziolek and de Neui	Spring 2015
Trauma and Healing	Elizabeth Pierre	Summer 2016
Faith and Health Symposium—Journeying Together: A Faithful Response to Addiction	Pierre	Fall 2016
Faith and Food	Chase-Ziolek	Summer 2017

Supporting the Church. Concurrent with the development of interdisciplinary courses in faith and health at NPTS, efforts were made to provide continuing education for the church. This resulted in the first pre-Midwinter conference (then called a "Connection") in January 2001 on "Faith and Health: Making the Connection." Seventy-five people attended, and G. Timothy Johnson, medical editor for ABC and NPTS/NPU alumnus, provided the keynote address. Pre-Midwinter connections were repeated in 2003 on "The Church's Challenge in Chronic Illness and Disability," 2005 on "The Church Responds to Health Care Injustice," and 2008 on "Faith, Food, and Fitness." These collaborative events were supported by the ECC and by Swedish Covenant Hospital, which provided continuing education credits.

Informal education and networking approaches took advantage of online media. For example, in January 2002 forty people from across the United States and Mexico participated in an online conference, "Trans-

forming Power of the Church to Promote Healthy Communities," offered in collaboration with the ECC's Department of Christian Formation. In 2007 an email listserve enabled information sharing that continued through 2013. These informal approaches provided ways to network and share information.

In addition to national conferences held in Chicago, from coast to coast workshops were offered, questions were answered, and resources were shared. Between 2000 and 2010, I led at least one workshop on themes related to faith and health in eight of the eleven ECC regional conferences. Churches also took advantage of phone and email consultations I provided regarding developing health ministries. With the partnership of seminary students, I created resources for the church, including a publication on health ministries in the *Covenant Companion* April 2000[22] and two videos created in 2003. The Center for Faith and Health produced a video on the *Church's Challenge in Health*; seminary student Sue Radosti produced *All Together Healthy* as a summary of her field education.

Center for Faith and Health. In 2003 Health Ministry Programs was renamed the Center for Faith and Health. The purpose of the center was equipping Christian leaders in health and ministry fields to integrate faith and health in their professional and congregational settings by providing educational opportunities and consultation. The structure of the Center for Faith and Health followed the model of the newly created Centers for Justice Ministries and Youth Ministry Studies, which were also collaborative ventures between NPTS and the ECC. An outcome summary issued by the center in 2006 celebrated the progress made in the initiatives begun in both seminary and church since 1998 and united and carried forward through the center.[23] By 2006 eleven ongoing faith and health courses had been offered to a total of 332 students. Eight people had completed the certificate in faith and health, and five master of arts in Christian ministry graduates had completed a concentration in faith and health. Seven hundred people had participated in nineteen workshops on various faith and health topics offered through regional conferences, local churches, and the Covenant Midwinter Conference. At national meetings for health ministries and parish nursing, members

[22] Mary Chase-Ziolek, "Health Ministries Reach Out to Congregations and Communities," *Covenant Companion* (March 2000): 23.

[23] Mary Chase-Ziolek, "Outcomes of the Center for Faith and Health, 1999–2006," (2006), unpublished report.

of Covenant churches gathered for informal discussion.

Bridging academy and church, NPTS's 2005 Symposium on the Theological Interpretation of Scripture focused on "Health and Healing," bringing together scholars and practitioners from around the United States.[24] This symposium provided me the opportunity to explore the biblical foundations for the church's role in promoting the health of communities. Working with individuals was the focus of much of parish nursing in the early 2000s. My background in community health led me to consider what the church could do to promote the well-being of neighborhoods as well as individuals.[25] My study of Isaiah 58 led to an understanding foundational to my work expressed as, "The health of each of us is related to the health of all of us."[26] This perspective continued to be part of my teaching and professional work, and later, when the Affordable Care Act first required hospitals to work with their communities to assess and address community health needs in 2014, it became an opportunity to further consider how churches could be part of this process.[27]

In 2006, NPTS received a Practicing Our Faith grant of $9,199 from the Valparaiso Project for a seminary wellness initiative implemented by the Center for Faith and Health. The grant expanded attention to personal wellness from the curriculum to seminary community life more broadly. Focused on the theme of faith, food, and fitness, the grant included a harvest dinner, a cooking class, theological reflection on faith and fitness, and small groups studying *Just Eating: Practicing Our Faith at the Table,* by Jennifer Halteman Schrock. In the area of faith and fitness, the seminary community engaged in a Walk to Jerusalem that had students, faculty, and staff collectively walk the 7,200 miles from Chicago to Jerusalem, fueled by devotions created by the community.[28]

[24] Proceedings of the 2005 symposium are published in volume 21 of *Ex Auditu.*

[25] Mary Chase-Ziolek, "The Transforming Power of the Church to Promote Community Health," *Covenant Quarterly* 61, no. 3 (2003): 29–42. Two additional articles on faith and health by Phillis Sheppard and James A. Swanson are also in this issue.

[26] Mary Chase-Ziolek, "Repairing, Restoring, and Re-visioning the Health of Our Communities: The Challenge of Isaiah 58," *Ex Auditu* 21 (2005): 150.

[27] Mary Chase-Ziolek, "(Re)Claiming the Church's Role in Promoting Health: A Practical Framework," *Journal of Christian Nursing* 32, no. 2 (2015): 100–107.

[28] "Faith, Food, and Fitness: Devotions on Honoring the Body," North Park Theological Seminary, December 2007, unpublished document.

This activity was repeated two years later in 2009 as part of a continuing pattern of encouraging wellness.[29]

The years 2004 through 2008 were peak times for the center, with faith and health well established in the seminary curriculum and community life and in regular denominational events. Building on the strength of the Center for Faith and Health and the Center for Justice Ministries, in 2005 a new course was added to the master of divinity curriculum, Living Responsibly in God's Realm, integrating themes of justice, stewardship, and health. Thus, from 2005 to 2015 all master of divinity students were required to take two courses that addressed health, one from a personal perspective and one from a community perspective.[30]

Collaboration was central to the work of the Center for Faith and Health. In 2004 as the center's director, I began providing a column for *inSpirit*, the Covenant Women magazine, which continued until 2009. Several workshops were held for Covenant Retirement Communities and Swedish Covenant Hospital. I also served on the board of the Galter Life Center from 2006 to 2012. In 2006 a collaborative venture with the ECC's Department of Church Growth and Evangelism sought to raise awareness regarding access to healthcare through a communication to Covenant congregations, sharing examples of congregations responding to this challenge and requesting prayer.[31]

Of particular interest is the diverse professional backgrounds of students who have completed a certificate in faith and health. In addition to nurses and people interested in chaplaincy, graduates have come from the fields of medicine, athletic training, occupational therapy, massage therapy, healthcare administration, and veterinary medicine.[32] Similarly,

[29] "The Walk to Jerusalem: Reflections, Challenges, and Prayers for the Journey," North Park Theological Seminary, January 2009, unpublished document.

[30] See Mary Chase-Ziolek, "Honoring the Body: Nurturing Wellness through Seminary Curriculum and Community Life," *Theological Education* 46, no. 1 (2010): 67–78, which summarizes faith and health work at the seminary.

[31] In 2006 I was aware of two Covenant churches that provided free medical care. The fullest congregational response to barriers to healthcare access was Covenant Community Care in Detroit, Michigan. Established in 2001, Covenant Community Care became a federally qualified health center. It now has multiple locations offering a full range of services. For more information, see https://covenantcommunitycare.org/.

[32] Early program graduates included Sue Radosti, a massage therapist and the first person to complete the certificate in faith and health in 2003, who later completed a master of arts in Christian ministry, concentrating on faith and health in 2005. Lorraine Beaumont, a veterinarian completing the certificate in faith and health in 2004 was the

faculty with diverse backgrounds have been engaged in teaching courses in faith and health from the fields of theology, ethics, Bible, nursing, pastoral care, and missions.

A Time of Transition (2008–2009)

With the presidential election of 2008, healthcare reform returned to the center of national discussion. The Center for Faith and Health organized a health and justice summit with leaders from NPTS, NPU, Swedish Covenant Hospital, and the ECC, held May 1, 2008. Anticipating the growing number of people without healthcare insurance in congregations and communities—and anticipating that healthcare reform would be high on the political agenda after the November 2008 election—this summit considered what resources the church needed to promote individual health, develop congregationally based health ministries, and be a voice for justice in national healthcare policy. While other collaborative efforts among Covenant institutions had addressed matters of health, the particular focus of the 2008 summit was access and inequity.[33] The follow-through on this summit was limited by the 2008 financial crisis.

The financial crisis of 2008 had more wide-ranging implications for faith and health initiatives at NPTS. In May 2009, amid responsive fiscal adjustments, North Park University decided to restructure or eliminate several centers, including the Center for Faith and Health. The professor of health ministries position was relocated from the seminary to the School of Nursing (a dual appointment was subsequently worked out with the seminary), and resources for faith and health were decreased to one seminary class each year in addition to one course load for coordinating an undefined "faith and health initiative."[34]

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first person to be ordained to specialized ministry in the area of health ministries by the Evangelical Covenant Church. See Center for Faith and Health newsletter, Summer 2008.

[33] "Covenant Health and Justice Discussion—Notes Thursday May 1, 2008," unpublished document.

[34] Memorandum of Understanding for Joint Appointment in NPU School of Nursing and Theological Seminary, October 15, 2009, unpublished document.

Re-evaluating: Living into the Faith and Health Initiative (2009–2018)

With the closing of the Center for Faith and Health and resultant decrease in personnel resources, development slowed. The role of faith and health at NPTS was re-evaluated, and collaborative work was rechristened as the Faith and Health Initiative. Linda Cannell, then academic dean of the seminary, was instrumental in working through this transition, along with the dean of the School of Nursing, first Linda Olson and later Linda Duncan. In 2012, the major activities of the Faith and Health Initiative were described as

> collaboration between the seminary and the school of nursing to provide interdisciplinary continuing education opportunities for professionals in healthcare and ministry and offering courses in support of the Certificate in Faith and Health. Collaboration with Covenant institutions continues on matters of faith and health. The seminary and the school of nursing continue to work on how to best develop this partnership.[35]

While faith and health efforts at North Park were being reorganized, momentum for the work continued. Just prior to the closure of the Center for Faith and Health, NPTS had received a second Practicing Our Faith grant from the Valparaiso Project. The grant, Honoring the Body: Spreading the Word, involved telling the story of faith and health at NPTS through publication.[36] A second activity was a forum on faith and food for Chicago-area seminaries held on April 17, 2010. This grant also enabled three regional conferences on faith and health for the Evangelical Covenant Church at a time when school funds for denominational sup-port of faith and health activities had been eliminated. In November 2009, a workshop on "Biblical Foundations for the Church's Ministries of Health, Healing, and Wholeness" was held in collaboration with Covenant Community Care in Detroit. February 2010 was a workshop held in Anchorage, Alaska, on "Faith and Health: Making the Connection," in partnership with Providence Alaska Medical Center and Eagle River Covenant Church. New Brighton, Minnesota, was the location for an

[35] Mary Chase-Ziolek, Faith and Health Initiative 10-2-12, unpublished report.

[36] Chase-Ziolek, "Honoring the Body"; Chase-Ziolek, "The Arts as a Lens for Understanding Spiritual Issues in Chronic Illness and Disability," *Teaching Theology and Religion* 12, no. 4 (2009): 348.

April 2010 workshop on the church's challenge in chronic illness and disability, in collaboration with the Parish Nurse Commission of the Northwest Conference of the ECC.

While only a single annual faith and health course was taught in the immediate aftermath of the center's closing, in time new courses were developed. In 2014 the seminary offered Stewarding Creation, Justice, Food and Health, a ministry course that built on the framework of Living Responsibly in God's Realm. In 2017, a new spiritual formation course was offered titled Faith and Food. Other faculty's expertise expanded faith and health offerings, most notably the work of Elizabeth Pierre, assistant professor of pastoral care and counseling.

The shared faculty position between NPTS and the university's School of Nursing opened new possibilities for collaboration in interdisciplinary continuing education. The first such event through the Faith and Health Initiative was the workshop "Health within Illness: Giving Voice to Experience," offered October 22, 2011. This half-day workshop, offered in collaboration between the seminary and the School of Nursing, brought an interdisciplinary audience of fifty-five people to participate in this public workshop portion of an intensive course, Spiritual Issues in Chronic Illness and Disability. Covenant Ministries of Benevolence, Swedish Covenant Hospital, and the newly formed Good Shepherd Initiative of the Covenant Chaplains Association[37] provided support for this collaborative event.

The publication of James Bruckner's book, *Healthy Human Life a Biblical Witness,* provided another opportunity for interdisciplinary conversation. An event held October 31, 2012, drawing fifty people, brought together a panel discussing the relevance of Bruckner's book to their work. The panel was comprised of Linda Duncan, dean of NPU's School of Nursing; C. Louise Brown, vice president of health ministries for the Progressive National Baptist Convention and former director of public health nursing for the city of Evanston; and Phil Staurseth, pastor of Ravenswood Covenant Church in Chicago.

In partnership with NPU's Center for Youth Ministry Studies, the Faith and Health Initiative sponsored a second interdisciplinary con-

[37] For a description of the formation of the Good Shepherd Initiative, see "Chaplains Group Pursuing Pastoral Care Initiative," *Covenant Companion* (May 25, 2011), available at https://covenantcompanion.com/2011/05/25/chaplains-group-pursuing-pastoral-care-initiative/.

tinuing education event, "Talking about Health: A Dialogue with Health Professionals and Youth Pastors." This workshop, held February 16, 2013, with forty-seven people in attendance, was also part of a youth ministry topics class and received support from the Good Shepherd Initiative.

