Introduction

[1] The role of religion in integrating the mind, body, and spirit relationships deemed important in the processes of health, healing, and dying is well recognized (Ai, Peterson and Bolling; Ellison and Levin; Koenig, McCollough, and Larson; George, Ellison, and Larson). Increasingly mainstream Christian congregations in the United States are amplifying the role of religion in contributing to the health and well-being of the whole person through the development of parish nursing programs (Trinitapoli, Ellison, and Boardman). They are also responding to the reality that despite advances in medical technologies and knowledge, many Americans have inadequate access to the health care they need (Shi and Singh; Rosenau). Driven by the pursuit of corporate profits, health care delivery systems and health insurance
companies are reducing the amount of time that professionals spend with patients. Increasingly, individuals are expected to assume greater responsibility for their own health. The impersonal and fragmented health care system (Cebul et al.) and an increasingly impersonal and fragmented society leaves many individuals with the daunting task of coordinating their own care without adequate knowledge and support systems.

[2] Through the aid of parish nurses, a growing number of congregations are assisting local people in taking responsibility for their own health or are assuming care for them when it is necessary and possible for them to do so (Trinitapoli, Ellison, and Boardman). Through qualitative research methods, this study constructs two ethnographic accounts of the local cultural dynamics associated with developing health and healing ministries. It examines one congregational health program centered on a parish nurse and a free clinic developed in an inner-city context and discusses the role it plays in the congregational mission. This study also explores the possibilities for a quite different parish health ministry centered in a rural community context.

The Role of Religion in Health and Healing:

[3] These twenty-first century parish health ministries are a continuation of the ancient and traditional Christian motivations for caring for the sick and the suffering. First through volunteers, then through a growing number of clergy, and later with hired attendants and professionals, Christians ministered to the sick, cared for widows, orphans, the old, the disabled, and the poor out of a commitment to love their neighbors (Ferngren). Social historian Rodney Stark further points out that in a society where most people shunned the sick, the Christian compassion of the early church presented a radically different religious ideology. Christians were recognized by their response to God's love for humanity by loving and caring for one another. That did not mean, however, that Christians did not support scientific medicine in caring for the sick. Church historian Martin Marty asserts that mainstream Christian healing was always based on the best of modern medicine in its attempts to achieve wholeness. But it was the combination of compassion with modern medicine in the training of religiously motivated nurses that theologian Granger Westberg (1990) argues enabled Christians to become the leaders in scientific health care in America in the nineteenth and early twentieth centuries (see also Rosenberg). But by the end of the twentieth century American health care was increasingly commoditized and health care was managed by corporations motivated by market demands to produce profits (Caplan). In addition, scientific bio-medicine focused more on expensive remedial attempts to restore individual consumers to health after becoming ill than engaging in preventative care (Burton).

[4] While holding a joint professorship in Religion and Health at the University of Chicago Medical School and Divinity School in the 1980s and working as a hospital chaplain, Lutheran pastor Granger Westberg became concerned that those compassionate and holistic care giving practices of Christian health care had been gradually transformed over time by

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Trinitapoli, Ellison, and Boardman argue that despite data collected by the National Congregations Study surveys, there is no way to reliably determine from this data the number of congregational health programs, their locations, the types of programs, or their effectiveness.
the specialized functions of secular medicine. Drawing on Christian health care traditions and his experiences with scientific medicine he sought a more productive synthesis of body, mind, and spirit in holistic healing. Recognizing that this synthesis needed another venue, Westburg turned to the level of local parishes, arguing that healing is not just for the sick in healthcare institutions; it should be an ongoing ministry of wholeness to the entire community (Westberg 1990). Westberg pointed to the example of Jesus who healed the deeper needs of individuals to put the mind, body, and spirit in unity (see Westberg 1979). Christians were called not only to heal others, but to seek a deeper sense of wholeness beyond the condition of the body. From this perspective, an active healing ministry takes an innovative whole-person approach to salvation, which means to be made whole. Westberg fostered a renewed understanding of the compassionate role Christians can play in holistic health and healing by extending the skills and influences of nurses into congregational ministry through development of the role of the parish nurse (Westberg 1986; 1990).

[5] Westberg moved his congregational health program to the Department of Preventative Medicine at the University of Illinois College of Medicine where he developed team based healing at holistic health centers supported by the Kellogg Foundation. Here a doctor, a nurse, and a pastor worked together to identify early health needs and to intervene to help individuals engage in more responsible stewardship of their own health with the help of others. The interdenominational program devised by Westberg recognized that people need personal motivation to engage in healthy lifestyles and that religious belief systems are often highly effective in defining the worldview of a healthy person (1990: 8). He further argued that parish nurses could offer the inspiration that motivates people to care for themselves by promoting the Christian mission of caring (see also Carson 1989).

[6] Based on his observations of the high level of influence nurses had with patients, Westberg’s program is largely dependent upon the development of the role of the parish nurse, primarily as a volunteer. Westberg found that at the congregational level, the balance between talking with the pastor and the touch of a nurse carried a great deal of power with parish members (1990: 18). As the most critical member of the parish team, the nurse listens, counsels, and prays with people at the spiritual level but she also places them in small support groups, educates them, and connects them with private and public health services (18). Nurses are particularly central to health and healing programs which address the whole person (Frisch; and Dossey et al.). They are often the best link between individuals and their families, communities, and the health care network (Swinney et al.). The goal of the parish nurse program is not to replace existing health care services, but to make them more accessible and affordable for people. Chase-Ziolek and Iris assert that “as creative ways are sought to address our country’s health care needs, there is a need to be cognizant of the synergistic effect created through providing nursing services in the context of a congregation that both practically and conceptually integrates faith and healing” (185).

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2 Westberg credits the nursing profession for pleading with the medical profession for 40 years to orient health care more toward preventative medicine and teaching people how to stay well (1990: 20).

3 This view is supported by Dean of Columbia University School of Nursing, Mary O. Mundinger, who notes “Nurses have traditionally focused more on preventative care.”
A robust literature argues that spiritual well-being and spirituality are a dynamic force in the holistic well-being of individuals (Price, Stevens, and LaBarre; Rydholm; Ryan). It is further argued by many that religious institutions and faith communities have the potential to greatly enhance the well-being of others by providing emotional and spiritual support (Curran; Boland; Kiser, Boario, and Hilton; Meux and Rooda; Salewski; Biddix and Brown; Miller Whitney). Healing does not just connect the body to the social, economic, and political structure of professional medicine. It identifies the self-conscious and unconscious actuality and potentiality of the individual that connects the mind, body, and soul in a cultural reality that places the emotions in a transforming process (Otis 1991:46-48). Other recent studies show that prayer and spiritual strengths have a positive effect on healing (Ai, Peterson, and Bolling). Studies recognize that religious beliefs and practices such as ritual and prayer can substantially reduce the medical needs of persons suffering from stress related illnesses (Benson). In these religious settings, it is asserted that nurses are the empowering catalysts (Ryan; Simington, Olson, and Douglas; King, Lakin, and Striepe; Minnick; Miller Whitney; Solarí-Twadell and Westberg; Swinney et al; Van Dover and Pfeiffer).

