# Religion and Healing

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Introduction

Medicine has worked marvels in our time. Today people live long and happy lives after incurring diseases and injuries which would have killed them in an earlier era. Despite complaints about healthcare delivery systems and arguments over HMOs and other financing schemes, there remains a societal-wide respect for the practice of healthcare. Indeed, the reason we debate the best way to obtain and finance healthcare is that it is a good we so appreciate and desire.

Still, despite the advances of medical science and the dedication of skilled professionals, the experience of suffering remains a pervasive reality in human life. Medical personnel may seek cures, but often all that can be done is to offer care. Healing may require a new wonder drug or surgical intervention, but it may commonly call for a consoling presence, the soothing of worries, words of forgiveness and reconciliation, the discovery of purpose and a sense of closure in a person’s life. Once these dimensions of healing come to the fore, the connection between religion and healing is more obvious.

Among healthcare professionals there is new interest in the role of religion and spirituality in the healing process. With regard to spirituality the language can be elusive and the ideas vague, but even tough-minded scientists are unwilling to dismiss the importance of further study and research in understanding what is needed to bring about genuine healing. In this issue we provide several essays, all but one by non-theologians, who discuss the multiple dimensions of the topic religion and healing.

In our first essay Christine Pulchalski surveys the emerging interest in spirituality and healthcare. Following that essay a brief but well-researched article discusses how pastoral care makes a difference in one particular area where healing is desperately needed, psychological trauma. The two subsequent essays explore spiritual traditions—the Carmelite and Franciscan—for illustrations of how healing can be facilitated by classic spiritualities. Finally, an autobiographical reflection by a skilled nurse provides insight into the various ways in which healing can and must occur within the healthcare system.

Besides our thematic essays we have two articles which take up quite diverse topics. Ruth Fox, through a meditation on a well-known painting, suggests new
ways to image the mystery of the Trinity. Finally, in what is something of a new format for this journal, we offer an extended review essay on a book. Moral theologian William McDonough discusses the import of a new book by the philosopher Alasdair McIntyre, in which the author rethinks some of the positions he had taken previously. Given MacIntyre’s impact on a number of Catholic and Protestant moral theologians, the change in his position is significant, notes McDonough.

As is our usual custom we provide our columns for short but informative comments. Our three columnists offer insight about our changing demographics, the revival of Mariology, and the need for homilies that are inculturated.

It is a pleasure also to announce the winner of the 2001 essay contest that this journal sponsors. Readers should also note the announcement of next year’s contest and the guidelines printed on the pages immediately following.

Coming in February:
*Pastoral Issues and the Bible*

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**New Theology Review**

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St. Catherine’s Parish  
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The editors and publishers of New Theology Review congratulate James Eblen and Victoria Ries upon the selection of their essay by the judges. They have received $2,000 along with the award. Their winning essay will appear in the February, 2002 issue.
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**THE PRIZE**

The publisher and editors of *New Theology Review* have instituted the NTR Prize in Theological Reflection to honor the best new article in theology on pastoral ministry. Each year the winning essay is published in *New Theology Review* and along with the award the author will receive $2,000.

**THE CRITERIA**

All submitted articles should focus on some aspect of pastoral ministry relevant to the audience of *New Theology Review*, i.e., Catholics of the United States and Canada. Submissions must be original work, not previously published, accessible to professional pastoral ministers, lay and ordained, provide new insight or synthesis of a pressing pastoral issue, and contribute to the ongoing theological reflection of pastoral ministers.

**THE JUDGES**

Submissions will be evaluated by a panel of distinguished authors who are expert in theological reflection on ministry. Thomas Groome of Boston College, Robert Kinast of the Center for Theological Reflection, and Evelyn Whitehead of Whitehead Associates will serve as judges for the prize.

**THE RULES**

All entries are due by May 1, 2002. The winner will be announced September 15, 2002.

Essays should be submitted in English, accompanied by a cover page with author information (name, mailing address, phone number[s], institutional affiliation [if any], etc.) and statement of intent that the essay is submitted in the contest. Essays should be no longer than 4,000 words in length.
and written according to the style sheet of New Theology Review (see following pages). No author identification should be on the pages of the manuscript. Judges will not be informed as to the identity of the author until after they determine the winning essay.

Please submit two copies of the printed text along with a copy on disk using a standard program (preferably Microsoft Word) in either PC or Macintosh format.

Send all entries to:

The Editors
New Theology Review
6896 Laurel Street, N.W.
Washington, D.C. 20012

Decision of the judges is final. Submissions will not be returned. Faculty and staff of Washington Theological Union and Catholic Theological Union are not eligible.

New Theology Review is a journal of Catholic theology that informs men and women in ministry of contemporary developments in Roman Catholic thought and its pastoral import for the Church.
The New Theology Review Prize
in Theological Reflection

STYLE SHEET

SPACING Begin the manuscript four double-spaces from the top of the page. Leave generous margins on the top, bottom and left sides. Double space everything, including any indented quotations, footnotes, and references.

CITATIONS NTR follows a modified version of the footnote and reference system of the Journal of the American Academy of Religion, examples of which may be found in this issue. Footnotes should not be used, unless absolutely necessary. Endnotes may be included, if the author deems useful. They should be kept to a minimum, however, and every effort should be made to include reference material within the body of the text.

BIBLE Abbreviations for books of the Bible, mode of verse citation, and transliterations of the Greek and Hebrew alphabets follow the system of the Catholic Biblical Quarterly.

HEADINGS Texts should be appropriately interspersed with subheadings. Keep these headings short and pointed.

LANGUAGE NTR follows a policy of using inclusive language. Plural forms are preferable to he/she or s/he.

TONE Articles submitted to NTR should be based on sound scholarship in theological disciplines, but should try as far as possible to maintain a pastoral focus of interest to those in ministry.

LENGTH The average length of an article should be 4,000 words, approximately 12–15 pages double-spaced, including any notes and references. Use a standard 12 pt. font.

BIOGRAPHY A short biographical note will appear in connection with your article. Please supply your name, position, institutional affiliation, and any pertinent data (publications, pastoral experience, etc.) that you wish included. Also indicate the mailing address to which future correspondence will be directed.
PERSONS  Proper caution should be exercised in making, or reporting, negative judgments on individual persons. Such judgments should be omitted if a case is in litigation unless specific permission is granted by the editors.

FOREIGN  Foreign terms (or phrases) should always include an English translation in parenthesis.

MAILING  Please submit two copies of the printed text along with a copy on disk using a standard program (preferably Microsoft Word) in either PC or Macintosh format. Hard copies and disk will not be returned. All manuscripts are subject to editorial changes.
The Critical Need for Spirituality in Our Healthcare System

Christina M. Puchalski, M.D., M.S.

Human suffering is something that needs to be attended to in our healthcare systems and our society. Finding meaning in the midst of suffering is spiritual at its core. We should have systems of care which support people as they cope with suffering, with illness and with dying. We need systems of care where people can take the time to reflect on their suffering and to engage their spiritual resources.

Suffering, illness, and dying are normal parts of life. In the last century, however, we have seen a dramatic change in how illness and death are handled. Medical technology has made tremendous advances and has as a result increased the average American’s life expectancy. At the turn of the century, Americans’ life expectancy was fifty years. Now, 73 percent of deaths are among people at least sixty-five years old and 24 percent of deaths are among those at least eighty-five years old, according to an end-of-life committee of the Institute of Medicine (Institute of Medicine, 1997). Technology has given people cause to hope for and often attain cures. While this has been a very important and laudable advance in medical science, perhaps this success of technology has also contributed to the denial of death and even illness that is so prevalent in American society.

Christina M. Puchalski, M.D., M.S., is founder and director of the George Washington Institute for Spirituality and Health, and assistant professor of medicine, Division of Aging, the George Washington University School of Medicine.
Medical education has also been influenced by this technology. In the last half century the medical school curriculum has changed vastly, including new scientific information reflecting this technological advance. As a result, the parts of the curriculum that emphasize the doctor-patient relationship have diminished to allow room for this new scientific knowledge. These changes have contributed to a focus on cure and on fixing. The emphasis in much of medical education has been on making a good diagnosis and being able to fix the problems. While this is clearly necessary, people still must eventually deal with chronic problems such as diabetes, cancer, hypertension, dementia, and finally, death.

Medical education has not traditionally focused its courses on how to help patients deal with the issues that arise in those situations: issues of suffering, dependence, fear, anxiety, and grief. These issues cannot often be quickly diagnosed and fixed. The response to a broken bone may be one of fixing, but the response to suffering is one of service and support as patients try to find meaning in the midst of pain. Death is often seen by healthcare providers and patients alike as an unacceptable alternative and that any treatment, no matter how aggressive, has to be better than death. But in the midst of pursuing a cure, patients are not given the opportunity to face their own issues about their suffering, their mortality, and their meaning in life especially in the midst of chronic illness. These are inherently spiritual concerns that have not been emphasized in medical education nor reflected in our systems of care. Medicine is a service profession at its roots and the focus on technology alone may have diminished the compassionate aspects of our profession.

Observers of medical education have noted an increasing dissatisfaction on the part of society with today’s physicians and in our medical system of care. Physicians are seen as too technical and too distant. Medical care is seen as rushed and impersonal. Other studies such as the SUPPORT study (SUPPORT) and a Gallup survey (Gallup International Institute) have indicated that people would like to die in different environments such as home or hospice, and would like to have their wishes at the end of life respected. Yet this does not happen very often. The Gallup survey further showed that people would like warm, caring relationships with their physicians, and would like to be spiritually attuned with their doctors.
How can we better meet patients’ needs, where they can have compassionate care, their wishes respected, and have the time to reflect on their life, suffering, and their eventual death? How can we, as healthcare providers and as a society, give people the opportunity to have a peaceful, meaningful death? There are no easy answers, but it is clear that spirituality is a very important part of the solution.

Struggle with Illness and Dying: Finding Meaning

It is our responsibility to listen to people as they struggle with their illnesses and with their dying. We need to be willing to listen to their anxieties, fears, unresolved conflicts, hopes, and despairs. If people are stuck in despair, they will suffer deeply. It is through their spirituality that people become liberated from despair. As people are faced with serious illness or the prospect of dying, questions often arise:

- Why did this happen to me?
- What will happen to me after I die?
- Why would God allow me to suffer this way?
- Will I be remembered?
- Will I be missed?