The success of these initial interdisciplinary continuing education events laid the foundation for considering a larger venture. The idea for a faith and health symposium offered collaboratively between the seminary and the School of Nursing (which in 2015 became the School of Nursing and Health Sciences) emerged from conversation between Mark Olson, then NPU vice-president of church relations, NPTS dean David Kersten, and School of Nursing dean Linda Duncan. Valuing collaboration with the denomination, the input of ECC superintendents was sought as well. In these conversations, the theme of the church and mental health rose to the surface as significant and timely.[38] Covenant Ministries of Benevolence and the Good Shepherd Initiative contributed major financial support, enabling the livestreaming of many sessions. This symposium, held November 8, 2014, was highly successful, with more than 200 people in attendance.[39]

Building on the tremendous interest in mental health, addictions was chosen as the focus of the second faith and health symposium, "Journeying Together: A Faithful Response to Addictions," held November 12, 2016. Sponsored by Covenant Ministries of Benevolence, the Good Shepherd Initiative, and the Kappa Nu chapter of Sigma Theta Tau, 140 people from a variety of backgrounds attended. Elizabeth Pierre taught a course on addictions and the church, bridging continuing education and academic work.

Two recent events stand out as exemplars of the collaborative work between the seminary and the School of Nursing and Health Sciences. First, Joan Zetterlund was awarded an honorary degree at the May 2017

[38] Two recent, highly public suicides made this topic very timely, those of Matthew Warren, pastor Rick Warren's son, in April 2013, and actor Robin Williams in August 2014.

[39] Several of the presentations from 2014 can still be viewed online. John Swinton's keynote address, "A Faithful Response to Mental Illness," is available at https://vimeo.com/113926192. The password is "npts." Pablo Anabalon's workshop on "Culture and Mental Health" is available at http://covchurch.tv/culture-and-mental-health/. David Hawkinson's workshop, "Adding Our Voices: Spiritual Care and Reflection in Mental Health and Healing," can be viewed at http://covchurch.tv/spiritual-care-and-mental-health/.

NPTS commencement ceremony, in acknowledgment of her instrumental role in establishing the faith and health program and her ongoing commitment, advocacy, and support for this interdisciplinary effort. Zetterlund is the first nurse to be awarded this honor. Second, the third biennial faith and health symposium, held November 10, 2018, reflects progress made through the past nine years of living into the faith and health initiative. Moving beyond illness to the church's role in promoting health, the theme for the symposium was "Being Well: Connecting Church, Faith, and Health." The day began with devotions on John 5:6 considering the question, "Do you want to be well?" Reflections from both Linda Duncan, dean of the School of Nursing and Health Sciences, and Dwight Perry, dean of faculty at NPTS, modeled interdisciplinary dialogue for the church, one of the key event objectives.[40] In the history of faith and health at NPTS, this symposium marked a strong collaborative effort and ownership from NPTS, SONHS, and denominational entities—the strength of which resulted in a particularly strong program. Sponsorship expanded beyond the previous symposia to include Covenant Retirement Communities, which hosted group viewings of the symposium livestream at four locations.[41] Thus, almost ten years after the closing of the Center for Faith and Health, a firm commitment to the interdisciplinary work of the Faith and Health Initiative endures, building on the distinct strengths of the seminary and the School of Nursing and Health Sciences and working in collaboration with the Covenant denomination.

Looking to the Future

Having reviewed the past twenty years of faith and health initiatives at NPTS, it is fitting to look to the future and what it might hold for both the seminary and the church. Several avenues of further inquiry

[40] The full program is outlined in this issue's Comment, pp. 1–4.

[41] Through the support of the Good Shepherd Initiative, video of Ruth Haley Barton's keynote address, "Honoring the Body as a Spiritual Practice," can be accessed at https://youtu.be/p8OmPTWYbvE?t=2769; Scott Stoner's plenary on "Living Compass Model of Wellness Ministries" can be accessed at https://youtu.be/p8OmPTWYbvE?t=17872. Kara Davis's plenary, "Works without Faith Is Dead: Restoring Purpose to Health Ministry," can be accessed at https://youtu.be/p8OmPTWYbvE?t=21404. James Bruckner's workshop, "Integration of the Heart and Mind? Biblical Root-Concepts," can be accessed at https://youtu.be/p8OmPTWYbvE?t=9379. Video of Michael Washington's workshop, "Healthy and Not: Being Both at Once," can be accessed at https://www.youtube.com/watch?v=p8OmPTWYbvE&feature=youtu.be&t=26229.

would provide a more robust understanding of the past two decades in faith and health, its significance, and impact. Regarding education, it would be useful to know how those who completed the certificate in faith and health have used this education. A comparative study with other seminaries that offered concurrent programs in faith and health would also be instructive. This would include Andover Newton Theological Seminary, Wesley Seminary, Duke Divinity School, and Candler School of Theology. Regarding practice, it would be useful to study the impact of faith community nursing and other models of health ministry on congregations and communities. In this area, the Northwest Conference would have the largest number. Additionally, it could be informative to look at Covenant congregations that had ministries of health for a limited season, what work they did, and what factors contributed to their ending these ministries. Oral histories with key figures in the development of this work, from both North Park and the ECC, would add insightful dimension to the chronology of events. This article is written from the perspective of one who was intimately involved in the events it narrates; an outsider reviewing similar material would undoubtably offer complementary insights.

In looking to the future, it is critical to consider the next generation that will shape ongoing work in faith and health. What questions are young Christian health professionals asking about how to integrate their faith in their practice and with their congregations? What questions are young clergy asking about how their faith might influence their own health practices and the ministries of their churches? We are seeing increasingly diverse models of health ministries beyond faith community nursing or a health ministry team. A growing number of churches are engaged in growing healthy food through gardening; fitness ministries of all kinds are getting people moving together; and support groups abound to help people through challenges from addictions to grief. Particularly in communities with limited resources, churches are seen as valuable partners for collaborative efforts to improve community health. What do these many faces of health ministry look like, and how might they contribute to the mission of the church?

The work continues. The faith and health work of NPTS has survived the closing of the Center for Faith and Health and emerged streamlined yet strong through the Faith and Health Initiative. At the time of this writing, there are four students currently enrolled in the certificate in faith and health. Three faith and health classes will be taught during the

2019–2020 academic year. The work of the past twenty years has been built on the shoulders of many who went ahead of and alongside me. I pray that others in turn will be able to build on this work going forward.

Timeline of Significant Events

Year	Event
1998	First faith and health course taught at North Park Theological Seminary—Theology of Caring and Health
1999	Covenant Ministries of Benevolence provides funding to hire director of Health Ministry Programs and assistant professor of health ministries at NPTS
2000	First online faith and health course taught—Developing Congregationally Based Health Ministries
2001	First faith and health pre-Midwinter conference, "Faith and Health: Making the Connection"
2003	Pre-Midwinter conference, "The Church's Challenge in Chronic Illness and Disability"
	Center for Faith and Health begins (former NPTS Health Ministry Programs)
2005	Pre-Midwinter conference, offered with the Center for Justice Ministries, "The Church Responds to Healthcare Injustice"
	NPTS Symposium on the Theological Interpretation of Scripture, "Health and Healing"
2006	Practicing Our Faith grant received for Faith, Food, and Fitness
2008	Pre-Midwinter conference, "Faith, Food, and Fitness"
	Second Practicing Our Faith grant received for Honoring the Body, Spreading the Word
2009	Center for Faith and Health closed, Faith and Health Initiative (FHI) begins
2011	First continuing education event of FHI, "Health within Illness: Giving Voice to Experience"
2013	FHI continuing education event, offered with the Center for Youth Ministry Studies, "Talking about Health: A Dialogue with Health Professionals and Youth Pastors"
2014	First faith and health symposium, offered with NPU's School of Nursing, "Being Present: A Faithful Response to Mental Illness"
2016	Second faith and health symposium, offered with NPU's School of Nursing, "Journeying Together: A Faithful Response to Addictions"
2017	NPTS awards Joan Zetterlund honorary doctoral degree in recognition of her foundational work in faith and health
2018	Third faith and health symposium, offered with NPU's School of Nursing and Health Sciences, "Being Well: Connecting Church, Faith, and Health"

Flesh and Blood Spirituality: Honoring the Body as Spiritual Practice[1]

Ruth Haley Barton, founder and chief executive officer, Transforming Center

I am writing as a spiritual seeker and as a spiritual director, someone who has been on a journey of connecting the dots between life in the body and my own spirituality for many years. Now I am intent on bringing that integration to my work with others in spiritual direction and in the Transforming Center.[2] I am always working toward integrating life in the body with my spirituality, because whatever we are doing or not doing in our own lives is what we will bring to those to whom we minister. If we do not have an integrated view of life in the body ourselves, it will be very hard to bring a positive spiritual perspective to others as we care for them in their bodies.

The Spiritual Journey and Life in a Body

Unfortunately, when it comes to life in a body we Christians have inherited what Stephanie Paulsell calls "an ambiguous legacy."[3] Knowing

[1] This article derives from the author's keynote address for North Park University and Theological Seminary's 2018 faith and health symposium, "Being Well: Connecting Church, Faith and Health." It has been lightly edited for publication. Thanks to Mackenzie Mahon for her transcription of the lecture video.

[2] The Transforming Center exists to create space for God to strengthen leaders and transform communities. We serve leaders and influencers of purposeful communities—churches, nonprofits, and businesses—who long for new rhythms that allow them to flourish in their life and leadership. We walk with pastors and leaders, helping them distinguish God's voice beyond all the noise so they can lead from that place. For more information, see https://transformingcenter.org.

[3] Stephanie Paulsell, *Honoring the Body: Meditations on a Christian Practice* (San Francisco: Jossey-Bass, 2002), 5.

this is an important first step in understanding the lack of integration many of us experience. But after we understand this ambiguous legacy and how it developed, our task is to move beyond the ambiguity, first by engaging the biblical witness—ascertaining what Scripture has to say about our bodies—and then by exploring spiritual practices that help us receive life in a body as a gift, which is the first step toward learning how to honor God in our bodies.

It was in the process of trying to stay faithful to my spiritual journey that I first began to face my own profound ambivalence toward life in a body. At the ripe old age of thirty, I could no longer ignore the fact that I was tired, lethargic, and somewhat depressed. Thinking that my lethargy and lack of enthusiasm for life were psychological in nature, I went to a psychologist who was also a spiritual director. To my surprise, some of our initial conversations dealt with my physical condition: my eating patterns, how much sleep I was getting, whether I was getting enough exercise and drinking enough water. I learned that the human body is 60 to 65 percent water and that I was dehydrated much of the time, a problem exacerbated by the fact that I was relying on caffeine for energy. My director also inquired into whether I was paying attention to my overall health.

In all of this, I realized that even though I had been a Christian all my life, here I was in my early thirties never having paid attention to my body. Even though I had been raised in the church as a pastor's kid, nobody at church or home had ever helped me pay attention to life in my body as a part of my spiritual life. So it was astonishing to me that a spiritual director would start her work with me by helping me pay attention to life in my body.

During that time, I was also reflecting on the story of Elijah and his journey into the presence of God in 1 Kings 19. I was struck by the attention God gave to Elijah's body at the very beginning of that journey. He helped Elijah give attention to his physical condition, even going so far as to send an angel to Elijah in the wilderness with a jar of water and "angel food cakes" (cakes baked by angels on a hot stone in the wilderness!). The angel told Elijah, in his depleted state, that the first thing he needed was to eat; "otherwise, the journey will be too much for you" (1 Kings 19:7). In other words, "if you don't strengthen yourself physically, you will not be able to take the spiritual journey."

I was comforted to find Elijah in the wilderness, slumped down under the solitary broom tree, needing an angel to tell him how to care for his

body, because I resonated with this experience. I realized that I, too, needed to pay attention to my body and to care for it. Thank God for a good spiritual director who could say, "You know what, Ruth, you have *got* to connect the dots between your spirituality and your life in your body." I had to admit that I had the same blind spot as Elijah. I began acknowledging that I had become so run down that I could no longer be present to the journey to which God was calling me.

This experience was eye-opening. It forced me to face the fact that rather than caring for my body as I would any other highly valued gift, I had been driving my body like a truck. I had been using it for my own ends to the point that it was now protesting and trying to get a bit of attention. As I paid attention, I discovered that my diet included far too much sugar and junk food. Rather than getting enough rest, I was caffeinating for additional energy. I had never considered the importance of drinking enough water. I hadn't realized that sometimes feelings of tiredness were indications that my body was dehydrated. As a busy parent of three young children juggling the demands of home and family and vocation, I thought I didn't have time for exercise or other physical activities I enjoyed.

The other sad truth is that I was routinely pushing my body beyond its human limits—in God's service, of course. I was a good Christian and already on staff at a church I loved, but I was not treating my body as the gift God intended it to be. Up to that point I had been quite out of touch with any sense that life in my body had anything to do with my spirituality. Intent on trying to be spiritual, I had relegated life in my body to a lesser category that warranted very little attention. I figured that as long as the warning lights weren't going on, I could ignore my body in favor of more "spiritual" activities such as solitude and silence, Scripture reflection and prayer.

It didn't help that my surrounding culture idolized perfect bodies, valuing people on the basis of their physical appearance and sexual appeal. As a serious Christian young woman, that made me all the more hesitant to pay attention to my body. I for one did not want to fall into the excesses of a culture that placed an inordinate value on physical features rather than the beauty and dignity of the human soul reaching toward God.