Recognizing the Role of Local Congregation Parish Nursing Ministries in Healthcare:

The religious community focuses on the spiritual dimension in the promotion of healthy lifestyles and individual empowerment (Brown; Buijs and Olson; Droege; Westberg 1990). Chase-Zioleck and Iris argue that religious settings can contribute to health promotion and prevention because they provide opportunities for healthy psychosocial environments that reduce stress, foster long-term relationships of social and emotional support, and offer opportunities for developing healthy lifestyles as part of growth in faith and spiritual care. Because of their abilities to organize resources to address human needs, churches can also address public health care for those members of American society who are increasingly underserved by the contemporary health care system (Evans). Because it is widely known that religion does affect health, the local church is an ideal place for promoting health and healing (Matthews, Larson, and Barry). Pastors and pastoral health care professionals can provide the leadership in motivating Christians to sense responsibility to the needs in their own communities (Droege). The parish nurse program that Westberg (1990) developed begins by identifying all the possible contributions that a parish nurse could make in a particular setting and then identifying the interest of the pastor in the program and his/her level of support for the idea. Next, involving the congregation requires identifying a support group who can gather information and make presentations to various interest groups, including the church council. With congregational support, a health ministry committee is then formed to further educate the congregation about the role of health professionals on the ministerial staff. The healing ministry committee can then also work to integrate a parish nurse program with other churches in the community. Several churches can work together to share a nurse. They can do this by identifying volunteer nurses and/or by hiring a nurse as

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4 The socio-environmental definition of health defined by the World Health Organization (https://apps.who.int/aboutwho/en/definition.html) realizes that politics, economics, society, culture, environment, behavior, and biology all affect physical, mental, and social health and well-being, but they do not recognize the role of religion.
Religion, Health, and Healing

a part-time member of the ministerial staff. The nurse or team of nurses can then establish links with a local hospital and the chaplain staff as well as develop relationships with medical staff. In some instances, the local hospital will initiate a parish nurse program to coordinate services in several churches.

[9] Parish nurses serve an important role as coordinators of volunteers and support groups. In addition to their nursing roles, depending on the size of the congregations, they are also essentially the coordinators and administrators of congregational health ministries. As such, they need volunteers (nurses and non-nurses) to help keep records and document care, visit homes, hospitals, and nursing care centers, present health education programs, assist with health screening, and coordinate referral sources for the community (McDermott and Burke). McDermott and Burke found that the growth of these programs across the nation, and particularly in the Midwest, reveal the following successes: 1) enhancement of health knowledge; 2) greater awareness of personal responsibility for individual health issues; 3) enhanced awareness of health and wholeness; 4) improved coping abilities; 5) attitude adjustments; 6) better management of chronic disease; 7) changes in health behaviors; 8) increased home safety; 9) physiological changes; and 10) optimization of referrals and resources (185).

[10] The general contributions of parish nurses are to provide education, counseling, referrals, and advocacy in addition to their roles as facilitators (Matteson). They provide opportunities for the integration of health and faith by building trust and promoting a trusting psychosocial environment for long-term relationships (Chase-Ziolek and Iris: 177). Chase-Zioleck and Iris found that by linking the psychosocial, spiritual, and medical elements of health and healing in a supportive environment, parish nurses were able to reduce anxiety for the chronically ill and aged, motivate lifestyle changes, prevent suicides, help people cope with grief, death, and teen pregnancy, and intervene in potentially dangerous family settings (180).

[11] Since the development of Westberg’s parish nurse programs, communities have identified locally specific particular health needs ranging from concerns about high rates of cancer for middle-aged people to high-risk behaviors for adolescents to insufficient support services for the elderly (Swinney et al.). As more seniors enlist the aid of informal support systems for long-term care services in their homes, faith community nursing is playing a larger role in proactively connecting seniors with those necessary services (Rydholm). Parish nurses have greater success with persuading seniors to seek care before there is a spiraling downward of symptoms. Additionally, parish nurses have increasingly contributed to health promotion interventions and programs that support equity and social justice (Buijs and Olson). Parish nurses are not simply just another institutional community nurse. They are different in that they collaborate with other members of the community to identify and meet unattended needs by building partnerships that extend institutional health care where needed (Weis, Matheus, and Schank; see Miskelly for four models of relationships between the nurse, the church, and health care institutions).

Recognizing Local Congregational Cultures in Developing Parish Nursing Ministries:

[12] This study assumes that congregations reflect denominational subcultures and organizational cultures that influence their structural configurations, leadership
characteristics, and courses of action (Trinitapoli, Ellison, and Boardman). It further argues that these cultures will reflect very different dynamics based on urban and rural contexts. This study employs a socio-cultural theoretical approach within the field of medical anthropology to identify health practices and the role of social relations within a wide range of social and cultural institutions associated with health and healing in the social reproduction of health behaviors (Janzen: 36). From this perspective, congregations are understood as social-cultural institutions in terms of organizational structures, leadership dynamics, economic resources, values associated with health and healing, and beliefs related to caring and compassion for those in need. They can also be seen as part of a larger system of health care in which they can collaborate with biomedical institutions. This study fills a gap in the literature by providing ethnographic details of how parish health and healing programs and the role of the parish nurse are developed and implemented in particular local contexts. While studies show that church members, both professionals and lay members, are increasingly seeing healing ministries as ways to practice their Christian faith (Droege), this study shows that the development of these ministries is highly context specific.

[13] The existing literature on parish health ministries has produced some generalizations found in the literature. Congregational-based health ministries with paid parish nurses are typically found in large suburban congregations of some means because they have the professional and financial resources to develop these programs (Catanzaro et al.). Along with adequate financial resources, churches that sponsor health ministries also typically have pastors who are committed to vulnerable populations (see Hale and Bennett). From the point of view of these pastors, it is important that congregational involvement focuses on serving the needs of members as well as the larger community of need (Catanzaro et al.: 14). In order for parish health ministries to have a positive effect on the quality of life in congregations, it is important that the ministry teams identify and acknowledge the particular concerns of the host faith community (Brudenell: 92). Enhancing the overall well-being of congregational members as well as the larger community of need will generate respect for and collaboration with parish ministries. Brudenell also asserts that successful health care practices within any faith community need to identify and enhance a local spirituality of health and healing (93).

