Health Ministry in the Life of a Congregation with a Parish Nurse: Caring and Connecting Through Christ

Mary Ann Chase-Ziolek
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_diss

Part of the Nursing Commons

Recommended Citation
https://ecommons.luc.edu/luc_diss/3746

This Dissertation is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Dissertations by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.

This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License. Copyright © 1998 Mary Ann Chase-Ziolek
LOYOLA UNIVERSITY CHICAGO

HEALTH MINISTRY IN THE LIFE OF A CONGREGATION
WITH A PARISH NURSE:
CARING AND CONNECTING THROUGH CHRIST

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

SCHOOL OF NURSING

BY
MARY ANN CHASE-ZIOLEK

CHICAGO, ILLINOIS
MAY 1998
ACKNOWLEDGMENTS

If there is one thing I have learned through my doctoral education, it is that no woman is an island unto herself. This has been a shared journey that has connected me to many companions who have nurtured, supported and challenged me, and without whom the journey would not have been complete.

This journey was launched from my home base that provided my anchor and centering point. My husband Keith has been an unfailing source of encouragement, support and practical assistance. My son Andrew has provided invaluable computer assistance and compassion while my daughter Emily has been my study buddy and inspiration. Long before my dissertation began, my early academic journey was launched with the blessing of my parents Helen and James Chase. I am particularly indebted to my father, who first showed me the connection between health and ministry through his example as a pastor.

My committee members; Drs. Mary Ann McDermott, Dorothy Lanuza, Patti Ludwig-Beymer and Stephen Schmidt all provided invaluable insight and assistance. I am particularly indebted to Mary Ann McDermott, my director, for her insight and compassion. I am thankful not only for what she did to guide me through my dissertation, but also for the caring and Christian way she provided her guidance.
I am grateful to the members of First Church who so graciously and willingly participated in my research. Learning about their culture was both educational and personally enriching.

There have been so many friends and colleagues who have shared this journey offering support, useful advice and prayers. The nurses I work with through the Volunteer Congregational Health Program have been a particular gift of God’s grace for me during my dissertation.

I am indebted to Ron Tabeta of Loyola University Instructional Design for his assistance with my graphic figures.
To God be the glory, great things he hath done.  

Fannie Crosby
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ........................................................................................................ iii
LIST OF FIGURES ........................................................................................................ iv
LIST OF TABLES ........................................................................................................... x

Chapter

I. STATEMENT OF THE PROBLEM ........................................................................ 1
   The Concept of Health Ministry ................................................................. 2
   Societal Significance ................................................................................... 7
   Significance to Nursing ............................................................................. 13
   Assumptions .............................................................................................. 16
   Purpose ...................................................................................................... 18

II. REVIEW OF THE LITERATURE ........................................................................ 21
   Health Ministry .......................................................................................... 21
   Parish Nursing ........................................................................................... 42
   Healing ....................................................................................................... 54
   Congregations as Partners in Promoting Health ......................................... 60
   Congregational Culture .............................................................................. 68
   Conceptual Framework ............................................................................... 72

III. METHODOLOGY .............................................................................................. 77
   Qualitative Research ................................................................................... 78
   Study Design .............................................................................................. 80
   Procedure ................................................................................................... 86
   Evaluation .................................................................................................. 98

IV. HISTORICAL CONTEXT ............................................................................... 101
   John Wesley and the People Called Methodists ........................................ 102
   Wesleyan Theological Beliefs .................................................................... 104
   Methodism in the United States ................................................................. 110
   Methodist Polity ......................................................................................... 116
   Involvement of United Methodist Church in Health .................................. 119
V. FINDINGS ........................................................................................... 123
Cultural Descriptions ............................................................................ 123
Gaining Entry into the Culture .............................................................. 130
Research Participants .......................................................................... 132
Domains and Categories ...................................................................... 133
Domain Related to Individual Context .................................................. 135
Domain Related to Historical Context ................................................... 155
Domain Related to Community Context ................................................ 158
Domain Related to Organization ........................................................... 178
Domain Related to Ministry ................................................................. 188
Themes ................................................................................................. 215

VI. DISCUSSION ...................................................................................... 219
Significant Findings .............................................................................. 219
Implications for the Congregation ......................................................... 233
Implications for Nursing ....................................................................... 235
Strengths and Limitations ..................................................................... 236
Future Research .................................................................................... 238
Conclusion ........................................................................................... 239

APPENDIX

A. RESEARCH ON RELIGION AND HEALTH ..................................... 242
B. RESEARCH ON PARISH NURSING ............................................... 247
C. INTERVIEW GUIDE FOR PARISH NURSE COORDINATORS ...... 251
D. RESEARCH ON INVOLVEMENT OF CHURCHES IN HEALTH PROGRAMS .................................................. 253
E. RESEARCH ON CHURCHES AS SITES FOR HEALTH PROGRAMS ................................................................. 256
F. INFORMED CONSENT ...................................................................... 261
G. INTERVIEW GUIDE .......................................................................... 263
H. A PLACE FOR HEALTH BROCHURE .............................................. 268
I. PERMISSION TO USE SUNRISE MODEL ...................................... 273
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Graphic representation of health ministry</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Relationships in health ministry</td>
<td>6</td>
</tr>
<tr>
<td>3.</td>
<td>Contextual factors impacting the development of health ministry</td>
<td>8</td>
</tr>
<tr>
<td>4.</td>
<td>Four dimensions contributing to an understanding of health ministry</td>
<td>22</td>
</tr>
<tr>
<td>5.</td>
<td>Leininger's Sunrise model</td>
<td>74</td>
</tr>
<tr>
<td>6.</td>
<td>Ethnographic domains constituting worldview of First Church</td>
<td>136</td>
</tr>
<tr>
<td>7.</td>
<td>Participant identified attributes and semantic relationships of health</td>
<td>140</td>
</tr>
<tr>
<td>8.</td>
<td>Participant identified attributes and semantic relationships of ministry</td>
<td>190</td>
</tr>
<tr>
<td>9.</td>
<td>Participant identified attributes and semantic relationships of mission</td>
<td>196</td>
</tr>
<tr>
<td>10.</td>
<td>Participant identified attributes and semantic relationships of health ministry</td>
<td>202</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Summary of literature on health ministry</td>
<td>23</td>
</tr>
<tr>
<td>2.</td>
<td>Biblical references used to support health ministry</td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>Practical implications of naturalistic inquiry</td>
<td>79</td>
</tr>
<tr>
<td>4.</td>
<td>Taxonomy of ethnographic analysis</td>
<td>96</td>
</tr>
<tr>
<td>5.</td>
<td>Overview of First Church according to Leininger’s theory of culture care diversity and universality</td>
<td>131</td>
</tr>
<tr>
<td>6.</td>
<td>Domains and categories of findings</td>
<td>134</td>
</tr>
<tr>
<td>7.</td>
<td>Individual context: categories and subcategories</td>
<td>138</td>
</tr>
<tr>
<td>8.</td>
<td>Ways being part of First Church promotes health: Categories and subcategories</td>
<td>143</td>
</tr>
<tr>
<td>9.</td>
<td>Community context: Categories and subcategories</td>
<td>159</td>
</tr>
<tr>
<td>10.</td>
<td>Domain of organizations: Categories and subcategories</td>
<td>179</td>
</tr>
<tr>
<td>11.</td>
<td>Domain of ministry: Categories and subcategories</td>
<td>189</td>
</tr>
<tr>
<td>12.</td>
<td>Cultural themes reflected in health ministry</td>
<td>221</td>
</tr>
</tbody>
</table>
CHAPTER I
STATEMENT OF THE PROBLEM

*I came that they may have life and have it abundantly.* John 10:10

As the twenty first century approaches, the nursing profession is faced with a rapidly changing health care environment including shifting nursing practice from the hospital to the community; from acute care to primary care; from treating disease to preventing illness and promoting health. During the past decade, churches have emerged as a growing area for community based nursing practice. This type of nursing, commonly referred to as parish nursing, is based on a renewed understanding of the Church's (being the global body of all Christians) role in health, led by the work of Granger Westberg, a Lutheran hospital chaplain (Westberg, 1979, 1986, 1990).

Concurrent with the development of parish nursing, the disciplines of pastoral care and public health have become interested in the potential role congregations can play in promoting health. Pastoral care professionals have studied health promotion as a way to live out the responsibility of the Church to heal, as well as a way to respond to contemporary needs (Droege, 1995). Public health professionals have seen churches as solid community organizations that can provide access to underserved populations.
(Evans, 1995). More recently, medicine has become interested in how religion affects health, as evidenced by the work of the National Institute of Health Research (Matthews, Larson & Barry, 1993). Each of these disciplines is involved with the local church as a place that can promote health, but from different perspectives.

The Concept of Health Ministry

Health ministry is a concept guiding nursing knowledge and practice when working with congregations. The term health ministry can refer to any of the following:

- The work of a Christian health professional who sees his/her work as ministry (Bakken & Hofeller, 1988).

- The provision of direct health services by a Christian group (Commission on Catholic Health Care Ministry, 1988; Evans, 1995; Hilton, 1995).

- The work of a parish nurse with a congregation (Health Ministries Association, 1995; Droege, 1995).

- The need of the Church as a global body to respond, out of a desire for justice, to inequities in health status around the world (Christian Medical Commission, 1990; Droege, 1995).

- An understanding that for the Church an extension of the work of Jesus is to heal the sick and promote health and wholeness (Archbishop's Commission on Community Health, 1995).
• The community life of a congregation including worship, fellowship, education and service that strives to promote wholeness (Droege, 1995).

Health ministry is a shared sense of ministry by an individual congregation to promote health and wholeness which can be directed towards individuals, families, communities, the environment or the world. The parish nurse as a component of health ministry, the exploration of health ministry as an extension of the work of Jesus, and the community life of a congregation that promotes wholeness were the components of health ministry on which this study focused.

Health ministry is a way to understand how health fits into the life of a church. Churches, at their best, promote health through the experience of community, providing strong social support and teaching about a positive way of life (Droege, 1994). The relationships that a congregation offers its members are integral to health ministry. There is a mutual and necessary relationship between the person ministering and the person being ministered to that benefits both participants. In a broader sense, health ministry also cultivates organizational relationships through collaboration. Health ministry is inherently collaborative: collaborative with the health minister and the person being ministered unto; collaborative between health professionals, lay persons and other professionals within the church; collaborative between the church and health care agencies.
Definition of Health Ministry

Although there is diversity in how health ministry is discussed in the literature, attributes were identified through concept analysis that resulted in the author's following definition of health ministry. Health ministry was defined as the intentional reaching out to others by a community of faith to promote wholistic health, that is seen as an integration of body, mind and spirit. The motivation for health ministry comes from a shared understanding of the call to wholeness and service as illuminated in the Christian scriptures. Health ministry is directed by a health professional and respects the culture in which it is expressed, recognizing individual responsibility for health among those it serves (Chase-Ziolek, 1996). This definition focuses on terms that are consistent with Christianity, but could be modified to include other world religions as well. Figure 1 provides a graphic representation of the definition, reflecting the interactive processes that are part of health ministry. A sense of health, understood as wholeness, exists in the overall pattern of the interactions.

The terms healing ministry, health care ministry and wellness ministry are sometimes used interchangeably with the term health ministry. Tom Droege (1992, 1994, 1995) from the Interfaith Health Program of the Carter Center has articulated the difference between healing ministry, health care ministry and health ministry. Healing ministry, understood as the restoration of health, is the term most frequently interchanged with health ministry. Depending on one’s understanding of health and healing, everyone needs some degree of healing. Even those with physical well being
A church reaches out through health ministry to its members, the community and the world, offering the message of wholeness and salvation leading towards health.
experience some degree of brokenness with self, others and God that calls for healing. Health care ministry, a term less used, refers to providing direct health services.

Another related concept emerging in the literature is wellness ministry, which focuses on promoting health through educational, spiritual, environmental and organizational activities in the church (Miller, 1987). Health ministry involves trying to help people keep themselves well, which may involve restoring health through healing, yet goes beyond that to health promotion. Health ministry acknowledges the integrity of the individual in promoting their wellness and healing. Figure 2 shows the relationships between these four terms.

Figure 2. Relationships in health ministry. Chase-Ziolek 1996
Societal Significance

Contextual factors are important in understanding the conceptual evolution of health ministry. The convergence of factors from the health professions, history, society, the health care system, health knowledge and the Church all contribute to the current relevance of health ministry as shown in Figure 3. According to Kelsey (1995), "When the same insight emerges from very different sources it is usually an indication that some important aspect of life has been ignored" (p. 186).

Trends in the health professions of nursing, public health and medicine have had an impact on the evolution of health ministry. Nursing has changed in the past ten years as decreased length of hospital stays have increased the acuity of hospital nursing, while a growing number of nurses work in community settings. There is also an increasing number of nurses serving either in paid or unpaid roles within congregations as a parish nurse or health minister (Lloyd & Djupe, 1993). The growing number of nurses willing to volunteer their services as parish nurses and the number of hospitals and congregations that are salarying parish nurses reflect the current interest in health ministry.

Concurrent to the growth of parish nursing, public health professionals have identified the church as a prime site for health interventions to reach underserved populations. Physicians are increasingly acknowledging that health is more than the absence of disease (Evans, 1995) and medicine has taken a new interest in the role of religion and health as reflected in the investigations of the National Institute of Health.
Figure 3. Contextual factors impacting the development of health ministry. Chase-Ziolek 11/97
Research on the impact of religious behavior on health.

Three organizations have played important roles in the development of health ministry. The Health Ministries Association started in 1989 with a small group of individuals working with parish nursing. Their current membership of 1,112 (M. Ahrens, personal communication August 29, 1997) reflects one group of individuals who identify their work in health as a ministry. The International Parish Nurse Resource Center in Park Ridge, Illinois began in 1985 to provide resources and training for the development of parish nursing. The Carter Center in Atlanta, Georgia began in 1982 and through its Interfaith Health Program has brought resources to the development of health ministry through exploring issues of faith and health in national programs, conferences and publications.

Historically, churches were a major source of health care provision with clergy often serving as healers. The religious rituals clergy provided of anointing and confession served a healing as well as a religious purpose. There has also been a history of significant involvement of religious groups in providing direct health care. This is exemplified in the number of hospitals, nursing homes and hospices that began with the sponsorship of a congregation or denomination. This sponsorship has gradually diminished over the past 100 years and with it the responsibility to heal and provide health care has largely been turned over to Western medicine (Kipp, 1988; Kelsey, 1995).
Three additional historic factors have created patterns making health ministry relevant for contemporary congregations. The first historic factor was the deaconess movement. The role of deaconess goes back to the early Christian Church. Phoebe is identified in the Bible as the first deaconess. A deaconess was a woman who cared for sick and needy persons. The deaconess role continued to be utilized intermittently from Biblical times, becoming popular again in the 19th century as an expression of the social gospel (Holifield, 1986). Nursing as a profession emerged in part from the deaconess movement (Zersen, 1994).

Second, in some African American churches there has been a longstanding role of the church nurse, who provides first aid and care to members as needed during worship services. The church nurse is not necessarily a licensed nurse, but a person who is seen as capable, caring and compassionate. The existence of the church nurse responds to identified health needs of particular congregations (Newsome, 1994; Segall, Wince & Constant, 1985).

Finally, the wholistic health movement of the 1970's led by Granger Westberg created a wholistic framework of caring for people as bio-psychosocial-spiritual beings (Westberg, 1979). These three historic movements laid a foundation making many contemporary congregations receptive to health ministry.

Changes in social thinking have contributed to the current interest in health ministry. There has been a growing interest in "secular" spirituality and a search for meaning not associated with a particular religion. This is evidenced by the popularity
of the work of Larry Dossey, a physician, who has written books such as *Healing Words, Meaning and Medicine,* and *Prayer is Good Medicine.* Deepak Chopra, also a physician, has written on spirituality and health in books such as *Quantum Healing.* In addition, there has been a growing interest in alternative medicine that taps into both secular spirituality and dissatisfaction with the health care system, as evidenced by the growth of wholistic health centers providing non-traditional treatments (Edelberg, 1994). Finally, the interest in the philanthropic community in supporting health ministry initiatives has provided resources for program development.

Developments in health care financing have contributed to the evolution of health ministry. The growth in government financing of health care and the rise of for-profit health care institutions has displaced some of the need for religiously sponsored health care. The current inability of the health care system to adequately finance health access for all has brought denominations of all faiths into the debate in strong support of universal access to health care (National Council of the Churches of Christ in the USA, 1991). In addition, the provision of health care has increasingly moved to communities of which congregations are an integral part, while simultaneously the increase in medical technology has made hospital-based health care more complex, costly and less personal.

Knowledge of health has changed over time. We have moved from a time when understanding health as the absence of disease made sense because the major causes of death were infectious diseases, to a time when the major cause of disease is chronic
illnesses, which are greatly impacted by individual lifestyle, environmental and socio-political factors. Public health knowledge has also demonstrated the impact of community based interventions on health status (Mason, 1990). The growing scientific awareness of the myriad of factors that create health provides an opportunity for congregations to participate in promoting health in new ways.

Churches have participated in the evolution of the concept of health ministry individually and through denominations (Presbyterian Church USA, 1988, 1991; Evangelical Lutheran Church of America, 1994; Metropolitan Chicago Synod, 1990; Peterson, 1982; United Methodist Church, 1987, 1995). With the advent of government involvement in health care financing through Medicare and Medicaid in the 1960's, denominations have looked for other ways to fulfill their mandate to heal (Commission on Catholic Health Care Ministry, 1988). One way denominations have traditionally provided health ministry has been sending missionaries to third world countries. Changes in understanding health and health missions has led to more local control of health services, altering the focus of health missions in other countries (Crawley, 1986). The experience of health care mission in the third world has also provided important insight for health ministry in this country, including the importance of community development in promoting health (Hilton, 1995). Concurrent to changes in the mission field, many mainline Protestant churches have had a steady decline in membership. There has also been a decrease in denominational support causing churches and denominations to look for new approaches to stay relevant in
contemporary society (Schaller, 1994).

Individual congregations and denominations have cultures that share values. Congregations both influence and are influenced by the larger culture within which they exist. This is particularly evident with the concept of health ministry. Broader issues that are part of American society affect how the concept of health ministry has emerged within religious groups. Conversely, how religious groups express health ministry affects American society as well.

Health ministry is a concept whose emergence is clearly associated with a particular point in historic time. There would be no need for wholistic health if Western thought had not separated body, mind and spirit. It would be redundant because the understanding of wholistic would be implicit in health. There would be no need for health ministry as a distinct concept if the Church had never minimized its responsibility to heal because promoting health would be implicitly understood in the concept of ministry.

Significance to Nursing

As nursing practice continues to include work with and in churches, understanding the concept of health ministry takes on increased importance. Because of the grassroots nature of parish nursing, it is impossible to give a reasonable estimate of the number of nurses practicing in this role. However, one reflection of the growing interest is the number of attendees, 850, at the 1997 annual Westberg Symposium on
parish nursing (A. Solari-Twadell, personal communication October 1, 1997).

Concurrently, the growing interest by the public health community in working with congregations to access underserved populations involves many public health nurses. Similarly, the expanding body of knowledge on health promotion and the impact of lifestyle on health status makes partnerships with congregations appealing because religious beliefs address many lifestyle issues. In some cases, such as Seventh Day Adventists and Mormons, religious beliefs include lifestyle standards. In these groups, religious beliefs help to promote health which is reflected in their morbidity and mortality rates (Vaux, 1976). Recent research (Strawbridge, Cohen, Shema & Kaplan, 1997) indicates that persons who frequently attend religious services of any denomination have lower morbidity and mortality.

Health ministry involves health professionals, predominantly nurses, working within the culture of the congregation to provide culturally congruent care, integrating religious beliefs and health promotion knowledge. When the nursing client is an aggregate, as it is with a congregation, it is essential that the nurse understand the culture of the group. Understanding the meaning of health ministry is important as churches are a relatively new site for nursing practice and often there is not a clear understanding of what a nurse could, or should, do for a congregation.

Knowledge of a congregation’s shared understanding of health, ministry and health ministry is necessary to tailor nursing care to congregations. Understanding any religiously based belief about health within a congregation is prerequisite to the nurse
introducing professional care beliefs about health, recognizing that religious beliefs can have a significant impact on health behaviors. This search for cultural knowledge needs to be included when a nurse does a congregational or community assessment.

For nurses working as parish nurses, an understanding of the concept of health ministry can help in developing programs that transform their congregations. Through understanding health ministry from the perspective of an individual congregation, a parish nurse will be better equipped to provide culturally congruent care within that congregation. It is not difficult for nurses working in a congregation to focus on the needs of individuals or to focus on providing activities. However, an understanding of health ministry can help nurses to focus on the group and identify how to address needs of the aggregate. Furthermore, an understanding of health ministry can help nurses focus on changing the congregation's way of thinking about health that ultimately has the potential to make all nursing activities more effective.

For nurses who work as coordinators of parish nurse or health ministry programs, understanding the concept of health ministry can help him/her to relate to congregations in a culturally congruent manner, facilitating the development of partnerships. When health professionals, clergy, leaders and members of congregations mutually understand health promotion and the theological understanding of health, then stronger and more meaningful partnerships can be created between congregations and health care institutions to promote the health of the community.
Assumptions

There are four assumptions in this study. First, health is understood as being multidimensional and wholistic. Although the term wholistic has been used in various ways, for the purposes of this paper, it means body, mind and spirit integration. Health is more than the absence of disease. The multidimensional nature of health is reflected in the impact of the physical, work, political and social environments on the experience of health (Hardel & Mull, 1994). When health is understood wholistically the relationship between congregational activities and health promotion become more apparent (Droege, 1995).

Second, culture is an organizing dimension of human existence which shapes the meaning of health (Leininger, 1991). The meaning of health comes both from the individual and from the culture or cultures in which one is a member. Meleis in a dialogue on health states "Health is to grow within a group, and have the groups or family grow, and health is to be part of that group" (Huch, 1991). For many individuals, the church is one group that shapes the meaning of, and motivation for health through shared religious values and experiences.

"What has changed, what has evolved, and what is characteristically man - in fact, what gives man his identity no matter where he is born - is his culture, the total communication framework; words, actions, postures, gestures, tones of voice, facial expressions, the way he handles time, space and materials and the way he works, plays, makes love and defends himself. All these things and more are complete communication systems with meanings that can be read correctly only if one is familiar with the behavior in its historical, social and cultural context" (Hall, 1976, p.42).
Third, the experience of the aggregate frames the opportunities for health of individual members. Not all communities provide the same opportunities for health (Milio, 1981). Health is experienced by individuals, but it is experienced within the context of community and culture. This context shapes the opportunities for experiencing health, as well as the meanings that will be attached to the experience of health (Meleis, 1990). This study was informed by public health nursing practice that looks at the community as the client. In this case, the community client is a congregation (McDermott & Burke, 1993).

Finally, ministry is service with a motivation that is a direct reflection of and a response to the relationship of an individual or a community with God. Ministry is understood as the work of the Church, seen as a continuation of the work that Jesus began on earth. Variations in the meaning of ministry come about in understanding exactly what the work of the Church should be (Wylie, 1990). The Oxford English Dictionary (1989) defines ministry as rendering a service. However, as the concept has developed within congregations, ministry means more than service. Ministry involves first being called, then being sent. The call comes from an understanding of scripture and a personal relationship with God. The sending comes through a congregation as a community. Ministry is a way that people become a channel in the world for the will of God to be done (Thomas & Alkire, 1989).

Although a relatively new concept, the research opportunities in relation to health ministry are abundant. There has only been one research study explicitly on
health ministry. The literature on health ministry has focused on the ideal of what a congregation can do to promote health. However, congregations as human organizations are limited in their ability to be idyllic (Couture, 1993). What is needed in the literature is an understanding of the reality of health ministry. Health ministry to date has been discussed predominantly from an etic (outsider) perspective. What is also needed is an understanding of the emic (insider) perspective.

Purpose

The purpose of this study was to understand how health ministry exists within the culture of a congregation, examining both the emic and the etic perspectives. Leininger's (1991) theory of culture care diversity and universality was the conceptual framework and ethnography was the method (Spradley, 1979, 1980). This research approach makes the assumption that each congregation is a unique culture, which shares some patterns with other congregations and has distinctive qualities.

The framework of culture is appropriate for understanding health ministry because congregations are cultures with shared values, experiences, language and beliefs (Wind, 1993). The field of congregational studies provides an additional framework for understanding congregations as cultures (Carroll, Dudley & McKinney, 1986; Dudley & Johnson, 1993). Health ministry involves integrating two cultures, the culture of the congregation and the culture of the health care system. Each contributes a particular set of values and language that together creates something new
and different. Health ministry requires creating new meanings and language for health (Peterson, 1995). Language can both enhance and limit communication, as it shapes reality through the structure and existence or nonexistence of words reflective of cultural values. (Leininger, 1991; Hall, 1976). The language of health ministry is a bridge between the language of the congregation and the language of the health care system with parish nurses being in a unique position to be interpreters (Westberg, 1990).

Understanding health ministry in the life of a congregation with a parish nurse can best be studied through naturalistic inquiry. The contextual variables that affect a phenomena and valuing the viewpoint of the research participants who provide the emic perspective are important components of naturalistic inquiry (Leininger, 1991). A congregation with a parish nurse was chosen because parish nursing is one of the most common modes of implementing health ministry. Gaining an understanding of health ministry will provide valuable information to assist nurses in providing culturally congruent care when working with congregations.

**Research Questions**

This ethnographic study was designed to gain an understanding of the following research questions:

1. How does health ministry reflect the worldview and cultural care values of a congregation with a parish nurse?
2. What are the patterns, meanings and expressions of health ministry in a congregation with a parish nurse?

3. What is the emic (insider) understanding of health ministry in a congregation with a parish nurse?

4. How is the emic (insider) understanding of health ministry similar and/or different from the etic (outsider) understanding of health ministry?

Summary

Health ministry is a concept of contemporary interest because of converging contextual factors. Health ministry is a reflection of the culture of Christianity as lived out in the culture of individual congregations. The history of the Church, nursing, health patterns and the health care system, as well as emerging patterns in contemporary society all contribute to an understanding of health ministry. Health ministry is a concept that brings together health and ministry, once understood as closely interrelated, then separated, and now attempting to be integrated. Health ministry is a concept of significance to the nursing profession as it creates new opportunities for nursing practice and new partners for nursing as the profession confronts a new century.
CHAPTER II
REVIEW OF THE LITERATURE

I have set before you life and death, the blessing and the curse. Choose life that you and your descendants may live. Deuteronomy 30:19

Having identified the questions to be studied and the context within which they arose, the literature was examined for information relevant to understanding and studying health ministry in the life of a congregation with a parish nurse. Literature both provides the context within which health ministry is experienced and reflects the public discourse around the subject. The following primary concepts included in the review of literature were seen as essential to this study: health ministry, parish nursing, healing, the church as a partner in promoting health, and congregational culture. In addition, the conceptual framework for this study on health ministry is discussed.

Health Ministry

Pastoral theology and denominational publications are the areas where the concept of health ministry is most clearly articulated. This literature builds on Biblical references and theological understandings that justify, discuss and describe health ministry, painting a broad picture both philosophic and pragmatic. In reviewing the literature explicitly addressing health ministry, three main dimensions of discourse were
identified: understanding the meaning of health, motivation for health ministry and actualizing health ministry which includes defining the concept and identifying potential health ministry activities. This body of literature has certain key concepts that reflect the particular perspective of the author(s). Table 1 provides a summary of this literature. An additional dimension of health ministry discussed in the literature includes the health promoting qualities of congregational life. This includes literature explicitly on health ministry as well as religion and health in general. Figure 4 summarizes how each of these four dimensions has a slightly different slant on health ministry.

Figure 4. Four dimensions contributing to an understanding of health ministry. Chase-Ziolek 11/97
<table>
<thead>
<tr>
<th>Source</th>
<th>Definition of Health</th>
<th>Motivation for Church’s Role</th>
<th>Health Ministry Actualized</th>
<th>Key Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lutheran Church Missouri Synod (1996, undated)</td>
<td>Health is norm in Christian community.</td>
<td>Biblical mandate to heal</td>
<td>Parish health ministry is a ministry of Christian service shaped by Christ’s concern for all aspects of the human condition and directed to the service of the whole person. Includes parish nursing, AIDS ministries, care of the professional church worker and the healing power of faith. Functions include education, consultation, personal health counseling, health resources, advocacy, Christian lifestyle, voluntary care-giving, home health visitations, community liaison, corporate congregational health and handicapped access.</td>
<td>Developing new health ministry builds on current health ministry</td>
</tr>
<tr>
<td>United Methodist Church (1995, 1987)</td>
<td>A dynamic state of well-being of the individual and society. Wholistic wellness which is physical, mental, spiritual, economic, political and social. Being in harmony with the natural environment and with God.</td>
<td>Empowering people to take responsibility for their health by making positive lifestyle changes</td>
<td>Health ministry is a wholistically oriented profession. Health ministry combines therapeutic qualities of church, community, and faith in God to the healing task. Local churches can address issues of accessibility of health care, bring a wholistic perspective to the community’s understanding of health and health promotion.</td>
<td>Empowerment; Importance of individual, community and global health</td>
</tr>
<tr>
<td>Source</td>
<td>Definition of Health</td>
<td>Motivation for Church's Role</td>
<td>Health Ministry Actualized</td>
<td>Key Concepts</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Health Ministry Association</td>
<td>Wholeness of body, mind and spirit</td>
<td>Centrality of healing in Jesus' ministry</td>
<td>Health ministry emphasizes the wholeness of body, mind and spirit in congregations. Healing, health and wellness are promoted among the members and among people in the wider ministry. It is a cooperative effort that may include members interested in health and wholeness, hospitals and other health agencies in the community.</td>
<td>What keeps people well?</td>
</tr>
<tr>
<td>(1995)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Archbishop's Commission on</td>
<td>Everything which can effect the well-being of a person,</td>
<td>Extension of Jesus' healing ministry</td>
<td>The activity to provide health or ministering to the well being of members of the community.</td>
<td>Responding to needs within the</td>
</tr>
<tr>
<td>Community Health</td>
<td>e.g. housing, food, clothing, work, relationships, and access to health care awareness and resources.</td>
<td></td>
<td></td>
<td>community</td>
</tr>
<tr>
<td>Health (1995)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evans, A.R.</td>
<td>Wholeness</td>
<td>Extension of Jesus' ministry</td>
<td>Health ministry addresses the need for meaning, understanding healthy lifestyles and change, maximizing health, making health care decisions, supporting health professionals and fair allocation of resources. Categories of health ministry are liturgy and preaching, education for healthier lifestyles, advocacy and support programs, direct health services and resource organizations.</td>
<td>Church has a theological call to participate in health ministry</td>
</tr>
<tr>
<td>(1995)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Summary of Literature on Health Ministry

<table>
<thead>
<tr>
<th>Source</th>
<th>Definition of Health</th>
<th>Motivation for Church’s Role</th>
<th>Health Ministry Actualized</th>
<th>Key Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Droege, T. (1995, 1994, 1992)</td>
<td>Wholeness; Healthy souls make healthy bodies</td>
<td>Restoring God intended wholeness</td>
<td>Congregations promote health through community building, enhancing the meaning of life, nurturing core spiritual values and sponsoring health-related programs. Inspiring hope, pursuing social justice and serving people in need also promote health.</td>
<td>Integrity of creation; Personal responsibility; Health facilitates ability to serve; Transformation</td>
</tr>
<tr>
<td>Evangelical Lutheran Church of America (1994)</td>
<td>Multidimensional, spiritual, physical, emotional, relational</td>
<td>Congregations offer sense of belonging</td>
<td>Health ministry is based on awareness of limitations of medical technology. Health ministry involves self care of oneself, one’s family and community. Health ministry may provide direct service by support groups, offering spiritual care and advocacy</td>
<td>Stewardship</td>
</tr>
<tr>
<td>Association of Brethren Caregivers (1993)</td>
<td>Wholeness Spiritual and physical well-being</td>
<td>Abundant life in Christ</td>
<td>Whole person health ministry combines healing ministry and health promotion</td>
<td>Transformation; Empowerment; Community</td>
</tr>
<tr>
<td>American Baptist Churches USA (1991)</td>
<td>State of a person in Christ, a new creature made whole by spiritual conversion. Integration of spirit, body, mind. Health as wholeness, abundant life.</td>
<td>Biblically based understanding of health. Transformation of perspective through the power of the Holy Spirit.</td>
<td>Congregations are called to empower members to live a Christian model, discuss health related issues, participate in health agency boards, utilize Christian model principles in hospital and homebound visitation, address ethical issues in health care, provide information on health services and advocate for access to health care.</td>
<td>Conversion; Biblically based Relationship with God</td>
</tr>
<tr>
<td>Source</td>
<td>Definition of Health</td>
<td>Motivation for Church’s Role</td>
<td>Health Ministry Actualized</td>
<td>Key Concepts</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Presbyterian Church USA (1991, 1988)</td>
<td>Multidimensional physical, mental, spiritual</td>
<td>Extension of Jesus’ healing Stewardship of our bodies</td>
<td>The church models health in its own life, creates a healthy environment in worship and activities, reforms social injustice which is unhealthy and provides direct health services to the poor and oppressed.</td>
<td>Shalom; Justice</td>
</tr>
<tr>
<td>Christian Medical Commission (1990)</td>
<td>Health is a dynamic state of well-being of the individual and society; of physical, mental, spiritual, economic, political and social well-being; of harmony with each other the material environment and with God.</td>
<td>Addressing issues of justice, peace, integrity of creation and spirituality which affect health</td>
<td>Bible study on health, healing and wholeness. Facilitating self-discovery of causes for ill health. Practical health education. Studying questions of bio-medical ethics. Learning to take personal responsibility for health.</td>
<td>Justice; Community; Cultural determinants of health</td>
</tr>
<tr>
<td>Rosenberger, M. (1988)</td>
<td>Shalom-wholeness, rightness, wellness</td>
<td>Stewardship of life and health given by God</td>
<td>Church promotes health through anointing service for healing, hospital and nursing home ministries, counseling and support for the reduction of stress, teaching abstinence from harmful substances, teaching temperance in all things, and interpreting scripture giving guidance for physical as well as spiritual health.</td>
<td>Shalom</td>
</tr>
<tr>
<td>Source</td>
<td>Definition of Health</td>
<td>Motivation for Church's Role</td>
<td>Health Ministry Actualized</td>
<td>Key Concepts</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Poling, J. (1988)</td>
<td>Wholeness of the human spirit</td>
<td>Called by Jesus Christ to promote wholeness in the world</td>
<td>To promote wholeness of human spirit through the formation of healing community according to the vision of salvation revealed by God in Jesus Christ. Activities include the ministry of community formation, the ministry of crisis intervention, the ministry of prophetic witness and the ministry of community transformation.</td>
<td>Community</td>
</tr>
<tr>
<td>United Church of Christ (1985)</td>
<td>Social context of health; Harmony and wholeness in creation</td>
<td>Extension of Jesus' ministry</td>
<td>Ministries that support church's role in health are education and nurture within the church for healthy, wholistic ways of living, direct services, advocacy and empowerment.</td>
<td>Serving others; Shalom; Society</td>
</tr>
<tr>
<td>Mennonite Mutual Aid (undated)</td>
<td>Multidimensional Body, mind, spirit</td>
<td>Extension of Jesus' caring for the health of others</td>
<td>Purpose of health ministry is to enhance quality of life, promote wholeness in the community and enable individuals to fulfill their own ministries. Empower people to live in physical, emotional and spiritual health.</td>
<td>Community; Empowerment; Call</td>
</tr>
</tbody>
</table>
Understanding the Meaning of Health

The first dimension of health ministry found in the literature is a theological understanding of health. How health is understood in relation to religious belief, affects how it will be incorporated into ministry. The Methodist, Presbyterian and Lutheran (ELCA and Lutheran Church Missouri Synod) have been the most active Protestant denominations in publishing materials and supporting the development of health ministry. Methodists have health in the very roots of their tradition. John Wesley, founder of Methodism, was particularly interested in health and healing, publishing material on the subject, as well as offering a clinic for persons who were chronically ill (Hill, 1958). In 1747 he wrote the widely read *Primitive Physick: An Easy and Natural Way of Curing Most Diseases*, a best seller in its time. He emphasized attention to health, exercise, rest, equanimity, temperance and cleanliness as well as the importance of prayer for healing.

In the literature on health ministry, health is consistently described as being multidimensional and wholistic. Minimum components found in definitions are physical, mental and spiritual well being. Additional definitions of health are harmony with self, others, environment and God (Hilton, 1990; Tillich, 1984; United Methodist, 1995); a state of wholeness created by spiritual conversion (American Baptist Churches USA, 1991); and "...a physical, mental and spiritual unfolding of the person to God, to the community, to the world in which we live." (Carter, 1988, p. 60).
Health and wholeness are seen as God's will for creation (Dubble, 1988; Schecter, 1988). Consequently, promoting health and wholeness is believed to be in accord with God's will for humans. Health, however, is not an end in itself, but a means to an end. One does not pursue health only to be healthy, but because in so doing one can better serve others (Droege, 1994; Hilton, 1990; United Methodist Church, 1995).

The Bible is a source of authority for Christians, providing a rich source of understanding about health and healing. Identifying relevant Biblical references to health and healing provides support for health ministry in the context of Christian culture. Table 2 identifies the Bible verses most frequently cited in support of health ministry that were found in the literature.