Victor Frankl wrote that “man is not destroyed by suffering; he is destroyed by suffering without meaning” (Frankl, 135). Spirituality helps give meaning to people's suffering. Similarly Rabbi Cohen writes:

When my mother died, I inherited her needlepoint tapestries. When I was a little boy, I used to sit at her feet as she worked on them. Have you ever seen needlepoint from underneath? All I could see was chaos; strands of thread all over with no seeming purpose. As I grew, I was able to see her work from above. I came to appreciate the patterns, the need for the dark threads as well as the light and gaily colored ones. Life is like that. From our human perspective, we cannot see the whole picture, but we should not despair or feel that there is no purpose. There is meaning and purpose even for the dark threads, but we cannot see that right away (Cohen, 31).

Spirituality helps people find hope in the midst of despair. We as care givers need to engage with our patients on the same spiritual level (Puchalski, 1999).
Several national surveys have documented patients' desire to have spiritual concerns addressed by their physicians. A Gallup Poll found that 75 percent of Americans say religion is central to their lives; a majority feel that their spiritual faith can help them recover from their illness (Gallup, 1990). Additionally, it was found that 63 percent of patients surveyed believe it is good for doctors to talk to patients about spiritual beliefs (McNichol). The need for attentiveness to the spiritual concerns of dying patients has been well recognized by many researchers (Conrad; Moberg). Ehman and colleagues found that 94 percent of patients with religious beliefs agreed that physicians should ask them about their beliefs if they became gravely ill; 45 percent of patients who denied having any religious beliefs still agreed that physicians should ask their patients about them (Ehman, et. al.). In this survey, 68 percent of patients said they would welcome a spiritual question in a medical history; only 15 percent said they actually recalled being asked by their physicians whether spiritual or religious beliefs would influence their decisions.

There is a growing body of evidence documenting the relationship between patients’ religious and spiritual lives and their experiences of illness and disease (Levin and Schiller). In addition to surveys demonstrating that spirituality is important to people and that many would like their physicians to discuss their spiritual beliefs with them, a number of studies show that having spiritual beliefs is beneficial to patients, particularly those with serious illnesses. There is data that suggests that spirituality may be helpful to people as they cope with dying or with loss. It has been reported that parents who have lost a child have found much support following their child's death in their faith and church life (Cook and Wimberly). Patients with advanced cancer who found comfort from their religious and spiritual beliefs were more satisfied with their lives. They were happier and also had diminished pain (Yates, et. al.). Women with gynecological cancer reported becoming more spiritual after their diagnosis (Roberts, et. al.).

The twelve-step program Alcoholics Anonymous lists one of the steps as belief in a higher power. In this view, addicts see their drug of choice as central...
in their lives; recovery hinges on the ability to find a meaning and purpose outside of oneself. In a study asking older adults about God’s role in health and illness, many respondents saw health and illness as being partly attributable to God and, to some extent, God’s interventions (Bearon and Koenig). Prayer, in this study, appeared to complement medical care rather than compete with it. Meditation has been found to be a useful adjunct to conventional medical therapy for chronic conditions such as headaches, anxiety, depression, AIDS, and cancer (Benson).

That spirituality is central to the dying person is well-recognized by many experts, the most important of which are our patients. People overwhelmingly want to reclaim and reassert the spiritual dimensions in dying (Gallup International Institute). In the study, survey respondents said they wanted warm relationships with their providers, to be listened to, to have someone to share their fears and concerns with, to have someone with them when they are dying, to be able to pray and have others pray for them, and to have a chance to say goodbye to loved ones. When asked what would worry them, they said not being forgiven by God or by others, or having continued emotional and spiritual suffering. When asked about what would bring them comfort, they said they wanted to believe that death is a normal part of the life cycle and that they would live on, either through their relationships, their accomplishments, or their good works. They also wanted to believe that they had done their best in their life and that they will be in the presence of a loving God or Higher Power. It is as important for healthcare providers and other caretakers to talk with patients about these issues as it is to address the medical-practical side of care.

How does spirituality work to help people cope with their dying? One mechanism might be through hope. Spirituality and religion offer people hope. It helps people find hope in the midst of despair that often occurs in the course of serious illness and dying. Hope can change during the course of an illness. At an early stage, the patient may hope for a cure. Later when a cure becomes unlikely, the patient may hope for time to finish important projects or goals, travel, make peace with loved ones or with God, and experience a peaceful death. This can result in a healing, which can be manifested as a restoration of one’s relationships or a sense of self. Often our society thinks in terms of cures.

**Often our society thinks in terms of cures. While cure may not always be possible, healing—restoration of wholeness—may be possible to the very end of life.**
While cure may not always be possible, healing—restoration of wholeness—may be possible to the very end of life.

Beyond Data: Patient Stories

There have been an increasing number of books, publications, and television programs dealing with the issues of dying patients (Moyers; Puchalski, 1999; Nuland; Singh). In these venues, one can hear stories of personal transformation as a result of the struggle that often accompanies serious illness and dying. In my own experience as a physician who cares for patients with chronic and terminal illness, I feel privileged and honored to care for people who are facing death. Their strength and courage in the midst of suffering is inspiring. My patients are greater teachers to me and to my students on life than any philosophical text. The stories they share are ones of personal transcendence, courage and dignity. My patients continually live with dying, in the midst of which they are often able to face their losses, fears, and pains. They come to a point where they see their lives as rich and fulfilling. They re-order life’s priorities and find a place of deep meaning and purpose.

It is often humbling for me to recognize that things in life on which I place importance now may have little or no importance in the end, when facing my own mortality. My annoyance at rush hour traffic or emphasis on academic success pale by comparison to my patients’ descriptions of a glowing sunrise or the deep love they feel for another. Not every person finds meaning in illness, and even those people who can transcend their illness still have times of intense suffering and conflict. Sometimes that is just part of a person’s spiritual path in which the darkness of dying obscures their faith vision of meaning. But sometimes it may be the result of medical systems of care that do not provide the opportunity and resources for people to explore meaning in their suffering. We need systems of care including spiritual care, where people are able to search for their sense of meaning and purpose in the midst of suffering, and where they can find peace if that is what they choose to do.

Spiritual Care

Spiritual care at its essence is relational. Spirituality can include not only the relationship with the transcendent but also with others. The connection physicians, other healthcare providers, and families make with the patient who is ill and dying is at its root spiritual. The care that a physician provides is rooted in spirituality through compassion, hopefulness and a recognition that although a person’s life may be limited or no longer productive it remains full of possibility.
So, even though a person can no longer have curative therapy, they can still find meaning and purpose in their lives, they can still have relationships and they can still heal. The physician and other care providers can offer the opportunity for healing by being present to the patient. The patient and the physician, or other healthcare provider, connect with each other in the context of this healing relationship. There are numerous studies that document the importance of the doctor-patient relationship (Bensing; Backmeyer; Carter, et. al.; Inui, et. al.).

Spiritual care emphasizes the importance of the relationship between two people. Physicians or healthcare providers may be the professional expert in the encounter but we are still human beings. By relating from our humanness we can help to form deeper and more meaningful connections with our patients. What this requires is an awareness of the physician's or other caregiver's own values, beliefs and attitudes particularly toward one's own mortality. By confronting one's own mortality, one can be better able to understand what the patient is facing. Also, the stress of caring for seriously ill and dying patients can be better handled by an attentiveness to one's own spiritual and values framework. Many physicians speak of their own spiritual practices and how those practices help them in their ability to deliver good spiritual and good medical care (Sulmasy; Puchalski, 1999). Studies have suggested that family caregivers are better able to cope with the stresses of caregiving by having spiritual practices (Cupertino).

One of the key components of this relationship is the ability of the physician to be totally present to the patient, that is, the practice of compassionate presence. This means that the physician brings his or her whole being to the encounter and places full attention on the patient disallowing distractions such as time pressures or other thoughts from interfering with that attention. Integral to this is the ability to listen to the patient's fears, hopes, and dreams and being attentive to all dimensions of a patient's life: the physical, emotional, social and the spiritual.

Obtaining a spiritual history is one way to listen to what is deeply important to the patient (Puchalski, 2001; Puchalski, 2000). When one begins to discuss patient spirituality, one enters the domain of meaning and purpose and how the person copes with stress, illness and dying. The spiritual history affords patients the space and opportunity to address their suffering and their hopes. Having the
physician inquire about the patient’s spiritual beliefs gives the patient an opening and an invitation to discuss beliefs if that is what the patient would like to do.

The spiritual history also enables the physician to connect with the patient on a deep, caring level. In fact, many physicians who obtain spiritual histories remark that the nature of the doctor-patient relationship changes. As soon as they raise these questions they feel that it establishes a certain level of intimacy in terms of really understanding who that person is (Puchalski, 2000). Patients note that they feel more trusting of a physician who addresses and respects their spiritual beliefs. In a research survey at the University of Pennsylvania—65 percent of patients in a pulmonary outpatient clinic noted that a physician’s inquiry about spiritual beliefs would strengthen their trust in their physician (Ehman, et al.).

Once the physician learns about the patient’s spiritual beliefs, he or she can then inquire if there are spiritual practices that are important to the patient—these might be prayer, meditation, listening to certain music, enjoying solitude, writing poetry. One can then incorporate those practices as appropriate. Finally and perhaps most importantly, chaplains and other spiritual care providers are experts trained in the area of spirituality and religion. Working with these spiritual care providers is essential to holistic care. Chaplains should be integrated into interdisciplinary healthcare teams, not only in hospice and hospital settings, but also in outpatient settings as well.

**Changing Healthcare to Include Spiritual Care**

We have survey data showing that our patients think spiritual issues are central in life, particularly in death and dying. We have some data suggesting that people use their spiritual beliefs in coping with chronic illness and loss, and we have patients’ stories of personal transformation. Yet we have systems of care that do not incorporate spirituality into the care of patients.

Medical professionals are recognizing these inadequacies in the healthcare system. The American College of Physicians convened an end-of-life consensus panel where they concluded that physicians should extend their care for those with serious medical illness by attention to psychosocial, existential or spiritual suffering (Lo, et. al., 1999). Other national organizations have also supported the inclusion of spirituality in the clinical setting. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has a policy that states: “Pastoral Counseling and other spiritual services are often an integral part of the patient’s daily life. When requested the hospital provides, or provides for, pastoral counseling services” (JCAHO, 1996).

The interest in spirituality in medicine among medical educators has been growing exponentially. Medical schools are now teaching courses in end-of-life care and in spirituality and medicine (Puchalski, et. al., 1998; Puchalski, 2001).
Only one school had a formal course in Spirituality and Medicine in 1992. Now over seventy medical schools are teaching such courses. The key elements of these courses involve listening to what is important to the patient, respecting their spiritual beliefs, and being able to communicate effectively with patients about their spiritual beliefs and their preferences at the end of life.