[14] In each local context, however, the needs of the community to be served and how they are addressed reflect highly variable health and healing infrastructures, social structures, and value structures. This includes the local and regional scientific medical systems, church community resources, volunteers, pastoral leadership, social networks, the health-related cultural beliefs and behaviors of the local citizens, the level of compassion for those in need, and the local community priorities. The holistic approach to needs assessment enables healing ministry committees to tailor their parish nursing programs to their individual populations (Brudenell: 11). Within these contexts, qualitative research can identify individuals from various interest groups to determine aggregates of needs. In her “Wellness Inventory,” Sandra Miskelly identifies four holistic categories of wellness: 1) physical; 2) 

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5 The general problem addressed by this paper – that of inadequate health care in America – assumes the broader perspective of critical medical anthropology, which reveals the particular social, cultural, political, and economic factors that define contemporary local unmet health needs and local caring responses (Janzen).
emotional/relational; 3) spiritual; and 4) knowledge base of health systems (5). These themes are explored in more detail in the analysis of the data collected for this study.

[15] This ethnographic study employs the qualitative research methods of medical anthropology in examining two different ELCA Lutheran parishes in the Midwest, one rural and one urban, to identify their distinctive cultures of health and healing. The study was conducted through participant observations6 of congregational processes and interviews with clergy, a parish nurse, lay volunteers, and individual congregational members, to understand the roles of each of these stakeholders in different local settings. The data were analyzed by identifying the medical infrastructures in each community, the social structures of the congregations that shaped how they organized resources within their neighborhoods and communities, and the social and religious values that shaped congregational perceptions of needs. Needs were then analyzed in terms of themes particular to the congregational culture contexts. And finally, comparisons were made between the two congregational cultures to reveal critical differences in urban and rural congregational contexts. These cultural dynamics influence greatly the nature of a congregational relationship with the local health care infrastructure, and the larger community.

**Inner-city Omaha Parish Health Care Ministry and A Culture of Community Outreach**

[16] Kountze Memorial Lutheran (Evangelical Lutheran Church in America) in Omaha, NE established its inner-city parish health and healing ministry in 2010 as part of its outreach ministry to the surrounding community. Kountze Memorial is a 150 year old congregation that decided to remain in the community despite the changes that have taken place in its once affluent neighborhood. It is located within a few blocks of the inner-city Lutheran Family Services agency and works closely with its outreach programs. The church also owns and manages a senior citizen home in the neighborhood. The church is the site of a well-supported food pantry and many social service programs serving the downtown neighborhood. It’s large membership roll of approximately 2,300 remains well supported by loyal families and professionals who have historically meaningful ties to the parish and its surrounding neighborhood. These members and the church leadership are highly committed to outreach ministry to the poor in the neighborhood. The membership at Kountze Memorial is diverse in terms of class, ethnicity, age, education, and residence. Members live throughout the Omaha area. The annual budget of nearly a million dollars reflects a strong spirit of sacrificial giving and is accompanied by a strong volunteer ethic in the congregation. Kountze Memorial is recognized in the community for its affluence, lay leadership, and consistently strong pastoral leadership, which consists of a senior pastor, two associate pastors, and a vicar.

[17] This study examines the mission agenda, resources, support, and services that characterize this congregation’s outreach culture and its development of a parish nurse program and free neighborhood clinic. Despite the existence of ample health services, urban health issues are complicated by a decreased level of family support and more social isolation, more homelessness, more violence, and more immigrant populations (Wenger). Redevelopment of the inner city and mid-town neighborhoods surrounding the church has

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6 The researcher has been a member of each of these congregations for over ten years.
reduced the number of low-rent housing in the area, further assuring that social relationships among the poor in the neighborhood are highly changeable and unreliable. While few inner city residents in Omaha are homeless, those who are among the poorest are dependent upon shelters and other temporary or sub-standard housing arrangements in the area. Neighborhood residents are chronically unemployed and underserved by government funded programs.

[18] Kountze began its parish nurse program with the encouragement of its senior pastor and several health care professionals who formed the first Health Ministry Committee. The senior pastor began with a task force comprised of a nurse, physician, and pharmacist. They first hired a retired nurse to work twenty hours a week to develop health education. She also developed a wellness section in the church newsletter. Next the committee held education forums for wellness, living wills, nutrition, cardiac health, and the spirituality of healing during the congregational forum, which is an educational hour between two Sunday worship services.

[19] The primary responsibility of the nurse is to educate members in the health of their mind, body, and spirit. She educates them to be advocates for themselves when talking to physicians by asking more questions and getting better explanations and she helps members with follow through on physician’s instructions. The nurse checks blood pressure readings one Sunday a month at church and during the week in her office. She gets a list of names of people discharged from the hospital and calls them to see if they are making progress or if they have any needs. She also works with referrals of other members and calls these people to see if they need help and coordinates healing needs with the prayer chain. She is limited in that she cannot provide transportation for people to physician’s appointments but there are other volunteers at the church who can do that (interview with parish nurse). The nurse can also coordinate individual needs with a psychologist who is available to members one day a week.

[20] After six years of experience coordinating volunteers through the parish nurse program, the six members Health Ministry Committee at Kountze recognized that the congregation could expand its role in the neighborhood. It identified the need for a free clinic and the resources to establish it. The success of the development of the clinic was largely due to the strong leadership of the senior pastor (interview with associate pastors). The congregation was involved in the planning process through informational meetings in which the pastor, the health ministry committee, and health care professionals presented the plan as a necessary extension of Kountze’s ministry in the community.

[21] During the planning stage, several congregational forums were held during which objections to the free clinic were raised and addressed by the pastor. At one forum, a woman expressed concern that the church was becoming a market place for secular activities. The pastor responded that while healing and caring for the poor has been a central mission of the church, it had not been a primary concern of the market-place, recognizing that there were many un-met needs in the community. The pastor further responded to concerns about limited resources with a reminder that the congregation is blessed to have so many members of the medical profession who are willing to donate their time, talent, and money to the healing ministry. Other individuals raised a concern that the church would be overwhelmed...
by the needs of the poor in Omaha. The pastor responded that the service would not be
advertised to the larger community and would be offered only to the church neighborhood
(participant observation notes from congregational forums). Other individuals raised a
concern that the food pantry would be overwhelmed by additional numbers of poor people
and that large numbers of sick people would create an unhealthy environment for the
members. The pastor responded that many of the members who come to church every
Sunday are ill. The pastor further reported that the clinic area will be the cleanest area of the
church. The pastor listened to the concerns and responded to them from the perspective of
religious teachings, pointing out that members should not resist the free clinic out of fear,
but rather respond positively through faith and mission.