Shalom is an important concept in the Hebrew scriptures meaning wholeness, peace and well being. It is often referred to as the Biblical concept that best describes optimal health. The richness of the term shalom reflects the richness of the experience of health. The wholeness of shalom is seen as God's will for humankind (Carter, 1988; Presbyterian Church USA, 1988, 1991; Rosenberger, 1988; United Church of Christ, 1985). The Hebrew scriptures, shared by Christians and Jews, describe health as a right relationship with God (Wilkonson, 1980). The Ten Commandments found in the Hebrew scriptures (Deuteronomy 5:7-21) describe wholeness and harmonious relationships, providing a glimpse of health in the Bible and an image of right relationships with self, others and God (Tuttle, 1988).
Table 2
Biblical references used to support health ministry (RSV)

"I have set before you life and death, the blessing and the curse. Choose life, then, that you and your descendants may live, by loving the LORD, your God, heeding God's voice, and holding fast to God." Deuteronomy 30:19-20

"...walk in the way that I command you, that it may be well with you." Jeremiah 7:23

"And he called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to preach the kingdom of God and to heal." Luke 9:1-2

"I came that they may have life, and have it abundantly." John 10:10

"So, whether you eat or drink, or whatever you do, do it all to the glory of God." I Corinthians 10:31

"I appeal to you...to present your bodies as a living sacrifice, holy and acceptable to God..." Romans 12:1

"Is any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up..." James 5: 14-15

"Do you not know that you are God's temple and that God's Spirit dwells in you? If any one destroys God's temple, God will destroy him. For God's temple is holy, and that temple you are." I Corinthians 3: 16-17

"...your faith has made you well." Matthew 9:22

"Do you not know that your body is a temple of the Holy Spirit within you, which you have from God? You are not your own; you were bought with a price. So glorify God in your body." I Corinthians 6:19-20

"Children, obey your parents in the Lord, for this is right. Honor your father and mother' (this is the first commandment with a promise), 'that it may be well with you and that you may live long on the earth." Ephesians 6:1-4

"Just as each of us has one body with many members, and these members do not all have the same function, so in Christ we who are many from one body and each member belongs to all the others." Romans 12:4-5
The Christian scriptures, built on the tradition of the Hebrew scriptures, focus on healing which restores health. The concept of shalom is connected to the New Testament concept of salvation which has the same root as health, wholeness, holiness and healing (Duncan, 1988; Tillich, 1984). The purpose of Jesus’ coming was to provide salvation that would restore the wholeness of shalom God intended for creation. In fact, the story of Christian scripture is the story of God’s efforts to restore wholeness (Droege, 1994). According to Tillich (1984), salvation through belief in Jesus Christ is the ultimate healing which restores the wholeness of health.

Abundant life is another New Testament concept that contributes to understanding health. "I came that they may have life, and have it abundantly." (John 10:10, RSV). This Bible verse is referred to in the literature as the goal for health ministry (Presbyterian Churches USA, 1991; United Methodist Churches USA, 1987). Choosing the way of abundant life is health for the Christian (Miller, 1987; Peterson, 1982). An abundant life is a life that experiences shalom. Health ministry can be considered as nurturing shalom.

Motivation for Health Ministry

The second dimension of health ministry found in the literature is the motivation for the church’s role in health ministry. The primary source of this motivation is attributed to continuing the healing ministry of Jesus. The importance of Jesus’ healing ministry is reflected in the fact that his acts of healing were used as proof that he was
the Messiah (Matthew 12:15-21). The centrality of healing to the ministry of Jesus is used as an indication of the importance of health and healing in the work of the church (Commission on Catholic Health Care Ministry, 1988; Evans, 1995; Health Ministry Association, 1995; Mennonite Mutual Aid, undated; Presbyterian Church USA, 1988; United Church of Christ, 1985). The commission of the Church to preach, teach and heal is found in the gospels. "And he called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to preach the kingdom of God and to heal" (Luke 9:1-2 RSV). In this mandate, Jesus passed on the responsibility to his disciples to continue his healing work, which is often cited as a motivation for contemporary health ministry.

The need for justice to right inequities in the opportunities for health is identified as another motivation for health ministry (Presbyterian Church USA, 1988). Many people are oppressed in their opportunities for experiencing health and the Church is called to fight for the oppressed. One of the great injustices that affect health is poverty, which increases a person's likelihood of having health problems (Christian Medical Commission, 1990).

The theme of justice is prevalent in the medical literature relevant to health ministry. This literature has focused on a global view of health and the responsibility of the universal Church, being all Christian denominations, to respond to the health inequities in the world. Health ministry is seen as an issue of justice, peace, integrity of creation and spirituality. This literature has emerged from experience in medical

Related to justice is the responsibility to alleviate the suffering of others and a Christian's obligation to care for one's neighbors (Commission on Catholic Health Care Ministry, 1988). Restoring justice in matters of health is a health ministry. Justice motivated health ministry typically focuses on the global picture of health. One way that denominations have been involved in health ministry as a justice issue has been working on specific health problems such as AIDS or access to health care. During the recent national health care debate, several denominations formed the National Interfaith Health Care Campaign that lobbied for universal coverage as an issue of justice.

Stewardship of the gift of life is identified as another motivation for health ministry. Life is seen as a gift from God and preserving life is a responsibility that comes with that gift (Evangelical Lutheran Church of America, 1994; Lutheran Church Missouri Synod, undated; Peterson, 1982; Presbyterian Churches USA, 1988, 1991). Good stewardship of the gifts God provides is part of promoting health (Wind, 1995). Stewardship can be considered both an individual and a corporate responsibility. One is responsible for one's own health and one is also responsible for creating communities where health is possible. Droege (1994) attributes the notion of individual stewardship of the body to the concept of the body as the temple of the Holy Spirit found in I Corinthians 6:19-20.

Promoting the health and well being of employees is one area where churches have a corporate responsibility for stewardship. As the institution of ministry, the
church has a responsibility to be good stewards of their employees. (Presbyterian Churches USA, 1988). The United Methodist Church (1995) expands the concept of stewardship, identifying the importance of being responsible for individual, community and global health. This global view of health recognizes the interrelationships of all individuals in matters of health and disease.

**Actualizing Health Ministry**

The third dimension of health ministry found in the literature is actualizing health ministry conceptually and practically. An important source of information in this area comes from the Health Ministries Association (HMA), established in 1989, which emerged from the parish nurse movement and is the only professional association for people involved in health ministry as defined here. HMA defines health ministry as follows; "Health ministry emphasizes the wholeness of body, mind and spirit in congregations. Healing, health and wellness are promoted among the members and among people in the wider ministry. It is a cooperative effort which may include members interested in health and wholeness, hospitals and other health agencies in the community" (Health Ministries Association, 1995, p. I-1). HMA makes the distinction between healing ministry as trying to restore health and health ministry that looks at trying to keep people well.

The literature of the Health Ministries Association, provides a conceptual understanding and a great deal of pragmatic information on the what and how of health
ministry. General areas of health ministry activities identified are health education, coordinating volunteers, personal health counseling, health monitoring/screening and health resource and referral agent (Health Ministries Association, 1995). Other kinds of health ministry activities include support groups for: persons who are chronically ill (Schmidt, 1990); health professionals (Buschmann, 1990); and grief (Wind, 1990). These activities reflect a wholistic, multidimensional view of health.

An important activity of health ministry is the transformation of thinking. Health activities in the church will have limited impact unless the thinking of members is changed. Health needs to be reconceptualized by the congregation as a community, with people being empowered to act in ways that will promote their health (Association of Brethren Caregivers, 1993; Droege, 1992; Peterson, 1995). This may involve understanding Christian tradition in health and healing as well as Biblical concepts of health and healing. These transformational activities are prerequisite to concrete health programs that will positively effect people's lives.

One way to transform thinking about the interrelationship between faith and health is integrating Biblical principles into health education. To this end, denominations have supported the development of health education materials that integrate principles of health promotion with theological understanding and Biblical references. This approach has included courses on general wellness (Hardel & Mull, 1994; Hesson, 1995; Hesson, Dye & Perry, 1990) and weight reduction (Lewis & Smith, 1996; Morris, 1996a, 1996b). A creative approach to this integration is found
in "Walking in the Way" (Sailors, 1995) which provides guidelines for conducting a walking program for exercise using Biblical journeys as goals for distance.

In addition to the Health Ministries Association, there are two other organizations doing critical work related to health ministry. The first is the Carter Center in Atlanta, Georgia that is interested in the role of the church in promoting health. Their work combines a global perspective of public health with pastoral care. Tom Droege, who has published extensively on health ministry (1979, 1992, 1994, 1995), is the Associate Director of their Interfaith Health Program. One of the main purposes of the center is to be a clearinghouse for information on what congregations are doing in health. Their publication, *What If Every Congregation...?* (1994), provides a listing of congregation and community health promotion models which reflect responses of faith communities to issues of health.

The second organization is the International Parish Nurse Resource Center in Park Ridge, Illinois that provides information on, and training for parish nursing. Their work (Djupe & Lloyd, 1992; Lloyd & Djupe, 1993; Solari-Twadell, Djupe & McDermott, 1990) has been important in describing parish nursing, the most familiar mode of health ministry.

**Health Promoting Qualities of Congregational Life**

The final dimension in the literature on health ministry is the inherent health promoting qualities of congregations seen as support for the concept of health ministry.
The nature of the church as a community is one key health promoting quality. "Churches have always been health places in that their activities promote health by creating community, sustaining hope, and undergirding a sense of meaning and purpose in life - all of which are known factors in disease prevention and health promotion" (Droege, 1994, p 12-13). Humans are social beings who function optimally when they exist within caring communities with the church being one of the few remaining experiences of community in contemporary society (Hilton, 1995). Faith in a future with God is another way congregations promote health through the experience of community (Poling, 1988).

The importance of community in relationship to health is also found in the examples of Jesus' healing which always involved a restoration to community as well as physical healing (Carroll, 1995). To be part of a caring, competent community has the potential to promote health (Eng, Hatch & Callan, 1985). To belong to a community is a basic human need with the power to promote health. "The human situation is one in which the individual is continually seeking to be genuinely free and self-motivated, as well as to be in relationships of trust, love, and creative exchange with others and with the other, either the true center and source of life or some substitute reality such as possessions or power" (Browning, 1988, p. 177).

In addition to the positive qualities of being a community, the basic components of congregational life, including teaching, preaching, fellowship, worship, service and advocacy all can play a part in promoting health (Evans, 1995; Solari-Twadell, 1997).
As a community with a powerful religious message, each church has the potential to empower and transform people to be more healthy (Association of Brethren Caregivers, 1993; Mennonite Mutual Aid, undated; United Methodist, 1995; Westberg, 1986). Worship in particular can promote a sense of connection and wholeness in relation to God (Evans, 1995; Schecter, 1988, Solari-Twadell, 1997). The concept of observing the Sabbath can be seen as having a health promotion as well as a religious benefit in managing stress.

Impact of Religion on Health

Another body of literature on the health promoting qualities of churches comes from medical and social science research. While not dealing directly with the concept of health ministry, this research is extremely important to nurses interested in cultivating the health promoting qualities of congregations, both for the professional information it provides and also because of heightened public awareness through media attention. Appendix A summarizes selected relevant research studies on the impact of religion on health, several of which are highlighted in this discussion.

In the medical literature, the National Institute of Health Research has spearheaded the effort to explore the relationship between religion and health. In an analysis of 158 studies which included religion as a variable, they found that 77% demonstrated a positive effect of religion on health, 17% were neutral or mixed and 6% showed a negative effect (Matthews, Larson & Barry, 1993). Attending worship was
the measurement variable used most frequently, which also seemed to exert the most influence on outcomes. The behavior and practices of religion were more important than the religious beliefs (Matthews, 1997). According to Matthews (1997), "The scientific evidence of the health benefits of religious practice justifies its consideration in medical practice" p. 17.

Another recently published longitudinal study looked at religious service attendance and mortality over 28 years (Strawbridge, Cohen, Shema & Kaplan, 1997). Utilizing data collected in 1974, 1983 and 1994 from a large sample of 5,286 individuals the authors found that over time persons who attended religious services regularly had lower mortality than persons who attended infrequently. Even adjusting for health conditions and social connections, the results maintained their statistical significance. Combining social connections and health practices reduced the effect below statistical significance. The authors postulate that the impact of religious organizations on health practices may include, "...peer influence, increased self esteem, increased sense of perceived control, prescribed practices, and a general philosophical outlook that values social ties and treating one's body with respect" (Strawbridge et al, 1997 p.961).

An interesting offshoot of this literature has been trying to document physiological changes that might be related to religious attendance. Koenig, Cohen, George, Hayes, Larson and Blazer (1997) found in a study of 1,718 adults over age 65 that persons who attended religious services regularly had better immune systems than
those that did not attend regularly. Regular attenders had lower levels of IL-6. Higher levels of IL-6 are an indication of inflammation. This research, as other research in this area, shows a positive association between attending church and physical well-being, yet can not prove a direct cause and effect relationship.

The focus of relevant research studies in the social sciences has been the health impact of religious belief, religious behavior and religious experience. These studies are primarily quantitative. Comstock and Patridge (1972) conducted a classic study utilizing retrospective analysis of 91,909 people from an unofficial census. The authors found that frequent churchgoers had lower rates of heart disease, emphysema, cirrhosis and suicide. There was no difference in cancer of the colon and rectum.

Ellison (1991) studied the relationship between religious involvement and subjective well being utilizing a large, national survey. Religious involvement was measured by attendance at religious services, frequency of prayer, perception of closeness to God and sources of doubt about the respondent's religious faith. Utilizing regression analysis, this study revealed that persons with strong religious faith had greater life satisfaction, greater personal happiness and fewer negative psychosocial consequences from difficult life events.

Ferraro and Koch (1994) compared the effect of social support from religion in Black and White adults. Religious practice included attending religious services, reading religious books and watching or listening to religious television or radio. Religious identity was assessed through the importance of religious beliefs to everyday
life. Religious consolation was assessed through frequency of seeking spiritual comfort in times of distress. Social support was measured through a standardized index on affective support from others and participation in voluntary associations.

Findings from this study indicated that both Blacks and Whites benefited from the social support of religion, although Blacks report more religiosity. Blacks were more likely to turn to religion when experiencing health problems. This study included a thorough review of the literature. The comparison of Blacks and Whites provides a useful contrast.

One qualitative study was found on the impact of religion on health. An ethnographic study by Roberson (1985), a nurse, looked at religion and health beliefs among rural African Americans. Her findings indicate that religious beliefs affected the health beliefs and practices of African Americans in the community she studied. Health in this culture was experienced as a blend of the spiritual, psychosocial and physical components of health. Individuals' religious beliefs helped them to find meaning in their experience of health and illness.

One of the difficulties in conducting research on the effect of religion on health has been identifying appropriate variables to measure religious constructs. It is also difficult to identify the exact relationship between the health outcome and the religious behavior. Determining what is caused by religious behavior and what is an effect of religious behavior is challenging.
**Research on Health Ministry**

One research study was found that explicitly used the concept of health ministry. A dissertation by Jamison (1987) looked at barriers to participation in health ministry programs in a large sample of Seventh Day Adventist Churches. Interestingly, he found that one of the barriers was not integrating the program with religious beliefs.

To ensure that no research studies were missed, several key professionals in health ministry were contacted. They concurred with these findings (Thomas Droege, personal communication, March 28, 1996; Norma Small, personal communication, March 28, 1996; Maureen Ahrens, personal communication, March 28, 1996; Dennis Fey, personal communication, March 28, 1996; Margie Hesson, personal communication, March 29, 1996). There is one study in process using ethnography to look at the relationship between faith and health in three African American churches (A.F.Wenger, personal communication, March 30, 1996).

**Parish Nursing**

When parish nursing first began in 1985, it was seen as synonymous with health ministry. In fact, the Health Ministries Association emerged from persons involved in parish nursing. Over time, other possible forms of health ministry have developed. However, parish nursing remains the most familiar approach to actualizing health ministry in congregations.
The published nursing literature has focused on describing parish nursing as an area of practice. Parish nursing evolved from the wholistic health movement of the 1970's (Westberg, 1990). It is a form of health ministry and an example of how the church can live out its mandate to heal. Parish nurse practice involves functioning as a health educator, personal health counselor, coordinator of volunteers, community liaison and role model of the interrelationship between faith and health (Bergquist & King, 1994; Solari-Twadell & Westberg, 1991). The research literature on parish nursing has focused on describing the practice and the practitioners, focusing on who parish nurses are (McDermott & Mullins, 1989); what they do (Djupe & Lloyd, 1992; McDermott & Burke, 1993); how people are using their services (Lloyd & Djupe, 1993); how parish nurses help people (Scott, 1992) and the educational needs of parish nurses (Deliganis, 1994). These studies provide an important beginning for strengthening nursing practice within congregations.

Parish nursing is a little more than a decade old, and as such research in this area has been limited. Studies have focused on descriptions of parish nursing characteristics and activities. This information provides a basis on which to shape additional research. Appendix B summarizes the research on parish nursing. The studies on what parish nurses do and how people are using their services are particularly relevant to this study.

The first published study on parish nursing done in 1989 by McDermott and Mullins utilized a small, convenience sample to describe who parish nurses are and
what they do. Djupe and Lloyd (1992) utilized a survey to evaluate one specific parish nurse program. This study provided comprehensive information on the 32 nurses and 40 congregations in this program. Looking at what parish nurses do, McDermott and Burke (1993) utilized a larger convenience sample than the 1989 study and articulated in detail who parish nurses are and what they are doing. Of significance is the finding that the most common congregations with parish nurses were, in descending frequency, Lutheran, Catholic, Methodist or Presbyterian. This finding is consistent with the denominational support of health ministry in mainline Protestant groups. One limitation of the study is that 42 of the respondents were from one program that would skew the results. These three studies have provided valuable information about who parish nurses are and what they do. However, due to sample selection techniques, they can not be generalized to the total population of parish nurses.

Lloyd and Djupe (1993) summarized data from a survey of people who had used parish nursing services. Surveys were received from 1,043 individuals in 40 congregations. Their results identified that: people were becoming more aware of the relationship between faith and health; health and awareness were being integrated into the life of the church; and health and healing were becoming an explicit part of the mission of their churches. Parish nursing services most commonly used by congregations were reading bulletins and newsletters, followed by participating in health screening or talking with the parish nurse about a personal concern. This study provides valuable information about how church members are using parish nurses.
Field Study

Due to the limited published literature on the subject, a field study was conducted to further amplify the concept of health ministry. The field study utilized phone interviews with a purposive, non-random sample of parish nurse program coordinators. A list of 49 names from coordinators attending a national parish nursing conference was used. The name of this author, a coordinator from Canada and a coordinator from Hawaii were omitted. The remaining names were divided by region into Northeast (NE) n=6, Southeast (SE) n=7, Midwest (MW) n=25, Southwest (SW) n=5 and Northwest (NW) n=3. The regional division was done to ensure representation from all parts of the country. From this group every other person was called and if they were not reached the next person on the list was called. This resulted in complete interviews n=25 (NE n= 5, SE n=5, MW n=9, SW n=4 and NW n=2). The parish nurse program coordinators were willing participants in talking about their programs and the concept of health ministry.

This group was selected for field study because they were all nurses, with one exception, and involved in creating and overseeing health ministries within their respective institutions' programs. Because the nursing literature relevant to health ministry has focused on the practice of parish nursing, the field study was an opportunity to gain nursing understanding of the meaning of health ministry and it's relationship to parish nursing.
Seven hundred forty eight parish nurses were serving in the 25 programs, with six hundred thirty as volunteers and 98 in paid positions. One coordinator with both paid and volunteer parish nurses did not identify how her 10 nurses were distributed. Mean length of operation for the parish nurse programs was 3.4 years, with a range of 1 to 10 years. Mean length for the respondents being a coordinator in their present position was 3.2 years, with a range of 1 to 10 years. The question on longevity at the current position did not identify how long the coordinator had been involved in parish nursing. Some of the coordinators had prior positions in parish nursing.

Regional differences were not obvious in responses. However, several differences were noted in the program description. In the northeast 4 out of 5 programs were volunteer and all of them were in Catholic sponsored hospitals. Both of the programs in the northwest were volunteer and non-denominational in their sponsorship.

Four open-ended questions were asked in addition to demographic information (Appendix C). The two key questions of greatest relevance to this study were "What does the term health ministry mean to you?" and "What do you see as the relationship between health ministry and parish nursing?" Through analysis and synthesis of the responses, patterns were identified. Quotes from participants are coded with a number and their geographic region.
Meaning of Health Ministry

In defining the term health ministry, the most frequently mentioned concept was a wholistic approach to health that integrated body, mind and soul consistent with the literature on health ministry which recognizes health as involving more than the physical body. This concept was also consistent with the history of parish nursing that evolved from the wholistic health movement.

5NE "Health ministry is approaching health in a wholistic way in the congregational setting. Putting as much emphasis on spiritual, psychological and emotional as well as physical."

Health ministry being based in churches was another consistently identified concept. This was not surprising as all of these coordinators had programs focused on providing service within local congregations. This also reflected the importance of the local church in initiating and supporting health ministry. The local church creates a community foundational to the call and sending of health ministry.

22SW Health ministry is "A ministry of the faith community, so it has the authority of the church."

Health ministry was viewed as fitting into the mission and tradition of the church. It was seen as consistent with the purpose of the church and a way to reclaim the church's tradition in health.

4NE "Health ministry is refocusing in church communities the tradition of healing in the church."
In a similar vein, health ministry was seen as integrating faith and health for individuals as well as for the church/community. It is a venue that has the potential to make health promotion more meaningful when set in the context of religious beliefs. This recurring idea of "fit" relates to cultural congruence. The parish nurse coordinators described health ministry as an approach that makes health promotion culturally congruent to a church community.

10SE "Health ministry means joining what we know about our faith and our health together in a way that helps people recognize that our faith impacts our health."

The role of healing in health ministry is consistently identified in the literature and is also reflected in the comments of the parish nurse coordinators. Healing is viewed as an integral part of the process of health ministry.

21SW "It's carrying God's healing power and grace to the people where they live, work and play."

Health promotion, wellness and disease prevention was identified as important components of health ministry.

6SE "Health ministry is a focus on ministering to individuals in congregations to stress promotion of health and prevention of disease."

Involving lay people in health ministry, as well as health professionals, was seen as significant to health ministry. This concept is also consistent with providing
culturally congruent care. Utilizing lay people allows for integrating generic and professional care systems in parish nursing care.

1NE "Health ministry is a very inclusive group that truly operates within the mission of the church including professionals and lay people."

Finally, a recurring concept was reaching out to the community, as well as the church membership. While based in the church, the community was seen as an important focus for health ministry.

14MW "My concept of health ministry is reaching out to all people in the community, not just the churches."

In addition to the patterns identified in the meanings of health ministry, several images also emerged. The most prevalent image was that of reaching out. Reaching out is described as involving people in the church and community, responding to their needs and touching them. These images reflected the relational nature of health ministry. There is one ministering and one being ministered to creating a mutual and reciprocal relationship.

20SW Health ministry is "a form of reaching out and touching people in the name of Jesus in a wholistic approach of body, mind, spirit."

Presence is another image that demonstrates the relational nature of health ministry.

8SE "You are a presence in the community recognizing that God is present and powerful in all circumstances."
The images of atmosphere and presence reflect the permeating nature of health ministry for a church. Health ministry creates a way of thinking and an environment in a church conducive to health.

19MW "Creating an atmosphere of health in the church."

Relationship Between Health Ministry and Parish Nursing

Another question of significance was the relationship between health ministry and parish nursing. There were several patterns that emerged from responses to this question. Health ministry is broader than parish nursing. Parish nursing is one kind of health ministry, but not the only one. Parish nursing is a role that helps to actualize health ministry. Involving non-health professionals is characteristic of health ministry. Parish nursing is health ministry, but health ministry isn't necessarily parish nursing.

First, health ministry is seen as a more inclusive term than parish nursing. The image that several individuals used to describe the broadness of health ministry and the specificity of parish nursing was an umbrella. Health ministry serves as an overarching cover under which parish nursing and other health ministry activities can fall.

1NE "Health ministry is an umbrella and parish nursing is a part of the umbrella - a stabilizing part. A lot of things can be done under health ministry. It's like we've given people permission to look at the whole person."

In a similar line of thinking, several respondents identified that a parish nurse is a health minister, but a health minister is not necessarily a parish nurse.
5NE "Major difference is parish nursing requires a nurse, but in health ministry it could be a social worker or a lay health promoter."

Parish nursing was also seen as a role that helps to actualize health ministry. Through the role of the parish nurse, health ministry happens. Several interesting images were used to describe how parish nursing actualizes health ministry. The first sets of images describe parish nursing as a type of vessel or route through which health ministry will occur. The parish nurse becomes a link that allows health ministry to happen.

SE10 "Parish nursing is an intentional avenue for health ministry to develop."

17MW "Parish nursing is one vehicle for health ministry."

19MW "I see parish nursing as a conduit, not the only way of bringing health ministry to a church."

20SW "The parish nurse is a catalyst."

In the second sets of images action is utilized to describe parish nursing as the force behind health ministry.

16MW "I see the parish nurse as the one who empowers the health ministry."

22SW "I feel very strongly that the parish nurse is the person to carry out health ministry."

While two of the respondents felt health ministry and parish nursing were synonymous, the rest of the respondents distinguished and identified a relationship between the two concepts. This dialogue attempting to distinguish between health
ministry and parish nursing is important to identify the larger concepts informing parish nursing practice. It is also an important distinction to maintain clarity in our professional language.

Most coordinators identified some involvement of their congregations in health ministry programs in addition to parish nursing. Stephen's Ministry, a national program that provides intensive training for lay visitation, was frequently identified as another health ministry occurring within their churches. Four coordinators mentioned work with lay health promoters. Two coordinators mentioned that they offered a health ministry option that did not require a nurse. Other programs mentioned included hospice, AIDS ministry, and training members in a church with ample resources to work with a church with minimal resources. One program had a social worker functioning in a health minister role.

One other question of note in understanding the relevance of health ministry to parish nursing practice was found in the question "How do you feel your nurses are contributing to health within their congregations?" This question provides some insight into how parish nursing and health ministry interrelate. Several dominant patterns emerged from the responses. Integrating faith and health was repeatedly identified as a significant contribution to health by the parish nurses. Health promotion, screening and detecting problems at an early stage were also seen as significant (primary and secondary prevention). Promoting individual responsibility for health and self-care was seen as a way parish nurses promote health. Functioning as an advocate through
providing referrals, helping people to access the health care system, offering health education and providing needed information were also seen as valuable contributions. Finally, several coordinators of volunteer programs highlighted the benefit for the nurse and the church when the nurse is a member of the church where she/he volunteers.

The patterns found in the responses of the parish nurse coordinators provide support for the definition of health ministry discussed in Chapter I. The one attribute not mentioned specifically was the importance of cultural congruence in the expression of health ministry. This may be because it was not addressed directly in the questions. The importance of personal responsibility for health was found in the descriptions of the contributions of parish nurses. The patterns that emerged from the fieldwork were consistent with the literature.

In addition to the parish nurse coordinators, a small field study was conducted with three pastors whose churches have volunteer parish nurses. They were asked what health ministry meant and how they saw it fitting into their churches. One concept identified was health ministry as restoring the integrity of creation. The world was created whole and has been broken by sin. The church's purpose for health ministry is to restore the integrity of creation. The other concept identified was health ministry as an extension of Jesus' healing ministry that is discussed in the following quote from one of the pastors. "Ministry is what God calls all of us to do. Service to God and service to others. Health ministry focuses on physical well being. As Christ healed, we should heal others."
Healing

A brief look at the literature on healing, frequently referenced in the health ministry literature, provides further insight into health ministry. The Oxford English Dictionary (1989) defines healing as the restoration of health. If healing is the restoration of health, then it is integral to the concept of health ministry. Although the literature makes a distinction between health and healing ministry, in reality there is an overlap in people’s experience. Reviewing literature on the healing ministry of the Church and comprehending what is trying to be restored enhances an understanding of health ministry. This limited review of the literature on healing contained three concepts: the history of Christian churches as an agent of healing; the ability to be completely healed in this life and images of health as revealed in images of healing. In addition, a United Methodist hymnal was reviewed for its images of health and healing.

The first concept, the history of Christian churches as an agent of healing, is found in a classic book by Morton Kelsey Healing in Christianity (1995), first published in 1973. This text provides a thorough historical understanding of healing in the Christian church. In looking at the Bible there is a difference between the Hebrew and the Christian scriptures in content relevant to health and healing. While rarely using the term health in the Bible, the concept is clearly discussed. The Hebrew scriptures provide the most discussion relevant to health, seen as being in right relationship with God or righteousness (Kelsey, 1995). In the Christian scriptures, the actions of Jesus demonstrated a great concern for physical, mental and spiritual well being as shown by
his acts of healing. Healing is a theme in one third of the Gospel stories (Droege, 1994). The importance of healing was further highlighted in Jesus' commission to his disciples to continue his work of preaching, teaching and healing (Luke 9:12).

This injunction to heal was taken very seriously in early Christian churches, where healing was a normal part of church life. The healing ministry of the early church included all methods of healing and recognized that sickness and healing always have more than just a physical dimension. The rituals of baptism and Eucharist had healing significance in this community as they symbolized new life and reconciliation (Wilkonson, 1980).

Gradually over time the role of the church in healing was eroded through changes in belief and society. A significant turning point in the practice of healing is associated with two events in the 4th century. In 313 the Emperor Constantine legalized Christianity. This changed the tenor of Christian community making it easier to participate. Later in the century, St. Augustine wrote that healing was a special gift of the early church that was no longer relevant. Toward the end of his life St. Augustine changed his mind, acknowledging that healing still did occur. By the 600's when Gregory was pope, civilization was crumbling and the view that God sent sickness prevailed. Significant disease and poverty continued through the Middle Ages.

The final step that separated the church from healing came in the 12th century when monks became unable to study medicine because of a belief that the body was impure. The body became the responsibility of medicine and the soul the responsibility
of the church. In the 1600's, the philosophy of Descartes further contributed to the Western understanding of body, mind and soul as separate entities. This conceptual separation of body and soul persisted until the 19th century with the growth of the Pentecostal tradition which revived interest in healing within the church (Kelsey, 1995).

Religion and medicine, once intertwined, then separated, both continued to participate in healing. "The pervasive presence and deep dread of suffering has led to the development of means to address it: medicine and religion represent two ways in which human beings have sought to understand and relieve suffering" (Matthews and Larson, 1997, p.3). In more recent times, physicians have recognized the need to reintegrate medicine and healing, based on scientific studies that demonstrate a positive health impact from religion (Matthews, 1997). There has also been a significant body of literature by physicians who have recognized the importance of spirituality on health and the need to go beyond physical healing in order to promote health (Bakken and Hofeller, 1988; Chopra, 1989; Dossey, 1993, 1996; Sauvage, 1996; Tournier, 1965). We are returning to a time when medicine and religion are tentatively exploring partnership once more.

The ability to be fully healthy in this life is the second concept discussed in the readings on healing. The Bible reflects God's desire for people to be well. "Whether God wants perfect health for all people at all times one cannot be sure, but it is certain that God wants wholeness and salvation for each individual" (Kelsey, 1995, p.80). Health understood as wholeness is seen as a goal to strive for, but one that is not fully
realizable in this life (Anderson, 1989; Marty, 1990; Wilkonson, 1980). Health is only possible after the resurrection when Christians believe they will be joined with God in heaven. Understood from this perspective, healing becomes an integral component of health ministry.

Images of health revealed through images of healing is the third concept. The image of healing most frequently used is restoring wholeness. Wholeness of body, mind and spirit is God's will for humans and for all of creation (Droege, 1994; Dubble, 1988; Marty, 1990; Tillich, 1984;). Wholeness is mending the brokenness caused by sin that separates humans from God. To be whole is to be in relationship with God. For Christians, wholeness comes through salvation, which involves accepting Jesus as one's personal savior. Through a personal relationship with Jesus, one experiences salvation and wholeness which is the ultimate experience of health for the Christian (Tillich, 1984).

The Christian community plays an important role in understanding suffering, healing and health. "It is apparent that the Church tradition, born of faith, expresses itself both as interpretation, especially of suffering, and as community, especially for care" (Marty, 1990, p.59). Health which comes through salvation can only be experienced through participation in Christian community (Schmidt, 1994).

Another vivid image of health as harmony comes from Agnes Sanford's The Healing Light (1947). This classic book brought healing into modern thinking. Health is viewed as harmony with God. When individuals are in harmony with God, their
bodies function well. Sanford uses the analogy of electricity to describe healing. Electricity is all around; however, we need to have wiring in a complete circuit and then turn on the switch in order to access the power. Christian love provides access to healing power. While personally involved in numerous healings, Sanford also appreciated the contributions of medicine to healing. "God has made ample provision for our every need. He has supplied for almost every disease two specific remedies: one inherent in the properties of nature and discoverable by science, and one hidden in the being of man and discoverable by faith" (Sanford, 1947, p.98). Jesus Christ is seen as the ultimate healer. The thinking reflected in this book has been a building block for more recent materials on healing in Christianity.

Health ministry incorporates both the healing ministry of the church and the wellness ministry (health promotion). Health ministry is relevant not only to those who can join in an exercise class, it is also for people with chronic and terminal illness. Because the body, spirit and mind are inseparable, the church has an interest in what happens to people physically as well as spiritually. For people who are ill, one of the most health promoting experiences the church can offer is that of presence. (Hauerwas, 1986; Schmidt, 1990)

Healing is an ongoing process. It is not a one-time event, but part of the pattern of Christian life demonstrated in baptism, communion, prayer and praise (Anderson, 1989; Lundin, 1994). Healing involves a restoration of relationship with God that creates wholeness. This search for wholeness (health) is a lifelong spiritual
journey that becomes complete only after death when God is seen face to face (Thomas & Alkire, 1992).

**Religious Music and Prayer**

Within the culture of a congregation and a denomination, music plays an important role in worship. Hymns and ritual prayers are a reflection of values, feelings and beliefs associated with religious experience. The *United Methodist Hymnal* (1989) was reviewed to identify the images of health and healing and associated values. This limited look at one hymnal provided a glimpse of another source for information relevant to health ministry.

Looking under the subject index, there were no listings for health and eleven under healing. These images of healing provide insight into what health means in this religious context. The most common reference in the hymns was to Jesus as healer or physician. One classic African American spiritual "There is a Balm in Gilead (#375) images being healed as being made whole.

Three hymns provide a more substantive view of healing. One hymn "O Christ, the Healer, We Have Come," (#265) identifies Jesus as the source of healing and health. Health is represented as wholeness in the song and identifies the importance of community to healing. "Heal Me, Hands of Jesus" (#262) also identifies Jesus as the source of healing. The role of the mind and resolving sin in order to be healed is referenced. Peace is the result of healing. The third hymn "When Jesus Passed
Through Galilee (#263) describes a series of Jesus' healing miracles and identifies healing as wholeness. In addition to the hymns, two prayers were found for illness. The images in the prayers are God as the source of health and Jesus as healer and physician. The images of healing found in this hymnal are consistent with a view of health as wholeness and peace. God is identified as the source of health. Jesus as the healer can reconnect humans to the source of their health.

**Congregations as Partners in Promoting Health**

The literature on congregations as partners in promoting health, which includes both conceptual and research articles, is relevant to an understanding of health ministry. The Carter Center has provided some of the most thought provoking materials on how and why congregations can and should be partners in promoting health. William Foege (1994) identifies three areas of health related opportunities for congregations. First there are opportunities for congregations to engage in activities to prevent health problems. A great deal is known about how to reduce risk factors for health problems such as infant mortality, heart disease, and cancer, yet this knowledge is not consistently used. Second, opportunities exist to deal with the social issues that are part of health problems such as violence, environmental disrespect, and poverty. Finally, opportunities exist to understand life as a unified whole, appreciating how human, environmental and social actions are interrelated. Because of their interest in and influence on individuals, families and communities, congregations are in a unique
position to take advantage of these opportunities

The concept of the church as a partner in promoting health has received ample coverage in the public health literature. Jocelyn Elders (1994) identified partnership between congregations and public health agencies as a logical and beneficial combination. The literature from public health has focused on the church as a community organization that can increase access to underserved populations. While the literature discusses the importance of compatible goals (Eng et al., 1985; Hatch & Voorhoost, 1992; Couture, 1993), the concept of health ministry is rarely addressed.

Public health agencies are important partners for collaboration in health ministry and an important part of the communities where churches exist. It is noteworthy that the President-Elect session of the 1994 American Public Health Association (APHA) was entitled "Expanding the public health envelope through faith community - public health partnerships." A new caucus has been formed within the APHA on faith and health. The purpose of the caucus is to facilitate partnerships between the public health and faith communities to promote health and prevent disease, particularly for hard-to-reach groups (American Public Health Association, 1996).

Public health has made two major contributions of relevance to understanding health ministry: articulating the logic of partnering with churches and creating a body of research on health promotion programs done in partnership with churches. John Hatch and associates from the University of North Carolina, Chapel Hill have articulated reasons why churches in African American communities are logical partners for
promoting health (Eng, Hatch & Callan, 1985; Hatch, Cunningham, Woods & Snipes, 1986; Hatch & Voorhorst, 1992; Hatch & Derthick, 1992; Hatch, Moss, Saran, Presley-Cantrell & Mallory, 1993). Illustrations are provided in their writings of several successful programs, most notably the use of lay health promoters. While Hatch and colleagues' literature review did not include research studies, it provided an invaluable descriptive base and important implications for subsequent research.

The relevant research studies from the public health literature can be divided into two categories; the church's involvement in health (Thomas, Quinn, Billingsley & Caldwell, 1994; National Council of Churches, 1991; Olson, Reis, Murphy & Gehm, 1988) and using the church as a site for health promotion (Wells, Brown, Horn, Carleton & Lasater, 1994; Stillman, Bone, Rand, Levine & Becker, 1993; Kumanyika & Charleston, 1992; Smith, 1992; Wist & Flack, 1990; Mitchell-Beren, Dodds, Choi & Waskerwitz, 1989; Smith, 1989; Lasater, Wells Carleton & Elder, 1986). The majority of these studies have been conducted with African American churches. The reader will note that both the terms African American and Black are used in this review of the literature depending on which term the author(s) used.