Yet even though I was nervous and afraid, that early journey of trying to get healthy helped me begin to confront the reality that the physical and the spiritual are not as opposed as I had imagined. I started to become aware that I am not merely a soul or a spirit; I am an embodied

human being, and my body is a temple of the Holy Spirit. Whereas in the Old Testament the Holy Spirit came and went until eventually it found a dwelling place in a tabernacle constructed by human hands, God has chosen in these days to dwell permanently in the body of redeemed persons and in the body of Christ as it gathers.

As I began to grapple with the truth that in some unexplainable way God inhabits our bodies, making them places where we can meet and know him, I took a fresh look at a familiar Scripture passage and noticed that 1 Corinthians 6:20 indicates it is possible for us to "glorify God in our bodies"—not glorify the body, but glorify God in our bodies. I grew more and more curious about what it might look like to glorify God in my body, and I was pretty sure that walking around tired, overweight, and over-stimulated by sugar and caffeine was not it!

I began to be curious: why did God create bodies? Several answers came to me directly from Scripture. The first is that God is creative. Going all the way back to Genesis 1, we see a God who is creative. It is amazing to look at our world and see that every body, each and every one, is different. God could have made a bunch of clones. Instead, no two people are even remotely the same unless they are twins, and even twins have their distinctions. And God just keeps on creating: in our bodies, *we* are an expression of God's ongoing creativity. How wonderful to think that each of us is a part of God's ongoing creative work, just by being in the bodies we are in.

Second, Scripture is clear that God created bodies so that we could glorify God in our bodies (1 Corinthians 6:20). In fact, a body that is simply being the body it was created to be—in whatever capacity God has given it on any given day—is glorifying God. Being the best body we can be glorifies God. It is important to note that I am not talking about the perfect body that has become the obsession of our culture; I am talking about being the most God-honoring body we can be at each stage of life. It is the best body we can be *right now*, which will be different depending on whether we are nineteen, thirty, or sixty. An important aspect of glorifying God in our bodies is accepting where we are now and living in that stage with dignity. To accept that this is what my body can do now and to be all that I can be here and now, this is glorifying God in my body today.

Third, God created bodies so that the power of God can be seen in these earthen vessels. That's hard to fathom, isn't it? These bodies that are so unpredictable—sometimes messy, sometimes beautiful, all the time

vulnerable—can be vessels through which God's power can be seen in unique ways. And the way we carry around the gospel and our ministry in these earthen vessels can show forth God's glory and power. While this may be counterintuitive, this is another way we can glorify God.

Knowing that God has chosen to make our bodies his dwelling place opens the door to remarkable opportunities for heightening our awareness of God's presence with us. And isn't that what the spiritual journey is all about, heightening our awareness of God's presence with us and becoming more faithful in responding to God's presence and activity in our lives? So to recognize our bodies as a place of encounter with God is to embrace the body as a locus of spiritual experience.

Overcoming Challenges

A Varied and Wide-Ranging Experience. But there are challenges. Life in the body is, after all, a varied and wide-ranging experience, and there is no doubt that some experiences are better than others. As I look at life in my body from a mid-life perspective, I can recall both moments of great gratitude for the body I have been given as well as moments I have wished mightily for a different one. There have been moments when touch was shared in loving ways and moments when touch was not so loving. There have been moments of keeping my body to myself and moments of deep sharing. There have been moments of strength and physical accomplishment in my body and moments of physical weakness and vulnerability. Sometimes I do very well at living within the limits of life in a body and the bodily changes that accompany each season of my life. Other times I really resist these limits and say, "God, why? Why can't I do more? Why am so limited?" Sometimes I accept myself as God's created me, and sometimes I fight with God and wish I could do more and be more in this body.

This fact of varied experiences of embodiment is the first challenge to experiencing life in the body as a gift. Some of us have had very positive relationships in our bodies; others of us are still grappling with negative experiences we have had in our bodies. The #MeToo and #ChurchToo movements are bringing women into contact and into memory with some of the negative experiences they have had in their bodies—with how this has affected them, how they may have hidden it, and how it shapes who they are today. These are important areas of awareness. If we do not allow ourselves to be aware, we cannot invite God into these experiences. In a sinful and fallen world, some of our experiences are not so positive.

An Ambiguous Legacy. I named above a second challenge to experiencing life in the body as a gift: as Christians living in a fallen world, we have inherited "an ambiguous legacy regarding the body."[4] At best, many of us experience ambivalence about the body. We may try to ignore it unless something breaks or acts up. Or we try to control it, to manage its urges. At worst, some experience thinly veiled disgust or even a hatred of their bodies. This may be related to families of origin and how our bodies were treated as we grew and developed. There may have been early experiences that convinced us that the body is shameful, dirty, or ugly. Many of us are still marked (and marred) by these early experiences in terms of how we view the body, and we have never been invited to reflect on them and bring them into the light. We have never had the opportunity to say out loud to anyone, "This is what happened to me, and this is how it has shaped me," and then bring a God-breathed perspective to early experiences that have remained outside our consciousness.

At the very least, many of us are profoundly disconnected from our bodies, especially if we were shaped by a very conservative religious upbringing that was informed by dualisms created by a sacred-secular split. So on the one hand we have the excessive, misguided glorification of the body in the secular world, but on the other hand we have the denigration of the body or the dismissal of the body as being less than life in the spirit in many religious circles. We are going to have to shatter dualisms to get where we need to go.

Beyond Dualism. Dualism is the division of the human person into two elements, material and immaterial, that are at war with each other rather than being inter-related and inter-connected. At times, these two aspects may exist in an uneasy truce, but we experience an underlying hostility and discomfort between the two. Often we elevate one and denigrate the other. This is exactly what many Christians have done with life in the body and life in the spirit. We've divided these two aspects of human existence and made one good (life of the spirit) and one bad (life in the body). Alienation from the body—seeing it as separate from the spirit—is a profound and destructive dualism. It separates one aspect of myself from another aspect of myself, making me a fragmented person rather than an integrated whole.

Moving beyond dualism requires a shift in our thinking. We must

[4] Ibid.

recognize that that these two elements, while distinguishable from each other, can belong together and actually do belong together in the way that God created us. We must see the life of the body and the life of the spirit as belonging *together* in a creative tension as we learn how to live them together.

As we live with ourselves and minister to others, we must ask, "How do I view these aspects of myself, and is there anything that needs to be redeemed in my own experience of life in a body?" We must also consider how we can help others redeem their sense of themselves as a body. Even in those moments when they are going through the hardest things—the moments when they are deathly ill, the moments when they are going into a surgery, the moments when they are facing news of a terminal illness. How do we continue to hold this tension: that the body is still a gift and that every experience in the body is infused with the presence of God? This is our work, and it is spiritual work. No matter whatever else we're doing with people and their bodies, this is our spiritual work: to help them integrate and find the goodness of God in their experiences in their bodies, just as we have found it in our own.

There is a discipline within academia called body theology. Body theology attempts to do away with this dualism and to reflect on the bodily experience as a place of revelation from God and about God. So if we believe, as Genesis 1 and 2 teach, that our bodies are made in God's image—created male and female in God's image—then it follows that we can learn about God from how he created our bodies. The body can actually become a primary source of theological reflection, not a secondary one. This makes it so exciting to be in a body because it means I can learn from God here.

Body theology, the understanding that the body is place of a revelation about who God is, affirms our non-dualistic, Hebraic, incarnational Christian roots. The Hebraic tradition understood that we do not just *have* bodies but that we *are* bodies. In Hebrew, there is no word for separating the body from the person. For the Hebrews, the body was the person, and they did not differentiate between the physical and other aspects of being. A person was thought of as a whole, a totality. The Hebrew word *nephesh*, often translated as "soul," actually referred to the inner aspect of the body. All of it together was the person.

Similarly, in the Old Testament there was only one word for knowing, and it expressed full, experiential knowing between a subject and an object. There was no language to speak only of cognitive knowing.

When Scripture says that Adam "knew his wife" (e.g., Genesis 4:1), it does not mean that he had information about her. It means that he knew her physically. They had come together in full, experiential oneness; they knew one another on every level. The idea that we might separate cognitive knowing from other kinds of knowing is not a part of Scripture until we get to Paul and the Greeks. Even so, when Paul refers to the body, he uses the Greek word *soma*, an all-encompassing category that points to integrated body-selves.

Body theology attempts to shatter a dualism that has a long pedigree in our catholic Christian tradition. Among other things, this dualism has created a false dichotomy between the physical world, in which we exist as embodied beings, and the spiritual world—a contradictory and unhelpful perspective that points to our need to learn how to receive the goodness of the body as part of our life in God that God has pronounced very good. We need an approach to life in which the body is understood to be sacred. What do I mean by sacred? Set apart for a holy purpose. And what is that holy purpose? To know and experience God. Our bodies are temples, and what is a temple after all? It is a set-apart place for encounter with God, for prayer. Sometimes I wonder if we fully understand the implications of this biblical truth.

We often take out of context the verses about our bodies being temples, using them, for example, to talk about sexual abstinence with the youth group. But do we talk about the other functions of a temple? Do we talk about prayer as part of what happens in the temple? Where in our Sunday-school curriculum or preaching schedules do we teach that our bodies are a place set apart for encounter with God? I did not hear this in all my years being raised in a pastor's family and have not heard it since. All I heard were messages about how to be sexually pure; I never heard a message about the body as a place of prayer and encounter with God. What about you? This is one thing the church can start doing right away: preach and teach a more fully orbed understanding of life in our bodies as it relates to our spirituality.

Supporting the Journey with Good Hermeneutics

If you believe, as I do, in a hermeneutical approach that identifies the major themes of Scripture, and then looks at lesser themes within that framework, there is no doubt that honoring the body is central to the Christian faith. Let's walk through Scripture and see how it helps us move from dualism to wholeness as it relates to our life in the body. All the

major themes of Scripture affirm the spiritual significance of the body.

At creation God created human beings in bodies and declared these bodies very good. Not sort of good, not just good, but very good. Your body. My body. Very good. God could have created us as disembodied spirits, but he did not. He created us in these bodies. In Deuteronomy 30, speaking through his servant Moses, God affirms to his people the need to discern what is life for us from what is death so that we can choose life. He says, "I have set before you life and death, now choose life so that your descendants might live" (v. 19). This is a visceral, in-the-body knowing: "It is not in heaven, that you should say, 'Who will go up to heaven for us, and get it for us so that we may hear it and observe it?' Neither is it beyond the sea, that you should say, 'Who will cross to the other side of the sea for us, and get it for us so that we may hear it and observe it?' No, the word is very near to you; it is in your mouth and in your heart for you to observe" (vv. 12–14). In other words, our bodies are tools for discernment, helping us discern between what is life-giving and what is life-draining.

The psalmist talks about his desire for God as something he experiences in his flesh. "My flesh faints for you; my flesh thirsts for you as in a dry and weary land where there is no water" (Psalm 63:1). He goes on to affirm his body and soul together as part of God's created goodness when he says, "I am fearfully and wonderfully made; that I know very well" (Psalm 139:14). When was the last time you looked at your body and celebrated it? When was the last time you felt so much joy about being in your body that you said to God, "Thank you for all these things that I can do in my body. Thank you for the running and the dancing and the exercising and the sleeping and the showers and the love-making and the eating. Thank you for life in my body. Thank you that I am upright today. I *am* fearfully and wonderfully made, and that I know very well."

What about the incarnation, the Word become flesh? Jesus, the supremely spiritual being, who existed far beyond the material world as we know it, who existed eternally as the Word, became flesh. As Teilhard de Chardin said, "We are not human beings trying to become spiritual; we are spiritual beings trying to become human." Before God brought us forth as fully formed fleshly beings here on this earth, he knew our "unformed substance," as the psalmist describes it in Psalm 139:16.

Then, when Jesus was getting ready to leave his followers, he did not simply leave them with something to study or to think about, but he instituted the embodied practice of foot washing. He gave his disciples a

specific way of ministering to each other in their bodies and remembering his example when he said, "When you forget what you're about here, when you forget how you're supposed to be relating to each other, remember this foot washing. Remember that I, your teacher, got down on the floor and washed your feet. Remember that this is who you are" (paraphrasing John 13:12–15). Jesus did not merely leave his disciples with a theological thought to think. He left them with a physical, embodied act to remind them who they were to each other and who he was to them.

That same night Jesus introduced what would become the central sacrament of the Christian faith: the eucharistic bread and wine, symbolizing flesh and blood. This is the ritual and substance around which all Christians gather. In the most climactic moment of the worship service, the body—in all its beauty and its earthiness, its messiness and its vulnerability—is held high. "The gifts of God for the people of God!" the minister proclaims. And what are those gifts? Flesh and blood. In the highest moment of our life together as the people of God, our bodies are affirmed. Every time this happens it is Jesus's flesh and blood, and it is flesh and blood itself that is elevated.

And of course now that Jesus is no longer physically present with us, our bodies are temples of the Holy Spirit (1 Corinthians 6:19). How wonderful to know that when we don't have a physical temple to go to we can turn inward and meet God right in our bodies. And amazingly enough, our bodies know how to pray. If you pay attention, you might notice that your body wants to dance or sway just a little. If you were to listen to your body, you might want to kneel or lie prostrate on the floor before God. You might want to raise your hands or simply open them on your lap. If you listen to your body, your body can tell you how to pray, because that's what it was created for.

Second Corinthians 4 tells us that whatever ministry we have been given—including the ministry of the gospel—is carried in our bodies. Once your body goes away, your ministry cannot go on as it is right now. There will be other things God has for our resurrected bodies, but this is a unique moment when we get to be on *this* planet, in *this* physical body, carrying the ministry that God has given to us. And beyond our individual bodies, the church itself is the body of Christ (cf. Romans 12:4–5; 1 Corinthians 12:12–27)! When inspiring the writers of Scripture, the Holy Spirit could have used any metaphor to describe the presence of Christ on the earth today. How interesting that he chose to use this picture of a physical body.