The Association of American Medical Colleges (AAMC) has undertaken a major initiative—The Medical School Objectives Project (MSOP)—to assist medical schools in their efforts to respond to the concerns of the medical community that young doctors lacked these humanitarian skills. The report notes that “Physicians must be compassionate and empathetic in caring for patients . . . they must act with integrity, honesty, respect for patients’ privacy and respect for the dignity of patients as persons. In all of their interactions with patients they must seek to understand the meaning of the patients’ stories in the context of the patients’ family and cultural values” (AAMC, 1998, 4). In recognition of the importance of teaching students how to respect patients’ beliefs, AAMC has supported the development of courses in spirituality and medicine. In 1999, a consensus conference with AAMC was convened to determine learning objectives and methods of teaching courses on spirituality, cultural issues and end-of-life care. The findings of the conference are published as Report III of the Medical School Objectives Project. A part of this report developed a definition of spirituality relevant in the clinical setting:

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual’s search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another (AAMC, 1999, 25).

The outcome goals established by the AAMC are:

They [the medical students] will recognize that their own spirituality and cultural beliefs and practices might affect the ways they relate and provide care to patients. Students will be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient’s family, and members of the health care team involved in the care of the patient. They will be aware of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur (AAMC, 1999, 26).

Most of the medical school courses in spirituality and medicine are required and integrated into the curriculum. The response to these courses has been positive.
Students and practicing physicians find their relationships with their patients to be warmer, more meaningful and deeper once they talk with their patients about their spiritual beliefs. Medical students and residents are finding it easier to address end-of-life issues in the context of a spiritual history (Puchalski, 2000). Doctors stressed by the hectic schedules of managed care now feel that spiritual discussions give them a way to reconnect with their patients and bring compassionate care back into the practice of medicine. Most importantly, patients are more satisfied because their whole person (body, mind and spirit) is treated, not just their illness.

Conclusion

Our culture, as a whole, needs to look at dying very differently from the way it currently does. We need to see dying not as a medical problem but as a natural part of life that can be meaningful and peaceful. By thinking about our mortality early in life, we will not be caught off guard and pressured by the dilemmas of choice at the end of life. We will have had a chance to think about some of those choices sooner and to come to peace with our mortality. This is where religious communities can be particularly helpful. They can facilitate our discussions of suffering and dying and what illness and death means to us. They can educate their members about the importance of preparing themselves for the choices, both spiritual and medical, that need to be made throughout life and near the end of life.

There are changes occurring in medical education today which will affect the way we treat patients more holistically in the future. We are training young doctors to be able to deliver excellent technical care but also compassionate and holistic care so that the doctors of the future will not only be able to fix but also serve. But our healthcare systems need to mirror that change. We need to see our healthcare systems as multidisciplinary with physicians, nurses, social workers, chaplains, clergy, family and others all working together to deliver the most compassionate care to our patients. By recognizing that all dimensions of care (physical, emotional, social and spiritual) are important and by creating care environments where all these dimensions can be addressed, we will reclaim the most honorable of our profession’s values: to serve others and to help them heal.

References


Psychological Trauma
The Need for a Pastoral Response

Andrew J. Weaver, Walter J. Smith, S.J., David B. Larson

Accounts of the effects of traumatic events have been documented over the history of humankind. Post-traumatic stress is an expected reaction to an abnormally stressful situation and represents a significant public health concern that warrants attention. Religious faith is a primary way that people successfully cope with the negative effects of traumatic experiences.

Traumatic events shatter the sense of connection between individual and community, creating a crisis of faith.

Judith Lewis Herman, Trauma and Recovery

It was midday when twenty-five year-old Patricia was brought unconscious to the emergency room. She, her husband, and their fifteen month-old son had just come home from a summer vacation. Larry, her husband, was an officer at the nearby Air Force Base. When they returned to their apartment, Patricia decided to go out to get some groceries. She went alone in the family car while Larry stayed home with the baby. In order to get to the store, she had to get on the highway and travel two exits. As she left the on-ramp, her car was struck on the left side by an oil delivery truck.

From the accident site Patricia was taken unconscious to the nearest emergency room. The hospital chaplain met Larry while he was still in the reception
area. The young officer had been raised as a Southern Baptist in rural Texas but had not been involved in religion since his youth. Nevertheless, he was receptive to the chaplain’s interest in him and his wife.

The hospital chaplain had been alerted at the time of Patricia’s admission and was in the treatment area when her condition was assessed. This was very comforting to Larry and helped to establish a relationship between him and the chaplain. “I’m sure everything’s going to be all right with Patricia because you were there to say some prayers for her. God is going to listen to you.”

The neurosurgeon was not very communicative. His responses to Larry’s insistent questions were guarded, and it was clear that his judgments about Patricia’s condition were not optimistic. Should she ever regain consciousness, it would be impossible to predict the extent of her brain damage. Larry harbored hostile feelings toward the surgeon and was quick to ventilate them to his trusted confidant. The chaplain listened to the young husband as he described his frustrations with the hospital staff. “She’s going to get better despite what the doctor keeps saying.”

“We got married even though our families objected. Patricia was pregnant and we decided to marry, although we had intended to do so even before we knew about the baby. Her family did not come to the wedding, except one of her sisters. This really hurt both of us. We haven’t been very religious, though we both believe in God. Do you think God is punishing us for our lives?”

Patricia’s condition did not improve. Nonetheless, Larry kept his hopes alive, frequently entering her cubicle in the ICU, holding her hand and through his tears telling her how much he loved her, needed her, and wanted her to wake up and get better. Larry clung to the hope for a miracle.

At eleven o’clock on the sixteenth day of her hospitalization, Patricia died. Larry was not at the hospital, but was telephoned and asked to return. The chaplain was with Patricia when she died and remained at the bedside until her husband arrived. When Larry entered the unit, he bent down and embraced the body of his wife, kissing her and sobbing deeply. After a few moments of silent embrace, he looked up at the chaplain and threw his arms around his neck and wept.

For weeks after the funeral service, the grieving man could not work and spent most of his time detached and withdrawn. Larry was plagued with insomnia and disturbing nightmares about his wife’s accident. He had outbursts of rage, and could not concentrate. Prior to the accident he was active and upbeat; now he had lost interest in all activities. He constantly blamed himself for his

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Post-traumatic stress disorder is a normal reaction to an abnormally stressful situation.
wife's death and took little comfort in family or friends. Larry experienced a severe psychological trauma, which developed into post-traumatic stress disorder (PTSD).

**Many Suffer From Psychological Trauma**

Chaplains and community-based clergy need the skills to recognize and assist those who come to them for counsel in the aftermath of traumatic events. Many of these persons may be suffering what mental health professionals have identified as PTSD. The word “trauma” comes from a Greek root meaning “wound.” In much the same way that a physical blow may wound the body, bringing disability and pain, a psychological trauma can overwhelm the thoughts and feelings of a person and bring sustained suffering.

Graphic accounts of the effects of extreme stress on human beings have been documented in literature since Homer’s *Odyssey* and Samuel Pepys’ diary of the disastrous London fire of 1666. In the nineteenth century, Freud recognized the effects of psychological trauma in childhood, but it was only in the wake of the devastating wars of the twentieth century, particularly the return of Vietnam War veterans to the United States, that a scientific model was developed to understand the symptoms that result from extreme stress (Van der Kolk). Recently, the PTSD model for understanding psychological trauma has been applied to understand reactions to catastrophic accidents, natural disasters, and criminal victimization (Herman).

Post-traumatic stress disorder is a normal reaction to an abnormally stressful situation (Lifton). PTSD is not a sign of being “emotionally weak” or mentally ill. Those exposed to the shock effect of extreme stress will find their ordinary coping processes overwhelmed. PTSD is diagnosed when an experience occurs involving actual or threatened death or serious injury or a threat to the physical well-being of self or others if the response is one of intense fear, helplessness, or horror (American Psychiatric Association). The traumatic event is re-experienced in specific ways, such as recurrent and intrusive distressing recollections or dreams of it. Additionally, a person often persistently avoids situations associated with the trauma and has general emotional numbness. Hypervigilance and irritability also may be experienced. PTSD becomes the diagnosis when these symptoms persist for more than a month and create significant impairment in a person’s functioning.
Religious belief and practice are traditional ways through which many develop personal values and their beliefs about meaning and purpose. With psychological trauma, an individual's sense of order and continuity of life is shattered. Questions of meaning and purpose emerge as a person experiences a loss of control over his or her destiny. Religious faith is a primary coping strategy for many suffering from psychological trauma (Weaver, Koenig, and Ochberg).

A recent study (Astin, Lawrence and Foy) found evidence suggesting that religiously committed women who are battered suffer less severe PTSD symptoms than those without such commitment and that religious involvement of a couple reduces the risk of domestic violence (Ellison, Bartkowski, and Anderson). This finding is consistent with research related to combat veterans which discovered that those experiencing psychiatric problems or PTSD attend religious services less frequently than those not experiencing them (Watson, Kucala, Manifold, Juba and Vassar).

A study has examined the effects of stress in the wake of the terror and destruction caused by a class IV hurricane (Hugo) in South Carolina on sixty-one nursing students and ten faculty involved in disaster relief. After three weeks of work, three-quarters of those examined reported that religion was a primary positive coping strategy (Weinrich, Hardin and Johnson). In a separate study, researchers investigated religious coping methods used by 225 individuals who experienced the devastating impact of a major midwestern flood. Frequent prayer and worship attendance were associated with better mental health (Smith, Pargament, Brant and Oliver).

In addition to offering the social support of community, nurturing religion provides a healing means of addressing a traumatic experience. Faith can facilitate faster and more effective recovery (Pargament). In a long-term study of 124 parents who lost a child to sudden infant death syndrome, it was found that greater religious participation was related to increased emotional support by others and increased meaning found in the loss (McIntosh, Silver and Wortman). This is no small finding, given the high level of trauma that follows the sudden death of a child. Religion appeared to provide for these parents an effective means to make sense of the loss that enhanced well-being, lowered distress, and facilitated recovery.
In a well-designed study of persons grieving the death of a family member or very close friend, it was discovered that there is a strong link between the ability to make sense of the loss through religious belief and practice and positive psychological adjustment (Davis, Nolen-Hocksema and Larson). In a third investigation, fathers of children being treated for cancer in a hospital clinic were asked about various methods of coping. Among twenty-nine different strategies used, prayer was both the most common and most helpful for the fathers (Cayse).