**Church's Involvement in Health Programs**

The studies that examined the church's actual and potential involvement in health programs are summarized in Appendix D. Olson, Reis, Murphy and Gehm (1988) conducted a study that looked at the potential for involving Black churches to
serve as partners in developing health programs with a specific interest in maternal/child issues. They targeted a specific community and attempted to contact all 227 Black churches with 176 (78%) responses. Respondents were able to identify health needs in the communities served by their church and also identified some involvement in those health issues. The area where respondents felt their congregations would be most willing to collaborate was in providing information about health issues.

This study has significant methodological issues. The position of the respondent within the church was inconsistent. The majority were senior pastors, but assistant pastors, church officers, members and secretaries were also used as respondents. The variety of respondents would yield a very different perspective on the perception of community need and potential for church involvement in health programs. In addition, the location of the interviews was inconsistent, with interviews conducted either in person or by phone. Consequently, while the results are interesting, they can not be generalized.

In 1991 the National Council of Churches conducted a large national, random survey of Protestant pastors (n=4,592) to study the involvement of churches in health related activities. From the responses of 1,883 (41%) pastors, they found that churches were addressing a wide variety of health needs including nutrition, substance abuse, mental health, access to medical services, access to prenatal care, vision and hearing screening, health insurance coverage and immunizations. The congregations were addressing these needs through counseling, referrals, education, payment for services,
support groups, advocacy, transportation, screening and treatment. Congregations who were involved in implementing treatment were more likely to be in urban inner-city areas.

This study was commendable for the breadth of its sample and depth of questions. However, the unequal response rate across denominations raises the possibility of key issues being missed. In addition, the study did not identify the racial/ethnic composition of the respondent churches, which would be useful given the substantive body of literature that identifies unique characteristics of African American churches that may predispose them to being involved in health.

Thomas, Quinn, Billingsley and Caldwell (1994) did another major study looking at characteristics of Black churches involved in community health outreach programs. It utilized a purposive sample to contact 1,115 churches and has a response rate of 635 (57%). A computer assisted phone interview was utilized. Similar to the study by the National Council of Churches, a broad conception of health was used.

Utilizing logistic regression, they found that church size and the educational background of the senior pastor were the strongest predictors for church involvement in community health programs. Larger churches whose pastors had graduate education were most likely to participate in community health programs. In addition, the age of the congregation (how long it had been in operation), size and debtedness were seen as associated, but not statistically significant. Churches that had been in existence for 41 or more years, had memberships of 176 or greater and did not have significant debt
were more likely to be involved in community health outreach. This is not surprising, as these characteristics would affect the resources the church would have available for any program. The study also found that 86% of the respondents saw the role of the church as serving the surrounding community, as well as church members. Methodist churches were more likely to be involved in community health outreach, which is consistent with the findings reported in this paper.

**Churches as Sites for Health Promotion**

The second group of studies focused on churches as a site for community health programs. The churches in these studies often had predominantly African American membership. These studies, with one exception (Stillman et al., 1993), typically described the program and outcomes and did not address how the church's primary purpose might be linked to participation in health programs. Churches were not used as a study variable but as a way to gain access to a particular population. Studies looked at church-based hypertension screening (Smith, 1989, 1992), weight loss programs (Kumanyika & Charleston 1992), colorectal screening (Mitchell-Beren, Dodds, Choi & Waskerwitz, 1989), cholesterol screening (Lasater, Wells, Carleton & Elder, 1986; Wiist & Flack, 1990) and smoking cessation (Stillman et al, 1993). All of these studies are summarized in Appendix E. The most relevant studies are highlighted in the following discussion.
One major research study on the church as a site for health promotion is from the Health and Religion Project (HARP) of Brown University in Rhode Island. This longitudinal study dealt with churches with predominantly Caucasian membership in three different denominations (Baptist, Catholic and Episcopalian) as sites for community health promotion. One study (Lasater, Wells, Carleton & Elder, 1986), described church recruitment and research design. This project utilized research on African American churches as a rationale for their study, although it did not identify if any significant differences would be anticipated in Caucasian churches. In fact, this publication does not identify the ethnicity of the churches. Initially all churches in Rhode Island were surveyed through a brief mail and telephone survey, with a 95% response rate. Their exact procedure for selecting the churches was unclear. The 24 churches were randomly assigned to one of four treatment possibilities with one control group. The treatment was different levels of professional involvement with a church based task force.

Of interest is the statement of Lasater et al. (1986) that in meeting with pastors of potential churches "...team members were careful to avoid attempting to integrate health and religion except to state that they certainly seemed compatible" p. 127. In a later descriptive publication from the same study, Lasater, Carleton and Wells (1991) discussed the advantages of working with churches for health promotion programs. Some of the advantages cited include having access to entire families, churches being natural gathering places, multi-disciplinary, and having talented memberships and
strong social support networks.

The one study that actively incorporated church leadership, structure and values into program development and implementation studied smoking cessation in urban African American churches (Stillman et al., 1993). The study identified 130 churches in a target area and 22 of the 23 (95%) invited churches consented to participate. The churches were randomly assigned to receive intensive intervention to reduce smoking or minimal intervention. The research team was involved in community and church events in the process of building program support. It was a multidimensional study including gathering baseline data, intervention and program evaluation.

In this study a random telephone survey (n=941) was conducted to identify smoking prevalence in the community. In addition, three focus groups addressing smoking risks and factors affecting smoking behavior were held with 31 current and former smokers who were identified through the participating churches. A member of the church, usually the head of the nursing board or health ministry, was identified by the pastor to be the program coordinator for the church. All of the participating churches had health screening for cardiovascular risk. Of the 1,290 church members (20% of the church populations) who were screened, 22.2% were smokers (Stillman et al., 1993).

Educational materials for this program were developed in collaboration with the research team and church leaders. They incorporated the spiritual nature of the culture of the church, including Bible passages, devotional material, sermons and gospel music.
Volunteers were trained to lead the smoking cessation classes. In the control churches the only intervention was provision of the American Lung Association printed materials on smoking cessation. Three hundred and seventy four (91%) of the smokers identified in both groups were interviewed after one year. Five of the treatment churches held the minimum of four group smoking cessation programs. The study did not identify the findings related to smoking cessation. Instead, the report focused on the process of program implementation identifying the benefit of incorporating individual church structures and beliefs into the program (Stillman et al., 1993). This project provides a good model for equal partnership with churches and health professionals, recognizing the strengths each provide. Such a partnership can provide a powerful tool for developing health ministry.

Although the preceding research literature has provided information about successful health promotion programs in churches, none of the studies have investigated the characteristics, attitudes or beliefs of churches that make these programs work. Ransdell (1995) does an excellent job summarizing the literature and discussing why health promotion in churches is successful including the fact that many church leaders believe that spiritual and physical health are highly related.

Congregational Culture

Understanding congregational culture is essential to understanding the concept of health ministry. In a very broad sense, Christianity is a culture within which other
cultures exist. For example, denominations are a loose culture formed by a group of congregations and individual congregations are more organized cultures formed through close associations. The following review of literature provides a glimpse into the concept of a congregation as a culture.

Congregations are local cultures with four distinctive qualities. First, congregations consist of a group of people. Second, congregations engage in regular, intentional gathering. Third, congregations gather for the purpose of corporate worship. Finally, congregations gather to worship in a particular place (Wind and Lewis, 1994).

Congregations share an identity, a history, a heritage, a worldview, symbols and rituals (Carroll, Dudley & McKinney, 1986). Of particular interest to this study is congregational identity and worldview. From their study of forty churches Dudley and Johnson (1991) have identified five self-images that may shape a congregation’s identity. Written narratives supplemented by written survey questions, interviews with church leaders and observations from church members were the primary source of information for their study. What is significant about these self-images is not the specific definitions as much as the notion that congregations, as cultures, do share a worldview affecting how they approach life as a community, and within a community.

The first self-image is the survivor church that is reacting repetitively to crises in overwhelming situations. The leadership within survivor churches may be burned out by the crises at the same time that these crises may help to generate support in the
congregation. The second self-image is a crusader church that takes on causes. Leaders with vision and dramatic style characterize them. Members are active in mission, if not in decisions. The third self-image is the pillar church that has a strong sense of civic responsibility to a specific community. These churches tend to have professionally trained leadership. Their large membership tends to create a lower sense of intimacy and involvement in decision making. The fourth self-image is the pilgrim church that has a sense of caring for an extended family or a specific ethnic group. Leadership is characterized by traditional values associated with the ethnic group. There is a strong sense of history and involvement in social ministry. Finally, the servant church has a primary purpose of supporting persons in need. Leaders are caregivers and the membership is a gathering of individuals with low group cohesiveness.

The literature on congregational culture looks at research for purposes of application. The purpose of studying a congregation is to know how to work with it and enhance its ministry (Caroll et al., 1986). There are different ways of studying congregations. Wind and Lewis (1994) utilized historical essays on congregations from a wide range of faiths, to study the local culture of the congregation. Caroll et al. (1986) identified ethnographic methods, needs analysis, case studies, experimental and correlational designs as techniques for studying congregations.

In studying congregational cultures, ethnographic methods help to provide an understanding of the congregation's identity and the meaning ascribed to
congregational life. A needs analysis is the simplest design to study a congregation utilizing a survey or interviews that try to identify perceived needs. The purpose behind a needs assessment is developing a plan to address those needs. Case studies use a focused, in-depth approach to identify inferences that can be drawn from studying one group. Experimental and correlational designs seek to test a specific hypothesis (Caroll et al., 1986).

Another way to study congregations is through a systems approach that is similar to ethnography in looking at a congregation as one whole system. A systems approach to congregations "...observes the reactive patterns or nonconscious agreements or "understandings" that people have about how they are supposed to act or how to get along." (Parsons & Leas, 1993a, p.5). There are formal, informal and tacit agreements within a congregational culture. These three levels of agreements can be found in the following areas of congregational life: rules, roles, rituals and goals. A systems approach differs from ethnography in its use of quantitative methods. One example of a quantitative tool from a systems approach is the congregational systems inventory questionnaire developed by Parsons and Leas (1993b).

The literature on congregational culture is characterized by a nature of exploring who congregations are and what makes them tick. It explores how congregations can be understood in order to maximize their potential for ministry. The goal is to understand congregational culture in order to develop appropriate ministries rather than to predict or control.
Conceptual Framework

Leininger's theory of culture care diversity and universality (1991), which seeks to understand both universal and unique patterns of caring among cultures, stressing the importance of understanding meaning in context provides the conceptual framework for the present study. Congregations share universal characteristics with other congregations, while also having numerous unique characteristics. One central activity of congregations is caring with health ministry being one way congregations care about the health and healing of their members and the community.

According to Leininger (1991) culture is defined as "...the learned, shared, and transmitted values, beliefs, norms and lifeways of a particular group that guide their thinking, decisions, and actions in patterned ways" (p. 47). Individual congregations are one kind of culture that share values and beliefs. Denominations, created by groupings of like-minded congregations, are another type of culture with looser affiliation than the individual congregation. “The critical assumption guiding ethnographic inquiry is that every human group that is together for a period of time will evolve a culture” (Patton, 1990, p.68).

Within the theory of cultural care diversity and universality, cultures may be considered either high context or low context depending on the style of interaction. High context cultures have a great deal of interaction including long term relationships, many shared life activities and a restricted linguistic code while low context cultures have minimal interaction and an explicit language code (Wenger, 1991). A
congregation can be anywhere on the continuum of high to low context culture depending on their pattern of interactions. Individual congregations each share their own culture and often are affiliated in a denomination, which forms a broader culture.

Cultural congruence, which recognizes the importance of understanding culture when providing nursing care, is one of the crucial concepts of Leininger's theory for nursing practice in health ministry. Each culture has a lay system of care that the nurse integrates with the professional system to provide culturally congruent care. This is done through maintaining lay patterns of health care, negotiating patterns of health care or restructuring patterns of health care. The ability of the nurse to provide culturally congruent care is based on understanding the beliefs shared by the culture with which she/he is working (Leininger, 1991).

Through co-participation with the client (individual, family or community) the nurse supports cultural patterns that promote health (cultural care preservation), supports clients in culturally significant behaviors related to health experiences (cultural care accommodation) and works with the client to repattern health behaviors, in culturally sensitive ways, when change is needed (Leininger, 1991). Figure 5 shows Leininger's Sunrise Model for Culture Care Diversity and Universality, which provides a cognitive map for the theory. The model identifies different factors and interactions that constitute the worldview and cultural care values of a culture.
Figure 5. Leininger’s Sunrise Model to Depict the Theory of Cultural Care Diversity and Universality

Cultural Care Worldview

Cultural & Social Structure Dimensions

Kinship & Social Factors

Cultural Values & Lifeways

Political & Legal Factors

Environmental Context

Language & Ethnohistory

Religious & Philosophical Factors

Economic Factors

Technological Factors

Educational Factors

Influences

Care Expressions

Patterns & Practices

Holistic Health (Well-being)

Individuals, Families, Groups, Communities, & Institutions in Diverse Health Systems

Generic (Folk Systems) Nursing Care Professional System(s)

Nursing Care Decisions & Actions

Cultural Care Preservation/Maintenance
Cultural Care Accommodation/Negotiation
Cultural Care Repatterning/Restructuring

Culturally Congruent Care [Health/Well-being]

Reprinted with permission

Leininger, 1991
Summary

One obvious finding from this literature review is the diversity of perspectives on health ministry. However, there are patterns in the Biblical concepts used to support health ministry, including continuing Jesus’ ministry of healing, promoting justice and stewardship of our bodies. Often the literature describes health ministry rather than defining it. In addition, there is a lack of clarity in the use of the related terms healing ministry and wellness ministry.

The literature on health ministry provides support for studying health ministry from a cultural perspective. Health ministry occurs predominantly within the cultural setting of a congregation where the meaning of health ministry is experienced. Health ministry can not be understood without also understanding its meaning in the context of the congregation.

The methodology selected for a research study should be a logical consequence of the research question(s) and conceptual framework that guide the inquiry. The research method both shapes and is shaped by the purpose of the study. A logical consistency is needed between the questions that prompt a study, the conceptual framework and the method used to answer those questions. Another factor that guides the selection of a research method is the level of pre-existing knowledge and research on a concept. When there has been little or no research on a topic, qualitative methods are an appropriate way to study a concept (Lincoln & Guba, 1985). Since the ultimate purpose of this study was to gain understanding of health ministry in the life of
a congregation, as opposed to making predictions or generalizations qualitative research was the logical area from which to choose a research method (Morse, 1995).

There are several reasons, evident from reviewing the literature, why qualitative research is needed on health ministry. First, there has been only one published study to date that explicitly looked at the concept of health ministry. Second, the majority of the studies on topics related to health ministry have been quantitative, demonstrating a need for qualitative studies to gain understanding. Thus, this researcher conducted a qualitative study to learn how health ministry was understood and experienced within one congregation with a parish nurse.
CHAPTER III
METHODOLOGY

...whatever you do, do it unto the glory of God. I Corinthians 10:31b

As parish nursing and other types of nursing practice with congregations expand, understanding health ministry, which provides the conceptual framework for this practice, becomes increasingly important. Health ministry, although rooted in longstanding traditions, is relatively new as a discrete concept in the literature. No prior research has studied the perspective of how health ministry is experienced within an individual congregation. As stated earlier this study focused on the following research questions:

1. How does health ministry reflect the worldview and cultural care values of a congregation with a parish nurse?

2. What are the patterns, meanings and expressions of health ministry in a congregation with a parish nurse?

3. What is the emic (insider) understanding of health ministry in a congregation with a parish nurse?

4. How is the emic (insider) understanding of health ministry similar and/or different from the etic (outsider) understanding of health ministry?
The following discussion of methodology includes considerations in utilizing qualitative research, study design, procedure and evaluation.

Qualitative Research

The conceptual framework for this study, Leininger’s (1991) theory of culture care diversity and universality, is based in the qualitative paradigm of naturalistic inquiry, which has five basic axioms as identified by Lincoln and Guba (1985). The first axiom is that reality has multiple constructions that can only be studied wholistically. Second, there is an interaction between the researcher and who or what is being studied that mutually influences both. Third, the purpose of naturalistic inquiry is not to create generalizations. It is to develop working hypotheses that will be particular to the time and context under study. Fourth, cause and effect relationships can not be determined because of mutual interactions that take place. Finally, research is always value laden, with value components from the researcher, the study paradigm, the guiding theory and the context of the study. Lincoln and Guba (1985) have also identified fourteen logical implications for research studies utilizing naturalistic inquiry. Table 3 identifies how these implications were applied in this study.
Table 3  
Practical implications of naturalistic inquiry  

<table>
<thead>
<tr>
<th>Characteristics of naturalistic inquiry (Lincoln &amp; Guba, 1985)</th>
<th>Application in this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Research conducted in a natural setting to gain wholistic perspective</td>
<td>Congregation was the natural setting</td>
</tr>
<tr>
<td>2. Researcher and other human beings are primary research instruments</td>
<td>Human interaction was main source of data</td>
</tr>
<tr>
<td>3. Tacit knowledge and language are important in the nuances and values reflected</td>
<td>Tacit knowledge was expressed through behavior and cultural symbols</td>
</tr>
<tr>
<td>4. Qualitative methods are more sensitive to multiple realities than quantitative methods</td>
<td>Methods included participant observation, ethnographic interviews, semi-structured interviews and reviewing written materials</td>
</tr>
<tr>
<td>5. Purposive sampling reflects multiple realities better than random sampling</td>
<td>Significant categories of cultural members were identified and used to select participants</td>
</tr>
<tr>
<td>7. Theory emerges from data rather than existing a priori to avoid generalization</td>
<td>Grounded theory not used. Leininger’s theory of culture care diversity and universality provided conceptual framework</td>
</tr>
<tr>
<td>8. Emergent design responds to unfolding research process</td>
<td>Research design was modified as needed in response to changing knowledge</td>
</tr>
<tr>
<td>9. Meanings and interpretations are negotiated with participants to gain emic perspective</td>
<td>Written summaries of semi-structured interviews were shared with participants. Presentation done for all interested persons at end of study.</td>
</tr>
<tr>
<td>10. Case study reporting style better reflects multiple realities and values</td>
<td>Ethnography created to report the findings</td>
</tr>
<tr>
<td>11. Data interpreted relevant to case particulars rather than creating generalizations</td>
<td>No attempts were made at generalizations</td>
</tr>
<tr>
<td>12. Multiple realities and unique qualities of research make broad applications inappropriate</td>
<td>Application of findings identified possibilities without sweeping generalizations</td>
</tr>
<tr>
<td>13. Boundaries of research emerge as study progresses</td>
<td>Focus of inquiry determined by research questions</td>
</tr>
<tr>
<td>14. Criteria for trustworthiness need to be consistent with naturalistic paradigm</td>
<td>Utilized Leininger (1991, 1994) criteria for evaluation</td>
</tr>
</tbody>
</table>
Qualitative methods, appropriate for the goals of understanding the concept of health ministry and its place within the culture of a congregation, were used in the design of this study. Qualitative research methods are well suited to questions of understanding and are particularly useful when the insider or "emic" perspective of a phenomenon is desired. The researcher approaches a qualitative study as one who will learn from the persons who are being studied rather than manipulating them (Vidich & Lyman, 1994; Leininger, 1985, 1991). Understanding the perspective of members of the culture, the emic perspective, was an integral component of this study.

Study Design

Leininger (1985, 1990) identifies multiple methods from the qualitative paradigm suitable for research with the theory of culture care diversity and universality. Two research methods that are consistent with the goals of this study are ethnonursing and ethnography. Leininger (1985) defines ethnography as "...the systematic process of observing, detailing, describing, documenting, and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment" (p.35). Ethnonursing is defined as "...the study and analysis of the local or indigenous people's viewpoints, beliefs, and practices about nursing care behavior and processes of designated cultures" (Leininger, 1985 p. 38).

Ethnography was the qualitative research method of choice because the study focus required an overall understanding of the culture in addition to a specific focus of
nursing interest. Although nursing care exists in the parish nurse role, the desire was to look at the broader concept of health ministry requiring a broader cultural perspective. Health ministry is an interdisciplinary concept that includes but is not limited to nursing care. The usefulness of this research was first to nursing, but also to pastoral care and public health professionals. The interdisciplinary nature of the concept of health ministry, and the potential audience from nursing as well as other disciplines, made the use of ethnography, a method more widely known across disciplines, desirable. As Leininger (1991) identifies, it is "...encouraging to think nursing's knowledge could be used by other disciplines" (p.26).

Ethnography

The primary purpose of ethnography is to gain an understanding of the cultural meanings that organize and explain the experiences of a group of people (Spradley, 1979). This is done through "...collecting, describing, and analyzing the ways in which human beings categorize the meaning of their world" (Aamodt, 1989, p. 41). An ethnographic study attempts to describe a culture from the participants' point of view requiring the researcher to learn from the people rather than studying them (Spradley, 1979; Leininger, 1991). The ethnographic methods for this study came from Spradley (1979, 1980) and Leininger (1985) while the conceptual framework of culture care diversity and universality (Leininger, 1991) formed the cognitive principles shaping the study.
The meaning ethnographic methods seek to make explicit may be expressed in language or may be communicated indirectly through words, actions and symbols. This system of meaning that organizes the world is shared within a culture (Spradley, 1979). Ethnography is a wholistic approach grounded in the context and understanding of culture, emphasizing the contextual component of meaning and experience (Spradley, 1979; Aamodt, 1989; Leininger, 1985).

The central component of this study was understanding the emic experience of health ministry. The literature on health ministry has focused on the professional, etic perspective, often prescribing what congregations can do in the area of health ministry. What has not been studied is what congregations are actually doing and how individuals within congregations understand the meaning of what is being done in the name of health ministry.

**Definitions**

The following orientational definitions were used in this study. Leininger (1991) recommends the use of orientational definitions to guide the study of the domain of inquiry rather than operational definitions as traditionally used for quantitative research. Call - perception of direction from God, of an individual or a community, to engage in a particular ministry (Thomas & Alkire, 1992). Componental analysis – “systematic search for attributes (components of meaning) associated with cultural categories” (Spradley, 1980, p. 131).
Cover term - name for a cultural domain (Spradley, 1980).

Culture - "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 1991, p. 47.).

Cultural Care - "the subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable another individual or group to maintain their well being, health, to improve their human condition and lifeway, or to deal with illness, handicaps or death" (Leininger, 1991, p.47).

Culturally congruent (nursing) care - "those cognitively based assistive, supportive, facilitative or enabling acts or decisions that are tailor made to fit with individual, group, or institutional cultural values, beliefs, and lifeways in order to provide or support meaningful, beneficial, and satisfying health care, or well-being services" (Leininger, 1991, p. 49).

Cultural theme - "any cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning" (Spradley, 1979, p.186).

Domain - a symbolic category that includes other categories that share at least one feature of meaning. Domains have three basic elements; cover term, included terms and semantic relationship (Spradley, 1979, 1980).
Domain analysis – "...a search for the larger units of cultural knowledge" (Spradley, 1979, p. 4). Taxonomic analysis and componential analysis are components of domain analysis.

Emic - the knowledge of insiders within a culture (Leininger, 1991).

Etic - researcher or externally derived, presumed and pre-set ideas (Leininger, 1991).

Health - being in harmony with self, others, the environment and God (United Methodist Church, 1995).

Health ministry – "The intentional reaching out to others by a community of faith to promote wholistic health, which is seen as an integration of body, mind and spirit. The motivation for health ministry comes from a shared understanding of the call to wholeness and service as illuminated in the Christian scriptures. Health ministry is directed by a health professional and respects the culture in which it is expressed, recognizing individual responsibility for health among those it serves" (Chase-Ziolek, 1996, p.4-5).

Included term - names for smaller categories in a domain (Spradley, 1980).

Ministry - service with a motivation that is a direct reflection of, and a response to, the relationship with God of an individual or a community. Ministry is understood as the work of the Church, seen as a continuation of the work that Jesus began on earth (Thomas & Alkire, 1992).

Semantic relationship - links two categories (Spradley, 1980).
Taxonomic analysis - "A search for the parts of a culture, the relationships among the parts, and their relationships to the whole" (Spradley, 1980, p.116).

Worldview - "The way people tend to look out on the world or their universe to form a picture or a value stance about their life or world around them" (Leininger, 1991, p.47).

Setting

Four criteria were used for selecting the congregation for this study. The first criterion was that the congregations have a parish nurse who had been serving for a minimum of two years. The rationale for this criterion was that parish nursing is a nursing model of health ministry and one of the most common ways health ministry is actualized. The second criterion was that the congregation belong to a Mainline denomination that has been active in developing health ministry. This included the Lutheran, Presbyterian or Methodist denominations. The rationale for this criterion was that denominations active in developing health ministry provide written materials, training and personnel resources to their member congregations. This could mean that congregations in those denominations would be further along in integrating the concept of health ministry into their life and theology. The third criterion was that the congregation have an active health and wellness committee. The rationale for this criterion was that having an active health and wellness committee is an indication of broader congregational involvement in health ministry rather than depending solely on the activities of the parish nurse. The final self-explanatory criterion was the willingness
of the congregation to participate in the study.

A large, multiethnic, urban United Methodist church with a volunteer parish nurse who had been serving for three years at the beginning of this study, and with an active health and wellness committee consented to participate. The population of this congregation is noted for its diversity in ethnicity, age, gender, theological beliefs and sexual orientation. The majority of members live in the city, but many live in the suburbs as well. In this research, the congregation is referred to as First Church, to preserve confidentiality.

The senior pastor gave consent for the congregation to participate in the study. The congregation was informed of the study through an article in the church newsletter. In addition, the purpose of the study was identified whenever the researcher introduced herself to a new group.

Procedure

Multiple methods of gathering data were used in this study including participant observation, both informal and semi-structured interviews and review of written documents. The purpose of using multiple sources of data was to provide rigor and depth to the study. Also, through utilizing multiple ways of gaining cultural information, there was a greater likelihood of uncovering multiple realities.
Participant Observation

One way to understand the meaning of behavior is to talk with members of the culture. However, many cultural meanings are taken for granted and expressed implicitly through word and deed. Therefore, participant observation is an important component in creating an ethnography because it attempts to get at those implicit cultural meanings with inferences being made from what is observed (Spradley, 1979, 1980).

Everyone learns about their own culture and that of others through observation and asking questions, which is exactly what participant observation does. The researcher observes and asks questions to begin to understand how the culture works. Participant observation is essential in gaining access to the culture. Through observation, one learns the expected and accepted behaviors that will make the culture accessible to the researcher (Spradley, 1980).

It is virtually impossible to purely observe behavior and not participate because simply by virtue of one’s presence one participates in the group situation, even when silent. This was particularly true in the study setting of a congregation where worship was a major cultural event involving participation. By virtue of the researcher’s attendance at worship there was participation in the culture. It was important that the participant observation phase precede the organized interviews because it helped identify what questions needed to be asked of whom and how they might be asked. Participant observation was the research stage that helped provide the feel of the culture studied, as
well as who and what appeared to be of importance. Participant observation experiences
were recorded in field notes attempting to objectively document what was observed,
with separate documentation of personal comments and thoughts about the observations.

The participant observation phase of this study began with the following questions
in mind:

1. What are the references to health and healing in services, meetings or written
materials?

2. How are the components of Leininger's Sunrise Model, including technological
factors, religious and philosophical factors, kinship and social factors, cultural
values and lifeways, political and legal factors, economic factors and educational
factors manifested in the life of the congregation?

3. What is the nature of the physical environment? i.e. is it handicapped
accessible?

4. What are the activities of the church? Are there support groups? For what
groups are programs and services available?

5. Who is involved in the church? Ethnicity? Socioeconomic status? Age
distribution? How are people accepted? How are new members incorporated?
What are the criteria for membership? What are the patterns of attendance?

6. How is the church structured, both for the professional staff and the
congregation? Where does health ministry fit into the structure? How is this
congregation connected to the denomination?

7. What are the members talking about? What are the issues that are being addressed in services and publications?

8. What rituals are observed?

The initial phase of participant observation was used to familiarize the researcher with the congregation and develop relationships. As many activities as possible were attended at the church in the beginning phase of participant observation. These activities included worship services, committee meetings, programs and special events. The researcher also regularly attended the health and wellness committee meetings.

Interviews

Interviews, both informal and semi-structured were an important method for gathering data. Throughout the study, informal ethnographic interviews, which were spontaneous and unstructured, were held with participants to ask questions, clarify observations and share information. Semi-structured interviews were also held with selected participants.

As the researcher became familiar with the church community and developed relationships, potential participants were identified and invited to participate in semi-structured interviews lasting about one hour. These interviews were audio taped. The audio taped interviews were transcribed in order to facilitate data analysis.
Six key participants and thirteen general participants took part in the semi-structured interviews. Key participants had two semi-structured interviews and general participants had one interview for a total of twenty-four semi-structured interviews. The number of participants was consistent with Leininger's (1991) guidelines for a focused study of a culture. These participants took part in numerous informal ethnographic interviews during the study. As indicated in IRB approval, written informed consent (Appendix F) was obtained for the formal interviews. Interviews were conducted at a location of the participants choosing which included church, office or restaurant. Twenty additional participants also took part in informal ethnographic interviews. These interviews were not tape-recorded and information was included in field notes.

Participants

Spradley (1979) and Leininger (1991), as well as others doing ethnographic research have typically used the term informant to refer to the members of the culture who provide information to the researcher. The term participant is used for this study to refer to "individuals who provide the researcher with information relevant to the study," (Morse & Field, 1995, p. 243). This distinction is made to reflect the interactive, relational nature of ethnography.

Participants, who included members of the congregation and staff, were selected for the semi-structured interviews based on their knowledge of and experience with
health ministry and/or the congregation in general. A purposive effort was made to reflect the ethnic, age and gender diversity of the congregation in the selection of participants, as it was described in congregation publications and identified by the senior pastor.

Key participants were assumed to be more knowledgeable than general participants (Leininger, 1991). In reality, many of the general participants were also very knowledgeable about the culture. In addition to cultural knowledge, the decision to make someone a key or general participant was based on maintaining the ethnic, age and gender balance of the group and/or their ability to participate in more than one semi-structured interview.

An interview guide (Appendix G) was used for the interviews. Content of the interview varied depending on the person’s interest and expertise. Subsequent interviews with key participants were used to clarify comments and expand on areas of interest. In order to enhance the credibility and confirmability of the study, written summaries of the interviews were given to each participant to provide an opportunity to clarify and respond to the interview content. Questions that emerged after analyzing the interviews were clarified with the participants. After the findings were analyzed, a presentation of findings was done for interested persons in the congregation, which 35 persons attended.

Because the researcher is the primary research instrument in an ethnographic study, two practice interviews were held prior to beginning the interviewing phase of
the study. Interviews were held with two members of other congregations to identify the clarity of the topics to be covered and possible order for discussion. The interview guide was then modified accordingly.

The members of the culture were important partners in creating this ethnography. Impressions and thoughts were discussed with the participants as they emerged, and findings were shared to be confirmed or contradicted. Creating this ethnography was a participative process in which both the researcher and the participants had valuable knowledge to share with each other.

Review of Written Documents

In addition to participant observation and interviews, church documents relevant to health ministry were reviewed. These included the United Methodist Church Book of Discipline, worship book (included hymns, prayers and services), church bulletins, informational flyers, sermons, reports and minutes of the health and wellness committee. These documents were reviewed to identify support or conflict with findings from participant observation and interviews.

Cultural Context of Researcher

Research is always value laden (Lincoln and Guba, 1985). The ethnic, religious, cultural and gender identity of the researcher all had potential to impact this study in how the questions were asked, as well as how participants responded. The researcher
is a middle aged female of Anglo Saxon descent, married with children who has belonged to congregations from the Congregational, American Baptist, and Evangelical Covenant denominations. The researcher had prior contact with the parish nurse and two of the pastors through her work as a health ministry coordinator.

Data Analysis/Synthesis

Ethnographic analysis is "...a search for the parts of culture, the relationships among parts and their relationships to the whole. Combined with ethnographic interviews, ethnographic analysis leads to the discovery of a particular cultural meaning system" (Spradley, 1979, p.142). The final phase of the research study was the analysis and synthesis of the information collected, in order to discover cultural meanings. The main sources of information analyzed were written transcripts of the interviews and field notes. Additional sources of information analyzed less extensively included written sermons, weekly newsletters, bulletins, handouts and written reports.

The data analysis was done according to the guidelines provided by Spradley (1979, 1980). Every ethnographic description ends up being a translation. It is the job of the ethnographer to provide as accurate a translation as possible (Spradley, 1979). An ethnography creates a text that has a unique perspective, different from any one individual research participant. "Ethnography is an explicit methodology designed for finding out both the explicit and tacit knowledge familiar to the most experienced members of a culture...because much of our cultural knowledge is tacit, outside
awareness, the ethnographer ends up having far more explicit knowledge than informants" (Spradley, 1979, p.156).

Spradley (1979) identifies four types of ethnographic analysis, domain analysis, taxonomic analysis, componential analysis and theme analysis. These can be used on the data collected in field notes, transcripts of interviews, and other written documents.

Domains, a symbolic category including other categories and subcategories, are the main unit of analysis in creating an ethnography. Domains consist of cover terms and included terms that exist within a semantic relationship. Taxonomic analysis and componential analysis are used to further analyze domains. Theme analysis identifies connections among domains.

The data analysis process began with a preliminary search for cover terms, which are names for categories of cultural knowledge. These cover terms helped to identify what was of importance to this culture. The next step was looking for included terms that belonged to the category found in a cover term. The final step looked for semantic relationships connecting the cover term to included terms in its set (Spradley, 1979).

Domain analysis began with reviewing verbatim notes from an ethnographic interview. Transcriptions were read looking at how terms were used by the participants. Both interview transcripts and field notes were coded for cover terms and categories of cultural knowledge. Utilizing a word processing program, Microsoft Works, information from all interviews in each category of information was combined into a separate text for further analysis. These separate texts were then
analyzed to find the categories and subcategories in each. In each category cover terms were listed on index cards and then sorted into groupings with similar characteristics. The decision was made to use word processing software rather than qualitative research software due to computer limitations and the challenge for the researcher of learning a new software program simultaneous to mastering a research technique.

After identifying cover terms in several transcripts, initial domains were identified as well as their categories and subcategories, which reflected the cover terms and included terms. Domains are the largest categories of information that share some similarities. Domain analysis included identifying semantic relationships between terms and finding good examples. In the final analysis, five organizing domains emerged.

Once the domains were identified they were further analyzed through taxonomic and componential analysis. Not all domains required these additional analyses. A taxonomic analysis looks for the internal structure of the domain that will help to identify contrast sets. "Taxonomy differs from a domain in only one respect; it shows the relationships among all the folk terms in a domain. A taxonomy reveals subsets of folk terms and the way these subsets are related to the domain as a whole" (Spradley, 1979, p. 137). Table 4 shows the taxonomy of ethnographic analysis.

Another option for analyzing domains was componential analysis that involves finding the differences among attributes within a domain (Spradley, 1979, 1980). Componential analysis helps to identify attributes in order to contrast different cultural symbols. This analysis that looks for multiple relationships builds on domain and
taxonomic analysis (Spradley, 1979).

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Taxonomy of ethnographic analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ethnographic analysis</td>
</tr>
<tr>
<td><strong>Domain analysis</strong></td>
<td><strong>Theme analysis</strong></td>
</tr>
<tr>
<td>Larger units of cultural knowledge</td>
<td>Relationships among domains linked to culture as a whole</td>
</tr>
<tr>
<td><strong>Taxonomic analysis</strong></td>
<td><strong>Componential analysis</strong></td>
</tr>
<tr>
<td>Internal structures of domains</td>
<td>Attributes that differentiate symbols in a domain</td>
</tr>
</tbody>
</table>

Having identified the domains found within the ethnographic material, and conducting further analysis through taxonomic and componential analysis to discover cultural meaning, the final step in ethnographic analysis was theme analysis which "...searches for the relationships among domains and how they are linked to a culture as a whole" (Spradley, 1979, p.94). A theme is "...any cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning" (Spradley, 1979, p.186). Themes can be applied in numerous cultural situations and recur across two or more domains. Frequently members of a culture are not explicitly aware of their cultural themes. Even though they are understood, they are often only tacitly understood.

Graphic representations including attributes and semantic relationships and taxonomic analysis were created to visualize the relationships identified through domain analysis. A schematic diagram of the culture depicting relationships among domains was also created. These figures can be found in the chapter on findings.
Ethical Considerations

IRB approval for the study was obtained. The risks to the participants were minimal. Participants might have experienced a loss of privacy. They had the option to terminate interviewing at any time. The congregation as a culture may have experienced a loss of privacy, although it is a very public organization.

The senior pastor gave permission for the congregation’s participation in the study. Individual participation was strictly voluntary with no pressure or undue influence exerted to obtain participants. The purpose of the research study was identified to all participants who took part in the semi-structured interviews and a written consent that outlined the study was obtained. When participating in a group experience, the researcher identified herself to the leader and asked for permission to participate if it was not an activity widely open to the public. The purpose of the study was also described in the church newspaper at the beginning of the project.

The potential benefits for participants included assisting to provide new knowledge in an area without significant research. In addition, the study had the potential to provide knowledge that could be useful to the congregation in further developing their own health ministry.

Confidentiality of the participants’ responses was safeguarded through several measures. Information was not shared with the congregation about who had been interviewed. The typed transcriptions of the interviews used a code for identifying the participant. Identifying information on each participant was kept in a separate location.
All tapes and transcripts were kept in a secured area.