[22] While creating a successful and appropriate relationship between the congregation and
the clinic was clearly due to the emphasis on faith and mission stressed by the pastor, the
professional skills of key lay persons were also indispensable in assuring members that the
clinic and its potential liabilities would be well-managed. A council member reported to the
congregation, after careful consideration, that the clinic would be set up as a limited liability
corporation to separate the clinic from the church legally, as was the case with the church’s
senior citizen home (participant observation). And like the senior care center, whose
residents’ needs the clinic also serves, the clinic would be clearly an extension of the church’s
ministry. The Healing Gift Free Clinic, as it is called, is an all-volunteer free clinic to
empower those who need care towards health of the mind, body, and spirit. Even the part-
time paid parish nurse volunteers during the hours that the free clinic is open.

[23] There was little expense involved in setting up the two examination rooms and offices
for the clinic. Equipment was donated from Methodist Hospital and the church added some
shelving and security locks. Some additional equipment was borrowed from physicians’
ofices in the community for evening use at the clinic. The Healing Gift Free Clinic, L.L.C. is
currently seeing patients every Thursday afternoon from 4:00 p.m. to late in the evening,
depending on the demand. The criteria for need are broad but the scope of services is
limited to mostly shelter bound street people in the neighborhood. The focus is currently on
acute, not chronic health needs. There are at least ten volunteers on staff each week who
attend to an average of between 25-30 patients each night. The volunteers include a staff of
doctors, nurses (including the parish nurse), pharmacists, and several hospitality/sign-in
volunteer students and four other volunteers who fill out forms and do vitals. After ten
months of existence, the clinic has seen more than 180 people in more than 550 visits.
Patients are both male and female and generally young adults to upper middle-aged. The
most common ailments are diabetes, hypertension, and upper respiratory issues. The clinic is
able to provide glucometers, diabetic testing strips and anti-hypertensives. There is also a
chaplain for the clinic who is available to address spiritual concerns.

[24] Staffing of volunteers at the free clinic has not been a problem. The health care
infrastructure in Omaha guarantees a broad base of health care professionals. Through the
research contributions of its three major medical schools, Omaha is a major Midwest center
for specialized biomedicine, pharmacy, and nursing. In addition, the Alegant Health Care
Network has developed a parish nurse program that trains and certifies paid professionals
and volunteers. The parish nurse at Kountze is a member of this network, which provides
monthly meetings for sharing ideas and information. A volunteer nurse at the Kountze clinic
who teaches at Creighton has access to nurse practitioner volunteers from Clarkson and Creighton schools of nursing. The nursing schools provide the supervision of the nursing student volunteers since they are eager to provide services as learning experiences for their students. The clinic also provides opportunities for medical anthropology student volunteers in helping as greeters and gathering background information from patients. A former Lutheran Volunteer Services volunteer currently enrolled in a graduate program at Creighton University has been hired part-time as the clinic volunteer coordinator. She orders medications on-line for patients and manages the food pantry. A volunteer pharmacist who is a member of the congregation and an employee at Walgreens brings two other pharmacists with him as volunteers.

[25] The clinic is protected by a security system and does not dispense any controlled substances. Medications, which contribute to the main cost of the clinic, and lab work, are provided at low cost to the clinic. The clinic buys medications, particularly antibiotics, from Blessings International, which sells low cost to free clinics. Patients are also sent to the nearby Walgreens at 30th and Dodge and the pharmacy bills the church. Methodist Hospital is also donating drugs and supplies. The church has a budget for everything that is not provided for free, which they fund through congregational giving and foundation grants.7 The clinic has developed networks of referrals to other professionals in the community for chronic needs and has the capacity to refer people to other free clinics for services they cannot provide, such as the Creighton dental school and eye doctors in the community. Clinic coordinators have a list of professionals they can call who are gracious enough to help the people the Kountze clinic cannot help. The clinic is currently looking for a volunteer physician’s assistant and is interested in a social worker who would be available for patients to call on the phone or reach on-line. Despite its success and growth, the clinic is not advertised. The pastor stresses that it is a neighborhood clinic and not a city wide clinic.

[26] The planning and implementation of the Kountze health and healing ministry reflects its congregational culture. Its attitudes and beliefs associated with health and healing are congruent with the social statements of the Evangelical Lutheran Church in America and its ministry of wholeness of mind, body, and spirit. It identifies needs in terms of the themes identified by Miskelly as 1) physical; 2) emotional/relational; 3) spiritual; and 4) knowledge base of health systems. The clinic and the parish nurse address all of the needs with strong input on the spiritual from the pastoral team. The strong pastoral leadership provides the spiritual guidance for leading the congregation in identifying new ways to care for its members and reach out to the surrounding community. The pastoral staff consistently connects the teachings of Christ with justice issues through sermons and educational forums. Due to the respect members have for the leadership of their pastors and to their confidence in congregational resources, including a paid staff, effective professional lay leadership, sacrificial financial giving and committed volunteers, the congregation is able to develop and support well staffed and adequately funded programs as extensions of the congregation’s mission.

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7 In 2011, the congregation received over $20,000 in grants, including $6,000 for prescription drugs from the Mellon Foundation.
Rural Northeast Iowa and a Culture of Individual and Family Support

[27] In comparison to the large inner-city parish in Omaha, I examined another relatively large Lutheran congregation in a rural community I call “Lutherville” with a population of 8,000 in Northeast Iowa. The congregation I call “All Saints” has a membership roll of 1,900 individuals consisting of multigenerational families with diverse class backgrounds. The congregation is one of the oldest in the community and is located in the downtown area near the river that flows through the center of town. While other denominations have moved out of the downtown area due to the regular flooding of the river, “All Saints” has elected to stay in the area in order to better serve the needs of the community and because it is a central location for its parochial grade school. The congregation has an annual budget over one million dollars as a result of strong commitment to the ministry of the church through volunteerism and sacrificial giving. The community is strongly German and “All Saints” is the largest of the three Lutheran congregations in the community: two are ELCA and one is Missouri Synod. There is also a Lutheran Liberal Arts college in the community as well as the ELCA synod offices, a large Lutheran retirement home, and a Lutheran Children’s services institution. These institutions typically work collaboratively to develop the many programs that serve the local and surrounding community. The community is also home to a large Catholic parish, a large Methodist congregation, a large Baptist congregation, a large Open Bible congregation, and a smaller Baptist congregation and a smaller Episcopal parish.