Seeking Clergy Counsel

Clergy, vowed religious, and healthcare chaplains are in an ideal position to recognize and assist those suffering from psychological trauma (Weaver, 1995). There are 353,000 Christian and Jewish clergy serving congregations in the United States (4,000 rabbis; 49,000 Catholic priests; and 300,000 Protestant ministers, according to the U.S. Department of Labor, 1998). In addition there are 92,107 sisters and 6,578 brothers in religious orders nationwide (Stark and Finke). These are among the most trusted professionals in society (Gallup and Lindsay). They are often in long-term relationships with individuals and their families, providing ongoing contacts in which they can observe changes in behavior that can assist in the assessment and treating of PTSD. Surveys by the National Institute of Mental Health found that clergy are more likely than psychologists and psychiatrists combined to have a person with a mental health diagnosis see them for assistance (Hohmann and Larson). It should be noted that more than ten thousand of these clergy serve as professional healthcare chaplains working closely with medical professionals.

Ethnic minority persons are more likely to receive pastoral assistance in times of crisis and psychological trauma than European-Americans. African-American pastors are much more likely to go into the community and seek out people in crisis than their non-African-American colleagues. Many urban churches offer community outreach programs for those in need, including services to persons who suffer from conditions that place them at risk for PTSD. Among those conditions are homelessness, hunger, substance abuse, child abuse, domestic violence, AIDS, and imprisonment. Similarly, Mexican-Americans are more than twice as likely to seek help with personal problems from clergy than from psychologists and psychiatrists combined (Chalfant et al.). In fact, that study found that the degree of identification with Mexican ethnicity was strongly related to seeking pastoral help as a primary resource.

Clergy are most often called upon in crisis situations associated with grief, depression or trauma reactions, such as personal illness or injury, death of a spouse or close family member, divorce or marital separation, serious change in
the health of a family member, death of a close friend (Fairchild; Weaver, Preston and Jerome). People in “crisis” involving the “death of someone close” reported almost five times more likelihood of seeking the aid of a clergyperson (54 percent) than all other mental health sources combined (11 percent) (Veroff, Kulkap and Douvan). Further highlighting the prominent role that clergy play in community mental health, the U.S. Surgeon General’s 2000 Report on Mental Health found that each year one in six adults and one in five children obtain mental health services either from a healthcare provider, the clergy, a social services agency, or a school (Satcher).

Both pastoral care and mental health publications have found that clergy respond with pastoral care and counsel to persons exposed to a wide range of extreme stressors (Dykstra). They document responses to natural disasters such as floods (Smith et al.) and tornadoes (Chinnici), catastrophic accidents (Black), child abuse (Weaver, 1992), elder abuse, and human-created disasters including death camps (Cohen), war (Zimmerman and Weber) and torture (Lernoux).

Researchers have found that one in five adults (700,000 survivors) who are victimized in a violent crime (e.g., rape, robbery, assault) seek the counsel of a clergyperson. This is the same number who seek help from all categories of mental health professionals combined or a medical doctor (Norris, Kaniasty and Scheer). It is also estimated that 1.8 million women are physically abused each year by husbands or intimate partners (Brammer, Bradshaw, Hamlin, Fogarty, and Colligan). A national survey of one thousand battered wives found that one in three received help from clergy, and one in ten of their husbands were counseled by clergy (Bowker).

Often a person suffering from PTSD will have additional symptoms, particularly major depression or substance abuse. These problems may be the first means by which clergy and other religious professionals will recognize that someone has suffered a psychological trauma. Major depressions, which occur in about half the people who develop PTSD (Kessler et al.), are usually associated with a predominantly sad mood, hopeless feelings, very pessimistic thinking, loss of the ability to experience pleasure, pronounced and continual sleep disturbance, significant agitation or restlessness, suicidal thoughts and attempts, and the loss of self-worth (Weaver, 1993). Self-medication with alcohol and illicit drugs at first may allay PTSD symptoms, such as sleep disturbance and anxiety, but with time they exacerbate the distress. A comprehensive study of Vietnam veterans found that 75 percent of those with PTSD developed alcohol abuse or dependence (Kulka et al.).
Clergy are accessible helpers within communities that offer a sense of continuity with centuries of human history and an experience of being a part of something greater than oneself. They are visible and available leaders in communities that have a language of faith and hope. Rabbis, priests, ministers and vowed religious are also in a unique position of trust in which they can assist persons in connecting to support systems available through their faith communities and beyond (Weaver, Revilla and Koenig). Undoubtedly, persons in distress go to clergy in large numbers because accompanying the stressful state for many individuals are questions of meaning and purpose uniquely addressed by religion.

**Conclusion**

Faith communities can offer both social support and a healing means of addressing a traumatic event. Rabbis, priests, and ministers are in a unique position of trust in which they can assist persons in the aftermath of psychological trauma. They need effective skills to recognize the signs of PTSD and information about how best to respond.

The interventions made by the hospital chaplain with Larry during the hours immediately following the accident in which Patricia sustained her fatal injuries, contributed significantly to the way he managed the stress and its psychological consequences. The sustained relationship with the chaplain during the extended crisis helped Larry to gradually absorb the reality that his wife would not recover and that he would need to prepare himself and his son for life without her. The pastoral counsel and support helped the young officer regain emotional equilibrium in the face of a catastrophic loss. Without destroying his psychological defenses, the chaplain was able to work with his denial of the seriousness of Patricia’s injuries and begin to address his anger and guilt. Larry’s hostile reactions to other hospital professionals were linked to his sense of powerlessness in the face of this catastrophe. The chaplain provided a safe haven, as Larry began the difficult process of regrouping and reorganizing his life. Competent pastoral interventions, especially those at the onset of the crisis, can weaken the effects of PTSD and increase the likelihood of a positive prognosis.

**Note**

1 This article is dedicated to the co-founder of the Catholic Worker, Dorothy Day, who gave her life to the ministry of the poor. We wish to express our gratitude to The Rev. Carolyn L. Stapleton, D. Min., Eileen Gorey, R.N., and Lisa Matsumoto, MLIS, Head Librarian at Hawaii State Hospital, for their generous help in the development of this project.
References


A Spirituality for Times of Illness

The Case of Thérèse of Lisieux

Mary Frohlich, H.M.

This article uses the case of St. Thérèse of Lisieux to explore both the complexity and the rich potential of a holistic perspective on illness. Thérèse’s life offers a window into the spiritual dimension of illness even as the other dimensions are fully acknowledged.

Is being sick a physical event, a social event, a psychological event, or a spiritual event? The answer, of course, is that it is all of the above, woven together in complex ways according to the particular circumstances and character of the sick person. The tendency of today’s medical model to focus heavily on physical causes and remedies may obscure how profoundly both the source of pathology and its healing involve all levels of the person’s reality. The goal of this essay is to offer sick persons and their caregivers a spirituality that is fully realistic about physical, social and psychological factors while locating the core import of the event of sickness squarely in the spiritual dimension.

At first glance Thérèse may seem too unusual for the more “ordinary” sick person to identify with. She was raised in a highly pious and sheltered French family of the late nineteenth century, entered the Carmel of Lisieux at age fifteen, died there nine years later of tuberculosis, and was named an official saint of the Roman Catholic Church within less than thirty years of her death. A study of her experience of illness, however, is a quick way to discover how concretely...
she had to deal with the same physical and human realities as the rest of us. She was, indeed, unusual in the degree to which she stayed centered in the core spiritual dimension through it all. She did not do this, however, by being spared from a full dose of anxiety, loss, harassment, misunderstanding, distraction, temptation, and—in the end—horrendous physical suffering. The sick can truly find in her a sister who has, quite literally, lain in their bed of pain.

Although many other aspects of her life could be relevant to this study, this article focuses on three experiences of illness that were core life-events for Thérèse.

Thérèse’s Childhood Illness

On Easter 1883 (March 25), ten-year-old Thérèse fell ill with a strange trembling and state of exhaustion. Over the next seven weeks her symptoms became even more bizarre and troubling. She endured multiple involuntary contractions and movements of the body, hallucinations, intermittent terror and paranoia, and periods of incoherence. Sometimes she screamed and tossed herself wildly around the bed and even onto the floor; at other times her lassitude was so severe that she could not move or eat. After a brief respite during which she was able to attend her sister’s profession at the Carmelite Monastery, the symptoms again intensified. Then, on Pentecost Sunday (May 13), as two of her sisters wept and prayed beside her bed, Thérèse glimpsed a beatific smile on the face of a nearby statue of the Blessed Virgin and was suddenly cured. Except for two brief episodes of weakness, the symptoms never returned.

During the illness Thérèse’s physician, Dr. Notta, was unable to make a definite diagnosis. This was the era when the psychopathology of hysteria was much discussed in France, and he seriously considered that diagnosis even though he believed Thérèse was too young for such a syndrome. The extreme physical symptoms of trembling and contortions might suggest some form of chorea (popularly known as St. Vitus’ Dance), but Dr. Notta remained uncertain. In later years, Thérèse’s sisters usually spoke of the ailment as either a nervous reaction to stress, or the work of the devil. Thérèse herself echoed their intimations, and noted that for many years after the event she had worried that she had “become ill on purpose” (Thérèse of Lisieux, 1996, 62).

The concern about a nervous or hysterical reaction was not entirely unfounded. At this stage in her life Thérèse was, indeed, undergoing a period of major psychological stress. It was only about eighteen months earlier that she had begun to attend day school away from home, and although she did very well academically it was quickly evident that she did not fit in. She took no pleasure in children’s games and chatter, and she was harassed unmercifully by at least one fellow student who disliked her. Then in the summer of 1882, she had
learned that her sister Pauline (twelve years Thérèse’s senior) was planning to enter Carmel in October. It was Pauline whom four-year-old Thérèse had embraced as her “second Mama” when Mme. Martin died of breast cancer in 1877. Also, based on a previous playful conversation between herself and Pauline, Thérèse had believed that Pauline would wait for her so that they could go off and become hermits together. Thus Pauline’s departure was a double shock for Thérèse: she was losing both her “Mama” and her dearest dream.

Thus, it was easy for all to see that Thérèse was emotionally distraught and vulnerable during this period. Given the lack of a clear diagnosis for her strange malady, it is not surprising that both at the time and subsequently many have presumed that the problem was fundamentally psychosomatic. It seemed plausible to suggest either an hysterical reaction, in which repressed affects play themselves out in dramatic bodily feelings and movements, or simply the behavior of a needy child “playing sick” in order to draw forth the care for which she desperately longed.

Recently a psychiatrist, Dr. Robert Masson, has proposed another scenario. After carefully examining all the statements about the illness made by Thérèse and others, he concludes that the symptoms and their resolution are not consistent with those of either hysteria or “playing sick,” but that they closely match those of an encephalitis resulting from childhood infection of the brain by the tuberculosis pathogen. It is an accepted fact that Thérèse died at age twenty-four of tuberculosis, but the date or circumstances of her original infection have been unknown. Masson notes that nowadays it is common knowledge that the most typical time of contracting tuberculosis is between the ages of six and fourteen, and especially at the first entrance to school. It is quite possible for such an infection to have an active phase and then go into remission for years, emerging again only in adulthood. Thus, the most plausible medical explanation of Thérèse’s childhood sickness is that upon entering school she contracted tuberculosis, which incubated for several months and then attacked the brain; after seven weeks the infection went into remission and she remained essentially symptom-free for about ten years.