Evaluation

Evaluation criteria for research studies need to be consistent with the paradigm from which they are created. Criteria for evaluating quantitative studies can not be used for qualitative studies. There are specific appropriate evaluation criteria for qualitative studies that Leininger (1991) identifies as credibility, confirmability, recurrent patterning, meaning-in-context, saturation and transferability. Credibility refers to the believability or truth of the findings which both researcher and participants would find to be credible (Leininger, 1991). There are certain steps that can be taken to ensure credibility including prolonged engagement, persistent observation, and using different sources and methods of collecting data. Another technique for ensuring credibility is checking the information with the members of the culture and with peers (Lincoln & Guba, 1985).

Confirmability refers to the reaffirmation of what the researcher has experienced through repeated observations and explanations from participants (Leininger, 1991). The main technique for ensuring confirmability is creating an audit trail that documents the data collection and analysis of the study (Lincoln & Guba, 1985). Meaning-in-context refers to interpreting and understanding what the researcher has experienced within the context in which it has occurred. Recurrent patterning refers to repeated patterns of experiences that occur over time. Saturation refers to conducting an
exhaustive study until new data are redundant. Transferability refers to identifying similarities of findings that might occur in similar situations (Leininger, 1991). Research from the qualitative paradigm is not concerned with external validity because the goal is to understand, rather than to generalize. However, through providing descriptions of sufficient depth, often referred to as “thick,” other researchers can reach their own conclusion about the transferability of data (Lincoln & Guba, 1985).

The purpose of these techniques for trustworthiness is ensuring that the ethnography created has in fact captured the emic perspective of the culture. The complexity of collecting and analyzing the emic perspective creates a burden on the ethnographic researcher similar to ensuring validity and reliability for a researcher using quantitative methods (Aamodt, 1982). The following are the steps taken in this study to ensure its trustworthiness and rigor:

1. The researcher was involved with the congregation for 14 months.
2. Certain cultural activities such as worship, Sunday school classes and meetings were observed repeatedly.
3. Written summaries of interviews were shared with participants.
4. Questions that arose from the findings were checked with the participants.
5. A presentation on the study findings was held for all interested persons in the congregation to allow for their confirmation of the findings.
6. Transcripts of interviews were shared with some study committee members to allow for confirmation of the findings.
7. Documentation of the process of gathering and analyzing data was maintained.

8. Information was obtained from participant observation, informal and semi-structured interviews and reviewing written church documents.

In summary, the methodology for this study was based in naturalistic inquiry that seeks to understand meaning in context. Leininger's (1991) theory of culture care diversity and universality provided the cognitive map. Ethnography, described by Spradley (1979), provided the method.
CHAPTER IV
HISTORICAL CONTEXT

And he called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to preach the kingdom of God and to heal.
_Luke 9:12_

Understanding the historical context of a culture is an essential component of creating an ethnography. The history of a culture helps to shape important values and experiences for the group. The present is significantly influenced by the past, a fact that is certainly true for health ministry. The history of involvement in health issues of the United Methodist Church in general, and First Church in particular, is important in understanding how health ministry fits into the life of this congregation today. The United Methodist Church (UMC) was formed through a merger of the Methodist Church and The Evangelical United Brethren Church in 1968. The following discussion focuses on the history of the Methodist Church, the denomination to which First Church belonged prior to the merger, and the history of First Church, with an emphasis on their involvement in health related issues.

This historic perspective is intended to be an overview providing a background for the results of this study rather than an exhaustive historic analysis. There are two periods in Methodist history that stand out as examples of how Methodists became involved in health in responding to the needs of their times. The first occurred during
the life of John Wesley. The second occurred in the late nineteenth and early twentieth century when the social gospel movement inspired a concern for people's bodies as well as their souls.

History, the perspective of where a group has come from, is important to the United Methodist Denomination. There is a consistency and continuity in how they have lived out their faith. The United Methodist Church book of law, the Book of Discipline (1996), begins with a list of all of the United Methodist Bishops since 1784 and a statement of history. Clearly, this is a group that values its heritage. It is also a group with a very well documented history beginning with the prolific writing of John Wesley.

John Wesley and the People Called Methodists

The people called Methodist, from the very beginning until the present, have been very responsive to, and influenced by, the social issues of the times. This was true for John Wesley (1703-1791), the founder of Methodism who lived in England in the eighteenth century during a time of economic polarization. The Church of England, the predominant religious group of the time, did little to improve the conditions of the poor or to make religion accessible to them. John Wesley chose to take on the cause of improving conditions for the poor and providing access to religion and health knowledge. (Heitzenrater, 1995)
Wesley was ordained as a priest of the Church of England in 1726, but did not serve in a parish. Instead, John and his brother Charles (1707-1788), developed a small group of Oxford students who practiced spiritual disciplines including "...prayer, Bible study, fasting, receiving Holy Communion, and engaging in social work, especially visiting the prisons and caring for the poor." (Yrigoyen, 1996, p.5). The group was so methodical in their disciplines, modeled after the early Christians, that they became known as "Methodists," a term not considered a compliment at that time (Yrigoyen, 1996).

John and Charles became missionaries of the Church of England. They went to the colony of Georgia in March 1736, their only time spent in America. It was a discouraging and brief experience. After returning to England, in May 1738 John Wesley had a transforming religious experience leading him to begin a movement of renewal in the Church of England. Wesley traveled all over England proclaiming God's forgiving grace through Christ, speaking to all possible groups in all possible places. Charles Wesley is best known for the many hymns he wrote. (Heitzenrater, 1995).

Wesley was very organized in his work, creating structures that would help fulfill his mission of bringing the good news of the gospel to as many people as possible. Small groups, called societies were the foundation of his organization, creating caring, connecting communities. Care was shown in Methodism through the societies that nurtured people in small groups and through the faith that caused them to reach out to others in need (Yrigoyen, 1996).
Societies met weekly in people's homes for fellowship, prayer and singing. These groups were meant to provide renewal to the Church of England, not replace it. Members of the societies were expected to also participate in the Church of England where they took part in communion and baptism. Once started, the leadership of the societies was turned over to lay leaders. This use of lay leaders rather than relying solely on the ordained clergy enabled the movement to grow (Willomon, 1990). The societies were themselves formed into a network, a connection of societies, with John Wesley being the link between the connections and the Church of England (Heitzenrater, 1995).

Wesleyan Theological Beliefs

The Methodist Church has health at its very roots. Understanding the denominational foundation is important to understanding health ministry in an individual United Methodist church. Wesley's theological beliefs on salvation, creation and love, are particularly pertinent to his understanding of health. The first concept, salvation, was understood by Wesley to be "...a restoration of the soul to its primitive health" (Holifield, 1986, p.17). Salvation was understood as a life long process that involved one's continuing relationship with God and the world (Wesley, 1765/1991). Salvation and health were interconnected because, Wesley believed, illness and death came about as a result of the Fall in the Garden of Eden. Consequently, health and healing could be brought about through salvation (Holifield, 1986).
Creation is a second important concept in understanding how Wesley viewed health. From Wesley's perspective, all of creation was an interconnected whole. Creation was good and to be valued. It was the Fall that brought about disharmony among creation, causing disease, pain and suffering. He had a vision of a "new creation" that would restore humans and all of creation to a harmonious life (Wesley, 1747).

"Hence the restoring of the created order through God’s grace would also include the restoring of health to the physical body. Because creation was good, and because that goodness included health, then the healing of the body was in accord with the deepest nature of things" (Holifield, 1986, p.14).

Love was the third concept relevant to Wesley's beliefs on health. Salvation was a response to the love of God through grace. Having experienced the love of God through grace, the Christian was then expected to share the love of God with others. The capacity to love was essential to sanctification, which included loving God and loving one’s neighbor. Love could both promote health and lead one to try to promote the health of others (Holifield, 1986).

Wesley identified that there is both a social love for one's neighbors and a love of self that are part of the Christian experience.

"It (love) leads him into an earnest and steady discharge of all social offices, of whatever is due to relations of every kind: to his friends, to his country and to any particular community whereof he is a member. It prevents his willingly hurting or grieving any man. It guides him into an uniform practice of justice and mercy, equally extensive with the principle whence it flows. It constrains him to do all possible good, of every possible kind, to all men... (Wesley, 1753/1964, p.185)."
Wesleyan Understanding of Health

For Wesley, the body was not merely a receptacle for the soul, but the two were interdependent. The soul required the body in order to function. Creation was understood as being good and redemption was the restoration of the harmony among all of creation. One component of this restoration was renewing the harmony of the physical body. Likewise sinfulness affected both the body and the spirit. When the body was infirm, the spirit was affected and similarly when the spirit was infirm, the body was affected (Wesley, 1747).

Responding to the love of God experienced through salvation and leading to sanctification led the faithful Christian to reach out to others to express the love of God that they had experienced. One practical way the faithful Christian could express the love of God to others was through tending to the sick and promoting the health of others. It was one way of as John Wesley said “doing all of the good you can wherever you can ...” One of the primary means of promoting health, and spiritual well-being was through love. Wesley worked to bring about health and healing for others through the services that he and his followers provided to persons who were ill and through the message of God's love, the sovereign remedy (Holifield, 1986). Wesley believed experiencing the love of God had the capacity to remedy many miseries.

"The love of God, as it is the sovereign remedy of all miseries, so in particular it effectually prevents all the bodily disorders the passions introduce, by keeping the passions themselves within due bounds; and by the unspeakable joy and perfect calm serenity and tranquility it gives the mind, it becomes the most powerful of all the means of health and long life" (Wesley, 1747, p.22).
Wesley's understanding of health included the interrelationship of body, mind (which he called the passions), and spirit. He recognized that physical health could affect spiritual health and that mental health could become evident in physical ailments and likewise that a spiritual issue could manifest itself in the body. He recognized the need to get to the root of a physical disorder, evidenced in a story he wrote in his diary about a woman who had a pain in her stomach that had not responded to medication. However, the woman had lost her son and her grief had incapacitated her ability to experience love (Holifield, 1986).

The time in which Wesley lived presented the Christian with many opportunities to express God's love. The poor were extremely poor and there were orphans and elderly persons without any means of care (Yrigoyen, 1996). Because of the interrelationship that Wesley understood between body, mind and soul, and in response to God's gracious love, Wesley developed several practical approaches for helping the poor, sick and disenfranchised.

"...he founded dispensaries for the sick, homes for orphans, and schools for the poor. He led the Methodists in personal visitation and care of the imprisoned and impoverished. He published books, pamphlets, and tracts to enhance the spiritual life and improve the physical health of any who wished to read them." (Yrigoyen, 1996, p.10)

Service was an important part of Wesley's understanding of what it means to be a Christian. One of the ways he served people in need was offering a free clinic once a week where he shared his self-taught medical knowledge to help people. He attempted to make medical knowledge accessible and understandable to the poor. He also tried
to emphasize health promotion and not just treatment of disease (Wesley, 1747). Because medicine did not have a large body of knowledge at the time, this was not difficult for him to accomplish. He demonstrated the same understanding of the interrelationship between body, mind and spirit in his use of space, building a preaching house in Newcastle that also served as an orphanage, school, and infirmary (Heitzenrater, 1995).

He expanded his medical services to three of his preaching houses in London, Bristol and Newcastle. In 1746 he began a medical dispensary in London which provided services every Friday. Averages of 100 people per month were seen. The focus of care in the dispensary was on persons with chronic illness. People with more acute problems were sent to a physician. Wesley had reasonable success with his cures and often tried them on himself. The services were provided both to members of the societies and to non-members alike (Heitzenrater, 1995).

John Wesley’s practical theology involved going where he was needed the most and trying to meet those needs. He was acutely aware of the health needs of the poor in England. He was also aware of the expensive, complex polypharmacy offered by medicine that produced limited results. Having studied medicine on his own, Wesley wanted to get practical, understandable health knowledge to the common people for a nominal cost. To that end, he wrote a book, Practical Physick: Or an Easy and Natural Method of Curing Most Diseases, (it was also called Primitive Physick) that provided both his understanding of health in general and particular remedies with which he was
familiar. The book provides both general health principles and specific cures with a particular emphasis on hygiene. Wesley recognized healing as a natural process and offered the simplest, safest cures available at that time. The introduction to his book also identified the interrelationship between faith and health. This book became a bestseller and had 23 editions within his lifetime (Hill, 1958). The following comments from the book's introduction addressing general principles of health promotion, sound as if they could have been written today.

"Observe all the time the greatest exactness in your regimen or manner of living. Abstain from all mixed or high-seasoned food. Use plain diet ease of digestion and this sparingly as you can consistently with ease and strength. - drink only water if it agrees with your stomach. Use as much exercise daily in the open air as you can, without weariness...Above all, add to the rest, for it is not labor lost, that old-fashioned medicine - prayer; and have faith in God..." (Wesley, 1747, p.18).

Wesley was ahead of his time in demonstrating an understanding of health promotion and the interrelationships between body, mind and soul. This work made Wesley a powerful force for hygiene and preventive medicine in his day. There also was a positive relationship between his evangelism and health. People who were converted from a drunken, raucous life of squalor to a life of cleanliness, discipline and good citizenship were prone to be healthier (Hill, 1958).

In addition to dispensing medicine and advice from his chapels in London, Bristol and Newcastle, Wesley also organized teams of visitors who attended to the needs of persons who were sick at home. They were to visit regularly and do whatever they could to help the ill person (Yrigoyen, 1996). These visits to the sick were part of the
discipline of love. Caring for the sick was the loving thing for Christian communities to do. It both helped the person who was sick and also served as a means of grace for the one ministering to the sick person (Holifield, 1986).

Methodism in the United States

John and Charles Wesley first introduced Methodism to America in the 1730's. America continued to be part of Wesley's Methodist movement in England until 1784 when the Methodist Episcopal Church in America was organized as a separate entity after much deliberation and with the blessing of John Wesley. Francis Asbury and Thomas Coke became the leaders. The Methodist tradition of circuit riders, clergy who traveled from area to area to set up Methodist societies that would then be led by lay people, did well in the frontier of the United States. The tradition of the clergy providing basic information about cures for physical ailments also continued. John Wesley's book, *Practical Physick* was modified by Dr. Henry Wilkins to include information pertinent to people in the United States (Holifield, 1986).

History of First Church

First Church, established in 1831, was the first church in the city of Chicago. It's distinct location in the heart of downtown, has shaped it's ministry and it's mission over the years as the congregation has responded to urban issues. In 1831, 30 people gathered at the home of Dr. and Mrs. Harmon in Fort Dearborn to hear an itinerant
preacher Stephen Beggs preach, assisted by Jesse Walker. From this first gathering, a class meeting was organized. Being a member of a class meant being a member of the church. As a class grew, it started other classes. Wesley felt that twelve people was the optimal class size. This technique enabled the Methodist church to grow without relying solely on clergy (Pennewell, 1942).

After their initial meeting, First Church met in the home of Jesse Walker. In 1838 the building was moved to its current location. As the city population grew, so did First Church. In 1845, sixteen years after they first organized, the congregation built a new church building with an auditorium that could hold a thousand people. In 1858, recognizing the unique opportunity in being in the heart of the downtown area, the congregation built their first combination church and commercial building. From this distinctive situation, the church decided to use profits from the building to help build other Methodist churches throughout the growing city, contributing one million dollars to help build over two hundred churches in the first one hundred years of its existence (Pennewell, 1942). Another First Church building was built in 1872 after the Chicago Fire and the current building, which houses the church space, parsonage and commercial property, was built in 1924.

First Church's Involvement with Health and Welfare Institutions

The late 1800's with growing industrialization, immigration and urbanization presented the Methodists of First Church with some serious social issues that affected
the health and well-being of the people in the city. In responding to these needs, people from First Church and the conference of which they were a part, created many important institutions including a deaconess training school, hospital, university and seminary.

One of the critical forces for responding to the health and social needs of the late nineteenth century came from the deaconess movement, which in Chicago was spearheaded by Lucy Rider Meyer and her husband Josiah, members of First Church. They founded the Chicago Training School for City, Home and Foreign Missions to train women as deaconesses in 1885 (Gifford, 1987).

Deaconesses were single, lived in the community where they received room and board, wore distinctive outfits and worked among the needy. The role of deaconess was written about in the New Testament and existed in the earliest Christian churches. The deaconess role was revitalized in the late 1800's in response to massive changes in the United States. These changes included rapid industrialization, urbanization, increased non-Protestant immigrants and a widening gap between the rich and the poor. These troubling social phenomenon resulted in the creation of two major movements in the Christian community. The evangelism movement was based on the belief that social conditions would improve if souls were saved. The social gospel movement, of which the deaconess movement was a part, was based on the belief that you needed to tend to bodies as well as souls. Elements of both movements co-existed within the Methodist denomination (McEllhenney, 1992).
The social gospel movement reflected a change in social thinking, with poverty being seen as a result of social injustice rather than a personal attribute of an individual. The deaconess was an important part of the reformers of the Progressive Era which also included labor unions, women’s clubs, good government leagues and professionals in social work and health care who were all trying to make cities more healthy and safe (Gifford, 1987). Lucy Rider Meyer identified two conditions of that period as important in accepting the role of deaconess: “...a better understanding of the Christian doctrine of self-denial and an enlarged conception of woman and her work” (Meyer, 1897).

The following quote from the consecration service of deaconesses in the 1908 Book of Discipline of the Methodist Church describes the deaconess role.

“Released from other cares, you give yourselves without reservation to the service of Christ...The Church solemnly sets you apart for her special service. You are to work for Jesus only. You are to minister to the poor, visit the sick, pray with the dying, care for the orphan, seek the wandering, comfort the sorrowing, save the sinning, and ever be ready to take up any other duty for which willing hands cannot otherwise be found” (para 470).

Through the work of Lucy Rider Meyer and her husband Josiah, the Chicago Training School prepared many deaconesses. From this school, forty Methodist health and social service institutions were birthed around the country, including twelve deaconess homes, four girls homes, seven schools, one rest home, ten hospitals, four orphanages and two old people’s homes. Through their long and hard labor, these members of First Church helped to extend needed services to people all over the country in the name of the Methodist Church (Brown, 1985).
In the Chicago area, the most important health institution to emerge from this work and the work of others at First Church was Wesley Hospital. Wesley was the second hospital in the United States started by Methodists, the first having been founded in New York in 1887. Within fifty years of starting the first Methodist Hospital, there were fifty-nine Methodist hospitals in the United States and dozens in overseas missions. One motivation for this expansion of health services was concern for poor persons who were sick, in continuing the tradition of John Wesley. It also provided the opportunity for wealthy laity to enhance the prestige of the denomination, which had previously experienced condescension from other Protestants (Holifield, 1986). During this same time other denominations were responding to the needs of the time by building their own hospitals as well (Brown, 1981).

Wesley Hospital began its services at the Chicago Training school in 1888 and moved quickly to their own building in 1889 as needs grew beyond the space. Dr. Isaac Newton Danforth, also a member of First Church, was considered the founder of the hospital. The purpose of the hospital was to provide "...gratuitous treatment of the medicinal and surgical diseases of the sick poor." (Pennewell, 1942, p.161). By 1891 Wesley Hospital had a new building with 25 beds. In addition to the work of the deaconesses from the Chicago Training School who provided patient care, Wesley Hospital also benefited from another institution started by members of First Church, Northwestern University. The Northwestern medical school provided, and continues to provide, medical care for the hospital. In 1893, due to expanding needs of the
hospital, the Wesley Training School for nurses began (Brown, 1981).

Members of First Church were also involved in philanthropic support and serving on the hospital board of trustees. Arthur Dixon, a prominent member of First Church, was involved in philanthropy for the Wesley Hospital in its early years. Arthur’s son, George Dixon served as president of Wesley from 1924-1934.

First Church shared another dimension with Wesley Hospital in the Gothic style of their building architecture. The lobby of the hospital, which was known as the “cathedral of healing,” had a cathedral type ceiling and a mural of Jesus at the pool of Siloam. This mural symbolized the religious and medical connection of the institution to all who entered (Brown, 1981).

As the work of the Chicago Training School grew, it eventually became incorporated with another institution, Garrett Biblical Institute founded in 1854 by Mrs. Eliza Garrett, a member of First Church. The deaconess students of the Chicago Training School were able to take courses at Garrett, effectively creating a women’s department of the seminary (Pennewell, 1942).

Goodwill Industries was another significant organization that came out of the conference in which First Church participated. Goodwill was started in 1920 to help people who were physically or mentally handicapped to find jobs. This was a very practical example of Christianity in action responding to a need (Pennewell, 1942).

The most dramatic work in health and social services for First Church and the Methodists in America was during the period of 1885-1910 with a tremendous growth
of helping organizations emerging from the Chicago Training School. Later changes in the Methodist involvement in health were more philosophic than practical. After World War I, Leslie Whitehead, a Methodist psychotherapist, helped to identify the interrelationship between psychology and religion. This was later continued in the writings of Russell Dicks and Carrol Wise (Holifield, 1986). Over time the understanding of health within Methodist circles changed from the absence of disease or the ability to function to "...the harmonious functioning of a unified person within a community of persons. They became acutely sensitive to the interrelationship of body and mind; they thought of persons not as isolated individuals but as complex products of social formation; they viewed illness as a signal of distress within both a physical organism and a social community" (Holifield, 1986, p. 57).

Medical missions to other countries were another way Methodists became involved in health issues, with thirty-nine permanent hospitals in Africa, Asia and South America by 1950. Originally these missions were seen as a way of accessing populations for evangelization. Over time they came to be understood as a way of serving others in need (Holifield, 1986).

Methodist Polity

In order to understand the current involvement of the United Methodist Church in health, it is helpful to understand how the denomination is organized. As it was for John Wesley and his followers, being well organized and methodical continues to be
characteristic of today's United Methodists. One reflection of this methodological organization is the Book of Discipline, which is the United Methodist comprehensive book of law and guidelines for administration. It is published every four years after General Conference, which is the national meeting of the denomination.

The polity of the United Methodist Church includes an episcopal leadership style governed by bishops and a connectional structure. Bishops are ordained elders who are elected by the jurisdictional conference for life to serve in a particular area. It is the responsibility of the bishops to oversee the work and nurture of the United Methodist Church, including appointing clergy to their positions. While bishops have the power to appoint clergy within their jurisdiction to their assignments, the United Methodist Church is a democratic and representative organization (Book of Discipline, 1996).

"The manner by which the church is organized, the selection of leaders, and the way it uses its resources are determined by a majority of voting members at local, regional and international meetings called conferences" (McAnally, 1995, p.20).

Connectionalism in the UMC is an essential part of its organization. Individual Christians and individual churches do not stand alone. They are connected to one another around the world. Through these connections more can be done by a group than alone. The system of conferences is one reflection of the connectional system so characteristic of Methodism. The General Conference is the national decision making body of the church. They meet every four years. Jurisdictional conferences are a connection of congregations in a given region. Annual conferences are connections of
congregations within a local area. There are also charge conferences, which include one or more local congregations, connecting the local church with the annual conference and the denomination as a whole (Book of Discipline, 1996). "In Methodism we stand or fall together. Most of the final and big decisions are not made by the local church but by the Conferences." (Kennedy, 1958, p.123).

The United Methodist Church is connectional in terms of ownership. Individual churches do not own their property. Instead it is held in trust for the denomination. There is a connectional membership. One belongs to the entire Methodist "connection," as well as to an individual church, reflecting a sense of the entire denomination being one congregation. There is also a connectional ministry with clergy being considered part of the total ministry of the Church (Short, 1974).

**Distinctives of the United Methodist Church**

The Book of Discipline (1996) identifies four theological guidelines for accomplishing the task of the Church. These four guidelines, commonly known as the Wesleyan quadrilateral, are primacy of scripture, the tradition of the Church, personal experience and the ability to reason. The primacy of scripture emphasizes the importance of making disciplined Bible study a necessity for Christian life. Tradition recognizes the historical context of the Christian faith and the lessons learned by those who have gone before. Tradition is not inherently authentic, but relies on the support of scripture to be an authentic Christian witness. Experiences of individuals and groups
provide the opportunity to see the evidence of God’s grace. Finally, reason, as an essential human faculty is also essential to the disciplined Christian life as one studies and grows in the faith.

The United Methodist Church does not have any affirmations that are not also held by other Christian groups. There are eight distinctive emphases which are: “the availability of God’s grace for all; the essential unity of faith and works; salvation as personal and social; the church as a community of Christ’s disciples who seek to share in God’s mission; the inseparability of knowledge (intellect) and vital piety (devotion to religious duties and practices) as components of faith; seeking holiness of heart and life both as individuals and in our society; a cooperative ministry and mission in the world, often referred to as “connectionalism”; the link between Christian doctrine and Christian living” (McAnally, 1995, p.11).

Involvement of the United Methodist Church in Health

The United Methodist Church as a denomination has had health as part of their national organizational structure through Health and Welfare Ministries, a department of Global Ministries, which is the mission arm of the denomination. Until recently, the Book of Discipline mandated local churches to have a health and welfare board. As of 1996, the local church was given more flexibility in organization. Three general areas of ministry are identified: nurture, outreach and witness. Health and welfare became part of outreach on the local church level, with individual churches given the option to
have a health committee if they so desired. It is interesting to note that health and welfare are combined. Health and Welfare Ministries has a public focus in its charge which is to:

"...assist conference units in addressing emerging and ongoing global health issues, including community-based primary health care, HIV/AIDS, ministries with persons with physically and mentally challenging conditions, environmental health and particularly the health needs of women, children, youth, the communities of color in the United States, and racial and ethnic minorities globally" (Book of Discipline, para 1326).

Since the time of John Wesley and continuing today, Methodists have been concerned about social justice. It is not enough to experience the privilege of relationship with God; one also has an obligation to respond to injustice in society, which is reflected in the social principles found in the Book of Discipline. Those principles, first adopted in 1972, have been modified as new needs have emerged and have included several additional health issues in recent revisions. These additions include a statement on the right to health care, which includes the admonition to engage in a healthy lifestyle. “We encourage individuals to pursue a healthy lifestyle and affirm the importance of preventive health care, health education, environmental and occupational safety, good nutrition, and secure housing in achieving health.” (Book of Discipline, 1996, para 66). This statement also endorses the value and importance of organ transplants and donations.
First Church Health and Wellness Committee

The current health and wellness efforts at First Church emerged from the interest of one individual, a longstanding member of the church, who in 1993 retired from nursing and was interested in volunteering as a parish nurse. She sought out training in parish nursing and began to offer her services to the church. She provides 1:1 services for people who have health related questions, need referrals or a blood pressure check. She has been involved in calling or visiting people who have been recently hospitalized and nursing home residents. She provides a health column periodically for the church newsletter. An annual health fair and administration of flu shots has become a regular event. In 1995 individuals interested in working on health activities were identified, creating a health committee. As support for the work of the health committee grew, a staff person was assigned to work with them. Starting in 1996 the committee began planning a monthly health activity that is printed in a brochure.

Summary

In understanding health ministry in a United Methodist congregation today, there are two Wesleyan traditions to claim. First, responding to God's love leads one to want to share that love with others, leading to faith in action. One inevitable way of showing God's love to others is addressing their health needs. Secondly, Wesley's understanding of the interrelationship between body, mind and spirit provides good support for why the church should or can be involved in health ministry.
Just as John Wesley and Lucy Rider Meyer developed social and health ministries in response to needs they saw in their times, so too today's Congregational Health Programs of the United Methodist Church are a response to contemporary needs for wholistic health, including health promotion. While some of the health problems and most of the cures have changed since John Wesley's time, his goal of giving people the resources to promote health and wholeness is similar to the goal of contemporary health ministry.
CHAPTER V
FINDINGS

“...your faith has made you well.” Mark 10:52b

Having identified the significance of health ministry for the nursing profession, the relevant literature, appropriate research method and the historical context that has shaped First Church, this chapter presents the findings of this study. The sources of information for the findings were field notes, interview transcripts and written congregational materials. The purpose of ethnographic methods is to understand the emic perspective, which is interwoven with the etic perspective of the researcher to create an ethnography that describes the culture. As much as possible, the findings in this chapter are in the words of the participants.

“In ethnographic discovery we should make maximum use of native language. In ethnographic description we should represent the meanings encoded in that language as closely as possible. As a translation, ethnographic descriptions should flow from the concepts and meanings native to that scene rather than the concepts developed by the ethnographer” (Spradley, 1979, p.24).

Cultural Descriptions

Setting

The setting, people and activities of First Church provide a web of connections. For example, the geographic location of First Church connects it to residents of the city, local government and related civic concerns. Furthermore, activities of the
congregation provide opportunities for people to connect with others, while worship nurtures one’s connection with God. Finally, participation in the United Methodist Church connects First Church with Methodists around the world.

First Church, founded in 1831 is unique as the oldest church in the city and for its location in a high rise building in which First Church occupies the basement and floors one through four. The pastor lives on the top three floors of the building with a private chapel and steeple above the "sky parsonage." The remainder of the building is commercial property. It is also unique in having sufficient visitors each week that a tour of the historic building, constructed in 1924, is offered after each Sunday worship service. Unique is a term the senior pastor frequently uses in describing First Church.

The church building has three central points of activity: the sanctuary, the fellowship hall and the second floor, which includes the office area, public chapel and parlor. The sanctuary is the central location for cultural interaction. It is rich with symbolism in the objects it holds. The following description of the sanctuary is from the eyes of the researcher on the first day of participant observation.

The sanctuary is on the first floor at ground level...One enters through the narthex area. There are bulletin boards with some activities listed. A pile of the pastor’s previous week’s sermons was available. There are two sets of glass doors to the sanctuary. The sanctuary slants downward toward the pulpit area. There are many large, beautiful stained glass windows along the sides and back of the sanctuary (which do not show on the outside of the building). The ceiling has painted designs and curved wooden pieces. The pulpit area has two lecterns on either side of the platform where the pastors sit. The choir sits across the back of the raised pulpit area. The organ is at the left front of the pew area. The sanctuary has high vaulted ceilings. Two aisles separate a large middle area of seating from two smaller areas on each side. The pews are wooden without cushions. The sanctuary is large and well maintained. The
architecture speaks of a previous time period. To the right side of the pulpit area is a very large banner that has flowers on it and says “Earth and Heaven in Chorus Sing Alleluia” (these banners are changed periodically). The stairways off the narthex have shiny brass handrails (with a brass angel on either side). There were no stairs required to get into worship.

Other significant symbols in the sanctuary noted in later field notes included a large cross at the front of the sanctuary, two large brass candlesticks on the altar and a wooden carving on the face of the altar of Jesus looking over the city of Jerusalem. Six large stained glass windows added in the 1970’s surround the sanctuary and tell the story of the congregation’s history in the context of Christianity. The topics depicted in the windows are Creation, Great Witnesses (prophets), Preparation for Life and Ministry of Jesus, Early Preachers, Reformation and New City (includes Revelation and First Church).

The second area for activity is the fellowship hall located in the basement of the building accessible by elevator or stairs. Restrooms are located here. On the wall near the elevators is a large plaque with the following quote from John Wesley:

Do all of the good you can  
By all of the means you can  
In all of the ways you can  
In all the places you can  
At all the times you can  
To all the people you can  
As long as ever you can

In addition to having a prominent location in the church building, this quote reflects this congregation’s emphasis on putting faith into action. In contrast to the decorative and symbolic decor of the sanctuary, the fellowship hall is plain. It is a large room that sits
six steps lower than the entrance. There is a lift for wheelchairs at the right stairway.

At the back of the room is a stage with curtains. Off the fellowship hall is a kitchen and three small rooms with dividers.

The third area for activity is the second floor, which houses the church offices, a parlor for gathering and a chapel. The following field note excerpt describes the office area.

The waiting area outside the church offices is on the second floor. There is striped wallpaper, painted coving, all in very good condition. The furniture includes some tables and a clock that look like antiques. There are several sets of settees and upholstered chairs. On one wall is a row of previous senior pastors (paintings). All of them are Caucasian male. The inner office is locked (a reflection of the urban environment) and the receptionist sits behind a glass window. There is a carved wooden table with brochures and information on the church and church activities. There are two large brass hanging lights. 9/30/96

The parlor area on the second floor has one large, round stained glass window with a large round table in front of it. There is an area with upholstered love seats and chairs. To the side of the parlor area is the chapel, named after a prominent early member of the congregation, described in the following field note from a Saturday evening worship service.

The chapel on the second floor has leaded glass windows on one side, an altar with lit candles and a pulpit with red cloth with a symbol of a flame. The very back of the altar had a large brass panel with back lighting. A piano was at the back of the chapel. The seats were upholstered chairs with wooden arms. I would estimate there were about 75 seats. 11/2/96

The geographic location of the church building is another unique quality of First Church. It is located in the downtown area right across the street from city, county and
state offices. This proximity to the political seat of power is reflected in the emphasis on political awareness shown in the educational programs of the congregation. The church enjoys prominence in the downtown area as well as in the United Methodist denomination.

Permanent banners outside the church building on the light posts identify First Church as the oldest in the city. There is also a plaza alongside the building with ten small stained glass windows on the wall depicting significant historical events in the life of the church. Each window depicts an event in the history of the congregation identified by a plaque underneath the window. The plaza also holds a large abstract sculpture of a female figure with outstretched arms by Miro, called "Miro’s Chicago."

People

The unique downtown, non-residential setting of the church building also influences the people it attracts. Many downtown workers come for midweek services. People from all over the metropolitan area, including visitors from out of town, come for Sunday services. It is the diverse nature of the relationship these groups of people have with the congregation that leads the pastor to use the terms members and constituents. Members are people who have officially joined the church while constituents are people who participate in church activities, may even give financially on a regular basis, but have not officially joined. The total membership of First Church is about 1,000 people according to the pastor.
When the study participants were asked to identify how this church is unique, they were unanimous in highlighting the diversity of the church. The participants in the Sunday morning worship service are a racially/ethnically diverse group, with many African Americans, Asians, East Indians, Hispanics and Caucasians. A recent church bulletin identified the membership as 18% African American, 18% Asian, 5% Hispanic and the rest Caucasian non-Hispanic. There is diversity in age groups as well. Teenagers are the only age group that is sparse. Economic diversity is not as obvious as racial and age diversity. Judging from the appearance of people in worship, the groups looked predominantly, although not totally, middle class, a fact confirmed by the study participants. One exception to this perception was children’s Sunday School, identified by the Director of Christian Education as an economically diverse group.

**Congregational Activities**

Worship is a central cultural experience for the congregation involving a large number of people. There are two Sunday morning services. The 11 AM service has the largest attendance and is identified in the church bulletin as contemporary in style. The 9 AM service is identified as a "traditional Wesleyan" service with communion served weekly. On Saturday evening there is a small, informal evening worship service. Approximately 400 people a week attend the weekend worship services. There is also a midweek worship service on Wednesdays at noon that attracts 100-150 people working in the downtown area, most of whom are not members of the congregation.
Preaching is an important component of the worship services. The senior pastor preaches most frequently with the other pastors preaching on a regular, but less frequent basis. Periodically there will be a special emphasis in the worship service on a particular population, an issue or a specific group. Examples of such worship services included Hispanic Sunday, Asian Sunday, Black History Month, AIDS awareness, domestic violence awareness, Laypersons Sunday and United Methodist Women Sunday. When a particular group sponsored worship services, persons from the group led the service.

Music is another important component of the worship services. The 11 AM service has the most music with a choir of approximately 25-30 people, including professional section leaders. In addition to the choir, services may include the bell choir and the liturgical dance group as part of the ministry of music.

There are many different church activities for people to choose from including Sunday School classes for adults and children, United Methodist Women, groups specific to ages, ethnicity or marital status, mission trip groups and special interest groups. In addition, there is the potential to participate on many committees some by invitation and some by volunteering. The majority of congregational activities occur at the church on Sundays but sometimes small groups meet in people’s homes. Outreach and mission activities typically occur away from the church building. Committee meetings are often held on weekday evenings. There are no required activities, but members are encouraged to participate in worship, support the ministries of the church
financially and become involved in using their talents within the congregation.

Leininger’s (1991) theory of culture care diversity and universality, the study’s conceptual framework, provided an additional way of describing the culture. The factors of Leininger’s Sunrise Model (Figure 5, p.74) were used as a cognitive map for gathering cultural information. Table 5 provides a brief description of the culture derived from this framework.

Gaining Entry into the Culture

First Church was chosen as the site for this study for the following reasons: involvement in a volunteer parish nurse program, having an active health committee, affiliation with a denomination involved in developing resources for health ministry and willingness to be part of the study. The researcher’s entry into the culture was facilitated by the fact that the culture under study actively tries to incorporate new people. The following two field note excerpts identify the challenge of observing a group that encourages participation.