[28] The associate pastor at “All Saints” holds healing services at the church from time to time and is interested in developing a healing ministry in her congregation. While she informed me that the initiative of such a ministry is the prerogative of the senior pastor, this study provides insights into the process of developing such a ministry agenda should the senior pastor elect to focus his leadership role in the community in this direction. The preliminary findings from this initial needs assessment survey reflect an interest among members of this church community to explore how they might identify and address unmet health and healing needs in the community. Ethnographic insights into the local congregational culture at “All Saints” and the rural community in which it is situated reveal the context from which this congregation might define a locally appropriate health and healing ministry.

[29] The health care infrastructure in rural communities must be identified and considered when developing rural parish health and healing ministries. There are typically fewer resources in rural areas than in urban areas. Qualitative methods were used to characterize the health and healing infrastructure in “Lutherville.” I engaged in participant-observation as a part-time resident of the region. Interviews with local medical personnel and examination of local on-line and telephone directories of health care services were conducted. The community is well served by several doctors’ clinics, pharmacies, physical therapists, chiropractors, dentists, massage therapists, fitness centers, psychologists, psychiatrists, social workers, and a tri-county state funded mental health clinic that operates on a sliding fee schedule. Physicians in “Lutherville” are affiliated with the small but newly constructed well-equipped local community hospital and usually also with the three hospitals in a larger metro area 30 miles away with a population of about 80,000.
[30] Unlike many rural communities in the U.S., “Lutherville” does not have a serious shortage of health care professionals. The community is within 30 miles of a large metropolitan area with three larger hospitals staffed with resident specialists in all fields. The larger community also has cardiac and cancer clinics, which serve the wider area. Many specialists from the larger hospitals also hold office hours once a week in “Lutherville” to serve the needs of residents in the surrounding area. In addition, the community is located within two hours of two prestigious medical centers: the Mayo Clinic to the north and the Iowa City Hospitals to the south. State of the art medical care is available for those who can afford it. The problem with health care in this rural community is that many people do not have health insurance or they have limited coverage.

[31] To partly address these limited income issues in rural communities, the John Hopkins Medical Center has established a People’s Clinic in one of the small rural communities in the surrounding region of “Lutherville.” The clinic is staffed by a physician, physician’s assistant, nurse practitioners, and nurse’s assistants and it provides services on a sliding scale, depending on income. Due to its heavy emphasis on patient interaction, the clinic provides many services not provided to even patients who can afford mainstream care. These services include more opportunities to discuss lifestyle habits and health care concerns with nurses who encourage patients to engage in proactive health behaviors. But because the clinic serves a large number of people without adequate health care, it is stigmatized by locals as “the poor people’s clinic” and often those who could benefit from more personal care avoid utilizing the services offered. Individuals in rural communities are often reluctant to identify or address unmet needs for two reasons: 1) they can’t afford them, or 2) they can afford them but they don’t want people to know about them as they fear being placed in a marginalized socio-economic category. Many rural residents are reluctant to seek help for physical or mental health needs because of social stigmas attached to acknowledging problems associated with drug addictions, depression, or mood disorders. Even social problems like family conflicts and spousal abuse are often carefully hidden by all members of a family to avoid social criticism.

[32] There are some other infrastructure barriers to health and healing in “Lutherville.” The community also hosts a wide range of parks, bike trails, various sports activities for children, fitness centers, physical therapists, an outdoor swimming pool, and an indoor swimming pool. The indoor pool is located inside of a large community fitness center owned and managed by the local liberal arts college. It provides fitness training and recreation for all ages through its membership programs. Most of the senior citizens and many individuals and families, however, cannot afford the monthly membership dues at the fitness center. The fitness center has become the central class dividing issue in the community since it opened in 2008. This issue became politically sensitive when the City Council of “Lutherville” voted to contribute a large portion of its Parks and Recreation budget to the college fitness center and agreed to not offer any programs that would compete with those offered at the fitness center. This reduced the number of free or low cost recreational activities for low income residents in the community.

[33] This brief review of the local health and healing infrastructure reveals that health care issues in rural communities not only reflect health risks specific to rural settings and health care availability, they reflect the complex socio-cultural contexts in which individuals...
construct their identities and over-all sense of well-being. Comparison of urban and rural congregational contexts strengthen the argument that congregations seeking to develop health and healing ministries must be aware of the multiplicity of factors that define health risks, access to health care, access to health information, and opportunities to engage in healthy behaviors. Hence, the empirical studies of these two congregations contribute to literature on congregational sponsorship of health-related programs by providing relevant information regarding the cultural and ecological conditions under which congregational actions are shaped (Trinitapoli, Ellison, and Boardman).

[34] Recognition of the local socio-economic contexts of rural and urban health issues is central to this study. As is the case with the urban poor, the low incomes and reduced access to health services of the rural poor contribute to poor health and high rates of chronic disease (McConnel and Zetzman). However, compared to inner-city contexts, social relationships are more sustained in rural areas and frequent among people with whom individuals have much in common (Wenger). The rural poor may also be members of extended families from which they receive assistance, making their needs less visible to the larger community. Rural communities in general, compared to urban areas, have more young people and more elderly, higher rates of infant and maternal mortality and higher rates of injury (Hanson). But these rural poor are not often as clearly segregated in low income neighborhoods as they are in urban communities. Unemployed young people continue to live with their parents and the poor elderly often live with their children.

[35] The importance of recognizing individual identities as part of the support structures of the family and community in the maintenance of health and the promotion of healing (Kahn and Antonucci) cannot be over-emphasized in rural communities. This is certainly true in the region under study. I assert, however, that these individual identities must also be understood in terms of class. Class distinctions are highly sensitive in rural communities but they are often difficult to define in terms of household or even neighborhood aggregates. Class can often be seen, however, in congregational cultures in which the membership is predominantly middle, working, or lower class. In the rural area in this study, there has been a decline in middle class membership and a rise in the growth of non-denominational congregations, which serve predominantly working and lower classes in the last several decades. This is the result of a loss of economic opportunities in rural communities. Despite the prevalence of class distinctions in rural communities, there is also a strong sense of community in times of need. It is important to recognize that churches in rural communities frequently coordinate their ministry programs with other churches in the community to serve an interlocking social network of people who are intimately interrelated to each other through kinship ties and participation in civic activities. They interdependently share neighborhoods, school districts, business dealings, services, and public spaces as well as long term relationships with their churches. This is certainly the case in “Lutherville.”