A major biblical teaching about the body of Christ emerges from this metaphor. No matter how we feel about the church on any given day, no matter what conflicts are taking place among us, no matter if the church is a wreck and a mess—this is how Jesus has chosen to be present here. In the words of a poem attributed to Teresa of Avila, "Christ has no body now on earth but yours. No hands but yours, no feet but yours. Yours are the eyes through which compassion is to look out to the world. Yours are the feet with which Christ is to go about doing good. Yours are the hands with which Christ is to bless all people."

Then finally, we consider the resurrection of the body. Scripture tells us that we will spend eternity not as disembodied spirits, but as glorious embodied beings (cf. 1 Corinthians 15:35–44). While we do not know everything about what that's going to look like or how its going to happen, what we do know is that God does not give up on bodies. He's going to resurrect our bodies in the last day. And until then, every day—*this very day*—we have the opportunity to offer ourselves to God as living sacrifices, to offer ourselves to God in our bodies as a living sacrifice, holy and acceptable, which is our spiritual worship (Romans 12:1).

Today I can crawl up to the altar and surrender myself to God through concrete practices that take place in my body. I might not be in a church, but I can be worshiping right now by choosing to surrender myself to God in my body. These are beautiful and compelling truths that inspire us to wonder how worship ever got so disconnected from our everyday existence as bodies.

Practices for Honoring Bodies—Ours and Others'

The next question, then, is how do we open ourselves to experiencing the goodness of life in our body? How do we honor the spiritual significance of life in our bodies and the embodied lives of others as we care for them? Can we approach bodies with reverence, even when they're broken? Even when they're ill? Even when they're facing their death because of terminal illness?

Even in these circumstances, bodies are still the beautiful temples God has chosen to inhabit, to enliven, and then to take when it is the time for that person to move to another state of being in God. David Benner makes the point that authentic spirituality must ground us in the God-ordained reality of our lives, including our gender, race, sexuality, and unique experiences in our bodies. Authentic spirituality must be lived in those realities, grounded in those realities; otherwise, it is not authentic

at all.[5] What practices ground us in the God-ordained realities of our lives and help us open up to life in our bodies as a gift from God? How can we honor our bodies and other people's bodies as we are together?

Attentiveness and Breathing. You can start very simply by paying attention and noticing how things feel in your body. Notice how a warm bath feels. Notice the joy that comes from being physically active. Notice the difference between being hydrated and dehydrated. Be more attentive to different aspects of life in the body, and experience each sensation as the gift it is. Think about how you feel when you give someone a gift—a sweater, or a scarf, or a book you think they may enjoy. The next time you see them, you can't wait to see how they're wearing the sweater or the scarf. Or you can't want to hear them say, "I started that book you gave me, and it's fantastic!" Don't you think that may be how God feels about our bodies? He says, "I've given you this gift! I want to see you use it and enjoy it. There is nothing that gives me more joy than to see you enjoy the gift I've given you—the gift of life in your body."

Pay attention to your breathing. Breathing is one of the simplest ways of getting in touch God's gift of life in your body. The practice of paying attention to your breath is not an eastern practice; it comes right out of Genesis. God breathed life into the first human (Genesis 2:7), and God continues to give us our breath each and every minute. With each breath, God is affirming our lives. And there are many other beautiful gifts God give us through our breathing. Breathing can help calm us in times of stress—think of the breathing techniques a woman uses when giving birth. Did you know that when you are stressed, often you are breathing shallowly rather than breathing all the way into the bottom of your diaphragm? So even simply taking a moment to stop and breathe deeply can help you to slow down and get in touch with the Spirit of God deep within.

In his book *Into the Silent Land*, Martin Laird suggests that shallow, short breathing often indicates resistance to deep, ungrasping stillness. Those who refuse to enter into non-grasping stillness are often the people who breathe shallowly because they are resisting an open, receptive posture before the Lord.[6] Breathing can help us sit silently, openly, and receptively before God. So pay attention to life in your body, and start

[5] David Benner, *Soulful Spirituality: Becoming Deeply Alive and Fully Human* (Grand Rapids: Brazos Press, 2011), 9–10.

[6] Martin Laird, *Into the Silent Land* (New York: Oxford University Press, 2006), 42.

paying attention to things you've never noticed before.

Embracing Fundamental Experiences of Life in a Body. Paying attention also involves embracing the fundamental experiences of life in the body. To draw again from Benner, authentic spirituality must ground us in the God-ordained realities of our lives.[7] That includes gender and sexuality, but this is a hard place of integration for many of us. The appreciation of life in the body includes embracing maleness and femaleness as well as embracing our sexuality, which is also a gift from God. None of us exists in this world apart from being gendered. In fact, male and female is the most complete way God has revealed the diversity of God's self. One gender or the other could never fully represent who God is.

Another way we experience dualism is when we separate our spirituality from our sexuality. Such dualism cuts us off from knowing and experiencing God as one in whom there resides a powerful longing for union. Did you know that the reason we as human beings are driven to union is because God is seeking union and oneness with us? That longing for communion and union that sometimes feels so out of control is part of being created in God's image. Our spirituality is all about union and communion with God; our sexuality is all about union and communion with other people. In this way, sexuality and spirituality are tightly aligned within the human person, so ignoring our sexuality cuts us off from knowing important things about God, not to mention ourselves. When we fully comprehend that our sexuality represents something important about God that God has built into us, then we can actually embrace the powerful drives within us as a created good and bring this essential part of ourselves openly into our relationship with God. As we awaken fully to the spiritual, social, and sexual dimensions of ourselves in God's presence, we find that they are inseparably intertwined.

Race is also a very challenging experience in the body. To fully face whatever the experience of race has been for us—especially when that experience has included discrimination, oppression, and violence—and to open that up in God's presence is difficult. And yet God wants to meet us there. At some point we must seek redemption for this aspect of our bodily experiences as well, moving beyond the sin of racism that is so embedded in our world to internalize the fact that our existence in different races is also an expression of God's creativity. As something God built right into his creation of humanity, diversity is something to

[7] Benner, *Soulful Spirituality*, 9–10.

embrace as another aspect of the gift of life in a body, integrating this aspect of ourselves into our celebration of life in our bodies.

Physical challenges, including moments when we feel our body is betraying us—being born with a physical challenge of some sort, infertility, life-and-death battles with cancers and other serious and life-threatening illnesses—bring us face to face with a different set of questions. Can I find God here? How do I pray in this set of circumstances? Can I open this experience up to God and fight or rage with God? How do I make meaning of this? How do I experience God with me and for me in all this rather than feeling abandoned? All sorts of questions present themselves as we stay grounded in the true and fundamental experiences of whatever life in our body involves at a given time. To remain committed to the spiritual journey is to stay present to all of it in God's presence.

Caring for the Body. There is a very real connection between caring for the body and our ability to continue deepening our relationship with God and carrying out God's purposes for our lives over the long haul. To work our way into a more active and healthier lifestyle can be our answer to Jesus's question in John 5:6, "Do you want to be made well?" Moving far beyond our culture's focus on sex appeal, we can embrace a deep desire to live our lives well in God, to be the best body we can be in loving response to the One who created us. *That* is the motivation that will sustain us for the long haul. And we may discover that one of God's great gifts to us in the body is that exercise releases endorphins that are soothing to our emotions and ease pain and elevate our moods. Amazing!

There are so many ways of caring for our bodies that can become spiritual practices if we know to approach them that way: fueling our bodies with nutritious food, hydrating by drinking enough water, exercising, getting regular physicals and medical procedures, receiving a massage to bring relief to the tight sore places, focusing on breathing, and stretching our bodies through a good yoga practice. Really any kind of body work that helps us be attentive to our bodies and helps relieve stress and tension in our bodies can become a spiritual practice.

Other aspects of care for the body include paying attention to rest—getting enough sleep, practicing a weekly Sabbath, perhaps a quarterly retreat where we step back from all our cares, concerns, and work and give God the chance to minister to us. In these ways we live within the limits of life in the body, which is in itself glorifying to God. A good mantra for all of this might be "work hard, play hard, and rest well."

Living Sensually. And don't forget to enjoy life in your body, to live

sensually. We often think of sensuality and sexuality as being interchangeable words, but they are not. Sensuality has to do with our senses, and we can be intentional about incorporating into our lives an appreciation of all our senses. Make sure you really see and take in the beauty around you. Listen for and really hear beautiful sounds. (It might help to take your ear buds out!) Enjoy physical touch and sensation. That does not have to be sexual; a loving hug from a friend can be a sensual experience. Taking a hot shower and letting the water run over your body can be a sensual experience. Lying in bed and feeling how good it is to go prone after a long day and feeling the weight of the blankets around you is a sensual experience. And it goes without saying that love-making with the person to whom you are committed is also a sensual experience to be fully received and enjoyed when that is what God is giving you.

At mealtime, chew your food slowly and really taste it. Savor glass of wine (if that is something you enjoy) and linger, rather than rushing through every meal. Pay attention to scents. Our sense of smell is the strongest sense we have, so notice how different smells can actually shift your mood, bringing peace and a sense of physical well-being. Aromatherapy has emerged from the understanding that the right smells can actually be therapeutic and healing.

Listening in the Body. Our bodies have so much to tell us if we could only learn how to listen. Our bodies are the first to know that we are overcommitted, stressed, uneasy, or joyless. When we are able to attend to something that causes us pain or dis-ease in the body, we are alerted to the fact that something in our lives and needs our attention.

In her book *Confessions of a Beginning Theologian*, Elouise Renich Fraser writes about the significant role that listening to her body has played in her personal and theological journey.

> My body, once ignored and despised, has become an ally in the reorientation of my internal and external life. It lets me know when I'm running away, avoiding yet another of God's invitations to look into my past and the way it binds me as a theologian. I can't trust my mind as often as I trust my body. My mind tries to talk me into business as usual, but my body isn't fooled. Insomnia, intestinal pain and diarrhea, let me know that there's work to be done.[8]

[8] Elouise Renich Fraser, *Confessions of a Beginning Theologian* (Downers Grove, IL: InterVarsity Press, 1998), 31.

Learning to listen to our bodies can open windows of insight that might otherwise be closed to us. A flow of energy into us, a sense of energy draining from us, can be felt in the body. Discerning what is life-giving and what is life-draining is an in-the-body experience (Deuteronomy 30).

David Whyte, one of my favorite poets, writes, "What is precious inside us does not care to be known by the mind in ways that diminish its presence."[9] So often our mind dismisses what the body knows. There are things the mind does not want us to know, but our body knows and brings these to our awareness. There is a technique called focusing[10] or bio-spiritual focusing[11] that helps us notice, care for, and welcome the body's "felt sense" that something is not quite right, creating space for it to speak to us. That can be a powerful exercise that helps us pay attention to the wisdom the body has to offer us.

Praying in the Body. We often think of prayer an an activity that engages us primarily on a soul level. But since we know that the body is a temple of the Holy Spirit, we can intentionally cultivate a prayer life that incorporates the body. Human desire for God is experienced in the flesh as a visceral longing, and prayer is our response. Intimacy happens as we bring more and more of ourselves into God's presence. To pray with body and soul means to pray with all of who we are, our physicality, emotion, intuition, imagination, mind, and all of our bodily experiences. Therefore, when we pray with body and soul, or love with body and soul, or belong with body and soul, we are believing, responding, and surrendering with all of who we are.[12]

Here is a simple practice you can incorporate easily right now: pay attention to your posture as you pray. Settle into a relaxed and comfortable position with your back straight and feet on the floor. Feel the chair supporting your body. Breathe deeply as a way of releasing tension. Open your hands in your lap as a way of saying, "God, I'm letting go of whatever I usually cling to, and I'm ready to receive whatever you want to give me." The opening of my hands has become my favorite prayer

[9] David Whyte, "The Winter of Listening," in *The House of Belonging* (Langley, WA: Many Rivers Press, 1997), 29.

[10] Eugene Gendlin, *Focusing*, 2nd ed. (New York: Bantam Books, 1981).

[11] Peter Campbell and Edwin McMahon, *Bio-Spirituality: Focusing as a Way to Grow*, 2nd ed. (Chicago: Loyola Press, 1997).

[12] Jane Vennard, *Praying with Body and Soul: A Way to Intimacy with God* (Minneapolis: Augsburg Press, 1998), 5.

posture—so much so that I now assume this posture without even thinking. If I am really praying my hands are usually open as a way of saying to God *in my body* that I am letting go of what I usually cling to and that I'm open to receiving what God wants to give rather than trying to push-and-pull with my own agenda.

So stop reading and try that for a minute. Set aside what you are reading and just open your hands. See what difference that makes? It feels good and right to find a way to open to God that is beyond words.

There are so many ways to honor God and open to God in our bodies. I pray you will find them all. God created us for wholeness. When aspects of our selves that were always meant to exist together are integrated or re-integrated, the result is a spontaneous combustion of joy and vitality that goes far beyond the physical dimension. It is a spiritual vitality that speaks volumes about the abundance of our life in Christ—which is exactly what Jesus came to bring.

"The glory of God is humans fully alive!" (St. Irenaeus).

Care with Persons Both Healthy and Unhealthy

Michael Washington, staff chaplain and clinical pastoral educator, Northwestern Memorial Hospital, Chicago, Illinois

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.