I had a sense that worship was done very well with attention to detail such as the choir in the beginning of the service (they begin with a choral response from the narthex and process into the church) and the lights during the prayer (which are dimmed). The music was a real enhancement to the service. It was challenging to observe while worshiping. When the gentleman collapsed (during the service) my reaction to help was immediate. Then I thought how could one just observe? 9/8/96

It is very difficult to observe in a worship service because the service draws you in and I am used to worshiping in church. It is very inappropriate to write anything but the briefest notes during worship... The parish nurse and the senior pastor have been very friendly and welcoming. 9/29/96
Table 5.
Overview of First Church according to Leininger's theory of cultural care: diversity and universality

<table>
<thead>
<tr>
<th>Environmental Context</th>
<th>Religious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Affiliated with United Methodist Church</td>
</tr>
<tr>
<td>Downtown - central</td>
<td>Active in denomination activities</td>
</tr>
<tr>
<td>Commercial, high-rise building</td>
<td></td>
</tr>
<tr>
<td>Handicapped accessible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnohistory</th>
<th>Kinship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldest church in city</td>
<td>60% membership are single</td>
</tr>
<tr>
<td>Membership - 18% African American, 18% Asian, 5% Hispanic 59% Caucasian non-Hispanic</td>
<td>Few extended families</td>
</tr>
<tr>
<td></td>
<td>Growing number of families with children</td>
</tr>
<tr>
<td></td>
<td>Families of “choice”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language</th>
<th>Cultural Values and Lifeways</th>
</tr>
</thead>
<tbody>
<tr>
<td>English is the primary language of congregational activities</td>
<td>Putting faith into action</td>
</tr>
<tr>
<td>Spanish and Tagalog are other languages spoken by members</td>
<td>Diversity highly valued</td>
</tr>
<tr>
<td></td>
<td>Inclusive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Factors</th>
<th>Economic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority of members have college degree</td>
<td>Predominantly middle class</td>
</tr>
<tr>
<td>Emphasis on strengthening children’s education</td>
<td>No expenses for building</td>
</tr>
<tr>
<td>Value placed on educational opportunities</td>
<td>Budgetary challenges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technological</th>
<th>Political and Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology used to assist worship</td>
<td>Active in creating awareness of</td>
</tr>
<tr>
<td>Church website developed by young adults</td>
<td>political issues</td>
</tr>
<tr>
<td></td>
<td>Emphasis on issues of social justice</td>
</tr>
<tr>
<td></td>
<td>Liberal perspective predominant</td>
</tr>
</tbody>
</table>
In some ways the researcher was treated like a potential new member, demonstrated through invitations to participate in various events and classes. The parish nurse and staff were initial sources of information, helping the researcher gain access to groups and individuals. The researcher also personally identified many people as being active in the congregation through observations and self-introductions. This congregation has been involved in several studies before, so participating in research was not a new experience for members or staff.

In order to understand the culture of the congregation, the researcher attended worship services, Sunday school classes, church programs and committee meetings. The researcher also regularly attended the health committee meetings and after five months of participation was introduced as a member at one church health ministry event.

Research Participants

This study had two types of research participants: those who participated in semi-structured interviews and those who participated in informal ethnographic interviews. The first type of participants interviewed were chosen for their knowledge of the culture and/or health ministry as well as their availability and willingness to participate. A purposeful effort was made to engage participants who would represent the age, ethnic and gender breakdown of the active adult church membership. People were very cooperative with the interviewing phase of the study. The participants who
took part in the semi-structured interviews were characterized as follows: 13 female and 6 male; 12 persons were Caucasian, 4 African Americans, 2 Asian and 1 Hispanic; 11 informants were single and 8 were married; 11 had a graduate degree, 7 a bachelor's degree and one person a high school diploma as their highest level of formal education. They had been members of the church anywhere from 2-27 years.

Participant interviews were coded with K (key) or G (general) and a number.

In addition to the 19 participants who took part in the semi-structured interviews, 20 other people took part in informal ethnographic interviews. Information from those interviews was included in field notes.

Domains and Categories

The major source of information for the findings came from the transcriptions of the semi-structured interviews with support from field notes, printed sermons, weekly newsletters and handouts. Identifying and analyzing domains constituted the major activity of analysis. Findings were organized around five domains that constitute the major groupings of information shown in Table 6. Each domain included categories and subcategories. Themes, which are concepts connecting one or more domain (Spradley, 1979), were identified in the final level of synthesis and are discussed at the end of this chapter.
There are three domains creating the primary contexts that shape the culture of this congregation. First, the congregation consists of individuals with unique needs and experiences who both implement and benefit from the ministry of First Church.

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Domains and categories of findings</th>
</tr>
</thead>
</table>
| **INDIVIDUAL CONTEXT** | • Reasons to belong to First Church  
  • Ways to understand the meaning of health  
  • Ways being part of First Church promotes health  
  • Ways membership has impacted lives of participants  
  • Ways participants respond to the UMC definition of health |
| **HISTORICAL CONTEXT** | • How First Church has changed |
| **COMMUNITY CONTEXT** | • Explicit values  
  • Implicit values  
  • Ways First Church is distinctive |
| **ORGANIZATION** | • Kinds of people in the organization  
  • Parts of congregational structure  
  • Starting new programs  
  • Parts of the organization of ministry in the church |
| **MINISTRY** | • Ways to understand ministry  
  • Ways to understand mission  
  • Ways to understand the meaning of health ministry  
  • Ways participants respond to the UMC definition of health ministry  
  • Consequences of ministry |
Second, there are shared values held by members of the congregation that create the context of community in which ministry occurs. People are drawn to participation in this church because they can identify with these values. Finally, First Church exists within a historical context that includes the past that created the roots for the congregation’s ministry, the present that shapes the opportunity for ministry, and the future which charts the course for developing ministry. The historical context is discussed briefly in this chapter and extensively in Chapter IV.

Organization and ministry are the final two domains. The organization of this congregation is a reflection of the individual, historical and community contexts which create a foundation to support ministry. Organization consists of the organic structures that support the culture of the congregation. Ministry is the heart of the congregational culture. To be engaged in ministry is the primary purpose of the congregational culture. Taking part in ministry is one purpose of active involvement. Integrated these domains constitute the worldview of the culture. Figure 6 provides a graphic description of these domains and their interrelationships.

Domain Related to Individual Context

An understanding of the emic perspective of members, with a particular interest in their understanding of the culture of the congregation and health ministry, was the focus of this study. The experience of individual members both shapes, and is shaped by, the shared experiences of the group. The individual context reflects the connections
Figure 6. Ethnographic domains constituting worldview of First Church. Chase-Ziolek 10/97
participants experience with the congregation as well as conceptual connections with
the idea of health and health ministry. The categories identified within the individual
experience were: reasons to belong to First Church, ways to understand the meaning of
health, ways church membership has impacted the lives of individuals and ways
participants respond to the United Methodist definition of health. These categories and
subcategories are summarized in Table 7.

**Reasons to Belong to First Church**

Everyone belongs to multiple cultures. There are some cultures you are born
into, some cultures you enter by default, such as through a work environment, and
some cultures in which you choose to participate. First Church is a culture in which
people choose to participate. While children may be born when their parents are
members, it requires an individual decision to join. There are many different reasons
why people choose to belong to this congregation. For some people, such as the
following participant, it was because they knew about the church, it's denominational
affiliation and convenient location.

G4: First of all, location wise it was convenient for me and also I grew up in the
United Methodist Church and wanted to stay with that church and I liked the
people here, I like the services, the traditions...and I thought that this was what
a church should be in terms of including all types of people and that's why I
wanted to make my membership here.

Some participants were attracted by interpersonal qualities of First Church like
feeling they “fit in” here, appreciating the warmth and friendliness as well as having a
good experience when they first attended services. Specific components of congregational life such as music, preaching, evangelism and studying scripture drew participants into belonging. Composition of the membership such as its size, diversity, age specific groups or ethnic groups were yet another reason study participants choose to join First Church, as the following participants explain.

<table>
<thead>
<tr>
<th>Table 7</th>
<th>Individual context: Categories and subcategories</th>
</tr>
</thead>
</table>
| REASONS TO BELONG TO FIRST CHURCH | • Familiarity  
• Interpersonal experiences  
• Specific components of church life  
• Composition of the membership |
| WAYS TO UNDERSTAND THE MEANING OF HEALTH | • Synonyms for health  
• Absence of disease  
• Wholistic view of health  
• Components of health  
• Consequences of health  
• Ways to achieve health |
| WAYS BEING PART OF FIRST CHURCH PROMOTES HEALTH | • Extrinsic health ministry  
• Intrinsic health ministry |
| WAYS MEMBERSHIP HAS IMPACTED LIVES OF PARTICIPANTS | • Experience of worship  
• Interpersonal relationships  
• Opportunity for new learning experiences  
• Attitude and worldview cultivated by congregation |
| WAYS INDIVIDUALS RESPOND TO THE UMC DEFINITION OF HEALTH | • Areas of similarities  
• Areas of difference  
• Distinctly Methodist qualities |
K3: I found that they were unlike a lot of neighborhood churches. There were a lot of older single women and I fit in better here.

G9: Well, I like a bigger church. That is important to me, a larger church, and more members. Of course the diversity. At the point I got involved relatively early on with the young adult's group and so that's kind of what kept me, that attracted and what kept me.

**Ways to Understand the Meaning of Health**

Understanding the participants' views on health was an integral component of this study. Since health ministry includes the concepts of both health and ministry, understanding people's views on both concepts was important. Understanding health is very personal. Understanding ministry and health ministry integrates congregational as well as individual perspectives.

The participants' definitions of health were organized into the following six categories: using a synonym for health, defining health by the absence of disease, incorporating a wholistic view of health, defining health by its components, defining health by its outcomes and describing ways to achieve health. Many participants included several categories in their definitions. Figure 7 shows the attributes and semantic relationships of the definitions of health as identified by participants.

Synonyms used for health were well being, to be well, whole and feeling good. These synonyms were consistent with a wholistic view of health, but by themselves, did little to illuminate the individual's understanding of health. Five participants spoke of health as the absence of disease. For three of these participants, this was a very
is achieved by

- exercise
- nutrition
- weight control
- not smoking

enables

ministry

facilitates

longevity

means

absence
of disease

is experienced through

wholeness

consists of

physical
spiritual
mental
emotional
relational
ecological

feels like

being at
optimal
potential

Figure 7. Participant identified attributes and semantic relationships of health
personal definition because of experiencing a significant health problem. For them, the experience of non-health had a significant impact on how health was understood.

Some participants defined health in terms of the experience of wholeness, while others identified different components within a wholistic view of health. Physical, spiritual and mental health were the most frequently mentioned components of health. Additional components that were mentioned included emotional health, relational health and ecological health.

K2: Well spiritually, you know, mentally and physically - emotionally also. Those are the four aspects that we have to consider in the whole person. Now if one of the aspects is not healthy, I mean if there is something weak, you could not have them as healthy.

Outcomes from experiencing health were included in some definitions. The outcomes identified were enabling ministry, longevity, a productive pain-free existence, and a sense of being at one’s optimal potential physically and mentally, and feeling good.

The following participant explains how health enables ministry. This idea of health as enabling ministry defined health as a means to a social end, while the other outcomes were all specific to the individual.

K5: I would define health as physical, mental, emotional balance that allows you to get through and continue your ministry.

M: So you see the ability to do ministry as an important part of health? Is that what...

K5: I don’t know that I see it that way. I would turn it the other way...health is enabling - enabling ministry to happen.
The final category in the definitions of health included ways to achieve health which included taking care of yourself, exercise, nutrition, weight control, treatment of disease, doing actions needed to have a productive pain free, illness free existence, quitting smoking or not smoking. While many people identified a spiritual component to health, no one identified prayer or a relationship with God or Christ as something that would help to achieve health in their definition of health. Such a relationship was mentioned in the discussion of how being part of this congregation promotes health.

**Ways Being Part of First Church Promotes Health**

As discussed in the literature review, there has been a recent interest in medical research measuring why people who go to church are healthier. The participants in this study did not need any measurements. Most of them knew experientially that being part of First Church was good for their health and could articulate the reasons.

The goal of health ministry is to promote the health of members of congregations and the communities they serve through integrating faith and health. Two major categories of promoting health were identified in the response of participants, the majority of whom felt being part of First Church had a positive impact on personal health. The first category is what the researcher named extrinsic health ministry. This consisted of those activities readily identified as having a primary purpose of promoting health.
The second category was intrinsic health ministry that occurred through the experiences and feelings generated through participating in activities whose primary, explicit purpose was something other than promoting health. These were the psychosocial and spiritual consequences of participation in the congregation. In reality, persons with greater theological knowledge may understand worship and the experience of salvation as having an ultimate purpose of healing and restoring wholeness. However, persons in the congregation did not articulate this understanding.

Table 8 describes the components of the ways being part of First Church promotes health.

<table>
<thead>
<tr>
<th>Table 8</th>
<th>Ways being part of First Church promotes health: Categories and subcategories</th>
</tr>
</thead>
</table>
| **EXTRINSIC HEALTH MINISTRY** | • Parish nurse  
• Health fairs  
• Flu shots  
• CPR training |
| **INTRINSIC HEALTH MINISTRY** | • Challenging experiences  
• Positive attitude  
• Relationship between spiritual and mental health  
• Spiritual growth  
• Belonging to a community  
• Pleasurable experiences  
• Providing guidance |
| **ADDITIONAL COMPONENTS** | • First Church as a hospital for wholeness  
• Negative effects on health |
Extrinsic Health Ministry

Responses that reflected the extrinsic health ministry of the congregation focused on specific, concrete activities. The parish nurse was the one individual within the congregation participants named as being part of promoting health. A relationship with her and specific services she provides, such as blood pressure screening, were identified as ways in which personal health was promoted. In addition to the parish nurse, programs provided through the health committee such as health fairs, flu shots and CPR training were seen as health promoting. The following quote describes how health is promoted through extrinsic health ministry.

K3: Well, I think that (the parish nurse) cares about that (promoting my health) And I think that’s what the nurse, the program is about. Of course, we’ve had...those health fairs.

Intrinsic Health Ministry

The majority of the participants’ discussions on how being a part of First Church promoted personal health centered on the general activities of the congregation, particularly the feelings and experiences that are a byproduct of participation. Being part of this congregation provides opportunities for positive experiences that individuals enjoy, may reduce stress and make people feel good. Involvement in the congregation also gives people something to do, a place to serve, and a place to go. Specific church activities identified by participants that generated
health promoting feelings and experiences were worship, bell choir, Disciples (a small study group) and involvement in the United Methodist Women.

The participants spoke most often in general terms about how being part of First Church promoted their health, particularly emphasizing the positive psychosocial and spiritual consequences of church participation. The psychological components of church participation that were identified included cultivating a certain attitude that facilitated coping, provided guidance and reduced stress. These experiences were not part of an organized church activity, but were the result of participating in the life of the congregation.

**Challenging experiences.**

In the following discussion, K1 explains how being part of the Bell choir, a new and somewhat stressful experience, became a very health promoting experience. This experience included belonging to a specific group, dealing with a challenging experience that glorified God, and offered a physical challenge as well.

K1: Things like that are very health producing in our church. Where people find a place, they find community, they learn new skills, and they do something that glorifies God that has relational aspects to it. And that I think is very promoting of health, because that’s the angst, I think, of our society, you know. Where you can contribute, feel a part of things, be challenged, and glorify God. Learn how to forgive yourself for not being perfect, be sensitive to other people... and create something that’s beautiful... And working together. It’s a body thing...you’re using your body and it’s almost, it’s a form of dance, as well as music because you’re using, you have to use certain rhythms and you have to be, you have to do your body like the people next to you. So it’s a thing like all women menstruating, get on the same cycle. I mean, that’s what it’s starting to feel like.

M: (Laugh) Oh, how interesting. I never thought about it...
Kl: Yeah, and to me it’s symbolic. To me it was the thing that was very healthy for me...I think we need to encourage people to find their different places in a church body. That’s very healthy whatever it is.

**Positive attitude.**

Participants highlighted factors that contributed to their mental well being more than any other area. Resources for coping were found through a particular attitude cultivated at First Church with preaching being one event where this attitude was frequently articulated. G11 describes in the following quote how salvation, fellowship and mission contribute to this attitude.

G11: ...I see our church built around three things, for those who are actively involved in the church. There are three things going on at once. One of them, I would put under the category of personal salvation - one’s own understanding of, and relationship with, the Divine and, and things that really are very intensely, intimately personal things. A second part of it would be the fellowship. There is a very active social life...there are groups or cliques of people and, and it is not necessarily the melting pot that they appear to be, but there are at least connections between people in those groups, and at the very least, a sense of affinity. If we are not as fully integrated as we would like to be, racially, or age wise, or economically. We are nevertheless connecting with people, who are in very different places. I think that enriches my life, enriches my experience and I find that I have a lot to learn from those folks. And the third part is mission - actually going out and doing something constructive, positive, not with the idea of here we are the First Church to rescue the world. More of here we are to do our part. Here we are to actually live out what we believe. And the combination of those three things, having those three things in your life, makes your life a different experience from sitting at home on Sunday and reading a Sunday paper, watching TV in the evening instead of going to... a work area meeting or spending Saturday, watching a sports, or a cooking show on TV versus, going out and actually doing something, in an active way with your life...(the senior pastor) has given countless sermons that could be summed up in that story that if you try to figure out who are the people in the concentration camp who are going to survive. It’s not the youngest, it’s not the strongest, it’s not the, the best fed, it’s not the people with the most wealthy background, it’s not the smartest. It’s the people who a have certain attitude. That, how they’re going to, to address life, is not something that they’re going to let the Nazi’s control. But they are going to you know, look for
that which in life is positive and look for a way to live their lives around what they truly believe is important. And that what they truly believe is important is something that is not so much in the here and now. So that state of mind if one has it is as close to Nirvana as you’re likely get in Western Civilization.

Relationship between spiritual and mental health.

Some participants identified a positive interrelationship between spiritual and mental health as promoting health. For these participants, their mental health was enhanced by their spiritual health. Because participation in this congregation promoted spiritual health, it also promoted mental health. Similarly, through promoting mental health, spiritual health was also enhanced. Participating in worship was one way participants experienced enhanced mental and spiritual health, as explained by G4.

G4: If it’s been a really bad week, one of the things that’s been helpful to me is some Wednesdays I’ll come to service for the twelve o’clock service...I’ve got to get out of this stressful situation and I’ll come here for twenty minutes and try to get some direction and feel like I’m connected. So it’s helped from that standpoint.

Spiritual growth.

Being a member of the congregation promotes health through the opportunity for spiritual growth and expression through worship, prayer and small groups.

Participants were very cognizant that their spiritual health, which congregational life nurtured, was an important part of their general well being. G13 expresses this sentiment in the following quote.

G13: I view health in terms of the whole person, body, mind and spirit. I think in terms of the spiritual component, the church helps a lot. And I think in terms of a holistic approach toward myself that encourages constructive activities and approaches.
**Belonging to a community.**

Participants highlighted the social dimension of health in terms of experiences of belonging and community. To be an active member of this congregation is to be connected with others in a community that cares for, nurtures and supports its members. The sense of belonging generated by being active in the congregation was identified as health promoting. Having a place where you belong and are needed was important. Another component of the experience of community is the relational feelings that are cultivated, which K3 explains.

K3: But I think being needed and having something to do helps your health in a lot of ways...you have a feeling that somebody is always concerned about you and would care if something happened to you.

**Pleasurable experiences.**

Sometimes the simple experience of positive feelings, such as enjoyment and having fun were seen as promoting health. These feelings, associated with participation in the congregation, were perceived of as healthy, described in the following quote from G8.

M: Now, how do you find for yourself that being a member of First Church promotes your health and well being?

G8: Well I enjoy all the activities I do and they bring me enjoyment. So that, first off, is one of the things that makes me happy. And you know, people say, "Oh, you’re so busy" and I don’t look at it as so busy. I know I’m gone an awful lot, but I look at it - I do it because I like it. So it gives me... good feelings.

M: And that's all good for you?
G8: Yeah and, I mean, if I was coming because it was only an obligation, then it would be unhealthy. And then you would say, oh, I’m so busy or I’m so stressed but, I truly enjoy what I do. And I wouldn’t do it otherwise. So the activities make me feel good, which makes me feel better all around. Now that doesn’t say that there isn’t some, once in awhile at night, you go, “Oh, choir tonight.” But once (M laughs) I’m here, it’s such a positive thing, that I walk away and I’m very positive energy and uplifted. I mean...I go home at night and it’s like, oh that was great. I feel so good.

Providing guidance.

Being part of the congregation also provided guidance for life decisions which was perceived as promoting health. Several participants mentioned the thought provoking nature of the sermons as being health promoting. G9 describes the guidance she receives through First Church that promotes her health in the following quote.

G9: Well (laugh) definitely it promotes my health from the perspective of nurturing - nurturing that spiritual part of me. It’s very important to me. I can tell a big difference if I’ve had to miss church for a Sunday, and it’s not just...the preaching, although that’s a big part of it, but the fellowship too is really important to me. So I think it’s what helps...keep me grounded. It helps me, make decisions about right and wrong. There is a lot of nurturing that goes along here so, definitely it’s um, it helps my health in that respect.

Faith was also seen as related to health in the experience of illness. Three participants spoke about how important their faith had been in dealing with a serious health problem, as explained by G10 about dealing with a diagnosis of cancer. “If not for my faith I would have really gone, you know, crazy.”
Additional Components

Two additional components were identified in participants' discussion of how being part of First Church promoted their health. The first component was the congregation as a hospital for nurturing wholeness. The second component was the negative effect of church participation on health.

First Church as a hospital for wholeness.

Through providing extrinsic health ministry activities, as well as an intrinsic health ministry that promotes psychosocial spiritual well being, First Church promotes the health of its members. As K6 identifies, in the following quote, First Church is a kind of hospital that promotes wholeness for its members, bringing together their compartmentalized lives.

K6: I think the hardest thing for the western mind to understand is the Hebrew idea that body and soul are not separate. That what you see is what you get. That it's all one entity. And the Greek idea that I have a body that contains a soul, I think is one of the most devastating western concepts. Cause people really have a hard time understanding wholeness in terms of spiritual, moral, physical, intellectual, all being a part of the same package. People tend to live their lives in compartments...I'm reading Joseph Ellis' biography of Thomas Jefferson, American Sphinx. Jefferson has this amazing ability to live his life in compartments. And even for a man as intelligent as Thomas Jefferson, certainly one of the most intelligent people in the history of the United States, he had a way of never letting one compartment of his life talk to another. And that's very American. I think people do that constantly. And we have to learn to live our lives in one room, in one entity. And I think that's very significant in what a church like this can provide people. We have a lot of lonely, dismayed marginal (inaudible) people who have very difficult lives and I think a church like this can provide, kind of a hospital (for the whole person) that other churches can't, or don't.
**Negative effects on health.**

Three participants identified times when their involvement in First Church has a detrimental effect on their health. This was related to getting too involved, or too committed to church activities, which created stress. The very same involvement that reduced stress for some people, when carried to an extreme created stress.

**Ways Membership has Impacted Lives of Participants**

Related to the participants' understanding of how being part of First Church promoted their health were feelings some expressed about how being part of First Church had impacted their lives in general. Positive benefits included worship, interpersonal relationships, opportunities for learning and the attitude cultivated.

One of the positive benefits was the personal impact of the worship experience, which the following participants describe.

G10: I don't know, I just have such a good, my feeling when I (laugh) go there and worship. It's a you know, I'm just so satisfied and it's just, you know, a peace.

K5: I think the congregational singing is one of those, those times when you can, you know, just let it all come out. So I feel really good when we have good congregational singing.

The nature and the quality of the interpersonal relationships developed within the congregation was also identified by participants as having a positive impact. Several participants who spoke about creating their own extended family within the church described the experience of church as family. This seemed to be particularly
important to participants who were single or without family living nearby.

Other positive benefits of membership in First Church included opportunities for new learning experiences, such as in mission work and music ministry. As the following participant explains, there was a significant personal impact from involvement in mission projects.

G8: I've learned more things about what (the mission) does and their programs down there and all the different things that go on that I would've never learned and you know, had I not gone down and worked and seen over the years how it's grown and how it's changed and things like that. So I've learned a lot too.

First Church cultivates an attitude and worldview that some participants found helped them to make decisions about right and wrong as well as framing how they looked at the world. In the following discussion G11 talks about how being part of this congregation has cultivated a positive attitude towards life particularly the sermons and an adult Sunday school class.

G11: I have opportunities for stress and people doing obnoxious things all the time. How do I react to those and how do I experience them? You can't draw a direct connection between the fellowship or between the salvation or between the mission work, and that, but those fill, an attitude, a state of mind that, you know, does tremendous things to reduce stress or deal with stress because you, experience life differently. I mean, there are miracles going on around us all the time and most of us, never see them, never experience them. And even those who are attuned to the possibility that you could experience an event as miraculous doesn't, just cause you know that, doesn't mean you'll always do it. But being involved in a group that is active in world mission - this, outside the world mission and these connections with people - this is kind of like a constant reminder, that you can experience the world that way. You can experience life that way. You stop and think, anybody stops and thinks about you know, moments they've had when they've been under great stress or times they have had when they have seen, you know, terrible losses coming and no way to avert them. And then somehow something happens beyond their control, that is not something that they would have predicted and not something
that one could have expected would happen. Why not call that a miracle?

M: Why not?

G11: And if, if you live in a world where you say, well, if life has those possibilities in it. Then if that doesn’t happen maybe I can find something positive in what has occurred and why things have gone this way. So, that’s kind of my experience. I go to church every Sunday and I don’t go out of any sense of obligation. There was certainly a time when I went to church for a sense of relief and a time when I went to church out of a sense of excitement. Now it’s, it’s partly habit and it’s partly the possibility of what I’m going to experience.

Ways Participants Respond to UMC Definition of Health

The United Methodist Church (1995) defines health as “...a dynamic state of well being of the individual and society. Holistic wellness, which is physical, mental, spiritual, economic, political and social. Being in harmony with each other, with the natural environment, and with God.” This definition was shared with participants and asked how it compared to their own understanding of health. The majority of participants felt that they could accept the denomination's definition of health, although only one (K1) gave a definition that was nearly as comprehensive as the denomination’s definition prior to the researcher’s sharing the denomination’s definition. Comments included it's "just using different language" (K5), "we say this, but we've concentrated on the spiritual side at church" (G4). In responding to how First Church promoted the kind of health described in the UMC definition, participants spoke of specific, general church activities such as worship, outreach, evangelism, and publications with some
reference to health ministry.

There were different components of the denomination's definition of health that some participants did not feel were equally important such as economic health, political health, and social health. One participant identified that her definition focused on health of the individual while the denomination focused on the health of communities.

Another participant identified the definition as distinctly Methodist. In the following quote, G11 identifies the distinctly Methodist characteristics of this definition of health. This participant also felt that the definition mixed levels of health, with political health not being on the same level as physical health.

G11: This is so Methodist.

M: OK, tell me. How is that so Methodist? What makes it so Methodist?

G11: First thing is, if it carries within it a very distinct political slant. It’s one I agree with, but it seeks to be so inclusive - economic health, political health, social health. I suppose you know, that’s sort of the social gospel of the Methodist Church... it’s so Methodist to try to include everything.

M: It’s so inclusive.

G11: And to be focused on you know, we want to say something, I can see a committee sitting around (M laughs) saying how do we do this. We got to have something in there about the environment, we can’t leave the environment out. I mean there’s a very intentionality in the Methodist Church.

M: Um hum, but that it includes this.

G11: Yeah, to try to, include - to avoid excluding and you know, it comes across to a lot of people as political correctness. But on the other hand when you, when you’re in the environment, at least at (this church) you become aware of how some of those subtle things...So it, the Methodist Church knows that and so when it writes something it’s very, very careful and it tries to get everything broad.
M: Um hum, include everything.

G11: And never you try to say anything and call it Methodist without finding something from John Wesley, that you can rely on.

Domain Related to Historical Context

The historical context is important to this study for two reasons. First, members perceive that First Church has a distinctive heritage that makes the congregation unique. Second, the history of the congregation creates part of the context within which First Church's contemporary health ministry exists. An in depth discussion of the historical context of First Church from the beginnings of Methodism into the twentieth century is discussed in chapter IV. The following discussion reflects the perceptions of participants on the more recent history of the congregation and their thoughts on how the congregation has changed.

How First Church has Changed

The participants have been members of First church for 2-30 years and most of them could identify ways in which the church has changed. Changes focused on the membership, church activities, patterns of organization, worship and technology. Participants identified several ways in which membership has changed. There is an increasing number of ethnic minorities. There used to be a Chinese group and now there is a growing number of Indians and Pakistanis. The following participant
describes how the ethnicity of the membership has changed since joining the
congregation in the 1970's.

K3: There were always minorities here, but we have many more, and many
more different ones, you know. Like we’re getting an increase in Asians... I
think when I first came here it was predominantly white, but there were Blacks
and a few Asians, but our Filipino membership has gone up and now we are
getting more people from India as well.

There also have been changes in the membership by age groups. In the 1980's
the young adults group split into a young couple's group and the 30/40 Sunday School
class. Recently the young adults group, people in their 20's and early 30's, was revived.

The membership has also changed in terms of the time they have available,
creating issues for the style and structure of congregational life. Time was seen as their
greatest commodity. Members seemed to have become more stressed in the eight years
the following participant had been at First Church.

K6: I think the pattern of people’s day to day living, the pattern is becoming
more difficult and stressful. People are really concerned about time and health
and stress and they feel trapped. They don’t know how to get relief from all the
stress so they end up in a lot of cases doing all of the wrong things in my
opinion to try and get some relief. They’re as busy on the weekends trying to
have fun (M laughs) as they are during the week trying to earn money.

One participant who belongs to the Filipino Fellowship identified a change in
the membership's patterns of gathering. When the group first began in the 1970's and
80's, they used to frequently meet in people's homes. Now they meet at the church
more as members have moved all over the metropolitan area.
There have been changes in the roles of members. The following participant identifies how the role of women has changed in the past 25 years.

G5: When we first came, women did practically nothing in this church. Now women do everything and so the status and role of women just really is not an important issue at this church, because women are involved in all facets of the life of the church.

Participants felt the activities of the church had changed, with some activities declining and others increasing. The one activity that was identified as on the decline was Project Renewal, which brings disabled persons into the church once a year for fellowship and worship. Involvement in mission/outreach activities was seen as increasing. There also has been an increase in the congregation's involvement in city politics. The following participant elaborates on these changes.

K4: I think First Church is growing...in terms of it's missional outreach and in terms of it's vision for what it should be...could be and what it needs to be...

M: How have you seen that change?

K4: Well I think, you know, our involvement in the politics of the city, not just in the sense of being political, but in terms of saying the Church does have a voice in some issues...I think the scope of what this church can do in terms of outreach with the homeless. I think that has grown as well, and the SRO (Single Room Occupancy) I just saw.

According to participants, the patterns of organization had changed with recent major denominational changes in committee structure of local churches. Having a health and wellness committee was a change in the past four years. Another organizational change has been trying to look at ministry based, rather than program based, activities. The intent behind this change was to cultivate a more wholistic
approach to the life of the congregation.

Worship has changed. More children regularly attend and participate in worship. This change has occurred in the past three years. Another change in worship has been the music that has become more contemporary. A liturgical dance group periodically participates in worship.

The use of technology has been part of the changes at First Church. The church now has a web page, started by the young adults group. Telecommunications were recently used for a major United Methodist Church advertising campaign. Available technology has also affected members in their personal lives.

Domain Related to Community Context

The context of community consists of the shared values of the congregation, evident in what is explicitly articulated and what can be implied from the behavior and activities of members. Explicit values are those that people verbalize as being important and valued. The implicit values are those values tacitly understood by members, that could be surmised from the activities that have a great deal of support, areas of congregational life that produce conflict, people's behavior and cultural symbols. Shared values of this congregation were also reflected in how First Church was perceived as being distinctive. Table 9 summarizes the categories and subcategories within this domain.
Table 9
Community context: Categories and subcategories

<table>
<thead>
<tr>
<th>EXPLICIT VALUES</th>
<th>Interpersonal qualities of this church as a community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diversity</td>
</tr>
<tr>
<td></td>
<td>Worship</td>
</tr>
<tr>
<td></td>
<td>Teachings of the church</td>
</tr>
<tr>
<td></td>
<td>Opportunities for participation</td>
</tr>
<tr>
<td></td>
<td>Purpose/Mission of this congregation</td>
</tr>
<tr>
<td></td>
<td>Importance of social justice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPLICIT VALUES</th>
<th>Health ministry as a reflection of values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Activities with strong support</td>
</tr>
<tr>
<td></td>
<td>Sources of conflict</td>
</tr>
<tr>
<td></td>
<td>Symbols</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WAYS FIRST CHURCH IS DISTINCTIVE</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Location</td>
</tr>
<tr>
<td></td>
<td>Ministry</td>
</tr>
</tbody>
</table>

Explicit Values

Participants were asked to identify what the congregation valued. Their responses fell into five categories: interpersonal qualities of the church as a community, diversity, worship, teachings of the church and opportunities for participation. These values were a reflection of the public face of the congregational culture.

Interpersonal Qualities of the Congregation

Participants consistently identified the interpersonal qualities of First Church as a caring community as highly valued by the congregation. Certain characteristics of the interpersonal relationships valued included; concern for each other, warmth and
friendliness, the friendships that develop (with some people meeting their spouses here), being part of the community, church as family, and the inclusiveness extended to diverse groups. The group experience provided an anchor for some participants.

One of the unique features of congregational life in American culture is the opportunity for intergenerational relationships, not easily found in other settings. The experience of intergenerational relationships with the church becoming an extended family was identified as a value, which K1 explains in the following quote.

K1: I see people reaching out and adopting kind of families of choice, you know, with some older and younger people that kind of thing and that feels like it's a real healthy place and more of that could be encouraged.

The senior pastor, in a weekly newsletter column once identified "faith development" as the major task of the local church. Several participants supported that concept, identifying the opportunity to develop one's own faith, as a shared value in this congregation, as K5 explains.

K5: So any way I think the value to me is the church is a place that we can come to renew our faith, or build our faith because some people come in and don't know God at all.

Diversity

Diversity was a membership quality of First Church consistently articulated as being valued. There are many different ways that this congregation is diverse. The most common reference was to racial/ethnic diversity, which included African Americans, Asians, Hispanics, Caucasians non-Hispanic and persons from the Far East.
Other kinds of diversity participants identified included age, gender, sexual orientation, theological understanding, denominational background, different points of view, language, need, types of families, and backgrounds. In addition, the pastoral team is racially diverse and includes men and women. The congregation had socioeconomic diversity in its families that participate in Christian Education. However, the participants identified the majority of the membership as being middle class and well educated.

Diversity was of sufficient value that, for some people, diversity was a major reason for belonging to this congregation. The diversity evident in the Sunday worship services reflected a value of how the world should be seen as consistent with Christian faith that proclaims the worth of all people. This reflected congruence between the preaching and the life of the congregation, as G4 expresses.

G4: You know they always say that your eleven o'clock worship hour is the most segregated hour in the week and I just feel like if you are in the church, of all places, you should be more open to all people. You should be that at all times, but if you can't exemplify that in your church by having, you know, people of all ages and races and all different backgrounds together then I guess I don't see how you are practicing like you should.

One reason participants valued diversity was because of the exposure to varying viewpoints and the opportunity to learn from people who think in different ways and come from different experiences. The following participant articulates the benefits experienced from being part of a diverse fellowship.

G7: It is kind of intriguing to have that many fellow parishioners to fellowship with from so many different backgrounds (inaudible) you see something that you may have missed before and you were restricted to.
M: So seeing the diversity of how people experience being a Christian coming from different ethnic groups, different age groups, different relationship situations then adds to your experience of being a Christian? Is that what you're saying?

G7: You have to stop and realize we're (persons of European descent) part of the diversity, we're not the audience for it.

While diversity was valued, diversity was not equally evident in all areas of church life, as it was in worship. For example, the lay leadership of the church did not appear to have the same ethnic breakdown as the membership. Similarly, participation at programs and luncheons was not as diverse as in worship. While diversity did not always hold up equally in all aspects of congregational life, people were connected to each other and did interact when there were intentional efforts. G11 expands on this concept.

G11: There is you know a very active social life and a tremendous opportunity within First Church. There are groups or cliques of people and it is not necessarily the melting pot that they appear to be, but there are at least connections between people, in those groups, and at the very least, a sense of affinity. If we're not as fully integrated as we would like to be, racially or age wise or economically. We're nevertheless connecting with people, who are in very different places. I think that enriches my life, enriches my experience and I find that I have a lot to learn from those folks.

Many participants enjoyed the mix and give and take of the different cultures, learning a lot from the diversity. A diverse congregation was seen as providing a more realistic view of the world. One participant felt the diversity of the congregation made people feel better and less guilty.
G12: I know people feel better, less guilty (laugh) if they can be in a church that doesn’t look as racist as most churches do on a Sunday morning. I mean you see more segregation on Sunday morning in church, probably than anywhere else, or any other time..maybe people feel bad about that (laugh). I think some people come because they truly want their children to have that kind of diverse experience, to know, appreciate, and feel comfortable with persons of other cultures.

While unanimously expressed as a value of this congregation, diversity was also seen as having a few drawbacks. One participant expressed a sense of competition between programs for different ethnic groups. Another participant felt that the diversity of the congregation also made it difficult to have a sense of community.

There are many other ways the value of diversity was tacitly expressed within the culture of this congregation. The three different styles of worship available in the weekend worship services acknowledged a diversity of preferences in worship style. The pastoral staff in worship consistently used inclusive language. There was a lack of uniformity in clergy attire that allowed for individual diversity in dress. When there was a point in the worship service to stand, the person leading always said “stand as you are able.” This recognized diverse physical abilities. For each Sunday 11 AM service a lay person read the scripture. There was diversity, over time, in the gender, age and ethnicity of this person. There was diversity in the preaching styles of the pastors. Finally, there was diversity in what happened in Sunday 11 AM worship. While there were some common components from week to week, 11 AM worship was never exactly the same.
Worship

Worship was one of the central, highly valued cultural activities bringing together the largest group of members and constituents at one time. The Sunday morning 11 AM service had the largest number of people. Participants identified specific components of worship such as liturgy, preaching, music and being connected to God as being valued. One indication of the value on music was having a paid, professional quartet to lead sections of the choir. The following quote from K6 discusses the importance of worship.

K6: I think the worship experience on Sunday morning is the one uniting factor that people really value, the friendships they form here, the sense of being a part of a community and life-long friendships are forged out of different groups. I think they value the church’s warmth and friendliness.