[36] Identification of the local health and healing infrastructure of small rural communities should incorporate a survey of the programs sponsored by all the churches. It should include the programs offered by the park district and those offered by fitness centers as well as the promotions of physicians, therapists, and the hospital. In the case of “Lutherville” in this study, this information was collected through qualitative field methods including participant observation, interviews of church leaders, and examination of local church advertisements.
and mailings regarding their outreach ministry programs. The most active outreach congregations in the community of nine churches were the Catholic Church and two ELCA Lutheran churches, which includes the congregation in this study. They are the three largest congregations in the community and the most affluent. The primary health related focus of these programs is on hunger.

[37] One of the central congregations coordinating these activities I call “Welcome to the Table Lutheran.” The outreach ministry of this congregation recognizes that the church community can extend support networks that help families survive and their children thrive during times of difficulty (Clark and Olson; Stewart; Wallston et al.; Mangham, Reid, and Stewart; Smith). They serve as the center for SHARE, a nonprofit food buying organization that offers nutritious food at reduced costs through a volunteer-run, community-based distribution system. Members of SHARE do not pay dues or need to demonstrate eligibility to save up to 50% on frozen meats, fresh produce, and other groceries. “Welcome to the Table” also participates in WIC, a milk and food federal government sponsored program for women, infants, and children that offers immunizations, formulas, and nutritional counseling. Volunteers work with other churches in the area on the federally funded Backpack program that puts together food packs for children. The church also hosts MOPS meetings for mothers of pre-schoolers, who discuss child development issues. Volunteers at “Welcome to the Table Lutheran” also create food packs of individual meals for small households or seniors. They share health recipes from the Iowa State University Extension program and they list nutritional information on the products included in the food packages. The church sponsors TOPS (Take of Pounds Sensibly), which meet for nutritional education and weight control counseling. Members of the congregation exchange and share garden produce when in season and they collect food each Sunday for the community food pantry.

[38] The Catholic parish works with the “All Saints” Lutheran congregation to share resources and responsibilities for community meals. They are held at “All Saints” because the Catholic Church was one of the congregations that relocated on higher ground outside of town. “All Saints” remains in the center of the community. This program provides a family style meal for any members of the community during the last week in the month when budgets are stretched thin. It also serves as a social outreach to many seniors who live alone. Other congregations in the community contribute to the community wide food pantry. Most congregations sponsor nutritional education programs for their members. All pastors and visitation committees are very committed to visiting the sick and including them in prayer and social networks. Community members maintain the rural traditions of taking a “hot dish” or offering to watch children during times of need. These activities are largely reactive, however, and do not reflect proactive health or healing programs.

[39] I examined the congregational culture characteristics of “All Saints” Lutheran in more depth in this study not only because of the interests in a healing ministry by the associate pastor, but because it seems the most likely site for the development of a parish nurse program that could be defined to serve any or all of the congregations in the community. “All Saints” enjoys an established leadership role in the community due to its traditionally strong pastoral team, large membership, central location, and ample resources. The congregation has a strong base of professional and non-professional volunteers who support its many educational and social ministries, including a kindergarten through sixth grade
parochial school. Its membership includes many young families but it also has strong ties to the local Lutheran senior citizen’s home. Its educational and musical programs are supported through strong ties to the local Lutheran liberal arts college and its theology and music departments. The church is a vital center for numerous active senior social groups and Bible study circles. It seeks to provide activities for youth and families and to welcome newcomers to the community. The congregational leadership actively seeks new ways to serve community needs.

[40] In an earlier study that examined the rural health care infrastructure in the community, I focused on identifying the perceptions of unmet health care needs among rural women over fifty in the region. Data were gathered from this population group in the waiting room of the local hospital physical therapy clinic. The analysis of themes generated from this data revealed a need for social support opportunities to share diet and nutritional information. These older women expressed a need for low-cost or free opportunities to engage in more exercise to reduce pain, and to address weight gain, loss of energy, and a sense of well-being. Social support is particularly effective for middle-aged women seeking to lose weight (Eyler et al.; Pachana et al.).

[41] I shared my earlier findings with the associate pastor at “All Saints,” suggesting that these needs might be met through a congregational health and healing ministry. To more broadly identify the needs of “All Saints” members, the pastor encouraged me to interview eight adult lay leaders in the congregation who had expressed an interest in a healing ministry. The men and women I interviewed varied in age from 19 to 75. I engaged in open-ended interviews to gather their perspectives regarding holistic health and healing issues. They reflected the following characteristics and perspectives.

- “Ann” is an R.N. who works with patients at a local physician’s clinic to become their own health care advocates. She keeps records of her patients’ proactive health practices, reinforces what they are doing, and recognizes their success when progress is noticeable. She provides more knowledge of the health system for her patients. “Ann” thinks a group program at the church for diabetes patients would be successful if it were based on trust and acceptance of where people are in their struggle to control their blood sugar. She would be interested in participating in either a paid or a volunteer position as a parish nurse because she very much believes that healing and spirituality are closely connected.

- “Dan” is a gay man who expressed that the healing ministry of the church needs to be awareness of nurturing the wholeness of individuals in terms of the spiritual, mental, emotional, and physical elements of their lives. For him, that includes sexuality as well. “Dan” feels that wholeness in a community occurs when we can see everyone as human, but he thinks that churches often create social clubs and use traditions to create walls and barriers. To “Dan,” healing is truth telling and being honest about what we know and what we do not know about what the Bible says about issues regarding homosexuality. When reading the Bible for truth, says “Dan,” we need to create an environment where everybody is equal.

- “Allison” is a college student. She feels that the church is the place for assurance when big things in life have us confused. Because support is so important during
times of confusion, “Allison” thinks the church needs to create a safe place for kids to unload and share their problems. She feels that the community and the school have social cliques that exclude a lot of kids, especially when they have problems. According to “Allison,” all that most people need is just good company where they are accepted by other people. They need to share good relationships. She thinks that is what it takes for most people to be healthy.