ALIVE! Five African American Churches and a Medical Institution Join Together to Prevent Premature Deaths

Francine T. White, co-investigator for the ALIVE! project, staff minister emerita, Third Baptist Church of Chicago

Premature death refers to an individual's dying prior to reaching eighty years of life. It has been well documented that many premature deaths in the United States are caused by poor diet and lack of exercise,[1] two factors that have a major impact on many potentially debilitating chronic illnesses—illnesses that disproportionately impact African American communities. For example, while African Americans make up 12.7 percent of the total US population and non-Hispanic European Americans 61.5 percent,[2] African Americans ages 18–42 are twice as likely to die from heart disease as their European American peers; African American ages 35–64 are 50 percent more likely to have hypertension than European Americans in the same age range.

Behavioral recommendations to combat premature death usually address exercise, suggesting 10,000 steps or 150 minutes of physical

[1] The top two causes of premature death in the United States in 2010 were poor diet and lack of exercise (18 percent) and tobacco use (15 percent). See graph, drawn from J. Michael McGinnis, "Actual Causes of Death, 1990–2010," Workshop on Determinants of Premature Mortality, September 18, 2013, National Research Council, Washington, D.C., published in Mark Mather and Paola Scommegna, "Up to Half of U.S. Premature Deaths Are Preventable; Behavioral Factors Key," Population Reference Bureau, September 14, 2015. Available at http://www.prb.org/Publications/Articles/2015/us-premature-deaths.aspx.

[2] According to 2017 results of the American Community Survey. Accessed through the U.S. Census Bureau's American Fact Finder site, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_DP05&src=pt.

activity each week. Dietary recommendations advise a reduction in the intake of salt, processed sugar, and total saturated fats and an increased intake of fresh fruits and green leafy, orange, red, and yellow vegetables. Reasons for poor diet vary. For poor people of all racial and ethnic groups, food deserts and lack of financial resources often lead to high carbohydrate, low protein diets with few green leafy and red, orange, and yellow vegetables. Culture and tradition also influence diet. It is not unusual, for example, for some African American communities to have menus high in carbohydrates, fried chicken and fish, and overcooked leafy vegetables that are depleted of needed vitamins and minerals. Foods rich in carbohydrates such as macaroni and cheese and candied yams can also present nutritional challenges.

In the fall of 2014, a team from Rush University Medical Center's Department of Preventive Medicine and pastors of five African American churches in the Chicago metropolitan area joined forces to launch an initiative called ALIVE! (Abundant Living in Vibrant Energy) to support congregational members in developing improved health behaviors to minimize health risks caused by poor diet and lack of exercise that could lead to premature death. This article describes the development and implementation of that initiative. It narrates the genesis of the ALIVE! initiative, beginning with its precursor Sabbath in Community and culminating in an ambitious congregational project, using a community-based participatory research (CBPR) approach. After detailing the church- and individual-level intervention components of the research design, I conclude with an overview of the outcomes. One of the key findings of this study is that use of a CBPR approach of church involvement as well as the integration of Bible study with nutrition education contributed significantly to the success of the initiative.

The Genesis of the ALIVE! Initiative

In 2011, the staff of the Department of Preventive Medicine (DPM) at Rush University Medical Center (RUMC) was seeking a path of outreach for teaching communities how to minimize the ramifications of certain chronic illnesses. On October 6, 2011, RUMC's Department of Community Affairs, in cooperation with the DPM, held a forum for faith community leaders, "Care of the Flock: Teaching and Preaching for Better Health Behaviors." Participants included clergy, rabbis, imams, lay ministers, chaplains, and pastoral counselors. The forum was designed to improve faith leaders' understanding of health disparities and the negative

impact of unhealthy habits on the physical, spiritual, psychological, and social well-being of their parishioners.

At the end of the session, Alan V. Ragland, senior pastor of Third Baptist Church of Chicago, expressed to Elizabeth Lynch, associate professor of Preventive Medicine at RUMC, how much he appreciated the forum. Ragland shared his observation that too many pastors have a poor grasp on their own health needs and the potential dangers of neglecting healthy eating habits, exercise, and rest. He suggested that before faith community leaders could begin preaching to others about improving health behaviors, they needed help understanding what behaviors they needed to adopt for their own optimal health and decreased stress. Evaluations from other participants echoed the desire for more education focused on clergy self-care. This request began an exciting and challenging journey for the forum's executive team who partnered with a group of pastors for an initiative focused on improving clergy health behaviors: Sabbath in Community.

The Sabbath in Community initiative involved twelve Christian clergy in a nine-month program focused on four health concerns: (1) spiritual disciplines, (2) nutrition, (3) physical activity, and (4) stress management. Pastors are often insensitive to their own need for self-care—a neglect that puts them at high risk for obesity, cardiac issues, hypertension, increased stress, depression, and burnout, all of which can shorten life span. Self-care in body, mind, and spirit must be stressed; amid the busyness of shepherding congregations, pastors often fail to appreciate that even Jesus took time for deliberate solitude and time alone in prayer (Mark 1:35).

The Sabbath in Community programming began with a retreat in January 2012 to facilitate bonding among participating clergy. The gathering began with a devotional and a guest plenary speaker who, through examples and open discussion, helped participants explore their relationships with God, self, and others in deep and meaningful ways. Through discussion and reflection, this plenary session opened a level of vulnerability and common ground that the clergy welcomed. The recognition of their common work and shared experiences of internal spiritual and emotional dryness allowed them to quickly engage each other in spiritual transformation that awakened them to new possibilities of spiritual praxis, not only for themselves but for their families and their congregations.

The remainder of the program consisted of the twelve pastors and the program executive team meeting together for two-and-a-half-hour sessions. The group met twice monthly for the first two months, followed

by monthly meetings over the next seven months. Meetings opened with Scripture reading and group reflection regarding how participants were applying what they had learned in the previous sessions. This was a very rich component of our time together, as the clergy shared from their deep faith about the benefits they were experiencing as they practiced new health behaviors.

These sessions gave clergy participants space to truly internalize Scripture, using the text as a vehicle for reflection on their own needs. This was a shift for many whose reflection on Scripture for the purposes of teaching and preaching was commonly focused on the external needs of their congregations or communities. During the sessions, participants often used Scripture as a lead-in to conversations about self-care and God's Spirit at work in them. The communal reflection allowed the clergy to internalize Scripture in ways they had not done consciously in a long time. The use of Scripture in this setting brought energy, truth, new insights, and revelations to those gathered. They began to appreciate their right to Sabbath time and made new commitments for self-care as a result of these insights.

Each session also included group practice of mindfulness meditations and low-impact exercises. Participants were encouraged to set a goal of reaching 10,000 steps a week. Dietary lessons focused on eating three (primarily) low-carbohydrate vegetables each day. This was reinforced by our evening meals together, which consisted of recipes participants could use to prepare different kinds of vegetables. Non-invasive data (height and weight, blood pressure readings, and waist measurements) were recorded periodically. Questionnaires regarding food preparation and exercise and twenty-four-hour food logs were also used. An executive team member took general notes on key points of group discussion, being careful not to breach confidentiality. Participants were paired to provide mutual support and encouragement to one another. A list of participants' favorite Scripture verses and spiritual sayings was compiled and distributed.

By the end of the twelve sessions, participants had formed open and honest friendships. They had permitted themselves to take a day off, to play golf or partake in other non-ministry activities. This time away helped them appreciate themselves as whole beings, needing time for relaxation and hobbies that fed body, mind, and spirit. Some participants lost weight and reduced the amount of processed carbohydrates and fried foods they had been eating on a regular basis. No one gained

weight. Several of the clergy were able to reduce their cholesterol medications, and laboratory results showed decreased A1C levels for those with type 2 diabetes. The program impacted the pastors' congregations as well, as hospitality ministries implemented their pastors' suggestion that churchwide events include more vegetables and serve broiled or baked meats rather than fried. Overall, the clergy made great strides toward the important truth Kirk Byron Jones expresses: "I am no less precious to God than the work I do or the people I serve."[3]

Concerned that the pastors might not be able to sustain their newfound healthy behaviors, the executive team suggested they invite two partners from their leadership teams to encourage their perseverance in healthy eating and exercise behaviors. As a result of this suggestion, the ALIVE! initiative was conceived.

At the end of Sabbath in Community, five of the clergy participants, who pastored African American congregations, invited the RUMC executive team to bring a healthy behavior awareness program to their congregations. The executive team saw this as an excellent opportunity. It would allow congregants to not only support their pastors' healthy behaviors but also to learn spiritual and practical behaviors that would support their own health. The agreement between RUMC researchers and these five African American pastors was especially significant because of the disparities between African American and European American health outcomes described above. In light of these striking disparities, this partnership provided an opportunity to learn what would reduce the exacerbation of chronic illnesses and support healthy behaviors, thereby reducing disparities and preventing premature deaths.

The pastors' partnership enabled the researchers on the executive team to gather data on the impact of improved healthy behaviors in the categories of diet and physical activity—i.e., the two categories highlighted by research over the last twenty years as leading causes of premature deaths in the United States. The working hypothesis was that increasing vegetable intake to three cups per day would result in improvements in the specific health issues that plague African American communities. The issues that contribute especially to health risks are hypertension, diabetes, kidney disease, high cholesterol levels, and obesity. Accompanying behaviors to

[3] Kirk Byron Jones, *Rest in the Storm: Self-Care Strategies for Clergy and Other Caregivers* (Valley Forge, PA: Judson Press, 2001), xii.

boost the nutrients and fiber in the vegetables included walking 10,000 steps per week to reduce toxins in the body, and drinking eight to ten glasses of water per day (unless otherwise directed by the attending physician) to promote the flushing of toxins out of the body. Improvements were measured through changes in medication (dosage and/or usage), weight, blood pressure, and cholesterol levels. The National Institute of Health provided a three-year grant to the Department of Preventive Health of RUMC to develop and implement a congregational initiative.

The executive team considered faith communities to be critical partners in the development of an initiative to support change for better health behaviors. While researchers and clinical specialists know what behavioral changes must occur to improve health outcomes, it is the people in the faith communities who know the history, cultural norms, weekly activities, and special celebrations of the congregation as well as the best practices, language, and approaches for guiding the concrete implementation of project goals. Moreover, the church provides a community of mutual learning, support, and encouragement as participants practice new behaviors for important health improvements. As the spiritual leader of the congregations, the pastors set the vision through worship themes, sermons, approved Bible studies, and faith-related workshops and also gave input for program activities. For all these reasons, it was clear to the executive team that there must be a collaboration of researchers, medical and behavioral doctors, clergy consultants, and the pastors and a core of leaders from each of the five churches to develop and implement the ALIVE! initiative for the congregations. The decision was made to use a CBPR method, a collaborative approach to research. A CBPR board was formed, comprised of the following essential groups:

- Lay leaders. The congregants chosen by the pastors after completing Sabbath in Community advised the RUMC executive team on meaningful approaches to the participating churches (e.g., common foods in their communities and how to create healthier versions of these recipies).

- CBPR coordinators. Pastors assigned one person in their congregation to oversee the activities of the ALIVE! project. Coordinator responsibilities included scheduling activities and room assignments for small groups and churchwide activities and ensuring that audio-visual equipment was operative for meetings and that materials were distributed to the group

facilitators one week prior to meetings. Coordinators also did any needed trouble-shooting for program arrangements and staffing of meetings.

• CBPR facilitators. Persons in the congregation presented the materials provided by the executive team for Bible studies and the nutrition and exercise components of the project.[4] The facilitators were trained in small group facilitation and followed up with absent members to support and encourage them. Facilitators were also responsible for completing fidelity forms for each session to ensure consistency of presented materials across the five churches.

• Field workers. With approval from the pastors, staff members of RUMC's Department of Preventive Medicine attended worship service, churchwide events, small group question and answer sessions, and Bible studies and conducted group and individual interviews. Their purpose was to see, feel, and appreciate the spirit and culture of the people of the church.

• Executive team. Staff from RUMC's Department of Preventative Medicine used information and suggestions from the above groups of dedicated persons to design the ALIVE! project.

The researches and the CBPR board were equally involved in the development, tools, and approaches to the research process. Without the input from church participants, the researchers would not have understood the nuances of the theology or cultural norms of the faith communities nor what each community valued in its life together as the body of Christ. The unique strengths each member brought to the development sessions were recognized. We did not use formal titles of education or position, reflecting our belief that every person at the meeting had important insights to bring to the design discussions and decisions.[5] The agreed upon program goal was to provide education tools to support participants

[4] In three of the congregations, pastors led the Bible studies.

[5] Nina B. Wallerstein and Bonnie Duran, "Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to Improve Health Equity," *American Journal of Public Health* 100, Suppl 1 (April 2010): S40–S46. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837458/.

in improved dietary and physical exercise habits. All churches involved agreed that the initiative was an important component of achieving social change that would improve health outcomes and lessen health disparities.

This was a massive undertaking, for both the churches and the executive team, but God's Spirit was with us. We decided that we needed God's anointing for the work. A commissioning ceremony was held November 15, 2013, for the advisory board, field workers, church coordinators, and small group facilitators, all of whom would go through a similar program that the twelve clergy had experienced. The commissioning also included the researchers from the Department of Preventive Medicine at RUMC; the director from the Department of Religion, Health, and Human Values; the director from the Department of Behavioral Health; the senior pastor of Third Baptist Church of Chicago; and me, his associate pastor of pastoral care and program development. Families of all team members were invited to witness this occasion. (This also began extra church work for them!) It was a holy time, greatly appreciated by all present.

Beginning in January 2014, the full CBPR team met weekly for encouragement, support, and training informed by feedback sessions held in each of the participating congregations. Through question and answer sessions with potential participants, the research team gathered data on eating habits that shaped program design. The training was completed September 2, 2014. The full team met in mid-September to enjoy fellowship, develop a schedule of meetings, establish time-frames for the work, and name the initiative. The name decided was ALIVE!, an acronym for Abundant Living in Vibrant Energy! Our prayer was that we would develop, with God's help, an initiative to give many people a new life of healing and wholeness as they adopted those program components that would help them develop better health behaviors. In mid-September 2014, ALIVE! was launched in the five cooperating churches.