The sermons were printed each week and made available in the narthex for people to pick up in the week following the service, indicating a value for the preached word. It was felt to be valuable enough to want to pass on to people who come to the church during the week or who missed a church service. The sermons were also seen as educational. Education, often referred to in congregational life as increasing awareness, was an expressed value. Along with the explicit value on education, there was an implicit value for well-educated persons.
Teachings of the church

There were certain religious teachings participants valued including forgiveness of sins and accepting one’s weaknesses, as K1 explains.

K1: If you only went there for the liturgy and didn't care whether the preaching was good or bad, never got in any programs - you could, you could grow closer to God. You'd see that emphasis on, on forgiveness of sins and um you know trying to get over your own, accepting your own weaknesses.

Grace was another consistent theme in the sermons reflecting its value. The following is a small selection of sermon excerpts that highlight this valued concept.

The irony is that virtually every one of St. Paul’s letters begins on a note of grace. It is what he wishes his friends first, even before mercy, even before peace, and no matter how practical he is in his admonitions to the church, he always comes back to grace. Grace is the best he can wish them because grace is the best he has received from God. 9/1/96

This wonderful patient, gracious God gives them freedom, just as God continues to give it to us, not because it is earned or deserved. It is given in spite of our complaining, griping, whining. God’s grace at work. 9/15/96

What other religion has at its heart two Sacraments that take life’s basics--bread and wine and water--and declare that God’s grace is given, not earned, granted, not deserved through life’s simple ingredients. 10/6/96

It’s the saints, the people who live as best they can honest, decent, compassionate, faithful lives. People who get up and go to work, who try to make a difference, who seek meaning and try to touch others with something of the grace God has so generously granted us. 11/3/96

We are given the free gift of energy through the grace of Jesus Christ. 11/10/96

Grace is another term that is difficult to figure out its meaning. The closest translation in English, I think is, “steadfast loving kindness”--that is to say, it is unlimited, abounding, and given to us “gratis,” with no strings attached. 7/6/97
Opportunities for participation

The congregation had opportunities for participating in the congregational culture, which were highly valued. These included service opportunities both within and outside the church. Activities that reach out beyond the congregation were valued both for what they did for the people being reached out to and for the people doing the reaching. Involvement in volunteer mission activities connected people to other people who were members and constituents of the congregation as well as people in the broader community and the world. G4 explains why this connection is important.

G4: To know you're connected with people not just in this church but through mission work you're connected to other people outside of your local community.

Specific mission opportunities that were frequently mentioned as important were The Marcy Newberry Center, a United Methodist social service program in an inner city neighborhood that members of the church were working on renovating and raising funds. Primarily the younger adults in the church did this particular mission project.

Learning opportunities were another component of congregational life that participants valued, as expressed in the following quote.

K4: Even today I've heard, people see (the senior pastor's) sermons as an education, as a teaching moment. And they value that. They want to be taught. I mean we have, I think we have, a highly educated membership here. And I think that's part of it. And all of them... are out of college, have at least college training, if not more. But what they don't have is religious training, at that level. So that's what they want. That's what they expect. They expect the same sort of standards as they received in college, in masters and doctoral work, but on a religious, as a religious focus. So I know they value that.
Purpose/Mission of First Church

As in all cultures, members share an understanding of the purpose of the group. Members of First Church shared an understanding of purpose which incorporated not only an understanding for this congregation, but also an understanding of what the purpose of churches in general is, or should be. Another word for purpose in the language of this church was Mission. Mission with a capital M is utilized to indicate the primary task of the church. Mission with a small m refers to specific activities of outreach. The purpose or Mission of the church is the primary expressed objective of the culture. Ministry, discussed later as a discrete domain, refers both to the overall work of this congregation as well as specific components of church activity.

Participants were asked to identify their understanding of the purpose or Mission of First Church. Responses included two primary functions; bringing people in and sending them out. Nurturing people once they were brought in was seen as a supportive function. The significance of the church's location in an urban, downtown area was seen as having a significant impact on it's Mission.

Bringing people in.

Since its inception, First Church has been involved in bringing people in to become part of the congregation. New members were actively sought and encouraged to participate during the study. Engaging in worship was one of the primary events that brought people into the church, with evangelism being the identified ministry area responsible for doing this. Evangelism was also responsible for nurturing people who
are already members. The "bringing in" had two groups targeted: people who did not have a belief in Christ or an active involvement as a Christian and people who had been members of another congregation and were already Christians. The following quote from G13, describing the Mission of First Church, highlights the importance of bringing people into the church.

G13: I think of certainly providing a central place for worship, for people to come together and worship and this is in terms of serving God. And doing this in fellowship with other, like-minded people. And contributing in my own way toward their well-being and the collective way, you know, really supporting each other, but extending ourselves and um, outreach and to the community. And I think it is a way of acquainting people with and in bringing people to God. I see evangelism as being a primary Mission of the church at large. And these are other ways of contributing toward that.

Sending people out.

Once people are brought into the congregation, they need to be trained and sent out. People are not brought in to just stay and be part of the group. There was a very explicit expectation that people were brought into this church in order to be sent out to participate in mission work in a variety of capacities. This was expressed in a new member meeting the researcher attended, the weekly newsletter and consistently in the sermons and worship announcements. While it was expected, not all members actually participated in the sending out. The most active and involved members were those who were being sent out, or supported the sending out or were being nurtured within the faith community.
One participant (K4) described the purpose of this church as being a "mission church" that sends people out to be involved in missions, as opposed to an evangelistic church whose primary purpose is to get people to hear the good news of Jesus or an education church whose primary focus is teaching. Ideally, a church should be involved in all areas, but often there is a dominant emphasis. The concept of the purpose of this congregation being to send people out to serve in missions was consistently identified among the informants. The congregation's emphasis on social justice issues was consistent with the image of a mission church that sends people out. K4 elaborates on what it means to be a mission church.

K4: That's what this church is to be about. It's a mission church. So it's to open its doors to all the people. It is to call people to faithfulness and experience and to know the grace and the love of God. It is to train them up, not in the technical sense of the word, but in their knowledge and understanding of God and also to what God is calling them to and send them out, and send them out. Let them go. That's it. (Laugh). And gather more.

Another participant saw the purpose of the church as reaching out in a monetary way through financial support of various activities. Members of the congregation do provide a great deal of financial support for different service projects. For example, the congregation had given $50,000 to the building of a single resident occupancy building in the downtown area. The Heifer Project, which provides animals for increasing food production in poor countries, was another project for which the congregation raised about $10,000.
Nurturing members

Some participants identified nurturing members as part of the Mission of First Church. Members are nurtured through opportunities for faith development and being part of a community. K5 describes an understanding of the Mission in the following quote.

K5: I think it’s to open up opportunities to know God and to come and um, build a relationship with God...and enjoy their ministries working together in a community.

Impact of location on mission.

The location of First Church in an urban, downtown area had a significant impact on its Mission, shaping the opportunities for the church to be involved in ministry and shaping the people who were brought into the church as well. The Mission of First Church was described as a beacon to the city, which G6 explains in the following quote.

G6: It means bringing hope, lightening the load, letting people know that Christ is there for them. Primarily it's - who is the speaker that used to say - whatever you do, let them know God loves them. Whatever you preach, whatever you teach, whatever you exemplify.

During the participant observation and interviewing phases of this study, participants were not aware of a specific mission statement for this church. During the analysis/synthesis phase of the study, the following statement was published in the weekly newspaper, which articulated the Mission and Vision for this congregation. This statement had been created three years ago by a long range planning committee.
Our Mission:

Our Mission is to be the voice of United Methodism in the heart of the city.

Our Vision:

Our Vision for the First Church:

- The corner of (streets) will be recognized as a Christian Center of (city).
- We will be recognized by the community (city, state, nation) as living out what it means to be Methodists.
- We will be known as a theologically based, issues-oriented church.
- We will be recognized for challenging the community on moral issues.
- We will be a growing congregation characterized by our diversity, our outreach, our actions, our involvement.
- Our strength will come from superb worship, music and Christian education programs, widespread lay participation and inclusion of all.

The Importance of Social Justice

It was clear both through the interviews and through participant observation that awareness of, and involvement in social justice issues, was valued in the culture of this congregation. This was commonly referred to as the social gospel. The importance of social justice issues was evidenced in the words of the participants, the preaching from the pulpit, church publications and activities. The participants attributed this emphasis to the factors outlined below.

First, over time the pastors and their interest in the social gospel and issues of social justice had either helped to create the interest among members or attracted people who were sympathetic with the preaching. What was preached from the pulpit both reflected and influenced the issues valued within the culture of the congregation. The worship services on Sunday, particularly the sermons, were the mode of
communicating congregational values that reached the largest group of people at one
time. The following quote from a sermon provides some perspective on the importance
of social justice issues.

Anger is not always a sin. There are occasions when not to be angry is a sin.
Tolerance or indifference in the presence of evil may mean that we have lost the
crux of public faith. There can be no spiritual life without moral indignation.
10/26/97

Another mode of communication that expressed congregational values was the
senior pastor’s weekly column in the church newspaper. The following quote from the
column speaks about the social gospel of faith in action.

When I am asked why people seek the church, I often reply “Because they are
seeking meaning in their lives, and once they find some meaning, they want to
put their faith into positive, practical action.” 1/3/97

Location was identified as another reason for the congregation’s focus on social
justice. The location of First Church in a downtown area and the fact that the majority
of the members live in the city, dealing with urban issues daily that highlight social
justice concerns, made this a concern for the members. The impact of the pastors and
the church location on the social justice emphasis was articulated by the following
participant.

G9: Well clearly, I think that there are two major factors. One, is the influence of
the pulpit, I think that both, well all three, pastors are very, very oriented toward
the church and society and how the church functions in society and what our place
is in society as individuals, as individual Christians. That’s one thing I think the
leadership provides. The other thing is that I think when you have a church filled
with people who’ve lived, primarily - I mean, they talk about how people come
from all over the metropolitan area - but primarily it’s city people, you know,
people who are faced daily, with homelessness and hunger and poverty. I think
that they are looking for ways to do things to address those issues and the church
is a logical way to accomplish those...And you know, I don't want - I think that suburban people are also are very concerned about urban issues. So I just think that there's some like mindedness in our congregation about concern for social issues. Let me put it that way, and not make it a city/suburb kind of thing.

The emphasis on social justice was seen as something that created connections within the community because as K3 said, "what you can't do on your own you can do maybe in a group." This was identified as significant for the young adults who did a majority of the work on local mission projects. It was unclear to the participants which came first, the emphasis on social justice or the young people as expressed by G12.

G12: We have so many younger people that want to make a difference with their lives, that want to be involved in something significant, add meaning to their lives, or maybe since we do stuff, then we get those people here. I'm not sure.

The emphasis on social justice and the associated mission projects also served a social function for church members and constituents. These projects provided the opportunity to meet people and develop relationships, as a consequence of engaging in the mission project. The following field note excerpt about a mission trip to an Indian Reservation highlights the relational value of mission trips.

Then two persons who went on the trip spoke. The first person, who had just joined the church in the spring spoke about how First Church had reached out to her through including her in the trip. The second person spoke about it being a community experience and about the gift of community. 7/13/97

Implicit values

Implicit values are values observed through behavior that may not be explicitly articulated. Implicit values are one way that “actions speak louder than words.” There
were three areas that reflected implicit values of interest to this study: health ministry, activities that have a great deal of support, and sources of conflict.

Health ministry as a reflection of values

Health ministry was seen by some participants to reflect the values the congregation held for wholeness, integrating spiritual, mental and physical well being. Health ministry also reflected a value of caring for each other, as expressed by K3. “Well, we value each other and health ministry would help with that.” The work the parish nurse did with homeless persons was a reflection of the value held on reaching out to persons who are in need outside the congregation.

The existence of health ministry within this congregation was also a reflection of the value of allowing members to try new ministries. The current organized health ministry activities of the parish nurse and the health committee emerged from the interest and willingness of a retired nurse to serve as a parish nurse and initiate the development of the health committee. This kind of emerging ministry spearheaded by an individual member was valued within the congregational culture, as the following participants articulate.

G9: You really just need one or two people who are really committed and motivated and ten other people will follow.

G13: But it (health ministry) is one where a group of members felt they could make a contribution that would be beneficial to others and meet a need.
While health ministry did reflect some of the values of the congregation, one participant felt health ministry could be better integrated into the life of the community if it built on other values such as education and worship. In a congregation that has so much happening, increasing congregational awareness of health ministry requires effort and appropriate timing, as G12 explains.

G12: I think the health committee needs still to find a way to get the church involved in what it's doing more. Certainly, the health fairs go pretty well. I think those are helpful.

M: How would you envision that happening?

G12: Well I'm not sure, I think awareness programs maybe as a start that hit after church kinds of things with healthy brunches or something that would draw more people or some kind of focus in the services like, well, we did the domestic violence Sunday, a whole Sunday. Something where more people have to hear it.

M: And that would be Sunday morning for this church?

G12: For this church it's Sunday morning...In order for anything to catch on you almost have to drown people in it.

Well supported activities

One way that values are implicitly expressed is in activities that have a great deal of financial and personnel support. This congregation was unique because it was not responsible for any building expenses, which as the senior pastor said, "frees us up for ministry." Having a well trained professional staff was valued as evidenced by the number of well trained clergy and professional staff. Over the past several years positions were added in Christian education and music as well as a business manager.
Mission activities were the one thing participants consistently identified as being well supported. Financial support for mission activities was provided above and beyond members' regular giving. According to the senior pastor, members respond quickly when they see a specific need for a minority, marginalized group. At one point, a need for folding chairs was identified in a church that had burned. Donations were received for one hundred chairs within a week.

Sources of conflict

One implicit way that values become evident is in sources of conflict within the congregation. The extent to which diversity was valued became an issue with the congregation's decision to be a reconciling congregation, which, in the United Methodist Church, means openly including persons who are gay, lesbian or bisexual. The church decided several years ago to become an individual reconciling congregation, but not to become part of the denomination's Reconciling Congregation program that would have required a greater commitment. This continued to be a source of conflict that was addressed in meetings held to provide an opportunity for people to express their feelings on the subject. This was one situation where the congregation's value of diversity created conflict, as G12 explains.

G12: Sometimes...in an attempt to be in harmony with each other creates disharmony with each other as we talk about the reconciling congregation.
Ways First Church is Distinctive

One way the values of the congregation were implicitly expressed was in how members saw First Church as distinctive and set apart from other congregations. The participants were very clear that this congregation was unique and expressed a certain pride in that fact. Distinctive qualities were identified about people, location, feelings and history.

As mentioned earlier, this church was seen as distinctive because of the people who attend and the diversity in race, age, gender, sexual orientation and needs. There are many single professionals and many older long-term members with wisdom about Methodism. Participants stated that the majority of the members were middle class and well educated.

The church enjoys a distinctive location in a downtown urban area located in a high rise building. This gives the church a distinctive ministry to people who work downtown (but are often not members) and persons who are homeless.

There are certain distinctive feelings participants experienced in their relationships within the congregation including acceptance, inclusiveness and a family feeling. Persons who had not joined the congregation were able to have significant participation in church activities in addition to worship. Participation in congregational life was more valued than official membership. The congregation's programming in the area of outreach was seen as distinctive.
The congregation enjoyed a distinctive history as being the oldest in the city and a history of being a leader in the denomination. One participant referred to the church as a "flagship church" (K6) for the United Methodist denomination.

Symbols

Symbols are another way of implicitly expressing values. Some of the notable symbols in the church building included a large cross at the front of the sanctuary on the wall, reflecting the value of Jesus’ crucifixion and resurrection. Large banners changed periodically in the front of the church expressed certain values such as denominational affiliation or were specific to the season. The altar on the pulpit area had a carving on it’s front of Jesus looking over the city of Jerusalem, expressing a value on the urban environment in Jesus’ life, as well as on good artwork. The stained glass windows that surround the sanctuary were used to symbolize the importance of history to this congregation. The United Methodist Church symbol is a cross with a flame, expressing a value of Christ and the Holy Spirit.

Domain Related to Organization

The organization of a congregation is a reflection of the individuals who are members, the shared values of the community and the history of the congregation. Organization was important in the work of John Wesley and the early Methodists as a way of pursuing their Mission, and continues to be important in the United Methodist
Church today (Willimon, 1990). Consistent with the denomination, First Church is also organized to accomplish a Mission of engaging in ministry within the city. The organization supports the ministries of the congregation, connecting different groups and individuals within the culture. Table 10 identifies the categories and subcategories within the domain of organization.

<table>
<thead>
<tr>
<th>Table 10. Domain of organization: Categories and subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KINDS OF PEOPLE IN THE ORGANIZATION</strong></td>
</tr>
<tr>
<td>• Members</td>
</tr>
<tr>
<td>• Constituents</td>
</tr>
<tr>
<td>• Visitors</td>
</tr>
<tr>
<td>• Staff</td>
</tr>
<tr>
<td>• Kinds of leadership style</td>
</tr>
<tr>
<td><strong>PARTS OF CONGREGATIONAL STRUCTURE</strong></td>
</tr>
<tr>
<td>• Committees</td>
</tr>
<tr>
<td>• Groups and activities</td>
</tr>
<tr>
<td>• Denominational affiliation</td>
</tr>
<tr>
<td>• Finances</td>
</tr>
<tr>
<td>• Technology</td>
</tr>
<tr>
<td><strong>STEPS IN STARTING A NEW PROGRAM</strong></td>
</tr>
<tr>
<td>• Call or interest</td>
</tr>
<tr>
<td>• Generate support</td>
</tr>
<tr>
<td><strong>PARTS OF THE ORGANIZATION OF MINISTRY IN THE CHURCH</strong></td>
</tr>
<tr>
<td>• Areas of ministry</td>
</tr>
<tr>
<td>• How health ministry fits into the life of the church</td>
</tr>
</tbody>
</table>

**Kinds of People in the Organization**

There are several different kinds of people within the culture of the congregation. Staff people were paid to work for the congregation and included the ordained clergy and other professional and office staff. Some people were members of
the congregation while others, referred to as constituents, were people who participate regularly but had not technically joined. There were also many visitors. Indirectly, the people who receive mission efforts are part of the culture.

Kinds of Leadership Style

Leadership style is part of the congregational culture. First Church had a leadership style that combines strong pastoral leadership and individual initiative. The senior pastor was seen as having significant influence on what happened within the congregation. The following participant identified the strong pastoral leadership as a "top down approach".

K1: Our general impression after being at several different kinds of churches...is that it's a top down approach, where it's heavily staffed by professional ministers that each have their own section that they are responsible for and then involve lay people underneath them to carry out some of the goals and the tasks of the church. I do not see a heavy emphasis on laity taking leadership roles for training and planning, but more involved in carrying out the agenda of the pastors. That's got pluses and minuses in terms of you have a lot of extremely well qualified people there in leadership - pastors trained in education, you know music ministry, ah, social action programs. Those kinds of things. The down side is, I don't think all the giftedness of the professional congregation is being used, because there's a high percentage of people with lots of talents, lots of training in different areas.

While the professional staff did provide strong leadership there was also an atmosphere where people could try almost any kind of ministry that was not controversial or in conflict with existing programs (see values). At a new members meeting, when asked how the agenda for outreach was determined, the senior pastor
said, "The world sets our agenda. We see how our talents can meet the needs of the world. There is no specific plan."

This congregation was considered a leader within the United Methodist Church. The staff were active in denominational activities, as were many members. Because of it's active involvement in the denomination and social issues, First Church was well known.

First Church is a very public church, being both geographically and physically prominent in the city. Travelers and persons working downtown are frequent visitors. The congregation's involvement in the denomination and issues of social justice also make it very public. Within this public church, a private and intimate network of friends also exists.

**Parts of Congregational Structure**

The structure of the church organization was partly determined by denominational guidelines, written in the *Book of Discipline*, a denominational publication that is revised every four years, and partly by the individual style of the congregation. There were standing committees that do the basic work of the congregation, which are identified in the *Book of Discipline*, with some flexibility for the individual church. The *Book of Discipline* (1996) required the following members in the church council, referred to as the Administrative Council at First Church: chairperson of the church council, the lay leader, the chairperson of the pastor-parish
relations committee, the chairperson of the committee on finance, the chairperson of the board of trustees, the church treasurer, a lay member to annual conference, and the pastor(s). The parish nurse was also a member of the Administrative Council at First Church. Participants described the Administrative Council as serving an information sharing function, rather than a policy making group. No one group was identified as being responsible for planning and implementing church policy.

In addition to committees, there were a wide range of groups and activities people could participate in at First Church, including Sunday School classes for adults and children, covenant groups, Lenten Bible Studies, music ministries, choir, bell choir and the liturgical dance group. Efforts were also made to connect people to community service projects where they can volunteer. A handout was available at the church with information about volunteer possibilities within and outside of First Church.

First Church had a unique financial situation in not having the financial or personnel responsibility for building upkeep. Consequently, the majority of the budget and staff time could be devoted to the support of ministry. This did not create an excess of funds, however, because the ministry efforts were ambitious. The parish nurse served as a volunteer staff person. The health and wellness committee did not have a specific line item in the budget. However, they did have access to funds through the general area of outreach.

Technology was used to enhance worship services. Lights were dimmed during prayer to help create a reverent atmosphere. The clergy utilized portable microphones enabling them to move around during the service. The senior pastor always took
advantage of this technology to deliver his sermons, without notes, from the center of
the pulpit area.

Computer technology was also used to enhance communication within and outside
of the church community. A web page was created by individuals in the Young Adults
Ministry to communicate information about the church and its activities. E-mail was
also used by members and staff for communication. Records of financial giving was
computerized. Computer technology was observed being used at one health and
wellness committee meeting where a PowerPoint presentation was used by a pastor to
organize program planning.

Steps in Starting New Programs

Health ministry is relatively new (four years old) at First Church.
Understanding any cultural dynamics in beginning programs could help understand the
development of health ministry. No one approach identified for starting a new program
was identified. Participants identified important components in initiating a program as
going the senior pastor’s support and getting other people interested. Starting new
programs did not require the approval of the Administrative Council, although the
Council was often informed.

Parts of the Organization of Ministry

The major areas of ministry participants identified were outreach, education and
evangelism. These areas were slightly different from those identified in the Book of
Discipline that organized the local church's areas of ministry into witness, nurture and outreach. This congregation did not consistently use the Book of Discipline terms to describe their ministry. The term outreach was used, meaning activities directed to persons outside of the membership. Evangelism, as understood by the participants, involved both bringing new people into the congregation as well as nurturing the membership. Evangelism as understood at this church fit under the area of witness, as described in the Book of Discipline. Education was highlighted as a separate area of this congregation and was the only ministry area that always had a weekly column in the church newsletter. Educational programs were offered every Sunday for children and adults. In the Book of Discipline education comes under the ministry area of nurture.

The categories of nurture, witness and outreach were observed being used to organize the areas of ministry at First Church on one occasion at a health committee meeting. The pastor who worked with the committee outlined the actual and potential work of the committee according to these three categories. Cancer support groups and weight loss groups were listed under nurture. The health fair and workshop series were listed under outreach and the homeless group and regional/international efforts were listed under witness.
How Health Ministry Fits Into Church Organization

Health ministry, as understood by most of the participants, included the activities of the parish nurse and programs sponsored by the health committee. How health ministry fit into the life of First Church was related to how it reflected shared community values. In describing how health ministry fit, participants were implicitly, and sometimes explicitly, expressing values. For those participants who did not have a strong sense of how health ministry fit, it was a question of First Church having many agenda items important to different individuals and groups. Areas of ministry almost had to compete to get the attention of the congregation.

The following comments reflect the diversity of the participants' opinions about how health ministry fit into the life of the congregation.

K3: It seems to fit here and they’re trying to enlarge their health ministries by doing exercises and that sort of thing.

K4: It (health ministry) doesn’t fit in. It’s already a part.

K6: I see health ministry as an outreach.

G3: It’s (health ministry) just one more piece in the big pie.

G4: There’s a lot of programming around health that we could be doing that would foster that movement towards small groups, and creating opportunities for... people to have fellowship. It’s such a difficult environment, living in the city and a lot of people have a difficult time feeling connected to other people and so you know anytime that’s where we really tend to have some success.

G9: I’m not really sure where the current health committee fits, if it’s own committee or if it’s sustained under some other committee. It would seem appropriate to me to be under an outreach category.
G11: I think the reality is it’s not in any direct sense a high priority item. I mean on the list of outreach, mission projects, political actions and sort of day to day administering of the things that a church does.

G12: I think we have a long ways to go... I think people know (the parish nurse) is there and appreciate her and her work.

G13: I think it fits. It’s an accepted program and it’s not an established, mandated program.

For some participants, health ministry did not fit into their personal experience as articulated in the following quote.

G4: When I hear health ministry I get an impression that it’s either focusing toward older people or people who are really into their physical well-being... So the vast majority of it I don’t really connect with it.

Through observation, it was evident that health ministry, like all of the other areas of congregational life, had to fit into certain time parameters for gathering. The largest group of members gathered on Sunday mornings. Therefore, having health ministry activities targeted toward members needed to occur, and did occur, between the 8:30 and the 11 service or after the 11 AM service. This was also prime time for all other activities trying to reach a large group of members, which sometimes inadvertently placed groups in competition with each other.

If programs were targeting persons working downtown, who may or may not be members, the logical time for health ministry activities was the noon hour when people take lunch or around the Wednesday midday worship service. Services that were targeted to persons who were homeless needed to occur when they were at the
church for other services, which happened to be Tuesday morning. Activities the health committee planned that were in the evening and not associated with any other church activity were not well attended. The programs that were best attended were after the worship services either on Sunday or at a weekday noon hour. The parish nurse had organized her availability around these logical times when people gather at the church.

The role of the parish nurse was important in understanding how health ministry fits into the life of First Church. The parish nurse volunteered 16-24 hours a month and put the most time into the health ministry activities, followed by the health committee and the assigned staff. From the parish nurse’s perspective, she experienced a call to use her professional gifts for her church when she retired. She then brought in others who were interested in health ministry. The parish nurse has a strong sense of mission in her work, wanting to pay back God for all that had been provided in her life.

Significant components of the historical context also affected how health ministry fits into the life of First Church. These included the development of parish nursing, the parish nurse retiring, denominational development of interest in, and materials about, health ministry and resources being available for training. All of these factors contributed to creating a context at First Church where developing health ministry was feasible.

Health ministry fit into the organization of First Church in the following practical ways. The parish nurse was listed on the back of the bulletin with other staff:
For the first year of participant observation she was the only volunteer listed on the bulletin. Recently, the person who volunteered as an interpreter for the hearing impaired was added to the bulletin. The health committee became a standing committee in 1995, with an assigned staff person. The parish nurse is on the administrative council because of her position. Health ministry did not have a specific line item in the budget, but the health committee and the parish nurse do have access to funds from other accounts.

Domain Related to Ministry

Engagement in ministry was the central activity of First Church. Ministry created a focus and a meaning for what happened within the congregation. Several different ways to understand ministry emerged from this study. First, ministry has diverse qualities which frame it's meaning. Second, there are certain prerequisites to engaging in ministry that includes a relationship with God leading to a call. Third, the way ministry is organized reflects certain values of the congregation. Finally, ministry can be understood through looking at different kinds of ministry. The categories identified within the domain of ministry were ways to understand ministry, ways to understand mission, ways to understand health ministry, ways participants respond to the UMC definition of health ministry and the consequences of ministry. The categories and subcategories of ministry are shown in Table 11.
<table>
<thead>
<tr>
<th>Ways to Understand Ministry</th>
<th>Ways to Understand Mission</th>
<th>Ways to Understand the Meaning of Health Ministry</th>
<th>Ways Participants Respond to UMC Definition of Health Ministry</th>
<th>Consequences of Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Qualities of ministry</td>
<td>• Qualities of mission</td>
<td>• Way to address health issues</td>
<td>• Ways to relate definition to First Church</td>
<td>• Ways congregation cares for members</td>
</tr>
<tr>
<td>• Prerequisites to ministry</td>
<td>• Consequences of mission</td>
<td>• Theologically</td>
<td>• Important points</td>
<td>• Ways congregation cares for non-members</td>
</tr>
<tr>
<td>• Organization of ministry</td>
<td></td>
<td>• Concrete activities</td>
<td>• Critique of the definition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Part of church life</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Raising awareness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ways to Understand Ministry**

To be engaged in ministry involves connections: connections between members and constituents of the congregation, connections between members and people outside of the congregation and connections between individuals and God. Ministry had many different meanings and semantic relationships to the participants as shown in Figure 8.

Both individuals and groups engage in ministry. The Ministry of First Church, being the overall activities, is directed by the Mission, or primary purpose, which included
Figure 8. Participant identified attributes and semantic relationships of ministry
different kinds of ministries and missions. Ministry is, in the words of K4, "whatever God calls you to, to further enhance God's message of love and healing and salvation."

Ministry requires a relationship with God that leads to a call understood as a sense of direction and purpose for using one's talents. Ministry also requires relationships with others in the congregation and community from which needs emerge (Thomas & Alkire, 1985). To be engaged in ministry requires at a minimum two people. Reconciliation is one relational component of ministry identified as part of outreach by K4 in the following quote.

K4: There's a ministry of reconciliation I think that goes on through the outreach committee. And the ministry reconciliation works on the assumption that many of our problems such as hunger and poverty are not because there's a lack of resources. What is lacking (laugh) is the relationships, you see, that alienation between groups of people or between persons has caused the break down of seeing what the real resources out there are. So a ministry of reconciliation works primarily on trying to bring reconciliation between two groups of people, or groups of people, or individuals under the assumption that if you bring, if you tighten up the relationship, if you help the relationship then the other issues such as hunger and poverty will be taken care of...It's not because its, there's not enough, there's plenty, you know. Just like there's plenty of food. There's plenty of money. We already know this. I mean, no one has to be a rocket scientist to figure this out (laugh). What's the problem? The alienation is a big problem. People feel alienated from themselves, alienated from family members, alienated from society, alienated from God and so a ministry of reconciliation helps people to build those bridges back. So that healing can take place and also wholeness can take place. Both spiritual and in the body, you understand what I mean... So the ministry of reconciliation...has it's primary task as trying to rebuild those relationships. And I think, in this particular context it's between people in and outside of the church who have and those who have not.
Call

The concept of call was integral to ministry for several participants. Call was understood as the connection between members and God which ideally provides the direction for ministry. Although some members may engage in ministry without a sense of being called, ultimately it is the sense of call that keeps ministry connected to God as explained by K4.

K4: The term “call” means that the person experiences (laugh) a sense of - I was going to say unsettledness, but maybe that’s not the best word. The person’s call for me means that a person is engaged by God in a multitude of ways, but God gets across a message to this person, that I want you, not merely to do something, but I want you to be in a relationship with me. And that’s what I mean about call, that God engages individuals primarily for the sake of a relationship and out of that relationship they are called to do...actually it’s they’re called to be.

Both individuals and communities can experience a call. One component of call is recognizing the talents that one has, or the congregation as a community has, that can be used in ministry. While sometimes the term minister is used to refer to paid clergy, in this congregation the paid clergy are referred to as pastors and everyone can be a minister, if they so choose. The following quote from K2 discusses everyone being a minister within the context of health ministry.

K2: Everybody is a minister in the church, but in the aspect there is a health ministry, it has more emphasis on health in your ministry. Like for example as I said maybe each of us is given talent, their own talent and their own values. So in the health ministry I think if you are a nurse, or the health ministry committee ...should have more emphasis on the health ministering of the members. What I mean to say is they should perceive themselves as you know someone who for example ministers to the people and also in your physical body...also in your spiritual and all aspects. So that is I think you know as the minister of health we are called to be examples of health (laughter)
To help people identify a ministry where they can contribute was identified as a challenge by several participants. This was one area where it was felt the congregation could be more effective. The clergy can play an important role in encouraging members of the congregation to engage in ministry, as expressed in the following quote.

K1: The whole purpose of ministry is that people called to the professional ministry support and help other people find their places.

Organization of ministry

The organization of ministry is one reflection of congregational values. How First Church chose to organize their ministry was one reflection of what was valued by staff and members. The UMC, in the Book of Discipline, groups ministry into three areas: witness, outreach and nurture. These groups reflect the importance of providing a witness to members and non-members about Christ, to reach out to people beyond the membership and the importance of nurturing members.

First Church organized areas of ministry around functions. Participants identified ongoing areas of ministry in this church as music ministry, education, pastoral ministry, ministry of word, and sacrament. These areas of ministry would be found in most churches. In addition, this congregation has some ongoing areas of ministry that exist because a need was identified and the congregation had the resources to meet the need. These areas of ministry include health ministry, women's ministry, young adults, ministry to the hearing impaired, ministry to people working downtown, and homeless
ministry.

Several participants spoke about a new paradigm for ministry in the denomination called emerging ministry or entrepreneurship in which ministry emerges from need rather than a committee structure. Currently, there are standing committees for the basic areas of ministry in the church including music, education, evangelism, and outreach. Other committees are created as a need arises. Despite being a common organizational structure of First Church, committees were identified as sometimes having a potentially negative effect on ministry. Several participants mentioned that serving on a committee was not ministry. The implication was that ministry involved action as well as discussion. Likewise, a committee was not a prerequisite to engaging in ministry. One participant spoke about wanting to cultivate a ministry perspective about church activities as opposed to a program emphasis.

G3: Well, oftentimes when we are planning now we think, well you know, we’ve got to do something about the incidence of hypertension in our congregation or something. We are going to do a program on this. Well, rather we have a health ministry and so what comes out is a more holistic approach. And I’m just working on that inside my head right now, as to how that would look...but I think it would look more on what kinds of ministries do we provide through education and how do we achieve - how do we work on those. How do we make, you know, progress in those areas, rather than simply saying we have an educational program that we do... It’s a more holistic way of thinking and a more inclusive way of thinking. And, um, also I believe will help facilitate the ministry of all Christians of the Laity.
Ways to understand mission

Mission was a rich and complex concept at this church and an important component of the ministry of First Church. It was a concept that the participants frequently spoke about with the researcher and also was very present in the congregation's public discourse. Figure 9 shows the attributes of mission identified by the participants. There are many terms the participants used that have the word mission in them such as mission work, mission statement, mission team, mission church, missionary, homeless mission, mission oriented, and mission driven. Terms that participants frequently used in conjunction with mission and sometimes as synonyms were ministry, outreach, value, and goal. Mission involves a sending out, going away from the home base of the church or reaching out, which the following participant explains.

K4: To send people out. That's what I mean about mission to send people out into the world to proclaim the gospel in some very concrete ways.

In talking with the participants, the distinctive qualities of mission were identified as having a Christian purpose and involving action. Mission is not a passive activity. It is action oriented and involves interaction with others in partnership and in giving or sharing resources. The following sermon excerpt explores the reciprocal relationship between the people directing the mission and the people receiving the mission.
Figure 9. Participant identified attributes and semantic relationships of mission.
I believe, our attitude should be whenever we do mission is to help people recognize and understand God's grace has been working in their lives and in their history. And our messianic evangelistic songs and hymns should also be revised for we are not the only one who "have a story to tell to the nations." A truly liberating and incarnating way of doing mission (as Christ did) is also to learn from the people we serve. Let us stop doing things for them. Let us learn to work and risk with them. 7/6/97

The extensive involvement in missions was seen as a unique, distinctive quality of First Church. The Mission (being the primary purpose or objective) of this congregation was to be a voice of United Methodism in the city, to be an advocate for social justice issues out of a particular place, through engaging in missions and ministry. The value on missions was reflected in the strong financial support for mission projects discussed in the community context domain. Participants identified the motivation for being part of missions as helping, serving, having the opportunity to put faith into action and working on projects with like-minded people. On any given Sunday there were opportunities to sign up for different service projects as well as information about different social justice issues that one could support financially, requests to write letters, opportunities to be present at an event and/or opportunities to increase one's awareness on a specific issue.

Some of the consequences of mission expressed by the participants were a feeling of community among the people who are engaged in mission work together and with the world in general. Mission creates connections between many people causing the people who participate to get as much out of it as the people they are serving, a feeling that was expressed by G8.
G8: We’re going out to the Indian Reservation to help with, I think we’re helping build a day care center, but I know I’m going to learn so much from working with the people in the area.

An example of local missions from this congregation was the Marcy Newberry Center that provides services for children and families in an inner-city neighborhood. Members of First Church have been involved in building renovations, financial support and serving as board members. Another local mission is Project Renewal, a program that brings disabled persons to First Church once a year for a day of worship and fellowship. Missions that are more distant have included trips to Nicaragua, Russia, Ghana, and England. The congregation has also been involved in missions through raising money for Methodist affiliated health care institutions, homeless missions and providing substantial financial support for building a SRO (single resident occupancy). Some members’ involvement in missions included serving on the boards of community organizations. Involvement in mission, with a particular focus on women and children, was a focus of the United Methodist Women group.

Similar to ministry, individuals as well as groups may have missions. For the parish nurse, her volunteer work was a mission. She consistently spoke about her work being a way to “pay back” God for all that she has been given. Certain individuals within the congregation were important to missions. The senior pastor was influential in creating the focus on missions. There was one pastor designated to work with missions. One group identified as being particularly involved in missions at First Church was the young people.
Organizationally, missions are housed in the outreach committee. Until recently there had been a committee just for missions. Participants identified that it was not a mission to sit in committee meetings. The following quote helps to articulate the difference between mission and program.

M: Now when you talk about mission, what does the term mission mean to you? What makes something a mission as opposed to a program?

G9: Well, I think that we as Christians feel compelled, even though as I've been reading Paul - we are not saved by our works, we're saved by our faith but, through grace. But we still feel compelled to act out our faith. And so I see people involved, that's how I would kind of distinguish - things that people choose to get involved in because they, they feel driven, to do that. They, they feel committed to that. Helping other people is a very... weak way to say it, but that's what it is.