• “Richard” is a member of the worship board. He and his wife started going to the healing services held by the pastor just to see what was happening. He was struck by the number of people in the congregation who had health concerns that most members were not aware of. According to “Richard,” the pastor has a gift for creating intimacy in small groups and that gift met a need for a lot of people who came each month. When “Richard’s” wife “Ellie” got cancer, she wanted to have a good death. The group from the healing services gave her and the rest of the group the courage to handle it. He thinks that there are a lot of care-takers who need healing too. They are hurting and need someone to reach out to them to heal their pain.

• “Lois” was a friend of “Richard’s” wife “Ellie.” She feels that the congregation really does not have a culture of healing even though the pastor tried to develop it with the healing services. The healing services were held once a month and the sharing of concerns and laying-on of hands was very powerful. The power did not come from a physical healing but from the presence of God. Even when “Ellie” was dying, they did not pray to avoid death, but to help them accept it. But after “Ellie” died, people stopped coming. “Lois” reflected that it seemed as though the focus on the acceptance of death stigmatized the service. “Lois” feels that people in the congregation are afraid of experiences that are very emotionally powerful.

• “Lynn” is the chair of the congregational mission board and a former Iranian hostage. She thinks that one of the most critical elements in healing ministries is the living example of seniors who went through difficult times. According to “Lynn,” seniors need to help our children see that we can give up to God what our reality is and then do something with it. We do not have to fix everything but we can work with disadvantage to help us grow. That is healing of life’s pain and suffering. To her, being active in the church’s outreach ministry is a way to heal. It is a way of doing something whole with life.

• “Ben” is a younger senior citizen who volunteers to help the elderly. He says that he especially connects with crabby old guys who do not want to admit to anyone that they need help. He visits some of them every day. It is very easy for me to talk with them because I just listen, he says. He thinks that the elderly need relationships where they are respected and can maintain their dignity. Sometimes things about their families really bother them and they feel better if they can talk to someone and get things off their minds. Being listened to by someone who respects them is a form of healing, says “Ben.”

• “Pam” is the director of the local community senior center. She participates in the intercessory prayer group at the church and feels that it is a very powerful ministry
for healing. She believes that healing is an ongoing commitment to live out what the Bible says. According to “Pam,” the church does not need another class on anything. It needs activities to act on. She thinks that the culture of the congregation is too intellectual and feels that there are too many theologians who make it complicated. She feels that each and every one has the ability to heal through Christ’s love.

[42] The stories of these eight individuals reflect a strong understanding of some aspect of Jesus’ holistic healing ministry of caring for others, all of which are theologically mainstream Lutheran. They also reflect the four holistic categories of wellness Miskelly identifies: 1) physical; 2) emotional/relational; 3) spiritual; and 4) knowledge base of health systems. They also reveal themes that define some distinctive cultural characteristics of the “All Saints” Lutheran congregation. The emphasis on the emotional/relational needs of individuals seems to be the starting point for addressing physical, spiritual, and knowledge based wellness. Yet, there is also a tension between expressing needs and a fear of vulnerability. The nurse, “Ann,” expressed it well. She thinks a great deal of healing could take place at healing services if members washed each other’s feet. “The fear of touching relates to a fear of showing weakness,” says “Ann,” “and that is a denial of our deepest needs.”

[43] A closer look at these emotional/relational themes reveals that while the culture of this community places a high value on supporting individuals and families through religious education, social networks, and family activities, it is also often considered judgmental to individuals and families who are suffering from isolation, brokenness, or who are different in any way. Several of the persons interviewed expressed a concern for greater acceptance of suffering and support for those who suffer. Two expressed concerns that the larger community had problems with social acceptance of persons who were different or who were experiencing problems. The highly spiritual perceptions of health and healing expressed by the lay leaders interviewed for this study reveals a need to focus on emotional/relational healing more than physical healing. Yet, two of the members specifically noted that the congregation does not seem to be very open to healing ministries despite its deep needs. Both “Pam” and “Lois” sensed barriers to openness to healing experiences that challenged individual comfort zones with emotionally powerful and interpersonal experiences. Two felt that the congregation was either too intellectual or too fearful of commitment to take the necessary action to heal the suffering of others. Should the congregation decide to move forward with a healing ministry, these emotional/relational issues will need to be connected to spiritual issues and addressed by the clergy leadership team.

[44] The key elements of emotional/relational healing expressed by the “All Saints” informants are experiences of trust, honesty, and equality in relationships. Through difficult times, they sensed that when individuals are most vulnerable, they want to be in committed relationships with others who will respect them and uphold their dignity. The informants expressed that they value prayer and good listeners in giving them the courage to accept their realities. They also seek spiritual guidance in terms of assurance of the presence of God during times of great pain and suffering, especially death: their own and those of their loved ones. They want to be loved and to see that Christ is alive in interpersonal relationships with God and others. While all of these needs are already clearly being addressed by the well respected and highly effective pastoral team and the congregation’s active ministry, there are still obvious unmet needs among its members and the larger community. There are still
people whose needs are not met during difficult times in their lives, largely because those needs are not widely known, often because individuals fear exposing issues that are associated with social stigmas. They could be as simple as struggling with an eating disorder or as complex as agonizing over a drug addicted teen son or daughter.

[45] If this congregation proceeds to examine the potential of developing a health and healing ministry, it will first need to be defined as a mission priority by the senior pastor. The church council would next identify a committee of qualified lay professionals to further explore the congregational resources and to engage in additional assessments of needs through congregational forums and small group conversations.

[46] Of equal importance to the congregational study would be conversations with other churches in the community and with health care professionals. Rural health care professionals are well integrated into the social and economic fabric of local communities and have intimate social awareness of their patient’s lives. They care about their well-being and promote pro-active health behaviors. But because their time is limited, they rely greatly on interprofessional networks and community programs to serve the larger health care issues of their patients (Royeen, Jensen, and Harvin). A health and healing ministry that reached out to the larger community would build on these relationships and also likely reflect the existing networks between other congregations and the programs that they sponsor within this rural community.

[47] This preliminary study asserts, however, that a church based health and healing program would best be developed around the skills and professional networks of a parish nurse or nursing team. It further asserts that such a ministry would be most effective if it reflected rural community traditions of providing small intimate groups of acceptance and caring integrated with health care knowledge and professional support. Social support is central to congregational health and healing programs. While a parish nurse can be effective in working on an individual basis, he/she can expand the effectiveness of the parish programs by organizing sustainable social support networks that provide health care knowledge and professional services. Such programs can be pro-active as well as reactive and can serve individuals over time and across multiple health and healing challenges.