The Intervention Design

One misunderstanding regarding health improvement is that when people know better, they automatically do better. Researchers often grapple with the question, "The people know what they have to do to live healthier; why don't they change their habits and behaviors and live better?" In Paul's epistle to the Romans, he provides a succinct explanation: "I do not understand what I do. For what I want to do, I do not do, but what I hate, I do….For I have the desire to do what is good, but I cannot carry it out. For what I do is not the good I want to do; no,

the evil I do not want to do—this I keep on doing….What a wretched man I am! Who will rescue me from the body of death? Thanks be to God—through Jesus Christ our Lord" (Romans 7:15, 18b–19, 24–25, NIV). Most people do not change their behaviors simply because they know they should. They do need to know that their current behaviors are life-sapping rather than life-giving, but change requires deep-rooted acceptance that they are worth the effort of developing a new mindset and new disciplines that will help them live with more meaning, purpose, energy, and joy. Changing unhealthy habits can be hard, yet change is necessary if one is to stop lifestyle behaviors that lead to premature death and minimize the exacerbation of chronic illnesses.

Church-level intervention. Church-level intervention included the following activities that involved entire congregations:

- Sermons. The pastors addressed health-related topics in their sermons at least once a month. The five pastors discussed the topic for the preaching moment, so that topics and Scriptures were coordinated across the congregations, usually pairing it with the Bible study theme for that month.

- ALIVE! Bible study. A twenty-four-week curriculum used Scripture to emphasize the spiritual importance of taking care of one's physical body and provided spiritual guidance and support for needed behavior changes. The Bible study materials for the participants included reflection questions for individual participant and other questions for group discussion. Field workers took general notes, being careful to guard the confidentiality of class participants.[6]

- Bulletin inserts. Inserts with healthy eating tips, recipes, and announcements for churchwide activities were included in bulletins each month, with more frequent announcements as needed.

- Churchwide healthy eating activities. Activities organized by the church advisory board members were offered to the whole congregation (e.g., a workshop on emotional eating and a veggie smoothie contest).

[6] See pages 67–68 for an outline of the Bible study sessions.

Participants in these activities did not have to sign a participation agreement or complete food logs or have personal data monitored (e.g., blood pressure).

Individual-level intervention. Congregants who volunteered for the individual-level intervention signed a contract to participate in a variety of activities and agree to field workers monitoring specific non-invasive data across the nine-month period (e.g., height, weight, blood pressure, waist measurements).[7] Telephone interviews regarding meal planning and twenty-four-hour logs of all foods eaten with portion sizes were periodically recorded. Small group sessions allowed participants to give feedback to the researchers regarding class content and videos. Participant feedback was invaluable, as it allowed the researchers to modify activities to best suit participant needs and ensure clarity of information communicated. Specific small group activities included but were not limited to the following:

- Nutrition skills. These were presented within small covenant groups and included videos, demonstrations, and open discussions regarding culturally relevant nutrition education, food preparation, and healthy eating skill-building and modeling (e.g., buying, storing, and preparing vegetables). Participants learned to read food labels with increased awareness of the amounts of salt, sugars, and fat often hidden in shelf and refrigerated sections of grocery stores.

- Self-management training sessions. Led by trained facilitators from each congregation, these sessions focused on goal setting, self-monitoring, and problem solving. "B-SMART" (behavioral, specific, measurable, achievable, relevant, time-oriented) goals provided a framework for supporting participants in setting reasonable goals.[8]

- Group support. These sessions gave participants opportunities to share what was working for them and ongoing barriers they experienced to healthy food preparation, exercise, and goal setting. Group members brought recipes, and sometimes dishes, supporting lessons learned in the group setting.

[7] In order to protect confidentiality, participant names were not used in the research data that was gathered.

The executive team developed session materials with input from the advisory board, and uniformity of content was assured through facilitators' completion of fidelity sheets that included checklists of points to be covered in each session. While churches had flexibility in scheduling ALIVE! components, all five churches completed sessions within the same month. At the end of each session, the congregation's coordinator collected fidelity sheets and facilitator summaries and sent the reports to the executive committee for documentation by the analyst or field workers.

The Importance of Bible Study in Changing Behaviors. The pastors of the five churches enrolled in the ALIVE! project all agreed that linking behavioral changes to Scripture would be critical to achieving the hoped-for program outcomes. The Bible study series provided a way of grounding the people of faith in something they could trust. Sessions joined scriptural insights to practical guidelines and resources for healthy behaviors. The series had to be designed with cultural sensitivity. For many, the hardest part of change is getting past personal, familial, and cultural influences that have not served them well. The pastors of the five African American churches for the ALIVE! project along with Alan V. Ragland and Clayton Thomason, chair of RUMC's Department of Religion, Ethics, and Human Values, gave their input and support in the development of a curriculum we hoped would address barriers to the healthy behavior changes.

One core intent of the Bible study series was to strengthen participants' willingness to make positive behavioral changes through scriptural understanding. This included a deeper understanding of who and whose (God) they are; a general understanding of the complexity of the nutritional needs for their bodies, minds, and psycho-social connections to remain healthy as possible; an acceptance of God's constant presence with them to fortify them for the struggles they would experience as they practiced new disciplines; and an awareness of the empowering force of the Holy

[8] "B-SMART" goals focus on a concrete *behavior* to change ("walk one mile per day" rather than "lose weight"), naming *specifically* how the individual will achieve the goal ("I will take the stairs instead of the elevator"). The individual should attach a number to the goal so that it is *measurable* ("I will aim for 10,000 steps"), being sure that the number is *achievable* ("I only took 6,000 last week; better aim for 8,000 this week instead") and the specific behavior is *relevant* to their real life (e.g., it may not be a good goal to forgo the elevator for stairs if your work or home does not have stairs). Finally, goal-setting should be *time-oriented,* setting a specific timeframe for the goal. ("I will achieve 10,000 steps by week twelve.")

Spirit within and available to each of them to help them develop the disciplines needed for behavioral changes.

The Bible studies also allowed participants to confront demoralizing and life-defeating thoughts and feelings that were shame-based, causing low self-esteem, and spirits of anger, rage, and unforgiveness toward self and others. Sessions led participants in developing of a list of biblical texts that brought new positive responses to old, self-defeating memory tapes that kept them bound in unhealthy thinking and actions. The studies fostered in participants the right and will to develop a "can do" commitment to life-giving behaviors and attitudes. They helped participants organize their days and lives in ways that relieved stressors they had control over, and let go of the things over which they had no control, trusting that God was working even when they could not yet see it. Overall, the Bible study lessons sought to bring participants into a closer relationship with God and to help them accept that they were worth the new energy and zest for life behavioral changes would bring.

These themes were emphasized as much as possible in the selected Scriptures for study (see chart below). The format of each Bible study included (1) an introduction to the lesson, (2) the background and historical perspective for the presented Scripture, (3) Scripture elaboration or commentary, and (4) questions for personal reflection and group discussion. Clergy suggested aligning the Bible study series with the liturgical calendar (e.g., the seasons of Advent, Christmas, Epiphany, Lent, and Easter).

Scripture Used for Each Bible Study Session

1 In God's Image and Likeness	Genesis 1:26–2:3, 7
2 The Faithful God of Relationship	Psalm 139:1–18
3 Commitment	Mark 1:29–38
4 Planning and Engagement for Abundant Life in Health	Nehemiah 1:4–2:20
5 Gathering/Feasting/Sharing/Thanksgiving*	Deuteronomy 16:13–17; Acts 2:42–47
6 Hope and Joy/Forgiveness and Reconciliation*	1 Peter 3:10–16; Isaiah 40:28–31
7 Waiting and Anticipation/Love and Peace*	Luke 1:26–56; John 3:15–21

*These lessons were used during the Thanksgiving and Christmas seasons.

8 Listening to the Spirit of Truth Within	John 14:16, 17b; 16:12–15; Mark 5:21–34
9 Faithfulness and the Discipline of Healthy Living	Daniel 1:1–20
10 Led by the Spirit into a Wilderness Place: Sacrifice and Revelation Bring Strength	Matthew 4:1–11
11 Battles and Wrestling and Knowing God's Presence in Sacrifice and Victory	Genesis 32:1–32
12 Rooted and Grounded in Love: Sharing Abundant Life with Others	Ephesians 3:14–21

Final Outcomes and Reflections

A total of 206 members from five African American congregations enrolled in the initiative, and 182 members completed the nine-months. At the nine-month follow-up, the mean number of servings of vegetables participants consumed increased by one. Interestingly, the percentage of increase in vegetable intake was higher in the three churches where the pastor taught the Bible study (52 percent, 55 percent, and 63 percent); in the two churches where an assistant pastor or deacon taught the Bible study, the one serving increase was 39 percent and 33 percent. This reinforced the belief that the active participation of the pastor matters. Weight reductions ranged between three and forty pounds. The weight loss of many participants was evident. Participants reported that their A1Cs, cholesterol levels, and blood pressure readings were lowered. Approximately a quarter of participants were prescribed lower doses of their medications for hypertension, diabetes, and/or cholesterol. One participant gave testimony that she is no longer on medication to lower her cholesterol. Menus for churchwide events included less carbohydrate-heavy dishes and more and varied ways of cooking vegetable dishes as well as baked rather than fried and processed meats. Overall, participants expressed feeling energized and more interested in participation in physical activity since they enrolled in the project.

Several years after the initiative concluded, testimonies continue at Third Baptist Church of Chicago, including experiences of good energy, lowered blood pressure, decreased medications, and weight loss. In 2017 the church's Walking Club set a challenge to see how many collective miles they could walk between June 26 and August 27. Just over 150 people participated. The combined result was 37,564,503 steps, equaling

18,782.2 miles. Together this group of determined "ALIVE! steppers" walked three-quarters of earth's circumference—an accomplishment to be celebrated! The majority of walkers with hypertension noted a decrease in their blood pressure, and those with diabetes reported reductions in their daily blood sugar readings. Participants continued to incorporate more vegetables into their diets and drank more water than before they joined the ALIVE! initiative.

The success of the ALIVE! is likely due to a number of factors. (1) The study was conceived, designed, and conducted by a partnership of researchers, pastors, and church leaders; (2) the intervention incorporated pre-existing spiritual values and coping strategies (e.g., prayer and Bible studies) and was delivered in a format that was consistent with church culture; and (3) nutrition education content was culturally tailored based on pre-existing studies of conceptual frameworks around diet and health.[9]

Health disparities are significantly higher for the African American community than other racial and ethnic group in the United States, including higher rates of diabetes, hypertension, coronary, heart, and circulatory diseases. Yet many communities experience barriers to healthy behaviors, whether caused by cultural diet norms or by social, economic, or environmental stressors. Moreover, people of all races and cultures often do not know what concrete behavioral changes they can make to minimize the long-term, debilitating effects of these diseases. Through culturally appropriate education such communities can break free from the negative impact of illnesses that have permeated their families for generations.

While the ALIVE! initiative was developed specially for the African American community, the CBPR approach can be used for any cultural or ethnic group. Collaboration with members of the participating community provides invaluable input, ensuring program design and content delivery that draws on cultural strengths and values. The CBPR approach celebrates the uniqueness of the community and upholds what is life-giving and sacred to that community. This approach gives participants greater confidence that their family structures, social customs, and cultural norms will be carefully considered in any recommended behavior modifications.

[9] Lynch, "Results of ALIVE," 8. For more in-depth information on the ALIVE! Project go to the website for a plethora of additional information and resources, www.thealiveproject.org.

The church can be an essential partner in this work. As a safe haven for healing and wholeness, the church can equip its members to grow in their trust of God's healing grace and his power to bring wholeness where there has been brokenness. Church communities celebrate times of triumph and hold close those who are experiencing life's trials. They affirm each person's value as a human being made in the image and likeness of God. Congregations can also offer strength for the journey of life by encouraging improved self-care for each of their members—body, mind, and spirit—as the temple of God's Spirit.

"Do not be conformed to this world but be transformed by the renewing of your minds, so that you may discern what is the will of God—what is the good and acceptable and perfect will of God" (Romans 12:2).

Pastoral Reflections on Being Well: Connecting Church, Faith, and Health

Eric Hillabrant, staff chaplain,
Swedish Covenant Hospital, Chicago, Illinois

In the church I attended while growing up, there was a man named Louie,[1] who had lost his hearing early in life. Perhaps he was born with no sense of hearing, or perhaps an illness took his hearing when he was very young. Whatever the cause, Louie was deaf for all or most of his life, and that hearing loss had significantly impaired his ability to form words in understandable ways. He was always friendly and pleasant, and he would engage anyone in conversation, but whomever he spoke with had great difficulty making out what he was saying. With his hearing and ability to speak impaired, Louie was a vulnerable person who found safety and support through steady work in the community and his association with the Covenant church.

Louie faithfully served the church for years. Every Sunday morning his big Plymouth station wagon served as a bus that brought children to Sunday school from many of the outlying neighborhoods in the area. He was the head usher, putting in many hours to make sure the sanctuary was neat and ready for services. Louie was an integral part of the congregation.

Over the years, Louie's family members died and moved away, and eventually the congregation became his immediate family. As he aged and entered retirement, the congregation supported him in some significant ways. Difficulties began to be revealed. Concerns were discreetly expressed to the church leadership about problems with Louie's finances. Several congregational leaders sat down with Louie and explained the concerns, and, after thinking it over, he agreed to allow them to help him manage

[1] The person's name has been changed for privacy.

his money. Within several years he had saved enough to buy a newer used car. It was a proud day. I have seen pictures of the day he received the keys to his new car at the auto dealership. I am pretty sure there are also pictures of the day he received the title from the bank. Another proud day. The support and guidance Louie received helped him to live well in his final years, consulting his supporters about managing his own affairs, doing the things he enjoyed, serving the church, and even reconnecting with family.