M: ...the motivation for why you're doing it would be the difference between having something that would be mission as opposed to something that would just be a program?

G9: Right. And there's some motivation to help, the motivation to serve and the fact that the individuals that we're reaching out to are not members of our own congregation. They, they are people from the community.

The emphasis on reaching out to others was also reflected in the preaching of the pastors. It frequently challenged people to act out their faith, claiming that Christian faith should make a difference in behavior, as described in the following sermon excerpts.

Christianity says you find life in the midst of the world, or by taking the material gifts God has given and using them for greater purpose. 10/6/96

Jesus is saying that the difficulty is that too often people respond to God's invitation without changing their lives or behavior...Each of today's passages reminds us that the kingdom of God is not something we drift into--it is something which requires a committed response. God offers an invitation to
share in a banquet that is intended for the whole world. Sometimes we become too busy to respond. Sometimes we have forgotten God’s gifts to us and become self-centered or afraid. The one thrown out of the banquet is one who says yes to God’s invitation but does not change his or her behavior. 10/16/96

Colin Greer asked the famous evangelist (Billy Graham), “What is the relationship between love and service?” Dr. Graham immediately quoted Matthew, “Faith without works is dead,” and then went on to say, “We have to try to make things better. We have a great responsibility to our neighbors -- that’s what Christ taught.” 10/27/96

The terms mission and ministry sometimes were used interchangeably by participants. To clarify these two concepts, the researcher through reviewing interview transcripts, observation and reflection identified the following areas of contrast. In general, mission requires raising extra money while ministry is in the budget. Mission has a smaller staff commitment than ministry. Mission has predominantly lay leadership while ministry has both lay and staff leadership. In general, mission occurs outside the church building and ministry occurs inside. Frequently mission involves physical labor while ministry usually does not. In general, mission has distinct time periods for activity while ministry is ongoing and indefinite. In general, task forces are created to plan mission trips while ministry areas have standing committees. Everyone is called to engage in ministry. Not everyone is called to engage in missions. There are some kinds of ministries the church will always have such as music, worship and education. Specific missions will come and go over time. Mission requires the perception of there being another group in need. Engaging in ministry does not always require people in need. Ministry can be using one’s gifts for people who may or may not have a greater
need than your own. You can not have a church without ministry. You could have a church that's not involved in missions, although it could be questioned theologically.

Ways to Understand the Meaning of Health Ministry

Participants did not have a consensus about the meaning of the term health ministry. The diverse attributes and semantic relationships participants expressed in defining health ministry are shown in Figure 10. The wholistic perspective most participants included in their definitions of health was not as prevalent in the definitions of health ministry.

Health Ministry as a Way to Address Health Issues

Participants articulated an understanding of health ministry as a way to address health issues. Some participants emphasized physical health.

G12: When I think about individual churches, you know, health ministries are really narrow focused for me. If I think about the culture, health ministries is bigger. But if I think about the church health ministry, I think about our health committee. I think about doing things that promote awareness of physical health mainly among people - things for the elderly.

Some emphasized the concept of wholistic health.

G8: Health ministry is not only like health when you think of physical health, but health as in mental and emotionally. If people are really hurting emotionally, that is almost as bad as if you know, putting heat and lard (on your skin) by the handfuls physically.
is done by parish nurse

is needed by "wounded birds"

emphasizes wholistic health

emphasizes awareness of health issues

emphasizes spiritual health

includes relationship to God

is an issue of social justice

includes specific activities

could include stress management, wellness center, cancer support

is part of outreach

is part of nurture

Figure 10. Participant identified attributes and semantic relationships of health ministry
And some emphasized spiritual health.

G2: Health ministry means to me that you will use all aspects of health, particularly the mental part of health to help people to understand what kind of Christians they really are, and if they are to be good Christians, they have to have a healthy outlook on humanity...you would help people to acquire those spiritual things which they need to guide themselves to living a better life.

Health Ministry Understood Theologically

Health ministry was also understood theologically. Three of the participants explained health ministry from a theological perspective stating that health ministry involves our relationship with God, is an issue of social justice, and that the church is a place where sick people come to find health. The following comment from K4 identifies how health ministry involves a relationship with God.

K4: (Laugh) You see, so this whole idea of health ministry would be first of all, helping people to understand in a very practical way, who they are. And I think from the standpoint of, of a Christian health ministry, it would be whose (emphasis) they are. In Genesis it says, and we were made in the image of God and formed us out of the dust of the earth and breathed into us, the breath of life. (inaudible) and for the Christian its always a question of not just who I am, but of whose I am is more important than that. I am created in God’s image, I am a child of God and so, because I’m created in that image I have things in connection with God that pertain to my well-being (laugh) you know, integrity is not just, integrity has to do with our well-being. We can not violate our internal code of integrity without serious damage to our well-being. Why, because of whose we are. We were created with some internal mechanism that wants to center us around integrity. (Laugh)

M: That works, that works.

K14: So I think it’d be reminding folks of, or helping them to discover whose they are. The other part of health ministry, I think would be to um, nurture people in their relationship of whose they are. Prayer, exercise, all those things, not disconnected from whose they are.
Health ministry was also seen as an issue of social justice that needed to be looked at from a societal as well as an individual perspective. This perspective, expressed by K6, is consistent with the many different ways in which social justice issues are addressed in this congregation.

K6: I think again people want to put that (health ministry) into a compartment but that statement from the Board of Global Ministries is very important that you can not put health ministry into one compartment. You can't have a healthy person in an unhealthy society. You can't expect people to be well spiritually and morally if the atmosphere around them does not provide some opportunity for them to gain wholeness and wellness. So there's justice issues that are involved in a wellness or a health ministry in terms of how we give people the opportunity to live fully within the church and society.

The etic concept of health ministry understands the church as a place that promotes health. However, is health ministry promoting the health of persons who are already well or promoting the health of persons who are not well? K6 described First Church as a place where sick people come to be healed, not where healthy people come to maintain their well being.

K6: I think there's an underlying issue here that has not been identified but nevertheless is one of the operating principles. We do not see this church as a place where well people come to have their wellness reinforced. We see this church as a place where a lot of sick people (wounded birds) come to find health.

The discussion of how the church promoted the health of individuals confirmed that being part of this congregation did make most of the participants feel healthier.
Health Ministry as Concrete Activities

Concrete activities were commonly mentioned in the definitions of health ministry including what the parish nurse does, programs the health committee sponsors and activities that could be health ministry. The parish nurse and her activities were seen as a major component of health ministry. She was the most visible individual involved in health ministry.

K3: Well in following me around sometimes to get my blood pressure (the parish nurse) is practicing her ministry. I know she contacts all the people who are ill and sometimes they’re not even ill, but there’s somebody she knows hasn’t been here for awhile. She calls them.

G6: It’s sort of a puzzle to me (the term health ministry). It really is. I know that (the parish nurse) is there during the day and I know that she takes people’s blood pressure and I know that you can probably go to her and ask anything. I know that I have gone to her and asked her more than twice about something or other.

The health committee sponsors many different programs that also have a degree of visibility, such as a health fair, health education programs, and flu immunizations that were included in some definitions of health ministry. Considering what health ministry could be was another way participants looked at defining health ministry.

G4: I think of the physical part and I think of having the blood pressure screening and so forth, but I think the church could do better with like I said, more of the mental or the stress related concerns that people have.

Health Ministry as Part of Church Life

Several participants defined health ministry in terms of other parts of church life such as outreach, nurture, and the concern for one another. Health ministry conceived
of as outreach, serves persons who are not church members or constituents. The non-member groups served through the services of the parish nurse and the health committee are persons who are homeless and persons who come to the midweek worship service. The work the parish nurse did with church members was considered nurture.

Health Ministry as Raising Awareness

Some participants saw health ministry as raising awareness of health issues. This idea of “raising awareness” about different issues was frequently heard in the discourse of the congregation.

G9: I think that it’s (health ministry) an opportunity to raise awareness of the importance of health in the church.

One participant saw health ministry as institutional health care ministry and another participant focused on the person who is a health minister. Two participants were not familiar with the term health ministry.

While many participants expressed a limited understanding of health ministry, they easily identified how being part of First Church promoted their health. There clearly were issues of language and how terms were understood. The prevalent wholistic view of health in the definitions of health did not carry over consistently into participants’ understanding of health ministry.
Ways Participants Respond to UMC Definition of Health Ministry

In order to understand how the emic perspective of health ministry compared to the etic perspective of health ministry, the following definition of health ministry from the United Methodist Church (1995) was shared with each participant.

“Local churches can help address the need for more appropriate and accessible health care services and the inadequacy of our health care system. More importantly, the church can bring a wholistic perspective to a community’s understanding of health; one that integrates body, mind and spirit in congregations and communities, promoting prevention and wellness. The church, therefore is a strategic place where all elements of health and healing can be discussed. Here people can learn and be nurtured.”

Participant responses to this definition connected it to what was currently happening at First Church, highlighted parts of the definition and/or critiqued the definition. Participants identified plans for a wellness center, health education articles in the church newsletter and reaching out to seniors as existing components of health ministry reflective of the UMC definition.

Several participants related the definition to what was not happening in this congregation.

G2: Well I think that’s wonderful - what you have read to me but I do not see that occurring in this church.

G9: Well I don’t think we’re purposeful about any of this without being critical.

Parts of the definition participants identified as significant were the importance of nurture and the wholistic perspective of health. As K6 explains,” understanding the church as a place where people can be nurtured is really important.”
In giving a critique of the definition, participants used terms such as lofty, articulate and something to shoot for, recognizing that everything cannot be done at once. The following critique of the definition questions its emphasis.

G11: The first part seems to say that local churches can provide health care that the existing health care system isn’t providing, and I find it odd that the idea of - I don’t know what John Wesley would think of the idea of it’s more important to help the community get a holistic perspective on health than it is to help sick people. I don’t know, I mean I think that’s an acknowledgment of the reality that health care is becoming institutionalized and specialized and professionalized beyond the capacity of the local church. To simply develop a program around the Practical Physick, I think that’s a concession to the reality I was describing, which is not to say it’s not important, but to say it’s more important to change or to correct a community understanding of health, I find that interesting. Since this is dealing at what I assume to be theoretical level...I think another, a better way to say that might have been, “But in reality all we can do today is bring a holistic perspective, all that we can do at a church level is bring a holistic perspective to communities understanding of health.” And, it doesn’t say anything about what to do.

Another participant identified a difference in how health ministry was understood for members of the church as opposed to persons outside of the membership. The physical component of health was seen as the issue for the rest of the world, while spiritual and mental health were seen as the issue for this congregation.

G12: I think we assume that, at least in this church, that most of us have the resources to take care of ourselves physically, and what we need is kind of the ummph to pull ourselves together spiritually and emotionally (laugh) and then help the rest of the world pull themselves together physically, I guess.
Consequences of Ministry

The purpose of First Church was to be engaged in ministry within the city. This ministry produced several consequences. One consequence of ministry was to nurture people in faith development. Promoting the health and well being of members could also be seen as a result of ministry. Participants’ perspectives on these consequences were addressed in the section on individual context. The caring community created through the ministry of First Church was consistently identified in the discourse of the participants and is discussed below.

Ways the Congregation Cares for Members

Care of members is a central activity of any culture, and a central theme of nursing, as well (Leininger, 1991). The care of members and constituents was a primary purpose of First Church’s ministry. Participants identified experiencing care through relational experiences and specific activities. The primary way participants experienced care was through interpersonal relationships which connected members with each other and cultivated a sense of belonging. The overall relational atmosphere of the church was perceived by participants to be caring. Figure 11 provides a taxonomy of the experience of care within First Church. The following participant describes some of the ways in which care was expressed.

G9: I think the way we're faithful about hospitalizations, birthdays, deaths all of that in the (church newspaper), all of that in pulpit announcements. It's really amazing to me how there really is kind of a small town (laugh) feel... I think there is a great deal of caring and community.
Figure 11. Taxonomy of care for congregation members.
Participants identified small groups as a place where caring relationships were cultivated. Being a large congregation, small groups provided a more intimate sense of connection than could be found through worship participation. Some of the small groups participants referred to were Sunday school classes, Disciples classes (a year long study program), Lenten studies (happening once a year during Lent) and covenant groups. In the following quote, K5 discusses the importance of small groups in nurturing caring relationships.

K5: I think it's (the caring) really special at First Church. It gives people a place to talk about some of their real deep concerns about their faith about their expanding of their faith and I think that absolutely happens at First Church.

M: And where do you see that happening most? In what kinds of groups or experiences?

K5: In small groups as you begin to know one another.

Two key groups of some size were identified by participants as caring communities within the church. The first was the United Methodist Women (UMW), a women's group supporting missions and consisting of predominantly older women. The second group was the fellowship of persons from the Philippines that has different social and service projects. Both of these groups also have their own Sunday School class.

For those persons who choose to and are able to, participation in small groups can be an important caring connection. People who do not participate in small groups, either because of choice or because of circumstance, were believed to have a lesser
sense of connection to the congregation. The pastor estimated that sixty percent of the people do not belong to any group. One key fellowship group that several participants mentioned was the choir, that is it's own small community within the church. The following participant describes the care and concern experienced as a choir member.

G8: Like I know the choir, somebody's not there on Wednesday night we're all going where's so and so and why aren't they here and you know.

M: And does somebody call?

G8: Well... people call on each other and people check on each other and ...it's really nice because people are very close like that but if you're not in those kinds of groups I think you sort of get lost in the shuffle.

There were some specific acts of individuals or programs of the church that were seen as communicating care. The staff were key individuals to communicate caring through their behavior at times of need. The parish nurse was also singled out as communicating caring through her interactions. Two other groups of people identified as communicating caring were the ushers and the greeters.

Other ways individuals cared for each other was through prayer, phone calls, visits and sending cards. Collections were sometimes taken for individuals with specific needs. Specific programs such as those that work with the elderly were also identified as ways this congregation cares.

Worship was one major cultural event where participants experienced caring. Worship brings the largest number of members and constituents together, providing a time for connection with God and others which also fosters an experience of caring.
The sacraments, such as communion, were also mentioned as creating a sense of community and belonging. The following participant, when discussing the caring of this congregation, highlighted the worship experience.

G4: People who do come to church really get a lot out of the sermons and I think there's a lot of practical application to what's preached here. One of the things that I like about the sermons is that they aren't boring and you won't fall asleep.

First Church had people regularly joining and leaving, which made finding a sense of community and belonging important. Creating a sense of community and belonging was an important way that the congregation nurtured caring. A sense of belonging to the community of this congregation was expressed as coming from the relationships that were possible including adopting a family of choice, working and serving with others, knowing many people and feeling needed. The following quote identifies where K2 found a sense of belonging.

M: Now for you personally, what makes you have a sense of belonging. What makes you feel a part of the community that you really belong?

K2: Since they knew me, almost all of the members knew me, before they kind of welcome me. So and then I became involved...otherwise even if you are coming and they don't show any friendliness you know the tendency is not to come any more. And the friendliness of the people (pause)

M: Makes you feel good?

K2: Yeah, so belonging that's an important feeling. To belong to the organization because they make you feel that you belong because they are eager... to see you.
Being active in the congregation was seen as strengthening the sense of belonging and the opportunity to experience care through greater connections.

G4: Well I'm in everything

M: That might do it. Does that make you feel as though you belong?

G4: Oh yes it does. I feel like I know everybody in this church. I've... had so many different roles that by doing that I've met a lot of people. And so being involved and getting to know people makes me feel connected.

While participants were consistent in identifying the caring nature of First Church, several participants talked about personal experiences that did not meet the usual standards of caring at First Church. One area several participants mentioned where caring fell short was with elderly members who were no longer able to come to the church. Inactive members are another group participants identified for whom caring was an issue. Through a survey of inactive members, it was identified that some people felt they were only contacted when money was needed. In response to this issue, a program of reaching out to inactive members was established, for the sole purpose of caring.

Ways the Congregation Cares for Non-members

Both people who are members and people who are not members are important to the life of First Church. People who are not members are the focus of many of the outreach and mission activities, and as such play a role in the life of the congregation. People who are not members of the congregation are cared for through specific
programs offered including mission trips, the parish nurse, evangelism committee, homeless program, concerts, shelter committee and educational programming. The congregation also cares for non-members through participation in cooperative programs with other organizations, through providing services to persons who are homeless, parish nursing services, pastoral counseling and the Marcy Newberry Center.

Some of the ways the congregation supports the care of persons who are not members is through financial support, members and staff serving on boards and providing space. There are frequent opportunities for people to donate to different causes brought to their attention by individuals or groups within the church. Both staff and members of the church serve on the boards of many community agencies. The church also makes space available to a wide range of organizations whose goals are compatible with those of the church.

Themes

Themes are the final level of synthesis in creating an ethnography which connect one or more domains (Spradley, 1979). Taken together, the themes constitute the worldview of the culture as reflected in this ethnography. In considering the five major domains in this ethnography, the following themes emerged through the analysis and synthesis of the findings.
1. The Christian faith requires an active, caring, connecting engagement in the world.

This theme, significant in all five domains, was evident in the ministry of First Church. The caring among members was part of an active connecting engagement. It was demonstrated through reaching beyond the congregation in connecting engagement with the city, state, country and world, often referred to as missions. Health ministry was initiated at First Church because of the active connecting engagement of the parish nurse. This theme is also consistent with the UMC statement on social responsibility. It was evident in the financial and personnel support that church members and constituents have provided for many charities and social service agencies.

2. God's world is diverse so God's church should be diverse too.

This theme on the value of diversity was consistently articulated by members and staff as something that was important to this church and also made the church unique. It was significant in all five domains. The ministry of First Church connects members with other members of diverse ages, ethnicity, gender, sexual orientation and theological beliefs. This theme was also evident in the diversity of activities within which health ministry had to fit.

3. Individuals experience positive benefits from being a member of First Church.

Being an active member of First Church was seen as beneficial in the caring, connections, beliefs and health promoting experiences it cultivates. Being part of a caring community was a positive benefit. In addition, the tenets of the Christian faith in
practice and belief had many positive benefits. These positive benefits were reflected in the domains of individual context, the community context and ministry. Participants also saw involvement in the church as creating positive health benefits.

4. **First Church has a unique position in time (heritage) and space (urban, downtown, commercial building) that requires a unique approach to ministry.**

First Church has a strong sense of heritage and its place within the denomination, the city, state, nation and world, which is exemplified in the context of tradition and ministry. Identifying this church as unique occurs every Sunday when visitors are invited to participate in a tour of the church. For some individuals the uniqueness was an important and desirable part of their experience at First Church. This theme is not currently reflected in health ministry at First Church, but it has the potential to be incorporated.

**Summary**

Leininger’s (1991) theory of cultural care diversity and universality provided a useful cognitive map for exploring the culture of First Church. The Sunrise Model served as a treasure map, giving clues of where to hunt for treasures of cultural knowledge. This framework, utilized in conjunction with ethnography as a research method and Spradley’s (1979) methods of collecting and analyzing ethnographic data, yielded a rich description of the culture of First Church, as well as the emic perspective on health and health ministry.
The findings from this ethnographic study reveal an articulate group of people who bring their individual experience and understanding to membership in the community of First Church that shares certain values and is rooted in a particular historical context. The organization of the church reflects the cultural contexts and supports the ministry in which the congregation engages.

Health ministry is a part of First Church, yet it still is understood as a separate instead of an integrated component of the whole. The word health ministry itself seemed to put health into a box for participants rather than allowing them to see it permeating the life of the congregation. Participants knew that being part of First Church was good for their health. However, they did not gain this knowledge solely through what they identified as health ministry. They knew that being part of this congregation was good for their health through the whole fabric of their experience.
CHAPTER VI
DISCUSSION

Walk in all the ways I commanded you, that it may be well with you. Jeremiah 7:23

The ultimate purpose of nursing research is contributing to the knowledge base of nursing science. This ethnographic study on health ministry in the life of a congregation with a parish nurse offers knowledge that will strengthen nursing practice in working with congregations. The purpose of this chapter is to create the connections between study components, summarize significant findings, relate them to the conceptual framework, discuss study implications, identify strengths and limitations and the potential for future research.

Significant Findings

Significant findings from this study are connected to the four research questions framing the study and the four themes that emerged from the findings. The primary concepts from the literature review of health ministry, parish nursing, healing and congregational culture are discussed in light of the study findings.

Research Questions

The following discussion highlights the findings by research question. These findings integrate the domains and themes which emerged from analyzing and
synthesizing the data.

1. How does health ministry reflect the worldview and cultural care values of a congregation with a parish nurse?

   The worldview and cultural care values of First Church were understood through analyzing the domains of individual context, community context, historical context, organization and ministry. Four ethnographic themes were discovered. Table 12 outlines how these cultural themes were reflected in health ministry. The first theme, identified as "The Christian faith requires an active, caring, connecting engagement in the world," was reflected in the role of the parish nurse, a key component of health ministry. As an individual, the parish nurse was putting her faith into action. Others who supported health ministry, particularly the health committee, were putting their faith into action as well.

   Health ministry reflected an emerging pattern of cultural care with the parish nurse who was supported by the health committee, being concerned about the well-being of members and constituents. The people within and outside of the congregation who participate in health ministry activities have the opportunity to experience a caring, connecting engagement. Health ministry also reflects a cultural care value of enabling people to engage in ministry to which they feel called.

   The congregational culture values diversity in race, ethnicity, age, gender, sexual orientation, and theological beliefs. As a consequence of cultivating a diverse congregation, diverse activities are also cultivated. Members and constituents have a
wide range of activities in which to participate with groups competing for their attention and involvement. The diversity of activities presents a challenge for any one area trying to gain congregational support.

<table>
<thead>
<tr>
<th>Table 12</th>
<th>Cultural themes reflected in health ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>How Reflected in Health Ministry</td>
</tr>
</tbody>
</table>
| 1. The Christian faith requires an active, caring, connecting engagement in the world | * Parish nurse and health committee are putting faith into action  
* For people who use the services of the parish nurse, they experience a caring, connecting engagement with the congregation as a result of her faith in action  
* Health ministry programs, an example of faith in action, reach out to people beyond the membership creating a caring, connecting engagement |
| 2. God's world is diverse, so God's Church should also be diverse | * Diversity of activities/groups competing to get the congregation's attention, in addition to health ministry |
| 3. Individuals experience positive benefits from being a member of First Church | * One positive benefit is caring, which is communicated in the 1:1 interactions with the parish nurse  
* Another positive benefit is promoting one's health, that is experienced through both extrinsic and intrinsic health ministry |
| 4. First Church has a unique position in time (heritage) and space (urban, downtown, commercial building) that requires a unique approach to ministry | * Not currently integrated into health ministry  
* Utilizing pamphlet on "First Church as a Place of Health" could incorporate this theme |

Participation in the life of First Church is seen as having positive benefits. Two areas of positive benefits were revealed in this study. The first positive benefit is being part of a caring community. Individual interactions with the parish nurse, which are part of health ministry, were experienced as one way of caring. The second benefit of participating in the life of the congregation was promoting one's health. Participants identified that their health was promoted through specific health ministry activities as
well as the psychosocial and spiritual consequences of congregational life.

2. What are the patterns, meanings and expressions of health ministry in a
congregation with a parish nurse?

Two forms of health ministry, which promote health were found in this study. The researcher identified the first as extrinsic health ministry. This included activities whose identified purpose was promoting health. Activities participants identified within extrinsic health ministry included parish nursing services, health programs, health fairs, flu shots and CPR training. For some participants, the extrinsic health ministry was not meaningful because it did not connect with their lives. For participants who did connect with the extrinsic health ministry, it meant a way of nurturing members and reaching out to persons outside of the membership.

The second form of health ministry the researcher identified as intrinsic health ministry. This included activities and experiences that promoted health, although their primary purpose was something other than promoting health. Patterns and expressions of intrinsic health ministry were connected with the psychosocial spiritual consequences of participation in congregational life. The meanings of intrinsic health ministry were found in being part of a caring community, cultivating a positive attitude, engaging in challenging experiences, promoting spiritual health and consequently mental health, providing guidance for life issues and offering enjoyable experiences.

The health promoting benefits of intrinsic health ministry are consistent with what is documented in both the research and descriptive literature. Research literature
looking at religion and health has showed positive health outcomes associated with religious participation (Matthews, Larson & Barry, 1993). Two descriptive articles, Evans (1995) and Solari-Twadell (1997) discussed the health promoting qualities of worship, which was supported by the comments of participants.

3. What is the emic (insider) understanding of health ministry in a congregation with a parish nurse?

The emic understanding of health ministry was diverse. For some study participants, health ministry was not particularly meaningful. For others, it was a rich concept. Several participants expressed an understanding of health ministry from a theological perspective that included relationship with God, an issue of health and the church being a place where sick people come to find health. Most participants focused on the concrete activities of the parish nurse and specific activities of the health committee with health ministry seen as a way to address health issues.

4. How is the emic (insider) understanding of health ministry similar and/or different from the (etic) understanding of health ministry?

A definition of health ministry from the United Methodist Church provided an etic perspective for participants to compare to their own perspective. In responding to the etic definition, participants considered the specific context of First Church, rather than a general conceptual perspective. Some saw the etic definition as reflecting what happened at First Church and others felt that it did not reflect their experience. Critiques of the etic definition described it as lofty and something to shoot for.
This study began with a conceptualization of health ministry shown in Figure 1 (p.5), which represented the etic perspective of the researcher. In light of the findings on the emic perspective of health ministry, this figure was revised changing the central tenet to “A church reaches out through its ministry, which includes a health ministry, to its members, the community and the world, caring and connecting through Christ, which promotes health.” The remaining components of the figure that included body, mind, spirit interaction and individual, community and world connection, were supported by the emic perspective (Figure 12).

Similarly, the researcher’s definition of health ministry was revised as follows.

*Health ministry is the intentional reaching out to others by a church that promotes health. Health is understood as harmony with self, others, the environment and God. The motivation for health ministry comes from a shared understanding of the call to wholeness as illuminated in Christian tradition. Health ministry includes the intrinsically health promoting qualities of a congregation and health services provided with the support of a health professional. Health ministry respects the culture in which it is expressed, recognizing individual and community responsibility for health among those it serves (Chase-Ziolek 12/97).*
Figure 12. Revised graphic representation of health ministry. Chase-Ziolek 11/97
Findings Compared to the Literature

The literature review provided background information for creating this study. Literature on health ministry, parish nursing, healing, churches as partners in health promotion, congregational culture and the conceptual framework from Leininger's (1991) theory of culture care diversity and universality was reviewed. The study findings both supported and conflicted with the literature as described in the following discussion.

Health Ministry

Four areas were identified in the health ministry literature: understanding the meaning of health, motivation for health ministry, actualizing health ministry and health promoting qualities of congregational life. The participants in this study spoke only about health ministry activities and the health promoting qualities of congregational life. Most participants did not speak about expanding their view of health or the motivation for health ministry.

Health ministry is a term that emerged as professionals in health and pastoral care talked about how congregations could be involved in promoting health. The review of the literature, summarized in Chapter II, Table 1 provides a wide range of formal definitions of health ministry. The term health ministry was not one that was particularly meaningful to the participants, except to the parish nurse and the pastors. The term itself seems to separate health ministry into a discrete area of ministry rather than integrating it throughout the life of the congregation. While the term health
ministry was not meaningful to many people, the congregation as a place that promotes health and wholeness was meaningful.

Theologians are one source for the etic perspective on health ministry. According to Tom Droege, who has written extensively on health ministry (1992, 1994, 1995), everything a congregation does is related to health when health is understood wholistically with all contributing factors identified. Paul Tillich (1984) writes of salvation, as the restoration to wholeness, being health. Most participants, with the exception of the parish nurse and one pastor did, not articulate these concepts articulated by theologians. The people in the pew at First Church do not conceptualize everything the congregation does as related to health.

The literature looking at the meaning of health also discusses the purpose of health. From a perspective of faith, one pursues health not only as an end in itself, but because it enables one to do God's work of serving others (Droege, 1994; Hilton, 1990; United Methodist Church, 1995). This was affirmed by one participant who identified health as "enabling ministry."

The literature describes transforming a congregation's understanding of health as an important developmental part of health ministry, (Droege, 1992; Association of Brethren Caregivers, 1993; Peterson, 1995). This had yet to occur on a congregational level at First Church. For the purpose of presenting study findings to interested persons in the congregation, the researcher created a pamphlet "First Church: A Place of Health," (Appendix H) that summarized study findings on extrinsic and intrinsic
health ministry in a form useful to lay persons. Thirty five people attended the presentation and confirmed the findings as articulated in the pamphlet.

The last Sunday the researcher attended services at First Church during the study period was Health Promotion Sunday. This was the first time since the parish nurse and the health committee were initiated that health was identified as a focus for worship. However, in keeping with the theme of valuing diversity at First Church, it was also Hispanic Sunday and included recognition of a Mason lodge. The literature on health ministry does not talk about how to integrate health ministry into the life of a congregation with many diverse agendas.

The Health Ministries Association (1995) identifies specific activities of health ministry, in addition to providing a conceptual framework. Similarly, the participants in this study connected health ministry with the specific activities of the parish nurse and the health committee. Language shapes and reflects our experience of reality. Our language both enables and inhibits our ability to communicate. (Hall, 1976; Leininger, 1991). In some ways, for this congregation, the term health ministry compartmentalized health to the purview of a specific committee and the parish nurse. This is contrary to the wholistic health movement (Westberg, 1990) that came out of a need to bring the components of health together.

At one time, health was understood as an inseparable whole. Because our language and our experience separated the components of health, we then required the adjective wholistic to bring it all together. This has also been true for health ministry.
At one time, health and healing were implied in ministry (Kelsey, 1995). Because the meaning of health and healing were removed from ministry, we now need to add the adjective health to ministry. Our language has lost some of the meaning of health as being an inseparable part of ministry.

Parish Nursing

The roles of the parish nurse at First Church involved functioning as a health educator, personal health counselor and community liaison to resources. She was also a role model of the interrelationship between faith and health. This was consistent with the roles identified by Solari-Twedell and Westberg (1991), with the exception of coordination of volunteers. This may be related to the fact that the parish nurse is herself a volunteer. Consistent with the field study discussed in Chapter II, participants could distinguish between parish nursing and health ministry. The parish nurse was understood as a component of health ministry.

Healing

Kelsey (1995) discusses the changing patterns throughout history of the involvement of churches in healing. First Church had a period in the late 1800's and early 1900's when they were actively involved in a ministry of healing. This was done through the development of deaconess training at the Chicago Training School and the associated forty health and social service agencies that emerged nationally from this
school (Brown, 1985). Droege (1994) identifies that one third of the gospel stories involve healing. Periodically the sermons at First Church were based on a scripture story of healing. One worship service during the study period, a Longest Night Service, focused on healing from an emotional and spiritual level. Participants did not identify healing as a focus of contemporary life at First Church.

**Church as a Partner in Promoting Health**

One of the most interesting findings from this study which emerged in the participants’ own words was how being part of First Church promoted health. The research that has identified a positive association between participation in religion and health (Strawbridge et al., 1997; Koenig et al., 1997; Ellison, 1991; Ferraro & Koch, 1994) has not asked the participants why they think religious participation promotes their health. This study showed that people identified their experience as part of First Church as health promoting and were able to articulate the reasons why. Strawbridge et al. (1997) postulate one of the reasons for the difference between persons who attend religious services and those who do not may be a philosophical outlook attendees experience that values social ties and treating one’s body with respect.

This study can affirm the value on social ties, but can not affirm the idea of treating one’s body with respect because of religious beliefs. This study also found a health promoting effect in the philosophical component of attitude towards life. Participants in this study identified that being part of First Church cultivated a positive
attitude that made them look at life and handle stress differently. The benefit of a positive attitude cultivated through religious participation, which was not identified by Strawbridge et al. (1997), was included in the work of Ellison (1991). Ellison's study found that persons with strong religious faith have greater satisfaction, greater personal happiness and fewer negative psychosocial consequences from difficult life events, all of which are consistent with the findings from this study.

Thomas et al. (1996) identified characteristics of Black churches that had health programs. They found that education of the pastor and lack of building debt were positively correlated with having community health programs. Although a multiethnic congregation rather than predominantly Black, First Church has a pastor with a doctorate and does not have building debt which would support the church being a likely candidate to have community health programs.

One of the weaknesses in the research on religion and health has been utilizing the etic rather than the emic perspective to study the phenomenon. Researchers are trying to identify what the important measurable variables might be. The answer might be found if more ethnographic research were done with congregations, asking persons who attend regularly how this behavior promotes their health.

**Congregational Culture**

Consistent with the literature on congregational culture (Carroll et al., 1986; Dudley & Johnson, 1991), First Church functions as a culture with a distinct style and
worldview. The concept of a congregation as a system (Parsons & Leas, 1993a) was supported in this ethnography. Utilizing the self-images of Dudley and Johnson (1991), First Church could be described as a Crusader Church that has dynamic leadership and takes on causes. First Church also has components of being a Pillar Church that has a strong sense of civic responsibility to a specific community.

**Conceptual Framework**

The process of creating this ethnography and the understanding it generated supports the value of gaining cultural understanding when working with a group of people who are in relationship with each other. A cultural perspective enables a nurse to focus activities in effective ways for that group. This is congruent with Leininger’s theory of culture care diversity and universality (1991, 1997) which emphasizes the importance of cultural knowledge for nursing practice. Cultural knowledge was discovered through utilizing the Sunrise model as a cognitive map for studying the culture of First Church.

Wenger’s (1991) concept of high context and low context culture related to Leininger’s theory is also relevant to this study. First Church would be characterized as a low context culture, with flexible boundaries and rapid cultural change. As nursing studies cultures in a broader sense than specific ethnic groups, the concept of context will be increasingly important.
Implications for the Congregation

The implications of this study for health ministry at First Church focus on how to provide culturally congruent care, which is one of the final components of Leininger’s Sunrise Model. The following are thoughts on how the findings from this ethnography could be used to continue developing health ministry in ways consistent with the congregation’s culture. These comments assume that the staff, parish nurse and health committee desire a more thorough integration of health ministry in the life of the congregation.

- Because worship is the central cultural activity and the most public place where values are transmitted, images of health, healing and the role of health ministry in the life of the congregation would need to be highlighted in worship, in preaching, the sacraments, music with themes of health and healing, announcements and service emphasis.

- Although the ministry of the congregation is divided into areas such as Christian education, outreach and evangelism, if health ministry were to be integrated throughout the life of the congregation, the health committee would need to work cooperatively with all ministry areas of the congregation and not function solely independently. Specifically, the work of the outreach committee on issues with public health impact such as domestic violence and world hunger could easily be integrated with the health committee.
• The strong congregational value on faith in action could be highlighted to engage members and constituents who are health professionals in a direct service health ministry, if there was a need. This congregational value on missions could be used to make health ministry a cause. Emphasizing health as enabling one to better serve others would be congruent with this value on faith in action.

• Because of congregational demographics, which includes a growing number of single professionals in their 30's and 40's who are active in lay leadership, the needs of this group for health promotion should be identified and addressed in addition to current health ministry initiatives. This would help to cultivate support from this key lay leadership group.

• The strong sense of Methodist heritage at First Church and John Wesley's work with health could be incorporated into educational programs on the role of health in the church.

• Because increasing awareness is valued by this congregation, distributing the pamphlet created by the researcher on First Church as a Health Place could be used to increase awareness of the church as a place of health and healing. The purpose of the pamphlet, which was well received by the congregation, was to acknowledge the many ways that First Church promotes health.
Implications for Nursing

It is reasonable to assume, based on the growth of parish nursing and the interest of the public health community in working with congregations, that there will be an increasing number of nurses working with congregations as health ministers, parish nurses or in other community health nursing roles. This study shows the value to nursing of studying a congregation as a culture. This knowledge could be used to integrate an ethnographic approach into congregation/community assessment. This would help move nursing practice beyond getting facts and naming needs, to understanding the meaning within which those needs exist.

The most valuable implication of this study for nursing practice is demonstrating the usefulness of ethnography in creating a knowledge base for providing culturally congruent care for a congregation. The concept of culturally congruent care is one of the most valuable contributions to nursing from Leininger’s theory of cultural care diversity and universality (1991, 1996, 1997). When nurses are working with groups of people, they need to understand the culture of the group in order to provide meaningful care. For example, when working with churches, prayer is one generic health belief that would commonly necessitate recognition.

As nursing works toward Healthy People 2000 and its goals of healthier lifestyles (DHHS, 1991), congregations will be key players in creating healthy communities (Mason, 1990). Congregations are part of the expanding concept of healthy communities as new partnerships are being created to promote health
(Scott, 1990; Knaist and Sidel, 1995). In order for nurses to work with congregations in partnership, the strengths and limitations of congregational cultures need to be understood. Partnerships need to be careful not to add health activities to a congregation without understanding how health can and does fit within a congregation.

There is one caution for nursing regarding work with congregations. As both this study and the literature show, congregations have some naturally occurring health promoting qualities that do not require intentional health ministry. John McKnight (1995), in his book The Careless Society, talks about the professionalization of care that has weakened the natural ability of communities to care for each other and deal with problems. Caution must be taken when adding a professional health component to a congregation, either with a parish nurse or other community health nursing role, that the congregation’s natural health promoting qualities are not weakened by making health strictly the territory of the nurse.

**Strengths and Limitations**

The strength of ethnography is its ability to discover the emic perspective on the topic of interest. Utilizing ethnography for this study provided a broad perspective on the emic perspective of congregational culture and health ministry. The diverse sources of ethnographic information was another strength. In addition to field notes and transcripts from audio taped interviews, the congregation produced a great deal of printed material. Written copies of sermons were available. A weekly newsletter was
published. Bulletins and handouts were another source of written information. All of these written materials helped to augment the primary sources of data.