Conclusion

[48] This study asserts that the holistic health needs of both rural and urban communities can benefit from a strong role from its churches. The faith community can influence the development of healthy personalities, moderate unhealthy behaviors; influence the effects of pain and disability, stress management, and caring for others in a holistic framework (Buijs and Olson). Faith communities provide a positive focus and a nurturing environment that motivates individuals to care for themselves and each other more holistically. The promotion of health initiatives in faith communities fosters intersectoral collaboration with the health sector and supports social justice through more equitable distribution of health services and a commitment to respect and care for others (Buijs and Olson). The central role in providing this level of nurture and collaboration is that of the parish nurse.

[49] Local congregations are increasingly becoming new players in American health care dynamics through the contributions of parish nurses. As each church community defines
their local responses to local health and healing needs in terms of their own congregational cultures, they have in common a tradition of caring for others in need as their central motivation. While it is not possible to define an ideal model, this study identifies some of the essential processes and key elements in the development of context specific procedures for assessing needs, identifying resources, and defining responses. Health and healing ministries reflect local cultural dynamics, which are very different in urban and rural contexts.

[50] More specifically, this study affirms the claims by Schmitt that providing quality health care to rural communities is a matter of applying geographically and culturally sensitive programs to modify local culturally prescribed group behaviors in a holistic approach to health care systems (xxv). Because local rural authorities are responsible for sustaining the quality of rural life health care in partnerships with community groups and broader governmental agencies through collaborative processes (Royeen, Jensen, and Harvin), parish nurses can clearly augment those processes. Collaborative interaction depends on a rich context of valued relationships to effectively react to problems (Swisher: 241). No where is this more true than in rural communities. The role of the parish nurse can broaden the burden of decisions over a network of caring individuals and better recognize the structural problems of power and status differences that stigmatize some forms of health and healing needs.

[51] Those congregations seeking to develop health and healing ministries should recognize that the development of a local congregation/community response requires at least two years of study and planning. This ethnographic study suggests that identifying local needs and resources and generating the necessary support, both internally in terms of the sponsoring congregation, and externally in terms of the larger community, can best be done with the aid of a parish nurse. Identifying a nurse who can act as an advisor in coordinating the program, either as a paid employee or a volunteer is crucial at this stage. The parish nurse can provide leadership in identifying a health ministry board or committee that should include advisors from the medical profession and local health care institutions. He or she can also identify volunteers needed to assist him/her in the implementation of the program. The congregation also needs to establish a record keeping system and careful guidelines for practice, in addition to the resources necessary to develop the infrastructure (McDermott and Burke). A parish nurse can coordinate this system.

[52] Another important role is that of a social scientist 8 who can engage in a needs assessment study, beginning with open-ended interviews with individuals from diverse cross-sections of the community. The focus of such interviews should be to not only identify perceptions of needs and how these needs should be met, but also awareness of the structural problems of power and status differences that hinder holistic health and healing in the community. Interviews should be followed by focus group discussions from among diverse congregational groups to determine whether individual expressions are representative of the larger church community. Interviews draw out unique perspectives that can open up new areas of concern and response. Focus groups draw out shared perceptions. Subsequent

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8 Training in the area of medical anthropology is more desired here.
surveys of the entire congregation can also be useful to identify priorities and support for particular programs.

[53] Focus groups can also identify resources as well as risk factors and barriers to the success of congregational health ministries. Despite the initial enthusiasm of local communities, concerns about liability and limited church finances often preclude the development of congregational health ministries. Most congregations have attorneys who can advise them on these issues. While collaboration with several congregations and health care professionals can complicate these issues, the formation of limited liability non-profit corporations to provide health and healing ministries is not unnecessarily complicated or expensive.

[54] This study suggests that the skills of both health professionals and lay persons as caring volunteers in church communities can be quite easily coordinated in congregational based health and healing ministries (for practical information, see Hale and Koenig; Hale and Bennett). And while it may not be the direct goal of most ministries to challenge the mainstream healthcare system, this study supports the claims by Lavin et al. that the collaborative community approach has been used to address health related needs not well addressed by the mainstream, such as healthy eating, exercise, and safety strategies (147). Because of their highly intimate system of social interaction and their integration with other community organizations and agencies, churches are effective centers for the development of pro-active community participation health care.

[55] Churches like Kountze Memorial, with it large numbers of medical professional volunteers, collaborate well with the medical system because they play a highly significant role in enacting authority patterns in communities. But churches like Kountze Memorial can also act powerfully to over-turn social relations and authority structures in behalf of the poor and under-privileged. This is an example of how the local moral world can shape the social and cultural dimensions of health (Janzen: 43). Parish nursing and congregational ministries can broaden the vision of health and wholeness to include social justice. Kountze Memorial developed its health and healing ministry because it is a vital community institution in furthering social justice. While restructuring dysfunctional social relations to better serve the health and healing needs of a larger number of residents in rural areas may be desirable in some cases, it is more difficult to do. It is more likely that rural congregations will be most effective in collaborating with the local medical system through existing authority patterns to broaden the vision of health and wholeness for its residents.

[56] Like urban congregations, rural congregations can also assume leadership roles in public health programs. The health programs at Kountze are founded on the belief that parish nursing can also play a large role in public health promotion and disease prevention for all ages, from children to the aged (Boland; Moeller; Solari-Twadell and Westberg). As such, the Kountze programs illustrate the goals and objectives of congregational based health and healing programs identified in the literature by providing a viable alternative for non-acute care need (Wallace et al.) and filling in the gaps by collaborating with existing systems of health care delivery (Weis et al.). The parish nurse at Kountze works to motivate healthier lifestyles through dissemination of better health knowledge and a greater sense of spiritual well-being through social support. She works with the pastoral team and Stephen’s
Ministers\(^9\) to reduce social isolation and anxiety for individuals, and provide support networks for families undergoing crises and grief (see Weis et al.: 108). She does this through her presence, active listening, health education, and promotion of social support. The parish nurse at Kountze is a trained professional with a friendly and outgoing personality (see traits defined by Wallace et al.). As such, she easily develops relationships of friendship and support, and can integrate spirituality with health to encourage individuals to maintain or improve their own health through active decisions and responsible behaviors.

[57] This study shows how the parish nurse is becoming a new face and a new force in leading responses to the traditional call of Christian mission to serve a suffering humanity in all the multiplicity of ways it can be identified and addressed. In this mission, the parish nurse is a viable and valuable venue for enlisting legions of professional and non-professional volunteers in the twenty-first century to develop locally sensitive holistic health and healing ministries in diverse contexts.

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