Louie continued to face challenges that come with aging. Eventually, after consulting with his support system at the church, he made the decision to move into a senior apartment. Then came the difficult decision to stop driving. He grieved losing his independence, even if it was only a daily drive to a local restaurant for a cup of coffee. Finally, Louie moved to a nursing home. There he received regular visits from the church community and continued to consult his supporters about health issues and decisions for care. When Louie died, the congregation celebrated his life with a memorial service, and he is buried in the cemetery just south of the church building.

I tell Louie's story because it speaks about the unique way a congregation (or individuals within a congregation) discovers opportunities to care for a person's "health." The door opened for the congregation to support Louie's health when his financial health destabilized. Direct involvement in his medical care came years later. The gradual transition from financial help to supporting Louie as he died included decisions about cars and trips, hearing aids and dentures, minor surgeries and living arrangements, and which doctors to consult and treatments to receive. The list of the decisions involved was extensive, and the congregation's investment in Louie's care was literally lifelong.

Not every opportunity to provide support for a person's health will be as holistic as that congregation's call to care for Louie. In my experience, caring for people's health, both as the pastor of three Covenant congregations for more than eighteen years and for just over three years as a chaplain at Swedish Covenant Hospital, have been some of the most powerful and fulfilling moments in my years of ministry. The opportunity to reflect on those experiences, the scriptural models that inform them, and some of the tools used in them, was one of the gifts I received at the Being Well symposium.

As a parish pastor, it has always seemed natural to me to be involved with congregants as they maintained their health or were impacted by

injuries, acute illnesses, chronic conditions, and the effects of aging. I often helped congregants navigate the healthcare system. In traditional congregational settings, members of the congregation are often in supporting roles when it comes to healthcare, providing prayer, encouraging cards and phone calls, and maybe a visit or two. It tends to be the pastor who provides spiritual support in the more intense moments related to medical procedures and crises. To move congregations toward a more active engagement with people's health requires an imaginative leap from the somewhat passive congregational stance that leaves the more demanding situations to the professional clergy. Taking that leap into health ministry can be a challenge to the traditional roles of layperson and pastor, pushing congregants out of their comfort zones into more direct contact with the tremendous physical, emotional, and spiritual needs many people have.

In these reflections, I will focus on three areas that impact how individual people and local congregations enter, grow, and experience God in health ministries. The first area is the ability to discern our motives as we enter health ministries. The second is the potential for raising up compassionately energized lay people through the experience of health ministry. The final area is the genuine experience of God's grace that can surprise us as we care for people with health needs.

Our Motives: The Good Samaritan

Perhaps not surprisingly, the parable of the Good Samaritan (Luke 10:30–37) was the Scripture most often used throughout the symposium to reflect on how church, faith, and health connect in ministries of all types. The parable gives a compelling picture of the call to compassionate ministry to people who suffer. I begin my reflections by remembering that story, not primarily the parable itself but the larger narrative context in which Jesus tells it. The parable flows very naturally from a conversation Jesus was having with a lawyer who wanted to know what he had to do to inherit eternal life. Curious to know how the lawyer would describe his progress to that point, Jesus asks, "What is written in the law? What do you read there?" The lawyer then quotes from passages Jesus himself turns to when asked to distill the law into its simplest and most potent components (cf. Matthew 22:36–38; Mark 12:29–31): "You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself," says the lawyer. Jesus encourages him, "You have given the right answer;

do this, and you will live." Then comes a twist. Luke gives a brief comment on the lawyer's inner motivation: "But wanting to justify himself…." In this brief moment, we learn that the lawyer is using his ability to keep the law as a prop for his own self-worth. The lawyer asks, "But who is my neighbor?" The implied question is, "How far will I really have to go to satisfy my own need to feel as though I have accomplished the law's demands?" That is Jesus's cue to tell the parable.

As much as we use the Good Samaritan parable to prompt ourselves to compassionate action, we may also want to use it to examine conflicts within ourselves as we minister to our neighbors. During this symposium, I found opportunities to reflect on my own experience of leading a congregation as we offered health fairs to our community. In 2009, I was serving a small congregation in a first-tier suburb of Chicago. With the help of an energized and committed intern from North Park Theological Seminary, our congregation organized two health fairs for our community.

The first took place in the late winter of 2009. It was a broad experiment that tried to offer as many resources as possible to the community. We partnered with agencies that brought everything from a full portable dentist's office to breast cancer screening to information on juvenile diabetes. The local hospital offered cholesterol and blood pressure screenings, and our kitchen crew prepared heart-healthy food samples. We passed out copies of the recipes so people could prepare the dishes at home. We turned the sanctuary into a meditative space for prayer and prompted reflection by projecting images of Jesus that reflected many different cultures. The health fair was well received by both the congregation and the community.

The second fair took place in the late summer of the same year. We decided to focus on health screenings for school children. Many of the same organizations and agencies came and offered screenings and information, and a foundation provided free backpacks and school supplies for students. Again we experienced a positive reception from both the congregation and the wider community.

As the parable of the Good Samaritan was referred to time and time again during the symposium, I reflected on those health fairs. On one hand, they were very positive experiences. New people came through our doors. We shared food and fellowship with those who had never before been in the church building. They received health screenings, teeth cleanings, and information on staying healthy. Some prayed in the sanctuary, even asking church members to pray for them. Those days

were fulfilling, and good ministry happened. And yet, we never offered another health fair after the fall of 2009. That type of ministry event did not seem to catch on with our membership or leadership. It left me wondering what had happened.

Perhaps we had mixed motives. Our congregation was small, and like any small congregation we were concerned about our future. I think, ultimately, we probably did have some confusion about why we were engaging in health ministry. The unspoken questions might have included, “How much will this cost?” or, “How will this help us grow our congregation?” or, “Will this benefit our strained budget?” All of those questions are natural. As I look back on our experience, I see how we could have addressed those unspoken concerns more openly as we began to work on our health fairs. If we had questioned our motives, if we had been honest about our need to set self-interest aside for the sake of the ministry, would things have turned out differently? Perhaps not, but after this symposium I am certainly challenged by the missed opportunity to help my congregation recognize the impulse toward self-centeredness and to encourage them to walk with Jesus in the experience of self-emptying that is his incarnational love for the world.

Compassion and Energy: Health Ministry and the Layperson

The Being Well symposium brought back memories of many of the lay people who worked on our congregation’s health fairs in 2009. Amelia[2] embodies the blessings we experienced. Amelia lived in difficult circumstances. She was on public aid and receiving housing subsidies, and like many “working poor” she spent long hours on public transportation and worked hard to just keep her and her special needs teenage son housed and fed. Often she would come to church exhausted, but she found the energy to participate in our worship life and adult formation activities.

When we began to plan the first health fair, we encouraged all our congregants to be present for the day. Amelia worried about her role in caring for the neighbors. “What will I do?” she would ask. “I *cannot* cook,” she declared bluntly. We encouraged her to be a greeter at the church entrance, citing her gift for conversation. She had an outgoing personality, a curious mind, and a genuine desire to engage people. “You will do great welcoming people at the door,” we said. “Find out if the people are interested in something specific and direct them to that.” So,

[2] The person’s name has been changed for privacy.

even though she was uncertain about her role and her abilities, Amelia became the greeter.

About halfway through the day I went to the church entrance to see how Amelia was doing. As I climbed the stairs from the church basement, I could hear her talking with people in Spanish. She finished directing a Latino family downstairs to the health resources and screenings, turned to me and exclaimed, "I am having a great time! I was a Spanish major in college, and I always thought it was a waste of time. But here I am using my Spanish!" Amelia was one of the few people in the congregation who spoke Spanish fluently, and she spent the day using her gifts to serve the neighborhood and the congregation. She discovered her place in the body of Christ and was energized by the act of serving. Amelia's life continued to be difficult, and an undiagnosed heart condition took her life suddenly several years later. The congregation surrounded her son and daughter with compassion and celebrated her life and faith. In the sermon I preached for her memorial service, I told this story of her joyful discovery of compassionate service.

Moments of Grace: The Improvisation of Providing Care

The psychiatry unit at Swedish Covenant Hospital in Chicago, where I am a chaplain, can be a challenging setting for ministry. Serving patients who are experiencing severe psychiatric symptoms is unpredictable and at times intimidating. When Scott Stoner[3] mentioned improvisation as a valuable tool for ministry, my thoughts went immediately to encounters I have had with psychiatric patients.

In improvisational work for comedy or theater, the "yes, and…" rule is the basic tool for creating a scene with an acting partner. One partner begins the scene. The other says "yes" to what has been offered; the "and" then allows her to add to the original material. The cycle of "yes, and…" goes on between the actors until they have built the basics of their scene's reality. The setting, characters, obstacles, and conflicts are all developed by using this technique.

"Yes, and…" has been one of the most valuable tools for me as I interact with psychiatric patients. When I begin to speak with a patient, I enter into their world and have to, in some way, say "yes" to their current

[3] In his plenary lecture, "Living Compass Model for Wellness Ministries," available at https://www.youtube.com/watch?v=p8OmPTWYbvE&feature=youtu.be&t=2769, beginning around 4:59:29.

reality. Whether they are in the midst of a manic episode, are anxious, or are experiencing delusions, ministry starts when I begin to enter into their experience and accept that patient for who they are in that moment. Once I have done that, then they may give me permission to say "and…" to begin building the common experience of relating to each other.

On Thursdays I lead a group on the psychiatry unit. The group process is a very improvisational experience. There can be a lot of "yes, and…" happening. If I return later in the day after a good session, I often find patients who connected during the group experience continuing their conversations, establishing relationships that provide support and encouragement. One particular Thursday, a patient in the group had remained quiet throughout the session. It had been a good group interaction. Patients connected, shared their experiences of life, acknowledged their weaknesses, and talked about their hopes for a healthy future. At the end of our session, I asked the patients to look over the list of words we used to prompt our conversation. Then I asked, "Is there one more word we want to bring to the group as we finish?" The patient who had been quiet the entire session quickly responded, "Healing. This group has been healing." The other members of the group quietly nodded. It was not that this patient had participated extensively. Listening to the others the whole time had given this patient the ability to finally say "yes, and…" in some way. It was the nature of the interactions, the organic improvisation that we had experienced together, the prompting, the questions, the responses, the listening that had an impact on this individual. This patient had heard from others about their experiences of spirituality and mental illness. Patience had been shown as people listened to each other. Grace had been experienced through compassionate responses. The Holy Spirit had been present to comfort and bring hope to suffering people.

Conclusion

Health ministry can be risky. We risk ourselves, our time and resources, and sometimes even our sense of safety or security. We enter into relationships that can be demanding. Knowing ourselves, our motives, our boundaries, and our limits is vitally important as we engage in any kind of ministry with people who are in need or at risk and suffering.

Health ministry can be joyously and surprisingly fulfilling. Entering into experiences with some uncertainty and finding that our gifts are being used in unexpected ways brings renewed energy. Even the suffering person becomes the minister in health care settings. Our common

humanity, embodied in our common experiences of suffering, grief, and loss, is reaffirmed.

Health ministry can reveal God's creative and comforting energies. Communities created around healing and health, connecting people in honesty and vulnerability, can be life-giving. Salvation comes into our lives in little bits and pieces of grace-filled experience. Those experiences of grace connect and become our personal and communal faith.

The Being Well symposium has provided a day filled with opportunities to reflect on God's call to the church to continue to connect faith and health in the new life that Jesus offers to the world God loves. Thanks be to God for such rich opportunities.

Book Reviews

Mark Safstrom, assistant professor of Scandinavian studies, Augustana College, Rock Island, Illinois

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

Jodie Boyer Hatlem, pastor, Erb Street Mennonite Church, Waterloo, Ontario

Perry L. Glanzer, Nathan F. Alleman, and Todd Ream, *Restoring the Soul of the University: Unifying Christian Higher Education in a Fragmented Age* (IVP Academic, 2017), 324 pages, $35.99.

This timely and thoughtful evaluation of the state of Christian higher education is written for two primary audiences: Christians in the "multiversity" (that is, Christian faculty who work in a secular setting) and faculty, administrators, and staff at Christian schools (p. 12). In particular, the book speaks to the aspirations of those who wish to remake Christian higher education, framing this task as a process of "restoration."

The authors' program has three parts. The first section, "Building the University," gives a thematic overview of historical developments, including the evolution of the liberal arts since the ancient Greek and Roman conception and the history of the university from its origins in medieval Europe. This also includes the way European universities have been shaped by their complicated relationship to the state, especially after the Reformation, as well as the origins of academic freedom and pluralism. One chapter is devoted to explaining how the university was transplanted to the American context, resulting in some divergent trajectories.

The second section, "The Fragmentation of the Multiversity," identifies the historical and contemporary developments that have divided or

dismantled a holistic understanding of the Christian liberal arts. These include the competing roles and responsibilities imposed on and assumed by professors, the coherence of the curriculum or lack thereof, the innovations brought by changes in administrative culture, the pros and cons of athletic programs, and the perils of online and for-profit higher education.

The final section, “Restoring the Soul of the University,” identifies a remedy for these problems, which is first and foremost to return theology to the center of academic life. The authors conclude with several chapters that offer recommendations for how Christians in academia should reimagine their disciplines, the leadership of their schools, and their own vocation as well as that of their students.