Fourteen months, the length of time spent in relationship with First Church to gather information, was another strength. The final strength of the study was the ability of the participants to articulate and reflect on the culture and values of their congregation. This ability for reflective insight created rich data. This was a group particularly well suited to a research method that required articulating cultural insight.

The major limitation of the study related to the selection of participants. An intentional decision was made to seek out and interview people who were active in the life of the congregation. This decision was justified because it was felt that they would be the most knowledgeable about the congregational culture and health ministry. However, there are a number of members of the congregation who are not active. It is possible that they might have offered a different perspective.

Another decision was made to utilize a word processing program for managing the data, rather than software specific to qualitative research. This decision was justifiably made on the basis of computer capacity and the challenge to the researcher of learning a new software program simultaneously to learning a research method. While this approach was adequate for the purposes of the study, it did become awkward as the database grew.

As is always the case, the questions asked shape the information received. Focusing on the concept of health ministry rather than how the church promoted health
boxed people into a term that was not universally meaningful. Inadvertently, the researcher’s etic perspective was imposed on the process of inquiry by using the term health ministry. If this study were replicated, it should focus on talking with people about how the church promotes their health, rather than what health ministry means to them. Because the term health ministry is not well known in the general population, it would be beneficial to talk with participants about the components found in definitions of health ministry, rather than using the specific term. Health ministry has yet to become an emic term at First Church. How being part of First Church promotes one’s personal health, however, is part of the emic perspective.

Future Research

The research questions that shaped this ethnographic study are sufficient to fuel a program of research systematically seeking to identify the universal and the diverse patterns of health ministry. Ethnographic studies in a variety of congregations would, over time, provide an understanding of how health ministry fits into the life of diverse congregations, revealing any patterns that might exist by denomination, ethnicity, size of congregation or other factors. It could also reveal the meaning of addressing health issues from a faith perspective. This qualitative research base could be used to develop congregational assessment tools and guidelines for nurses working with congregations that would help reveal significant cultural factors. Such a program of research would provide invaluable information to assist nurses in providing culturally congruent care.
This research study explored how health ministry fit into the life of a large, multi-ethnic United Methodist Church with a volunteer parish nurse. Consistent with Leininger’s theory of culture care diversity and universality, which seeks to explore both diverse and universal aspects of cultural care, repeating the study with a different congregation for comparative purposes would be beneficial. Comparisons could be done with different ethnic groups or with different denominations. For example, it would be interesting to repeat the study in another large United Methodist Church that had a predominantly African American membership. Another possibility would be repeating the study with another large, multi-ethnic congregation from a different denomination. Comparisons could also be done between congregations with different manifestations of health ministry such as volunteer or salaried parish nurses.

One of the most interesting results of this study was how people described being part of First Church promoted their health. It is important to expand this to a larger scale, learning in people's own words, and from their own experiences, how being part of a congregation makes them healthy. This would be a beneficial adjunct to the current effort in medical research to measure the impact of religion on health.

Conclusion

The conceptual framework of Leininger's theory of culture care diversity and universality, and the methodological tools of ethnography, created an understanding of
health ministry in the life of a congregation with a parish nurse. Three essential concepts of caring, connecting and Christ were interwoven throughout the ethnography. First, this congregation has a self-image of caring for its members. While the membership, by some standards would be considered large, there is a core of active members who experience the caring characteristic of a small town. Specifically, in the area of health ministry, caring was experienced in the interactions of the parish nurse with individuals. For some members, the care experienced through being part of small groups within the congregational culture was health promoting. There is a cultural theme that being an active part of First Church has positive benefits. Two of these benefits are the experience of being cared for and the experience of one's health being promoted in a wholistic fashion.

Second, the concept of connections is significant for First Church, and for the United Methodist Church as a whole. The cultural theme of putting one's faith into action creates connections on a congregational, local, state, country and world level. The cultural value of diversity creates connections among diverse people, who might not know each other if they were not part of the same congregation. The cultural theme of being unique in time and space is reflected in the multiple levels of connections at First Church. Health ministry activities create connections between members of the congregation and with persons outside of the membership. For some members, the general experience of feeling connected with diverse persons in diverse locations is experienced as health promoting.
Finally, belief in Christ is a fundamental part of the culture of First Church. This belief is a focal point of the congregation’s overall ministry, which most participants identified as promoting their health. It was also a personal focal point for the parish nurse in her service.

There are many important roles for nurses in health ministry. Nurses involved in health ministry may help to co-create and share the vision of what health ministry can be for an individual congregation or for all congregations. Nurses may collaborate with congregations, creating partnerships to develop health ministry programs. In addition, nurses may provide health ministry services, functioning as health ministers or parish nurses within a congregation. Furthermore, nurses may empower others, training and supporting them in their ability to participate in health ministry. No matter what health ministry role(s) nurses play, it is important to be sensitive to the culture of the congregation in order to provide culturally congruent care for individuals or groups.

Nurses will continue to have opportunities to work with congregations in many capacities. As a knowledge base is built for this relatively new site and more importantly for this unique role in community health nursing practice, new and creative ways are needed to understand the dynamics of congregational culture. This will enable nurses to provide culturally congruent care while working to empower congregations to maximize their intrinsic health promoting qualities.
APPENDIX A

RESEARCH ON RELIGION AND HEALTH
## Appendix A
### Research studies: Effect of religion on health

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Koenig, Hayes, Larson and Blazer (1997)</td>
<td>Wave III in longitudinal study; Random sample N=2,569 1,727 participants 65 and older</td>
<td>Demographics ADL scales CES-D depression scale; Negative life events, Religious attendance, Laboratory</td>
<td>Home interviews Blood draw Logistic regression</td>
<td>Some support for hypothesis that persons who attend religious services regularly have a better immune system. There was a weak relationship. Results may be affected by regional culture of religious attendance.</td>
<td>Large sample; Part of longitudinal study; Multiple measures; Multiple comparisons not made</td>
</tr>
<tr>
<td>Attendance at religious services interleuken -6 and other biological parameters of immune function in older adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strawbridge, Cohen, Shema and Kaplan (1997)</td>
<td>Longitudinal N=5,286 Mean age 1965=39.8 1994=65.3 52.8% female 12.7% Black</td>
<td>Survey</td>
<td>Response rates analyzed for four surveys from 1965, 1974, 1983, 1994 Multiple logistic regression Cox proportional hazard models</td>
<td>Frequent attenders of religious services had lower mortality rates than infrequent attenders. P=.05 Females had a stronger result. Adjusting for health status or social connections did not change results. Adjusting for social connection plus health practices and body mass index made results slightly below statistical significance p=.08</td>
<td>Large sample; Longitudinal data adds depth and reliability; Can not determine cause and effect relationships</td>
</tr>
<tr>
<td>Study</td>
<td>Design/sample</td>
<td>Instruments</td>
<td>Procedure/ analysis</td>
<td>Outcomes</td>
<td>Strengths/weaknesses</td>
</tr>
<tr>
<td>-------</td>
<td>---------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Ferraro &amp; Koch (1994) Religion and health among Black and White adults</td>
<td>Multistage area probability sample design; National survey Full survey N=3,617 Subset N= 2,560 Af Am=889 Caucasian=1,671 Mean age=47.55</td>
<td>Survey Subjective health Health problems Activity limitations Religious practice Religious identity Religious consolation Socioeconomic status</td>
<td>Data analysis of existing national survey Regression t-test</td>
<td>Blacks and Whites benefit equally from social support. Blacks more likely to turn to religion when experiencing health problems. Religious practice is associated with better health for Blacks, but not for Whites.</td>
<td>Through literature review; Reliability discussed; Comparison useful Procedure for survey unclear</td>
</tr>
<tr>
<td>Ellison (1991) Religious involvement and subjective well-being</td>
<td>Cross-sectional N=948 Protestant 28% ModerateProt.16% Liberal Prot. 8% Non-denominational Protestant 4% Catholic 26% Mormon 3% JehovahWitnes 4% No preference 9%</td>
<td>General social survey</td>
<td>Data analysis of existing national survey Regression</td>
<td>Religious belief enhances cognitive and affective perceptions of life quality. Religious faith buffers negative effects of trauma on well-being. People with liberal non-traditional and non-denominational Protestant ties have greater life satisfaction than unaffiliated individuals. Effects of religious attendance and private devotion are indirect.</td>
<td>Broad religious representation Large sample size National sample Gender, age and race not specified Reliability not identified</td>
</tr>
</tbody>
</table>
### Appendix A
Research studies: Effect of religion on health

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walls &amp; Zarit (1991) Informal support from Black churches and the well-being of elderly Blacks</td>
<td>Descriptive/exploratory</td>
<td>Social provision of support scale Social support resource Dimension of religion scale Social integration of the aged in the church scale Philadelphia Geriatric Center morale scale</td>
<td>Interview Descriptive statistics MANOVA, ANOVA Regression</td>
<td>Perceived overall support from churchpredicted well-being. Religiosity and involvement in organized religious activity did not predict well-being. Family network perceived as more supportive than church network.</td>
<td>Multiple measures Reliability identified Family and church networks are not always separate</td>
</tr>
<tr>
<td>Williams, Larson, Buckler, Heckmann &amp; Pyle (1991) Religion and psychological distress in a community sample</td>
<td>Longitudinal (2 yr) N=270 Random sample 44% male, 11% Black, 26% unmarried Mean age =44.8</td>
<td>Gurin checklist for psychological distress Religious attendance Religious affiliation Index of undesirable life events Health problems index</td>
<td>Interview Regression Correlational matrix</td>
<td>Religion does not directly enhance well-being. Religion buffers effects of stress on mental health.</td>
<td>Random sample Multiple measures Longitudinal design Drop outs Reliability not discussed</td>
</tr>
</tbody>
</table>
## Appendix A

### Research studies: Effect of religion on health

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>McIntosh &amp; Spika (1990) Religion and physical health: the role of personal faith and control beliefs</td>
<td>Descriptive Correlational Convenience sample N=69 53 female, 19 male Mean age = 23.2 Race not specified</td>
<td>Measures of religion General locus of control Health and illness scale</td>
<td>Questionnaire Correlations Categorized by religiosity</td>
<td>Internalized, intrinsic, individually active religion associates with less illness than extrinsic and passive spiritual expressions.</td>
<td>Multiple measures of variables Thorough discussion Non-random sample Use of self reports may affect results Race not specified Reliability not discussed</td>
</tr>
<tr>
<td>Roberson (1985) the influence of religious beliefs on health choices of Afro-Americans</td>
<td>Ethnography 46 households African American</td>
<td>none</td>
<td>Interviews Participant observation</td>
<td>Religion affects view of health and use of health care system for African Americans in this study.</td>
<td>Number of informants is a strength No significant weakness</td>
</tr>
<tr>
<td>Comstock &amp; Patridge (1972) Church attendance and health</td>
<td>Retrospective N=91,909 90% response Sample not described</td>
<td>Unofficial census</td>
<td>Data analysis of existing national survey Death rates Relative risk</td>
<td>Frequent churchgoers have lower rates of heart disease, emphysema, cirrhosis and suicide. No difference in rates of cancer of rectum and colon.</td>
<td>Very large sample Very good response rate unclear methodology</td>
</tr>
</tbody>
</table>
APPENDIX B

RESEARCH ON PARISH NURSING
## Appendix B
Research studies: Parish nursing

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliganis (1994) Parish nurse perceptions of their educational needs</td>
<td>Naturalistic inquiry Purposive sample N= 14 interviews 57 biographical data</td>
<td>Interview guide Biographical data form Evaluation forms</td>
<td>Phone interviews Mailed bio. data form Ethnograph</td>
<td>Parish nurses perceive need for education in aging, grief, volunteers, relationship between faith and health. Orientation program seen as possible</td>
<td>Sending questions prior to interview Use of content experts Conceptual framework not clearly articulated Use of additional response on bio form not consistent with purpose of study</td>
</tr>
<tr>
<td>Lloyd &amp; Djupe (1993) Expanding our understanding of health and well-being: The parish nurse program</td>
<td>Survey N=1,043 people from 40 churches 70.2% female 30.1% 66-80 yrs 25.4% 31-50 yrs 25% 51-65 yrs 61.9% married</td>
<td>Survey</td>
<td>Self administered survey Descriptive statistics</td>
<td>People are understanding the relationship between faith and health. Health is becoming a more explicit part of the church’s life and mission. Most common service used was reading bulletins or newsletters followed by health screening or talking about a personal concern.</td>
<td>Good response to completing survey Results well summarized</td>
</tr>
<tr>
<td>Study</td>
<td>Design/sample</td>
<td>Instruments</td>
<td>Procedure/ analysis</td>
<td>Outcomes</td>
<td>Strengths/weakness</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>McDermott &amp; Burke (1993) When the population is a congregation: Emerging role of the parish nurse</td>
<td>Descriptive Convenience sample N=109</td>
<td>Questionnaire</td>
<td>Self administered questionnaire Descriptive statistics</td>
<td>Respondents were almost all female. Predominantly Lutheran, Roman Catholic or Methodist; serving in Lutheran. Catholic, Methodist or Presbyterian churches with less than 2,000 members. Their time is spent 20% in personal health counselor role, 14% health teacher role, 6% coordinator of volunteers and support groups and 19% as community resource liaison. Greatest satisfaction practicing wholistically and long term relationships with clients. Greatest frustration was unclear expectations and role ambiguity.</td>
<td>Larger sample than 1989 study; 42 nurses from one program may skew results</td>
</tr>
<tr>
<td>Djupe &amp; Lloyd (1992) Looking back: the parish nurse experience</td>
<td>Descriptive Retrospective evaluation N=32 nurses 40 churches 100% response</td>
<td>Monthly reports Survey</td>
<td>Mailed survey Descriptive survey Descriptive statistics</td>
<td>Parish nurses have more impact on church members than on community. Health publications/education, health screening, health counseling, referrals and service to shut-ins were services with most impact. No statistically significant difference between length of time parish nurse has been with a church and positive impact on members and community.</td>
<td>Well structured and analyzed Unable to generalize beyond this particular population</td>
</tr>
<tr>
<td>Study</td>
<td>Design/sample</td>
<td>Instruments</td>
<td>Procedure/ analysis</td>
<td>Outcomes</td>
<td>Strengths/weakness</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Scott (1992) An adult and higher education perspective on parish nursing</td>
<td>Triangulated study N=47 recipients of parish nurse services Purposive sample</td>
<td>Interview guide 155 yes/no 5 open ended</td>
<td>Phone interviews conducted by BSN students</td>
<td>Desire to learn about health or disease top concern. Arrangements for ADL and healthy lifestyle discussion most common nursing interventions. Respondents were less aware of emotional and spiritual needs.</td>
<td>Multiple questions per variable Lack of methodological clarity regarding use of triangulation</td>
</tr>
<tr>
<td>McDermott &amp; Mullins (1989) Profile of a young movement</td>
<td>Descriptive Convenience sample N=32</td>
<td>Questionnaire</td>
<td>Self administered questionnaire summary of responses</td>
<td>Parish nurse respondents were typically female, married and older than 40. 26 had bachelor's degrees or higher. Main responsibilities were health counseling, health education and making referrals. Nurses enjoyed the long term relationships.</td>
<td>First research study on parish nursing Small, convenience sample</td>
</tr>
</tbody>
</table>
APPENDIX C

INTERVIEW GUIDE FOR PARISH NURSE COORDINATORS
QUESTIONNAIRE FOR PARISH NURSE COORDINATORS

Demographics

How many congregations are in your program? Nurses? Paid? Volunteer?

Are there other health ministries than parish nursing in your program? In your area?

How old is the program and programs within?

How many years have you been in your position?

What is your professional background?

What denomination, if any, sponsors you?

Do you use any health ministry materials from denominations? If so, what?

Concept

What does the term health ministry mean to you?

What do you see as the relationship between health ministry and parish nursing?

Have you observed any differences by denomination in how health ministry is practiced? Size of congregation? Longevity of program? Any other variables that have affected success?

How do you feel your nurses are contributing to health within their congregations?
APPENDIX D

RESEARCH ON THE INVOLVEMENT OF CHURCHES IN HEALTH PROGRAMS
### Appendix D
Research studies: Church’s involvement in health programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomas, Quinn. Billingsley &amp; Caldwell (1994) Characteristics of northern Black churches with community health programs</td>
<td>Descriptive Correlational N=1115 churches 635 (57% response) African American Purposive sample by region</td>
<td>Questionnaire</td>
<td>Computer assisted phone interview Univariate analysis Logistic regression model</td>
<td>Church size and education of pastor are strongest predictors of involvement in community health. Majority (86%) of pastors sees role of church as serving members and the community. Methodist churches doing more outreach. Logistic regression model correctly classified 76% of churches.</td>
<td>Large sample Addresses a significant question Broad view of health Rationale for selecting predictors not discussed Criteria for community health outreach program not identified</td>
</tr>
<tr>
<td>National Council of Churches (1991) Results of church health survey</td>
<td>Descriptive survey National random sample based on denomination N=4,592 1,883 response (41% response)</td>
<td>Questionnaire</td>
<td>Mail survey Descriptive statistics</td>
<td>Churches are addressing health needs. Serious health problems are perceived in communities and congregations. Pastoral leadership is important for health initiatives.</td>
<td>Breadth of sample Addresses a significant question Unequal response rate across denominations Ethnicity not identified Criteria for health program not identified</td>
</tr>
</tbody>
</table>
### Appendix D
Research studies: Church’s involvement in health programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olson, Reis, Murphy &amp; Gehm (1988) The religious community as a partner in health care</td>
<td>Descriptive N=227 176 respondents 78% response African American</td>
<td>Questionnaire</td>
<td>Structured interviews in person or on phone</td>
<td>Churches identify health needs in their communities. Churches are willing to be involved in health issues, primarily in sharing information. Resources are a barrier to church involvement in health issues.</td>
<td>Relevant research questions Varying types of respondents Inconsistent interview format Poorly constructed questionnaire</td>
</tr>
</tbody>
</table>
APPENDIX E

RESEARCH ON CHURCHES AS SITES FOR HEALTH PROGRAMS
# Appendix E

## Research studies: Churches as a site for health programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wells, Brown, Horm, Carleton &amp; Lasater (1994) Who participates in cardiovascular disease risk factor screenings?</td>
<td>Intervention trial Descriptive Correlational N=658 participants and 326 non-participants from 20 churches Random sample 48% response rate Predominantly Caucasian</td>
<td>Interview</td>
<td>Personal interview Physiological measurements Logistic regression</td>
<td>Significant determinants of screening were worship service attendance, convenience and health characteristics. Older people living close to church with known HTN most likely to use screening. Screening use increased with CV disease knowledge, demonstrating need for educational component with screenings.</td>
<td>Large, random sample Persistence in getting respondents 48% response meant many people were not represented</td>
</tr>
<tr>
<td>Stillman, Bone, Rand, Levine &amp; Becker (1993) Heart, body &amp; soul Church-based smoking cessation program from African Americans</td>
<td>Quasi-experimental Pretest/posttest Purposive sample N=22 African American churches Random assignment Program evaluation</td>
<td>Physiological measures</td>
<td>Health fairs Phone survey Participant observation Program evaluation</td>
<td>Churches were receptive to the program. 29 volunteers were trained to lead smoking-cessation classes. Give of 10 churches completed minimum of 4 class sessions. There was some reluctance to acknowledge one's smoking habits.</td>
<td>Church values and leadership were integrated into program development Program design was multidimensional Success of smoking cessation was not identified</td>
</tr>
</tbody>
</table>
## Appendix E

### Research studies: Churches as a site for health programs

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kumanyika &amp; Charleston (1992) Lose weight and win: A church based weight loss program</td>
<td>One group pretest/posttests N= 187 African American women from 22 churches Convenience sample</td>
<td>Physiological measures</td>
<td>Treatment was 8 wk nutrition/exercise program BP, weight, med hx Ad hoc analysis Within person paired comparison</td>
<td>90% of women lost weight. Weight loss increased with attendance. Association between weight loss and blood pressure changes. Church site provided advantages of pre-existing support.</td>
<td>Sample size Recognizes built-in support system of church Limited measures</td>
</tr>
<tr>
<td>Smith (1992) Hypertension church-based education</td>
<td>Quasi-experimental One group pretest/posttests N=32 individuals in 3 African American churches F=29, M=3 Mean age = 46 Convenience sample</td>
<td>Hypertensive patient data record Hypertension knowledge test Social support inventory</td>
<td>Phase I - training nurse educators Phase II - education intervention Posttest after intervention and at 3 months t-test Multiple regression ANOVA</td>
<td>Program was successfully implemented in 3 out of 5 churches. Significant increase in knowledge, according to t-test. No changes in BP or sodium intake. No relationship between BP and age, knowledge, social support, stress, weight and health care orientation. ANOVA showed difference between people with controlled and uncontrolled HTN on knowledge of cooking with sodium and sodium intake. Measures and variables were found appropriate for the sample.</td>
<td>Well organized Reliability of tools identified. Good discussion of findings and limitations Convenience sample Lacks generalizability</td>
</tr>
<tr>
<td>Study</td>
<td>Design/sample</td>
<td>Instruments</td>
<td>Procedure/analysis</td>
<td>Outcomes</td>
<td>Strengths/weaknesses</td>
</tr>
<tr>
<td>-------</td>
<td>---------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Wiist &amp; Flack (1990) A church based cholesterol education program</td>
<td>Quasi-experimental Pretest/posttest usual care control group N=346 people in 6 African American churches Purposive convenience sample</td>
<td>Blood work Questionnaire</td>
<td>Tx group - ed program Control group - usual care Education provided by trained church volunteers Chi-square, t-test ANCOVA Regression</td>
<td>Control group had statistically significant lower blood pressure. Poor attendance at the education program. Both groups had statistically significant reductions in blood pressure. Church provided access to large numbers of people.</td>
<td>Research design incorporated structure of church Treatment was difficult to control</td>
</tr>
<tr>
<td>Mithcell-Beren. Dodds, Choi &amp; Waskerwitz (1989) Colorectal cancer prevention, screening and evaluation</td>
<td>Descriptive Random sample N=160 people in 20 African American churches</td>
<td>Survey</td>
<td>Phone interviews Descriptive statistics Chi-square</td>
<td>Returner group was significantly older and had fewer smokers. Main reason for not returning was difficulty and time involved.</td>
<td>Clinically significant research question Age as a confounding variable</td>
</tr>
<tr>
<td>Smith (1989) The role of Black churches in supporting compliance with antihypertension regimens</td>
<td>Descriptive Comparative N=2 African American churches 63 participants convenience sample</td>
<td>Sense of community scale Compliance questionnaire</td>
<td>Structured interviews Mailed questionnaire Med. Record review BP readings t-test</td>
<td>No difference in hypertension compliance between two churches. No relationship between support, compliance and BP control. Church without regular screening was perceived as more supportive.</td>
<td>Comparison between churches useful Missing data Churches were not well matched</td>
</tr>
</tbody>
</table>
### Appendix E

**Research studies: Churches as a site for health programs**

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/sample</th>
<th>Instruments</th>
<th>Procedure/analysis</th>
<th>Outcomes</th>
<th>Strengths/weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lasater, Wells. Carleton &amp; Elder (1986) The role of the church in disease prevention research studies</td>
<td>Quasi-experimental Pretest/posttest Comparison group N=24 churches Random sample Ethnicity not identified</td>
<td>Survey Program evaluation Bloodwork Ethnography</td>
<td>4 Tx groups 1 comparison group Unclear analysis of data</td>
<td>Churches are willing to participate in health research and make good sites for health promotion.</td>
<td>Study design includes random sample and longitudinal analysis Lack of clarity on data analysis and sample selection process Does not identify ethnicity of churches</td>
</tr>
</tbody>
</table>
APPENDIX F

INFORMED CONSENT
INFORMED CONSENT

Study Title: Health ministry as a reflection of the worldview and cultural care values of a congregation
Investigator: Mary Chase-Ziolek, PhDc, RN

Ms. Chase-Ziolek is a registered nurse and doctoral student in nursing at Loyola University Chicago, studying health ministry in the life of a congregation. Although the study will not benefit you directly, it will provide information that might enable nurses to develop meaningful health programs in churches.

The study and its procedures have been approved by the appropriate people and review boards at Loyola University Chicago. The study procedures involve no foreseeable risks or harm to you. The procedure involves an interview, lasting up to one hour, that will be recorded. You may be asked for additional interviews or there may be follow up questions. You are free to ask any questions about the study or about being a subject and may call Ms. Chase-Ziolek at --------- with further questions.

Your participation in this study is voluntary. You are under no obligation to participate and have the right to withdraw at any time.

The study data will be coded so they will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported or published. All study data will be collected by Ms. Chase-Ziolek, stored in a secure place, and not shared with any other person without your permission.

I have read this consent form and voluntarily consent to participate in this study.

Subject's Signature ___________________________ Date ________________

I have explained this study to the above subject and have sought his/her understanding for informed consent.

Investigator's Signature ___________________________ Date ________________
INTERVIEW GUIDE

CHURCH
As a nurse I am interested in how this church promotes your health and well being as well as that of other members. First, I would like to get your perspective on the church.

Can you tell me about how you came to First Church and chose to become a member?

Can you tell me about the church activities you are involved in?

Can you tell me what you believe the purpose or mission of First Church is?

What makes this church distinctive?

Can you tell me about any special meaning being Methodist has for you?

If you want to start something new at this church how does it happen?

Are there particular individuals or committees who are important to making things happen?

How would you describe the personality of this church?

VALUES
I would like to understand what is important to the members of this church.

What ideals and values seem to be particularly important for members of this church?

Are there any projects or issues that you have seen the people at First Church get particularly excited about, either positively or negatively in the past few years?

What kinds of activities are people usually willing to support financially?

What programs in your church are well supported by volunteers?
COMMUNITY
The experience of community has been identified as important to health.

How does First Church define the community they serve?

Can you tell me about how and when you experience community or a sense of belonging within this church?

Conflict is a normal part of community life. How does this church handle conflict?

CULTURAL CARE VALUES
I would like to understand how this church cares for others.

Can you tell me about how the church cares for its members physically, spiritually or psychologically?

Can you tell me about how the church cares for people outside its membership?

How have you or your family experienced care from members of the church? From staff?

I would be interested to know how the members and staff of the church care for others during illness.

I would be interested to know any experiences you have had where you felt the church cared about promoting your health.

HEALTH
I would like to understand your views about health.

Can you give me your definition of health?

Can you tell me about any ways in which your participation in this church promotes your health, or impedes it?

Can you tell me about any times when health or healing issues have been addressed in worship services or in Christian education classes or other church programs?

The following quote will be given to the informant on an index card to read along. “John Wesley, in his book Practical Physick and in his sermons, established for today’s Methodists the interconnectedness of health with spiritual, mental, and physical well-being.” The United Methodist Church defines health as “a dynamic state of well-being of the individual and society. Wholistic wellness, which is physical, mental, spiritual, economic, political and social. Being in harmony with each other, with the natural environment, and with God.” How does this definition relate to your own understanding of health?
The following quote will be given to the informant on an index card to read along. "John Wesley, in his book Practical Physick and in his sermons, established for today's Methodists the interconnectedness of health with spiritual, mental, and physical well-being." The United Methodist Church defines health as "a dynamic state of well-being of the individual and society. Wholistic wellness, which is physical, mental, spiritual, economic, political and social. Being in harmony with each other, with the natural environment, and with God." How does this definition relate to your own understanding of health?

HEALTH MINISTRY
The United Methodist Church as a denomination, and your church in particular, have been involved in promoting the concept of health ministry.

What does the term health ministry mean to you?

Can you give me an example of health ministry?

What is your understanding of how health ministry fits into the life of First Church?

Can you tell me about any health ministry activities that you have been involved in at this church?

What is your understanding of what the parish nurse does and how parish nursing fits into the church's ministry of health?

Are there any additional health ministry activities you would like to see at your church?

The following quote will be given to the informant to read along. The United Methodist Church in discussing health ministry says "local churches can help address the need for more appropriate and accessible health care services and the inadequacy of our health care system. More importantly, the church can bring a wholistic perspective to a community's understanding of health; one that integrates body, mind, and spirit in congregations and communities, promoting prevention and wellness. The church, therefore, is a strategic place where all elements of health and healing can be discussed. Here people can learn and be nurtured." How do you see this denominational viewpoint reflected in what is happening at this church?

HISTORICAL CONTEXT
I would like to understand the history and heritage of this church.

How have you seen your church change since you have been a member?

WORLDVIEW
Religious/philosophical factors

Do you find that your religious beliefs affect your health behavior? If yes, how?
Kinship & social factors
Do other members of your family worship in this church?

Do you have close friends, who are not your relatives, in this church?

Is there anything else you think would be important to help me understand First Church?

INTERVIEW 2
CHURCH
Can you tell me about how this church is organized?

What are the church bodies/organizations with decision making power?

Historical context
Can you tell me about the history of this church?

Can you tell me about Methodist tradition, what makes the Methodists distinctive?

Religious factors
What does your religion mean to you?

What does it mean for this congregation to be a United Methodist Church?

Can you tell me about things you do that promote your spiritual well being?

Kinship/social factors
Are there many members of this church who are related? If yes, can you tell me about these families?

Cultural factors
What cultural groups are represented in this church?

How do the different cultural groups within this church interact?

Political factors
Tell me how politics affect what happens in this church?

Economic factors
Are financial issues a concern for this church?

What types of church activities are given priority in the budget?

How would you describe the economic status of members of this church?

Educational factors
What educational opportunities are provided at this church?

What is your understanding of the educational backgrounds of people in this church?

Technological factors
How has technology affected the activities of this church?
APPENDIX H

"A PLACE OF HEALTH BROCHURE"
TIPS FOR PROMOTING YOUR HEALTH

1. Eat right
2. Exercise regularly
3. Don't smoke
4. Control your level of stress
5. Become part of a caring, connecting congregation like First UMC, Chicago Temple. It will be good for your health!

REFERENCES


"The love of God, as it is the sovereign remedy of all miseries, so in particular it effectually prevents all the bodily disorders the passions (emotions) introduce, by keeping the passions themselves within due bounds, and by the unspeakable joy and perfect calm serenity and tranquility it gives the mind - it becomes the most powerful of all the means of health and long life."

John Wesley, (1747) Primitive Physick

I will restore you to health and heal your wounds, declares the Lord. Jeremiah 30:17

Created by Mary Chase-Ziolek, in appreciation for participating in my dissertation "Health ministry in the life of a congregation with a parish nurse: Caring and connecting through Christ." for Loyola University Chicago, 10/26/97

If you are interested in participating in any of these activities, speak with a member of the health committee, a pastor or call the church office.

FIRST CHURCH
NOT AN OFFICIAL PUBLICATION

A PLACE OF HEALTH
in the Loop
Caring and Connecting through Christ
METHODIST TRADITION IN HEALTH

John Wesley, the founder of Methodism, recognized the interrelationship between body, mind, and soul, as together they create one's overall health. He wrote extensively about health and provided basic medical care to persons with chronic illness, recognizing that one needed to minister to the body as well as the soul. His best-selling book, Primitive Physick, written in 1747, attempted to provide basic knowledge to people about health promotion, hygiene, preventing and treating disease.

Today's United Methodist Church continues to acknowledge the interrelationship between body, mind and soul, defining health as... a dynamic state of well-being of the individual and society. Wholistic wellness, which is physical, mental, spiritual, economic, political, and social. Being in harmony with each other, with the natural environment, and with God.

Here at The First United Methodist Church, Chicago Temple, we too recognize the interrelationship of body, mind and spirit and provide the following services and opportunities to make this congregation a place of health.

SPECIFIC HEALTH PROGRAMS

Parish Nurse
A parish nurse volunteers her time on a regular basis to answer health related questions, provide referrals to health resources and offer blood pressure screenings. She also contacts persons who have been recently hospitalized or are homebound and works with our program for persons who are homeless.

Health and Wellness Events
Through the health and wellness committee regular health programs are provided which include an annual health fair and flu shots in collaboration with the Chicago Department of Health. Programs change yearly. Some of the program topics have been relaxation, play, living wills and enthusiasm and life long learning. Upcoming programs include a Christ centered weight loss program, exercise class and support group for cancer survivors.

Pastoral Counseling
Our staff are available for pastoral counseling.

HEALTH INTEGRATED THROUGHOUT THE LIFE OF THE CONGREGATION

Worship
Our worship is the central point of our life together as a congregation. Through the preaching of the word, the opportunity for forgiveness, reconciliation and the opportunity to feel and understand the grace of God, our spiritual well-being, and consequently our overall health is enhanced. Many people experience the beautiful music in our worship service as promoting health as it feeds the soul. Through corporate prayer, we bring the health concerns of persons who are ill to God. We are reminded as we observe communion that the ultimate goal of salvation through Jesus Christ is to become whole, which is to experience health.

Outreach
Our Christian witness extends beyond our own congregation, reaching out in concern to others in the city, state, country and world. Through our outreach committee the following health concerns rising issues of justice and social responsibility, have been addressed: domestic violence, world hunger, AIDS and environmental health. The Hadler Project, which we support each year, provides support for producing food to poor families around the world. Our shelter committee deals with the basic needs of persons who are homeless.

Providing service for other people through volunteering is good for your health. We offer many opportunities to volunteer in different outreach activities and mission trips.

Education
The continuing education of our children and adults are an integral part of our life as a congregation.

Within our children's department we are particularly concerned about providing a safe and healthy environment for our children. Snacks are based on healthy Biblical foods and we talk about our body being a gift from God. Christian Education is involved in nurturing healthy families and advocating for the health and social needs of children. Education is also an important part of promoting the health of our adults, through increasing awareness on important issues and providing opportunities for learning which offer mental stimulation.

HEALTH PROMOTING QUALITIES OF THIS CONGREGATION

Several recent research studies have found that participation in the life of a congregation has a positive impact on physical health. The following are ways that being part of First UMC, Chicago Temple, promotes health as expressed by members of this congregation:
1. Through the health programs that are provided.
2. Through the opportunity for worship and spiritual growth that strengthens one's relationship with God.
3. Through the opportunity to take on new and challenging experiences.
4. Through the opportunity to volunteer and serve others.
5. Through the positive attitude that is cultivated, which helps one to approach life in a new and constructive way.
6. Through the opportunity to be part of small groups, where you can get to know others well and share your faith journey, such as United Methodist Women, Mabeay Fellowship, Covenant groups, Lenten Bible Studies, Music Ministry activities including choir, bell choir and liturgical dance group and Adult Sunday School classes.
7. Through the connections that are created among diverse persons in the caring fellowship of this congregation, which for some people, becomes an extended family.
APPENDIX I

PERMISSION TO USE SUNRISE MODEL
Mary Chase Ziolek  
5347 N. Wayne  
Chicago IL 60604  

Dear Ms. Chase Ziolek,

I spoke with Dr. Madeleine Leininger regarding your request for permission to photocopy. She grants permission to photocopy a copy of the Sunrise Model (Volume 8, Number 2, *Journal of Transcultural Nursing*, p. 37) in your doctoral dissertation. I also grant permission from the *Journal of Transcultural Nursing* to use the above mentioned copy of the Sunrise Model.

Dr. Leininger requests a copy and/or summary of your work related to her model when you are finished with your research.

It was so nice to talk to you. Tell Patti hello from Marilyn and Angel. Tell her we are going to Australia for a conference and to visit the Outback in December with Marge Andrews.

Please feel free to contact me if you have any questions or need any additional information.

Thank you for your interest in the *Journal of Transcultural Nursing* and good luck in all of your future endeavors.

Sincerely,

Marilyn R. McFarland
REFERENCES


Evangelical Lutheran Church of America (1994). The whole church catalog. Chicago: ELCA.


Lutheran Church Missouri Synod. (March, 1996). *LCMS health ministries.* St. Louis: LCMS.

Lutheran Church Missouri Synod (undated). *The nurse in parish health ministry.* Unpublished manuscript.


Mennonite Mutual Aid (undated) *Nurse in the congregation: Coordinating health ministries with members of the church and community.* Goshen, IN: MMA.

Mennonite Mutual Aid (undated). *Living well package of sheets.* Goshen, IN: MMA.


VITA

The author, Mary Ann Chase-Ziolek was born in Newport, Rhode Island.

In September 1968, Ms. Chase-Ziolek entered Simon's Rock of Bard College, where in 1972 she received the degree of Associate of Arts in Liberal Arts. In September 1972, Ms. Chase-Ziolek entered Beloit College, where in 1974 she received the degree of Bachelor of Arts in Anthropology. In September 1975, Ms. Chase-Ziolek entered Rush University, where she received the degree of Bachelor of Science in Nursing in 1977. While at Rush, she was inducted into Sigma Theta Tau. In September 1980, Ms. Chase-Ziolek entered the University of Illinois Medical Center. While at the University of Illinois she received a traineeship from the Public Health Service, enabling her to receive the degree of Master of Science in Public Health Nursing in 1982. In August 1991, Ms. Chase-Ziolek entered Loyola University Chicago to pursue a Ph.D. in Nursing.

Ms. Chase-Ziolek has worked in community health nursing practice, education and administration. Currently she directs the Volunteer Congregational Health Program at Northwestern Memorial Hospital in Chicago. The idea for this research came from her work in developing health ministry in ethnically and religiously diverse congregations.
The dissertation submitted by Mary Chase-Ziolek has been read and approved by the following committee:

Dr. Mary Ann McDermott, Director
Professor, Maternal Child Nursing
Loyola University Chicago

Dr. Dorothy Lanuza
Professor, Medical Surgical Nursing
Loyola University Chicago

Dr. Patti Ludwig-Beymer
Clinical Specialist
Advocate Health Care

Dr. Stephen Schmidt
Professor, Institute of Pastoral Studies
Loyola University Chicago

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that all necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Ph.D.

4/26/98
Date

[ Signature ]
Director's Signature