The Illness of Thérèse’s Father

In the meantime, however, Thérèse’s life was invaded by an illness that, in some ways, was even more painful for her to bear. As early as May, 1887, her father Louis Martin was beginning to show initial signs of dementia and paralysis. It was at the end of that same month that fourteen-year-old Thérèse—his “little Queen”—asked his permission to enter Carmel immediately. Heartbroken but ever gracious, he acquiesced. Within three months after her departure for Carmel on April 9, 1888, Louis disappeared one day from the family home. After much
consternation on the part of the extended family, he was eventually located about thirty miles away in Le Havre. He did not seem to comprehend that he was behaving strangely. On October 31, he had another serious episode. Finally, on February 12, 1889, in the midst of a bizarre hallucination in which it was feared that he would harm one of his daughters, he was forcibly removed to the mental hospital in Caens. It was necessary for him to be interned there until May 1892, by which time he was so debilitated that he could be cared for like a small child. He was then brought home to stay with his daughters until his death on July 29, 1894.

Today, the most likely medical diagnosis that would be given for these symptoms is cerebral arteriosclerosis. At the time, the diagnosis that was given was mental illness. In the cultural milieu of the time, mental illness was regarded as supremely shameful. It cast a shadow over the whole family, since there commonly would be suggestions of inferior heredity or of causation by immoral behavior. Thérèse and her sisters had to endure a triple agony: first, watching their beloved father deteriorate; second, hearing his reputation dragged through the gutter; and third, knowing that, as the daughters of this wretched man, they too were being talked about with disdain.

The illness of her father forced Thérèse to meditate long and hard on the mystery of the suffering, decline, and degradation of the man she most admired on earth. She resolved it by comparing Louis Martin’s state to that of Christ in his passion, and affirming even more strongly the faith that this debasement of the just man was only a prelude to greater glory. All too soon, these meditations would be tested by her own physical and spiritual passion.

Thérèse’s Final Illness

Even before Louis Martin’s death, there began to be hints that twenty-one-year-old Thérèse was losing her youthful robustness. The progress of Thérèse’s adult tubercular illness can be traced in five stages:

- June 1894–March 1896, the stage of disturbing symptoms: Thérèse and others noted occasional troubling symptoms and health concerns, such as chronic sore throats and chest congestion.
• April 5, 1896–March 2, 1897, the stage of sickness while remaining active: On Good Friday 1896, Thérèse coughed up blood and knew she was seriously ill. Throughout the following year she repeatedly suffered from a cough, pain in the chest, and a pale demeanor, and was treated with various remedies such as tonics, cauterizing compresses, massages, and a meat diet (Carmelites were normally required to abstain from all meat). She continued, however, to carry on with nearly all the duties and ascetical exercises of community life.

• March 3–July 5, 1897, the stage of grave illness: During Lent of 1897, Thérèse suffered a breakdown. She was coughing violently, had intense pain in her side, and was increasingly weak. Dr. Cornière prescribed cough syrup, vesicatorys, and a diet of condensed milk which Thérèse hated (she was probably lactose-intolerant). In May she stopped attending the Divine Office; by mid-June she could no longer go even to the refectory. During June she spent most of her time in her cell, but could still walk around a little and sometimes sat out in the garden in a wheelchair. It was on June 9 that she explicitly stated that she knew she was going to die. She made her last visit to the parlor on June 30, and her last visit to the Blessed Sacrament on July 2.

• July 6–September 28, 1897, the stage of overwhelming suffering: From July 6 until August 5 Thérèse was coughing up blood daily and sometimes several times a day. During the first days of this period, she had a raging fever and was so weak that she could not be moved; they were finally able to bring her to the infirmary on the evening of July 8. The doctor acknowledged that one lung was essentially gone and the other already severely damaged. The suffering increased until, on July 30, she appeared to be suffocating and was given the Last Sacraments. This intense crisis of pain and suffocation (the result of the complete disintegration of the right lung) continued until August 6, when it abated somewhat for a few days. Her worst sufferings still lay ahead, however. Between August 22 and 27, as the tuberculosis attacked her intestines, Thérèse cried out in pain day and night. This was followed by another relative remission of two weeks. Finally, around September 17, the tuberculosis attacked the left lung in full force, and Thérèse—by now completely emaciated and on edge with nervous exhaustion—entered into the final period of gradual suffocation.

• September 29–30, 1897, the death agony: On the morning of September 29, the community was called in to recite the prayers for the dying. The prioress sent for a priest to hear the dying sister’s last confession. For the first time, Thérèse was given a spoonful of morphine syrup. Laboring for every breath, Thérèse remained in her final agony until about 7:20 p.m. on the following day, September 30. Her last words were: “My God . . . I . . . love you!” She then fixed her gaze just above a statue of the Blessed Virgin and, with a look of astonished joy, died.

MARY FROHLICH, H.M.
Thérèse’s Illness as a Period of Supreme Creativity

It is harrowing to trace, even in this abbreviated version, the physical chronology of Thérèse’s final illness. Yet it is noteworthy that the vast majority of Thérèse’s most creative insights and expressions came to birth during this very same period. It was not despite her illness, but in its very heart, that Thérèse forged the spirituality that was to be her gift to the world. Here is the corresponding trajectory of her developing spiritual insight during this time:

• 1894–March 1896, the stage of disturbing symptoms: The year 1894 marked not only the first hint of tubercular symptoms, but also Thérèse’s first real blossoming as a writer. Her first play, “The Mission of Joan of Arc,” was performed on January 21; she would write and produce seven more within the next three years. Although one poem had been written in 1893, in February 1894 she began to bring them forth on a regular basis. Even more significantly, it was in early 1894 that Thérèse discovered the scriptural texts that catalyzed her emerging articulation of a “little way.” Then early in 1895, Mother Agnes asked Thérèse to write the story of her life. She produced “Manuscript A,” now the first eight chapters of Story of a Soul. Finally, on June 9, 1895 (Trinity Sunday), Thérèse was inspired to write her “Offering to Merciful Love.” She and Sister Genevieve received permission to make this offering two days later. Three days after that, Thérèse “was seized with such a violent love for God that I can’t explain it except by saying it was as if I had been totally plunged into fire.” (Thérèse, 1977: 77)

• April 5, 1896–March 2, 1897, the stage of sickness while remaining active: On Good Friday, when Thérèse coughed up blood, she was experiencing “a clear and living faith.” Within only a few days, however, as the Church celebrated Easter, Thérèse had interiorly entered a dark tunnel from which she would never emerge. She spoke of facing “a wall which reaches right up to the heavens and hides the starry firmament” (Thérèse, 1996: 214). At the very time that her physical condition began to deteriorate, her faith was challenged to its core. Nevertheless, when she took her retreat the following September, she wrote “Manuscript B,” the letter to her sister Marie that would become chapter 9 of Story of a Soul—and one of her most quoted texts. It was there that she wrote: “Yes, I have found my place in the Church and it is you, O my God, who have given me this place. In the heart of the Church, my Mother, I shall be love” (Thérèse, 194).

• March 3–July 5, 1897: the stage of grave illness: Thérèse’s last poems were written in May. In early June, Mother Marie de Gonzague asked Thérèse to complete her life story; when she was able, she worked on “Manuscript C” (chapters 10–11 of Story of a Soul) from June 10 until the crises of early July. As illness encroached more and more upon her, Thérèse made a supreme effort to complete
this work and also to write some of her most profound letters. Her letters to her spiritual brothers, Père Rouilland and Abbé Bellière, are filled with her reflections on her mission of spending her heaven “doing good on earth.” Meanwhile, Mother Agnes received permission to record Thérèse’s spoken comments; this would become the *Last Conversations*.

- July 6–September 30, 1897: the stages of overwhelming suffering and the death agony. By this time Thérèse was able to write very little. Her last letter to Abbé Bellière on August 10 included the lines: “My pilgrimage seems to be unable to end. Far from complaining about it, I rejoice that God permits me to suffer still for His love; ah! How sweet it is to abandon oneself into His arms without fear or desire” (Thérèse, 1988, 1173). From then on, most of what we know of Thérèse’s reflections comes from the words recorded by others.

### A Holistic Perspective on the Human Person

The remainder of this article will reflect on these experiences of illness, in view of contributing to a positive spirituality for sick people and their caregivers. First, I will state explicitly the anthropological model that frames my approach.

I view the human person as composed of at least three distinguishable, but never separable, dimensions, which I term the core self, the dramatic self, and the embodied self. The core self is the self-in-God; it is what medieval writers sometimes called the “spark of the soul,” the ineffable yet utterly foundational urgency of our beings toward infinite love. The dramatic self is the psyche, living out its personal heroic drama forged in a complex alloy of culture, family, individual history, biochemical heritage, and both conscious and unconscious creativity. The embodied self is the public person, physically acting in, and acted upon by, the world and human society. While every human experience and event involves the person in all three dimensions, quite distinct dynamics may be operative in each dimension. In what follows I employ this basic framework to reflect on Thérèse’s experiences of illness, exploring the potential of each of the three dimensions in itself as well as of some of the complex interactions among them.

### Illness and the Embodied Self

If one views the person strictly at the level of the embodied self, one’s goal in understanding illness will be an empirically-based explanation that can undergird a physical intervention (i.e., drugs, nutrition, surgery, rest, etc.). Contemporary medical science has been astonishingly successful in doing this. On the
other hand, physicians often have to admit that they do not know for sure what is going on at the physical level; we have all heard about surgeries that turned out to be mistakes, or about people undergoing tests for months or even years without receiving a definitive diagnosis. Theologian Wolfhart Pannenberg reflects on this in view of the dialogue between science and religion (Pannenberg). He notes that any scientific explanation can only account for some parts of a phenomenon; it can never encompass absolutely everything about the empirical phenomenon. His conclusion is that this leaves room for the free action of God. Put in the terms of the more limited concerns of this article, Pannenberg’s perspective potentially frees the medical model from its limitation of viewing illness only as a physical event.