While a framework of “restoration” might risk creating an idealized past that never was, the authors are careful to explain what they mean by restoration. The “soul” that was lost or is at stake is “the study of God—theology” (p. 7), which they explain as a holistic and formative influence that is allowed to pervade academic life. This book is not first and foremost a work of history. Rather it engages history as a conversation partner in developing a thesis about the essence of Christian higher education. That said, the section on the historical background is sufficiently robust to lay a convincing groundwork for the later chapters. The authors’ contention is that Christians “need to think critically about past educational structures and institutions they helped to build and perhaps where they went wrong” (p. 7). Even the architects of the first universities struggled in implementing an education centered on theology, namely with how to organize the disciplines. The authors point out how the medieval view of theology as “queen of the sciences” is in part responsible for its later decline, in that it was seen as one discipline among many. Thus, while there may be no perfect past to return to, that should not prevent the reforming pursuits of modern-day educators. Restoring this “soul” is not as simple as re-establishing a hierarchy of disciplines with theology at the top. Rather, Christian educators must creatively cultivate an integrated learning experience for their students.

This historical section is one of the book’s strengths, worthwhile reading in itself for anyone who teaches courses on the liberal arts. The tour that the authors give of this history offers a clear and well-reasoned definition of what the liberal arts are and what they have to do with a holistic Christian education. Their assessment of the twelfth-century educator Hugh of St. Victor and the subsequent development of the University of Paris is substantive and not overly romanticized. They write, convinc-

ingly, that the centrality of theology as the soul of the medieval university lay not in its fragmentation into one department, reigning supremely and separately from all others, but rather in the integration of theology throughout the life of students and faculty (p. 21).

The other two sections offer insightful discussion of the challenges faced by Christian colleges today. "Multiversity" may not be a natural enough term to become common parlance anytime soon, but it serves the authors' purposes well in identifying why it is that most universities lack a "singular soul" (p. 3). Instead of the university serving to unify its plurality of departments, programs, and constituents, the reality on many campuses is that there are competing communities as well as a "tournament of ideas" that are left unmediated.

This is perhaps the main accomplishment of this book: it does not simply identify pluralism as a problem, as many Christian critiques do. Rather than a naïve appeal to a unity of truth, the authors assert that the multiversity is not something Christians should fear but something that should be properly understood. The framework for understanding how to restore the multiversity begins and ends with 1 Corinthians 12:12–14 and its analogy of the body of many members (p. 5). This perspective thus claims a dynamic pluralism on *theological* grounds and identifies *relativistic* pluralism as the hazard. The remedy is to reestablish a hierarchy of truths, as well as a "core identity, story, and source of moral insight and inspiration" (p. 6). This may not be the same as a college adopting a binding confession of faith or behavioral covenant. Rather, the multiversity that has had its soul restored is one that has re-centered itself on a hierarchy of curricular priorities and which regularly rehearses the biblical story in the center of its teaching and campus life, as well as in the community's narrative about itself.

Although one of the intended audiences is Christians in the secular setting, there is relatively less practical advice given to this group than the Christian setting receives. Yet much can be inferred from the authors' notion of apprenticeship in that professors in any setting can serve as models of a holistic and integrated approach to their academic discipline. Curricular choices must also be strategically made so as to further model the desired academic culture. Furthermore, these professors, as well as administrators and other staff, must also learn "to speak theologically" (p. 241), rather than purging themselves of this kind of language in misguided deference to the assumption that objectivity always demands it.

The final section on application is inspiring in its tone; if it is read

as a motivational sermon, it will likely satisfy the reform-minded reader in need of a pep talk. On the other hand, if this section is read by those looking for a detailed plan for their particular university's setting and challenges, they may find it heavier on Scripture references and lighter on plans for action.

On balance, this book serves its purpose in providing a working thesis for addressing the concerns that many Christian schools face from pressures on their tuition models that have often misled leadership to focus too much on practical educational programs at the expense of a classic, holistic, Christian liberal arts education. Academic departments in the humanities may gain the most grist for their mills from this book, as the liberal arts serve a common thread closely woven with the kind of theological education that is being identified as the university's "soul."

MARK SAFSTROM

Annette Brownlee, *Preaching Jesus Christ Today: Six Questions for Moving from Scripture to Sermon* (Baker Academic, 2018), 208 pages, $23.

Anna Carter Florence, *Rehearsing Scripture: Discovering God's Word in Community* (Eerdmans, 2018), 215 pages, $17.

Two publications by teachers of preaching offer motivation and insight for the minister's weekly work of biblical interpretation. Each urges readers and preachers to linger with the text. For Annette Brownlee, the task is to "stay in the room of Scripture" and not leave too quickly after grasping a sermon nugget. Using a theater metaphor, Anna Carter Florence urges us to stay on the scene: "How beautiful on the mountains are the feet…of those who walk straight into a text and wait for a word to say" (p. 54). Each author begins with close reading of the text then heads in a different direction of emphasis: Brownlee follows the theological thread, Carter the experiential, although each attends to both.

Annette Brownlee, an ordained priest in the Episcopal Church USA, is chaplain, professor of pastoral theology, and director of field education at Wycliffe College in Toronto. She calls her work a practical book on preaching and it is, but it wouldn't be an exaggeration to call it a practical theology. Brownlee's guiding questions, expanded in separate chapters, are best summarized in her own words: "The Six Questions move from attentiveness to the scriptural text (What do I see?); to the text's center and completion, Jesus Christ (Whom do I see?); to Christ's address to

us personally (What is Christ's word to me?); to Christ's address to us as the church (What is Christ's word to us?); to the identity Christ offers the church and disciples (What is Christ's word about us?); to how we inhabit our identity in Christ for and in a disobedient world (What does it look like?)" (p. xv).

The questions follow out of the conviction that the preacher has three roles: witness, confessor, and theologian. Although it is the church that interprets Scripture, the preacher is called to lead the way by attending to what is in the text, allowing it to speak to herself and proclaiming the same as a member of the listening congregation. Another list of six activities guides the preacher in careful reading: read slowly and attentively; focus on the movement of the passage; read around; read through the eyes of your congregation; do your homework; and identify God's activity in the passage (pp. 26–27). The last is especially important, as the simple noticing of nouns, verbs, and direct objects points to God as main actor.

"Reading around the Scriptures" involves noting references to common words, motifs, and images, including a figural reading that seeks fulfilment in Jesus Christ, the telos and center of Scripture. For example, Brownlee's intratextual reading connects the silence of the rich man before Jesus (Mark 10:22), the uninvited guest without a wedding garment (Matthew 22:11–12), and unrepentant Israel in the prophet Isaiah. A figural reading will see this inability (or unwillingness) to plead for mercy fulfilled as Jesus takes on the sin of the world before his accusers, "as the sheep before its shearers is silent" (Isaiah 53:7).

Chapters three and four are perhaps the best, reminding preachers that the step of letting the word address them is the most important. Because those first-person discoveries are not usually presented in the sermon, this step is most easily passed over or forgotten. Yet the preacher witnesses as one of the many addressed by the word. Luther taught that the word creates its hearers, so whatever our similarities and differences as a congregation, we are all Ezekiel's dry bones in need of prophecy. As the preacher moves from witness to confessor to theologian, differences of identity are not erased but embraced.

Brownlee's work leans on theological writers like David Yeago and William Abraham along with their precursors Augustine and Luther, George Lindbeck and Hans Frei. It is therefore an essential complement to preaching advice that looks to literary studies, sociology, or communication theory. Examples of reading with the six questions and resulting sermons keep the emphasis on preaching practice.

Anna Carter Florence is the Peter Marshall professor of preaching at Columbia Theological Seminary and an ordained minister in the Presbyterian Church USA. She took a theater course in college and learned that repertory companies interpret scripts by reading and rehearsing together. Her guide to reading Scripture is therefore directed to groups, although preachers are encouraged to join. In that way, the book complements her predecessor Lucy Atkinson Rose's *Sharing the Word: Preaching in the Roundtable Church* (Westminster John Knox, 1997), a call for preachers and hearers to do sermon work together. Florence uses repertory practice to offer additional ways for sermon study groups (and any other Bible study group) to venture into a text and listen for a true word to speak.

Florence believes that we hear the life-giving word when we pay special attention to the verbs in the text. Nouns like "Philistines" and "fleshpots" put distance between the biblical world and ours, but we all know what it is to take, eat, have eyes opened, and hide, whether or not those actions come in the order of the Genesis story. Best practices of close reading are on display as Florence teaches us to ask what verbs surprise us, how God's verbs differ from human verbs, and how adjectives and nouns take on their meaning in juxtaposition with the verbs. The exercise helps readers slow down and use imagination to explore what is said, what is not, and why.

Once the verb's actions have been unpacked, the repertory group can further explore what happens when readers get out of their chairs to embody the action, when characters are placed or even switched, and when "what if?" and other questions are asked. A list of six questions reviews the experience of reading and enacting before moving on to what will be said: Where did the text get you? Why does it get you? Based on that reflection, what do you know about God? Why does your community need to hear this today? What do you want to say? What do you hope these words will do? (pp. 196–97)

A series of dispatches from the field shows how reading groups can ask new questions of familiar texts in Mark, stay with hard texts of terror like the rape of Tamar, and learn to speak truth by considering Esther's own reluctance to speak. One example: Florence shares her own amazement that the life-over-death stories in Mark 5 opened up in new ways when, after years of reading it in seminary classes, she took it to church groups. People who weren't learning to preach asked the question that had never come up before: why is it that some of the people Jesus helps are allowed to speak? They are not professionals like Jairus the synagogue

ruler; they are unnamed, common people like the woman who told her story of healing (Mark 5:33) and the demoniac whom Jesus ordered to go tell (Mark 5:19–20). Further examples of group readings follow in appendices, with specific procedures the reader can use and adapt. More than any other I know, this book helps its readers get at the life issues in Scripture texts, the matters people care about, and the reason they come to hear sermons.

I hope preachers and teachers will read about and try out each approach and then go back to their usual practice to observe how it has been enriched. Better yet, preachers could recruit a sermon prep and review group to try out both approaches and debrief after the resulting sermons have been preached.

PAUL KOPTAK

Amy Laura Hall, *Laughing at the Devil: Seeing the World with Julian of Norwich* (Duke University Press, 2018), 144 pages, $18.95.

Laughing at the Devil: Seeing the World with Julian of Norwich is primarily a work of theological ethics, but it is also, at times, a spiritual memoir. There is a richness to Amy Laura Hall's book despite the volume's slimness. It is a book that resists easy characterization and summary. Hall demonstrates that Julian's visions about time, truth, blood, and bodies were both formed in a particular social and political context and speak powerfully to our own post-9/11 era marked by the politics of fear and anxiety. This is a book about statist violence but also a reflection on domestic abuse and divorce. Hall's admixture of personal and political is intentional. In *Laughing at the Devil*, she insists that seeing the world with Julian of Norwich requires a radical recalibration of how theologians categorize what is significant and what is insignificant.

Laughing at the Devil sees in the theology of Julian of Norwich a repudiation of what Hall terms a "Gospel of Austerity" (p. 8). The resurgence of Calvinism in the post-9/11 era is a central example of this austerity theology. Purveyors of the Gospel of Austerity insist that human desires and needs are petty compared to God's grand scheme. Hall seeks to demonstrate that this vision of God's providence can easily lend itself to moral utilitarianism reflected in drone strikes, torture, and treating other human beings as moral contagions. Julian's theology of providence scrambles Calvinist providence—in large part because Julian insists that

God is not only all-knowing and all-powerful but that God is also all-loving. Hall refers to this all-loving as God's "omniamity." Julian refuses to deny either the horrors of this world or the sufficiency of divine love: cruelty is truth, but Jesus is also the truth (p. 9).

Julian also, according to Hall, challenges the Gospel of Austerity by her refusal to see time as progressive. Because of this, modern readers must resist reading Julian's most famous statement, "All shall be well, and all manner of things shall be well," through the lens of an enlightenment faith in inevitable progress. Julian never argues that pain is being transformed "incrementally into blessing" (p. 23). Instead, Hall insists that Julian offers a personal God who is working toward the salvation, reclamation, and restoration of little things as well as big things, but this happened and is happening all the time through a "poynte"—that one decisive moment on the cross. Hall refers to this as Julian's doctrine of "eschatological reclamation" (p. 110). That the little things and the big things are held by God means that they are "held in a way that scrambles calculation and the usual ways we weigh, measure, and sort ourselves, strangers, our children, our churches, or our neighborhoods" (p. 23).

Hall believes that this Gospel of Austerity shapes Christians who are inclined to misunderstand radically what it means to follow Jesus and, in particular, to suffer with Jesus. "Jesus's sacrifice is not to be repurposed for yet another political agenda.…What Jesus suffered is not to be suffered by anyone else as part of God's work of salvation" (p. 82). It would have been good to have seen this point fleshed out further, as it would hold significant ramifications for practical questions around criminal justice. Hall's account of Julian's theology also has implications for atonement theology. Hall sees the danger of reading the cross through the metric of utility. She notes, "the cross is gratuitous, non-necessary, and a creation of love out of non-sense and non necessity of evil" (p. 84). In other words, the cross of Jesus Christ is first and foremost about the Trinity's profligate love and grace. To continue to see the life of Jesus through the metric of the grand plan is always to risk missing that the cross is essentially a message about God's love.

Hall's book is valuable because she resists a bloodless and spiritualized vision of Julian's theology. Covenant theologians seeking to understand the significance of Waldenström's insistence that the cross was a demonstration of divine love will find in Hall's Julian an important conversation partner. Moreover, a parish pastor might find solace in a vision of a God who does not see his followers as cogs in some divine program—the God

who “uses us”—but instead realizes that our lives are sustained by a God whose love for us is total and non-instrumental.

JODIE BOYER HATLEM

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