Thérèse experienced illness in the era immediately before the full flowering of modern medical science. As we examine her case with the help of today’s more sophisticated diagnostic skills, we can be saddened by the way lack of medical knowledge contributed to her physical and psychological suffering. Her childhood malady mystified the family doctor and thus was given a humiliating psychological and/or spiritual diagnosis by those around her. Similarly, her father’s deterioration was not fully understood by physicians and so was subjected to the cultural assumption that it was mental illness, perhaps even due to moral turpitude. In regard to her adult illness, it is not clear whether the medical personnel who examined her in its early and middle stages knew that she had tuberculosis but were circumspect about saying so because this too was culturally regarded as shameful, or whether the tuberculosis really was not recognized until it was far advanced. In either case, the treatments she received were of minimal medical value.

Thérèse’s experience in all three incidents could have been quite different if the illnesses had occurred in the context of today’s medical expertise. This case illustrates how a lack of good medical diagnosis and treatment may not only increase the suffering of the body, but also may contribute to the psychological agony of the dramatic self and the spiritual crisis of the core self. On the other hand, we also learn from Thérèse’s case that it would be foolhardy to reduce the human phenomenon of sickness simply to its physical

[A]ny scientific explanation can only account for some parts of a phenomenon; it can never encompass absolutely everything about the empirical phenomenon.
dimensions. The illnesses in Thérèse’s life are powerfully interwoven with the unique gift that she was destined to offer to the world.

**Illness and the Dramatic Self**

For the dramatic self, the challenge of illness is to fit it into a story of meaning. For one person illness may be imagined as a despicable and terrifying enemy to be fought with all one’s might; for another it may be seen as a tragic failure; for another it is named as a trial sent by God to strengthen the soul. These stories are partly written onto the individual’s psyche by culture, family, and interpersonal relationships, for, as we have seen, the influence of prevailing interpretations and characterizations of illness is powerful. Yet a story that “works” is necessarily also a deeply creative act of the individual.

In her book *The Body in Pain*, Elaine Scarry explores the dialectical relationship between pain and imagining. She terms pain as a “site of invention” (Scarry, 22), most obviously because of the intrinsic urge to find a way to alleviate the pain. She proposes that, in fact, all human creativity and construction have a deep relationship to the fact of pain. This perspective is very significant for a spirituality of sickness. The sick person is in a variety of forms of pain, not all of which can be assuaged by physical interventions. Caregivers, too, bear their own deep forms of pain. To be able to find meaning in what is happening is a crucial form of relief. Yet meaning in such situations cannot be prefabricated; it has to be personally generated by the individual, fueled by the raw energy of their struggle with affliction. Thus, there is a deep potential for creativity in sickness.

The case of Thérèse demonstrates this creative potential in its most intense form. As a little girl, her acute illness culminated and resolved itself in the very moment in which she saw a vision of the radiantly loving face of the Blessed Virgin. It is easy to locate this event within the psychological drama of Thérèse’s life, since at this point in her life she had already lost three “Mothers” and was in an acute period of crisis over the last of these losses (i.e., the departure of her sister Pauline for Carmel). Extreme physiological distress, acute psychological need, and divine grace all contributed powerfully to this resolving event, which was burned into her memory as a lifelong spiritual lodestone.
In the other episodes of illness reviewed here, the conscious dimension of Thérèse’s search for meaning is more to the fore. As her father declined, she meditated over and over again on the suffering servant texts from Isaiah, the Gospel passion stories, and the image of the abused Holy Face. With their help, she creatively mined the insight that the good person’s suffering is, indeed, for the sake of divine glory. Then, coinciding with the period of her final illness, came the full blossoming of her gifts as a writer and artist. While dealing daily with physical, psychological, and spiritual affliction, she told “the story of her soul”—a personal tale of faith and practical wisdom that has brought joy and hope to millions throughout the world.

Obviously, relatively few sick people can write as Thérèse did—and even fewer will have their stories published and widely distributed. Yet, if we look for it, we will find the same process going on in the “ordinary” person. About a year before he died, my father financed a private publication of poems he had written earlier in life. They would never have been accepted for publication by a regular publishing house, yet in the small sphere of his family, friends, and colleagues there was much joy in his sharing of a life’s wisdom. In their last weeks, neither of my parents was able to speak coherently, yet with each of them there came a day when they sat up, flailed about, and struggled with the entire energy of their beings to say something to us. We will never know for certain the words they wanted to speak, but I would still name their efforts as a creative act that was deeply meaningful to those around them. These are only two, very personal examples; I suspect every family that has lived through grave illness or shared a loved one’s dying process can tell similar stories of how unique experiences of shared meaning emerge in the midst of great suffering.

**Illness and the Core Self**

Every human life is, in a true sense, a mystery. A mystery is not something that cannot be known, but rather something that belongs so intimately to God that one only knows it in the context of one’s relationship with God. Our own sickness, or that of a loved one, is one of the events that may force us to grapple with that mystery with a desperation we never dreamed could overtake us so completely.

Overwhelming pain, Elaine Scarry writes, can annihilate the ability to speak, to be in a meaningful relationship, even to remember one’s most basic commitments and values. Pain can be the “site of invention” when it is still at least somewhat manageable, but when it overflows those bounds, it can become the site of the destruction of one’s very humanness. Torturers play upon this, seeking the undoing of the victim’s self even more than the ruin of the body. Scarry focused primarily on the effects of physical pain, but the phenomenon she names applies...
also to other sufferings such as the multifaceted loss, social marginalization, feelings of dread, etc. that commonly accompany illness. At times, people can feel as if they are being tortured, pushed beyond their limits of endurance as everything good is stripped away. The ultimate crisis engendered by illness is the question of the core self: “When there is literally nothing else left, who am I in relation to my God?”

Thérèse did, in fact, face this crisis as fully as any human being ever has. The last eighteen months of her life were largely bereft of any comforting sense of God’s consoling presence. Meanwhile, monastery culture and spirituality discouraged any use of painkillers by nuns, and both Thérèse and her prioress held to this norm until the very last days of her life. Between July 6 and her death on September 30, she was frequently in truly overwhelming physical pain. During this time we only hear her voice filtered through the words recorded by her sisters and compiled in Last Conversations. Some of these words are almost reduced to cries of pain. Yet to the end, she continued to tell her story as one of meaningful suffering. A few days before she died someone said to her, “Ah! It’s frightful what you’re suffering.” She replied: “No, it isn’t frightful. A little victim of love cannot find frightful what her Spouse sends her through love” (Thérèse, 1977: 200).

Those who find the terms of this spirituality rather offensive might ponder the difference between such a statement being made as a pontification from “on high,” versus its being made as an expression of personally discovered meaning forged in the crucible of extreme suffering. As Cristina Mazzoni said about Gemma Galgani (1878–1903), Thérèse learned how to convert her pain into a kind of joy by “turning her supposed powerlessness into an embraced empowerment bestowed upon her by her relation to the divine” (Mazzoni, 177). Without holding up as a model the refusal of Thérèse and those around her to moderate her physical agony, we can still acknowledge that a unique gift of spiritual wisdom has emerged from that site of radical pain. Thérèse found a personal voice to affirm her core self in loving relation to her God, despite the loss of all things.

**Conclusion**

A viable spirituality for the sick and their caretakers must give each dimension its due: realistic medical care, attention to meaning-making in the con-
text of culture and community, the ultimate solitude of facing one’s God. The case of Thérèse of Lisieux illustrates how, viewed through this multifaceted lens, the time of illness need not only be a time of loss, but also potentially can be a time for the discovery of great giftedness.

References


A Franciscan Spirituality of Healthcare

Daniel P. Sulmasy, O.F.M.

There is no generic spirituality but specific spiritualities arising out of various traditions. The author, a Franciscan friar and physician, explores what are the qualities of a Franciscan spirituality of healthcare, specifically a Franciscan inflection on compassion.

Towards a Definition of “Franciscan”

One way to approach a definition of “Franciscan” is through the insights of Ludwig Wittgenstein (187). Most people recognize that there are certain things in life that really are mysteries; things that defy language. According to Wittgenstein, the meaning of these things can only be “shown, not said.” The...
word “Franciscan” seems to point to a reality of just this type. Franciscanism is more easily shown than said.

The definition of Franciscanism is, in some ways, boundless; yet, it is boundless along particular dimensions. One can define “Franciscan” too narrowly—restricting the number of dimensions along which its boundlessness is expressed.

Despite the caveats and risks, I would like to propose that there are three specific dimensions of compassion that pertain to Franciscan spirituality. These dimensions, while not exhaustive of the charism, are at least necessary dimensions of the kind of compassion that would appear to characterize a genuinely Franciscan spirituality in healthcare. No Christian spirituality of healthcare will neglect compassion. But Franciscan healthcare will not be characterized by generic compassion. Franciscan compassion is mediated along at least the following three specific dimensions: it is personal, incarnational, and imaginative. These dimensions, I believe, essentially define the word “Franciscan.”

By its personal character, I mean that Franciscanism is the most intensely personal of all religious charisms. Francis anthropomorphized the universe. For him, literally everything was personal—the sun was a brother and the moon a sister. And when Francis described the perfect friar, he named actual persons—individual friars, not abstract characteristics (Habig, 1218–19). Everything, even death, has the mystery of the person.

Franciscan spirituality is also incarnational. God is found in matter—in the pus of leprous wounds as well as in the Word of God as it is proclaimed and preached. As Bonaventure puts it, the light of God is refracted through the matter of the universe, as sunlight through a stained glass window (Bonaventure, 1970: 179). According to Scotus, God is found in actual thisness (Shannon and Ingham).

Franciscan spirituality is also characteristically imaginative. Franciscans insist on the imagination that is necessary for empathy. To understand the suffering of God and the suffering of one’s brothers and sisters, as they experience and understand it themselves, requires imagination. As personal, incarnational, and imaginative, it should come as no surprise that Franciscan spirituality is inherently hagiographic—the personal stories of real people who live the charism. Consequently, Franciscan spirituality is without method. There are no exercises.

Persons live concrete historical lives. What does this mean for those who care for the sick? I would argue that Franciscan healthcare must be informed by this
same spirit of compassion: one that is personal, incarnational, and imaginative. This means that a Franciscan spirituality of healthcare must be marked by the Sign of the Cross. This is the sign that Francis saw throughout his life—marking the shields of his sickbed dreams; marking the illness of the leper; marking his body on Alvernia; and finally marking his death. All are redeemed through the Cross of Christ, the visible sign of God’s love. All are redeemed as persons by a God who is personal, became incarnate for us, and gives us the imagination to hope in the love that heals us.

Franciscan Spirituality and Healthcare

The Gospels tell us that the physical suffering of Christ was concentrated into a period of less than twenty-four hours. All that any patient (or any healthcare professional) will ever suffer was subsumed in a drama that unfolded in less than a day. Francis understood this drama. He saw it in the San Damiano crucifix. He saw it in his dreams. He saw it in the leper. He saw it in his own suffering, and in his own death.

Personal Compassion

Franciscan spirituality of healthcare must be marked by a compassion that is as deeply personal as the passion of Christ. Franciscan spirituality will always recognize that illness is a spiritual as well as a physical event. Affliction can enlighten spiritual awareness in anyone, just as the early illness of Francis awakened his spiritual life. Human persons are constituted as body and spirit at once, and illness grasps human beings as whole persons. In fact, whatever threatens the essential unity of the human body and the human spirit is what one means when one says that a person is ill.

Franciscan spirituality understands this. A Franciscan approach to healthcare can never be mere bioengineering. It must engage patients as persons (Ramsey), endowed with the dignity that comes not just from having been created in the image and the likeness of God, but also with the alien dignity that comes from having been redeemed by the Cross of Christ (McCormick, 10–12). A genuinely Franciscan spirituality of healthcare does not treat patients as mere isolated organs or as mere consumers of healthcare resources. Rich or poor, young or old, citizen or alien, able or disabled, the personal in every person is boundless, and of inestimable worth.

A practitioner imbued with a Franciscan spirituality will even be sensitive enough to note the embarrassment of patients, just as Francis understood the embarrassment of the poor Knight. Practitioners imbued with the Franciscan spirit will recognize how the sick are often shunned. They will move past any initial hesitation or revulsion and reach out to touch their patients personally, as
Francis embraced the leper. Practitioners imbued with the Franciscan spirit understand the essential unity of their own suffering and the suffering of Christ. They will be able to feel the suffering Christ in their own persons. They will find unity with His suffering through active engagement with their own suffering and that of their patients, just as Francis did on Alvernia. And they know that they can only truly minister to the needs of the dying if they can learn to call death, Sister.

Personal compassion of this sort can only be shown, not said. It is the compassion of Francis and Clare. It is the compassion spoken of by Mother Alfred Moes, foundress of the Rochester Franciscans, who once told Dr. Mayo, “The cause of suffering humanity knows no religion or sex; the charity of the Sisters of Saint Francis is as broad as their religion” (Kauffman, 132).

**Compassion in Action**

A Franciscan spirituality of healthcare must also demonstrate incarnational compassion, which means compassionate action. The most tender stories of Francis and Clare concern their personal care and solicitude for the sick brothers and sisters of their Orders. Austerity was always tempered with concrete compassion—relaxing fasts (Armstrong, Hellman and Short, 2000: 359), feeding grapes to the sick (Ibid., 152, 360), and providing them with feather pillows and wool blankets (Armstrong and Brady, 1982: 220).

Incarnational compassion means emptying bedpans. It means using morphine judiciously to relieve the pain of dying patients. It means binding their wounds with reverence and love. And it means taking the time to listen, even as time becomes increasingly scarce. Healthcare professionals who live a Franciscan spirituality will be present to their patients in the flesh.

Incarnational compassion also demands working for justice in healthcare. Francis gave the leper an alms before he kissed him. Incarnational compassion means going the extra mile to fight for the needs of patients when they are denied essential care by the new merchant class that is now transforming healthcare the way the new merchant class transformed the thirteenth century Europe of St. Francis. Incarnational compassion means working to change a system that, by denying them health insurance, has exiled forty-three million Americans outside the walls of the medical city-state. Incarnational compassion means preaching the “Gospel of Life” to a violent society that systematically kills the unborn, and now wants to do the same to its elderly and its dying.

**Imaginative Compassion**

A Franciscan spirituality of healthcare will also be imaginative. Practitioners with genuinely Franciscan imagination see in the suffering of patients, and in their own suffering, the suffering of Christ the Lord. Francis felt he had a duty towards the sick and the poor because he always saw in them the image of Christ, poor and suffering (Bonaventure, 1978, 254).
The world is suffused with suffering. Doctors, nurses, psychologists, and other healthcare professionals know this better than anyone. They are capable of learning to identify with that suffering. “The world’s our wound.” Like the friars at the deathbed of Francis, healthcare professionals put their hands into the bloody wound of human suffering every day. Healthcare professionals must have the religious imagination to find God there. At the tip of the spleen, at the point of the knife, at the rising mercury’s edge—God is in the suffering, and in the compassionate hand that reaches out with healing.

A Franciscan spirit of imagination will also encourage and engage in scientific research for the sake of the sick. Franciscan spirituality is not anti-scientific. All those who wear glasses or contact lenses can thank Friar Roger Bacon for his pioneering work in optics. To find cures for diseases through research, imagining new ways to ameliorate the symptoms of those who are suffering is pre-eminently Franciscan. To do so is to work creatively with the gifts God has given humankind through our sister Mother Earth and through the exercise of God’s gifts of reason and imagination. Perhaps a Franciscan of the twenty-first century will discover a new pharmaceutical agent to treat Alzheimer’s disease.

Franciscan imagination will also challenge healthcare professionals to create new healthcare structures. Perhaps the command of the Crucified Christ to Francis, “Go and repair my house which is falling into ruin,” also speaks loudly to healthcare professionals today, urging them to rebuild the house of healthcare which is surely falling into ruins. Healthcare today is increasingly impersonal. Healthcare today increasingly replaces the incarnational aspects of care with machines. Healthcare today increasingly dulls the imagination, turning patient care into an assembly line, and drowning out the desperate cries of the sick and the poor with narrow-minded mantras, chanted by the gurus of cost-control.

**Conclusion**

Francis saw in the suffering of others the suffering of Christ. He engaged them with a compassion that was personal, incarnational, and imaginative. He saw all around him a people redeemed by the blood of Christ. The blood that
flowed from the five wounds of the Crucified One of San Damiano bathes and suffuses and redeems all people. The blood of Christ made the blood of Francis shake. But one should never forget that the blood of a leper also made the blood of Francis shake—for the sake of the blood of Christ. The blood of our wounded brothers and sisters—the ones we see in our hospitals and offices every day—ought now to make our own blood shake, as the blood of the leper shook the blood of Francis.

In the care of our patients, we stand daily at the foot of the cross. The blood of Christ, the blood of Francis, the blood of the leper, the blood of our patients, and our own blood are all one. For “the cup of blessing that we bless, is it not a sharing in the blood of Christ?” (1 Cor 10:16). Francis almost never says “communion” when he refers to the Eucharist. Consistently personal, incarnational, and imaginative, Francis always says we receive “the Body and Blood of Christ” (Armstrong, Hellman and Short, 1999, 52; Armstrong and Brady, 64). These days it has almost become cliché to say that one’s spirituality is “incarnational.” Franciscan spirituality recognizes that this means real blood.

It was said that the followers of the Poverello would remain vital and strong “...as long as the blood of the poor Crucified was warm in their memory and the wonderful cup of his suffering inebriated their hearts” (Armstrong, Hellman and Short, 1999, 540). This is our challenge in healthcare today: to follow the course of the blood that ran through the veins of Francis. To practice our healing professions in a way that is shown, not said; lived, not recited. To practice in a way that is personal, incarnational, and imaginative. To render compassionate care in the blood of Christ. This is the gospel way Francis showed us.

References


The Ministry of Healing
A Nurse’s Reflection

Joanne Schatzlein, O.S.F.

In her autobiographical reflections, a former nurse provides a narrative of personal discovery that reveals multiple dimensions to the practice of healing. It is often more than the patient who requires attention and ministry by caregivers.

Already a member of a religious community when I first began my college education, I assumed I had to be a teacher since my congregation was primarily a teaching community. After three semesters, the formation director asked me what professional work I wanted to do. My immediate response was, “Be a nurse!” That desire had been sitting unnamed inside me, and I realized that I was influenced by my mother who had worked as a nurse when I was a youth. I recalled her leaving home late evenings to work the night shift as a surgical scrub nurse. I remembered her working in doctors’ offices and being present the first time I needed stitches. And most of all, I remembered the many times we would be home from school, sick with fevers, colds, chicken pox, and measles.

Mom had a way of making us feel better just by creating an environment of healing. She would never have called it that but the little things she did made a difference. For example, she would set us up on the couch with blankets, pillows and TV trays for meals so we would not be isolated from the household action; ginger ale, chicken soup and crackers were served on a special tray; the touch of her hand on our foreheads, the back rubs, the talcum powder after bathing; the ice packs or hot water bottles depending on what was wrong; the music she played from our favorite records, and the stories she would read to us, all made the time go faster. Yes, Mom was indeed a minister of healing.

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Caring for the Sisters

I finished my bachelor’s degree in nursing from Marquette University and began a career which included many years working with our aged and infirmed sisters. They taught me so many things about suffering, humility and dependence on others, about faith in God and acceptance of death. They expressed constant gratitude for things I did for them, and they constantly assured me of their prayers for me.

Working with the sisters laid the foundation for my own understanding of what healing meant. It was a word that spoke not to an outcome but rather to a process. These sisters were in their eighties and nineties. They would not be “healed” of their illnesses and their sufferings.

My role in their lives was to help them experience their days comfortably and in peace, nourishing them not only with daily food, but spiritual food to sustain them on their final journey. My blessing in this ministry was to be a witness to their final days, filled with awe at the transformation that took place as they approached death, and rejoicing as they attained their ultimate goal—to be united with God in new resurrected life.

After several years of working with our older sisters, I recognized another dimension of my ministry. I became aware of the fear that existed in the hearts of other sisters who were anticipating their own personal diminishment. Consequently, they did not like to visit the geriatric floor I was working on. They did not know how to be with their friends, classmates, and/or former teachers, who could no longer remember names, places, or what day it was. They were uncomfortable in the midst of suffering, feeling a desperate need to alleviate it, and knowing they could not. They wanted to be present and pray with the sisters in their final moments, but to sit for long periods of time awaiting the end was difficult. This realization led me to look more closely at dimensions of healing that had nothing to do with medications, treatments, or other medical interventions.

To encourage the sisters to visit our geriatric unit, we began sending out personal invitations to come for a Sunday afternoon visit. During that time there were refreshments and some options for what the visitors could do during their time with the sisters. We recommended wheelchair rides to the different chapels at our Motherhouse, rides outside to see the beauty of the convent grounds if the

These sisters were in their eighties and nineties. They would not be “healed” of their illnesses and their sufferings.
weather was nice, and, if the visitor was willing, a ride over to see Lake Michigan right across the street. Words were not necessary during these excursions. But the presence of another and the mutual prayers that were said in the chapels all became moments of healing. Sometimes the visitors would help our elders eat and drink the refreshments. Sometimes manicures were in order. Sometimes letters were dictated and mailed. And sometimes one just sat at the bedside of a sister who was not feeling up to activity. Gradually the fears of the visitors faded, and we did not need to plan special times to get people to come and visit.

Another lesson I learned was the importance of creating a peaceful environment in the room of a sister who was dying. In our health center we were not confronted with weighty decisions about extraordinary means to sustain life. Most of our sisters made it clear that they wanted to go to God when their time came. Our number one priority was to keep the sister comfortable. But more than that, we made sure that the room was neat and clean. We used the brightest and prettiest pillow cases. We dressed the sisters in their best gowns and made sure that they were bathed and nicely groomed. These small details made a difference to those who came to sit with the dying sister. Again, we encouraged visitors to hold the sister’s hand and speak their prayers out loud. If someone was staying a long time, offering juice and breaks became important.

The spiritual journey into death is one taken not only by the person going to God but by the companions as well. The healing ministry includes attention to all those impacted by the sickness or death of a person. And the satisfaction of this ministry is in knowing that, while a person may not be healed in body, certainly all the small efforts toward comfort and a peaceful environment restore one to wholeness in body and spirit.

A Clinical Assistant

After several years of ministering to our aging sisters, I was invited to consider working for a vascular surgeon. This medical professional, whom I called Dr. K., had come routinely to our health center to take care of our sisters. One day out of the blue, he asked if I was looking for a new position. At that time I was the administrator of the health center, and we were going through the very painful process of closing it. Financially, we could no longer sustain the center because we were not licensed. Along with that, the structure had never been built to allow accessibility for wheel chairs. The plumbing was poor. Medical care had advanced way beyond our own ability to provide the necessary treatments and services on our own. So we made the decision to close down and move our sisters into a public nursing home. The doctor’s question came at a perfect time for me. Accepting his offer, I entered into a whole new experience of healing ministry.
In many ways, Dr. K. healed his patients both physically and spiritually. His whole purpose in hiring me was to provide a healing presence to his patients in the hospital. Because his surgical schedule occupied most of his day, he was not as visible as he wanted to be. He was aware that anxiety and fear can disrupt the healing process and he recognized that, in this changing medical environment, nurses and other medical personnel no longer have the luxury of spending quality time with the patients. He was convinced that my role would alleviate these concerns. He was also aware that offering this service to his patients could likely influence future referrals as well.

While my primary role was to care for the patients before, during, and after their surgeries, I became aware of two other groups who were in need of the ministry of healing: family members and hospital staff. The patient population I served under Dr. K. differed greatly from the elderly sisters of my community. Many were financially well established, although some of our patients came from areas of extreme poverty. They were dealing with critical illnesses related to vascular insufficiencies. Most required high-risk surgery and long-term follow-up. This reality led to great fear and anxiety, not only on the part of the patient, but on family members as well.

I quickly learned that my “clients” included not just the patients in the hospital but those who would accompany the patient to the office for the first visit; those who would be waiting for the news after surgery and during the hospitalization, and who would be taking on responsibility for care after discharge. Once again, it was not what I did in terms of procedures and treatments but rather how I did these in a way that diminished anxiety.

The greatest anxiety for both patients and caregivers came from not knowing or understanding what was happening to them. I learned to communicate information as clearly and as often as possible to those involved. I learned that often the patient and/or family members just needed a listening ear. I realized that factors beyond the specific medical problem exaggerated the experience of pain. While we may have been successful with a surgical procedure, therefore, personal difficulties at home or work often prevented healing in a more holistic way.
The Case of Mary

Mary was an elderly woman who had at least four major vascular surgeries. She was diabetic, hypertensive, and often in heart failure. Surgical intervention was often delayed until one or the other of these difficulties was brought under better medical control. Mary was well cared for by her daughter and son-in-law. But when they would visit the anxiety level in the room increased, not because Mary herself feared surgery, but rather because her son-in-law Harry had serious vascular difficulties and was avoiding being treated. This distressed both Mary and her daughter. Mary was a real, visible demonstration of what Harry was facing. He feared for Mary, certainly, but mostly he feared his own fate.

In this situation, it became critically important to care not only for Mary but also through gentle and consistent encouragement, to alleviate Harry’s fears. Mary’s experience was going to be a prototype of Harry’s future. So it was important to make sure Mary’s pain was well managed. It was important that Harry clearly understood the surgical procedures, the treatments after surgery, and the follow-up plan. It was important that Mary had confidence in Dr. K. and felt comfortable with my presence to the point where Harry might have the same confidence. And it was critically important that after Mary was discharged, I would make follow-up calls not only to her but also to Harry and his wife as well. It was worth all the extra effort because Harry eventually had the courage to make an appointment with the doctor. He went through vascular surgery successfully, and to this day we stay in touch.

Caring for Colleagues

There was a second group looking for healing from me. Although employed by Dr. K., I was not connected with the hospital staff as a fellow worker. Every day, however, I visited several different hospital departments while making rounds on our patients. On any given day I was in the intensive care unit, surgery, the recovery room, day surgery, the outpatient department, the x-ray department, the medical records department, and the various nursing units in the hospital. I got to know the staff members in each of these areas and discovered another need for healing.

Because of the critical nature of the surgery we performed, it was extremely important that any changes in the status of our patients be reported immediately to Dr. K’s office. This led to great tension between the hospital staff and the doctor. Not reporting changes could lead to a stroke, or the failure of a vascular graft, requiring repeat surgery. When this happened, Dr. K. would be upset and the staff would feel his anger. In response, and out of fear of repeating this mistake in the future, the staff would often make phone calls about non-essential things to Dr. K. in the middle of the night. They did not mean to be bothersome but were just concerned about not reporting something important. This also led to upset, and so it was a no-win situation for the staff.
I learned early on that the staff would much rather deal with me, and my constant presence made that possible. They knew I could sift out important information and communicate it directly to Dr. K. if I thought it important. He trusted that when I called, it was something that really needed his attention. I spent a good part of my time reassuring staff of our appreciation of their care for our patients. And I educated them regarding the importance of reading signs and symptoms accurately so that we could prevent surgical complications. I made sure that I was available to help with very complex dressing changes, and was respectful of their time when requesting updates and reports on our patients. I realized that very little appreciation is given to these persons who do the most critical care around the clock. They often work under considerable pressure with inadequate pay, and are often spoken to harshly by both medical personal and family members who are under stress due to the complications of a patient’s illness.

“Healing the healer” is a neglected ministry. We become so busy healing the patient that we forget about those affected by the pain and suffering of the patient witnessed every hour. And “healing the physician” seems like an oxymoron. Yet, as I learned, most of a physician’s upset and anger is related directly to the inability to heal the patient, or the discouragement that arises when a complicated surgical procedure has failed. Having been in surgery many times, I appreciated the constant stress a surgeon deals with. I was privileged to see his vulnerable side as he tried to alleviate pain and suffering, only to realize that he was fallible and sometimes unsuccessful.

**Conclusion**

Although I am no longer in active nursing, I continue to integrate what I have learned from the ministry of healing in my present ministry as a pilgrimage guide to Rome and Assisi. I am amazed how the lives of Francis and Clare continue to give me spiritual insight into the art of healing, and I am constantly reminded that the spirituality of healing is a holy ministry. The holiness is the journey into situations that are often difficult, filled with pain, suffering, isolation, and loneliness. On this journey, one is often confronted with an awareness of personal limitations. While one is equipped to do physical things to comfort and
assist a person who is suffering, it is the presence of a listening ear and all the little things one does to create an environment of peace and comfort. Those in need of healing often include people on the periphery who are neither patients nor healthcare professionals, that is, those who are most intimately involved in the life of the person who is ill. They too look to us to receive consolation and peace as they deal with illness and life’s difficulties.

We are all called to be ministers of healing as part of our spiritual journey. One does not need a medical degree or special training in therapeutic areas. What one needs is faith in God, a heart open to listening to the experiences of another and a belief that, together with our redeeming God, we can all be compassionate healers in an ailing world.
New Images of the Trinity for the New Millennium

*Ruth Fox, O.S.B.*

Much of our thinking about God is influenced not so much by creeds as by our imaginations and the mental images we have. This is particularly true for images of the Trinity. Expanding our repertoire of trinitarian images will permit us to “see” and experience God in new and vital ways.

At my age I should no longer be surprised when God bursts into my prayer to rattle some venerable theological foundations. But I was surprised and then delighted with the latest intrusion. I was pondering an essay on the Trinity by theologian Catherine LaCugna when I chanced to glance up at the framed picture of *The Gleaners* by Jean-Francoise Millet hanging on my bedroom wall. With that glance I realized that I had discovered an exciting new image of the Trinity for myself. This picture had hung on my wall for twenty years, ever since I acquired it from my mother’s home after her death. Perhaps because she was named after Ruth, the biblical gleaner, she had treasured this picture, and I valued it as a keepsake since I carry the same name. On this particular day, however, I discovered that this painting was also inviting me into further readings and reflections on the Trinity.

I found two books that helped me to articulate my own questions and to search for new answers in regard to the age-old doctrines surrounding the Trinity and the nature of God: *She Who Is: The Mystery of God in Feminist Theological Discourse* by Elizabeth Johnson and *God for Us: The Trinity and Christian Life* by Catherine LaCugna. Both authors see the Trinity as a model of mutuality, equality, reciprocity, and as a communion of persons seeking to enter into a deep relationship with all creation. “In the end, the Trinity provides a sym-

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bolic picture of totally shared life at the heart of the universe. . . . The Trinity as pure relationship, moreover, epitomizes the connectedness of all that exists in the universe” (Johnson, 222). These authors supported my growing uneasiness with current prevailing images of the Trinity.

I have become convinced that it is imperative for Christians to formulate new and inspiring visual and verbal images of the Trinity. For nearly two thousand years Christianity has been dominated by the one prevailing image of the Trinity which features two bearded, white males enthroned on the clouds, with a white dove hovering over them. This portrayal is becoming increasingly unacceptable to many Christians, especially as current theology acknowledges the inadequacy of an image of God devoid of the feminine. Yet images are necessary for the human mind to articulate and explore the mystery of the divine nature and to ponder God’s involvement with the world. But no single human thought, word, or picture can adequately capture or describe the identity of God. Thus a variety of images are needed in order to begin even an elementary appreciation for the mystery of the divine nature.

**Variety of Images of God**

Although our Sacred Scriptures do not provide us with explicitly trinitarian images, we can glean examples from them of how to stretch our imaginations when we try to talk about or to picture God. The Hebrew Scriptures provide a wonderful variety of images to describe God, the most common being creator, king, lord, lawgiver, warrior, and liberator. But there are others less well known, mostly from the Wisdom books and Isaiah, ranging from inanimate to human metaphors: light, stronghold, shelter, rock, wisdom, helper, mother, father, midwife, farmer, and shepherd, to name just a few. Jesus (the unique image of God in human form) gave us other profound word-pictures of God, including abba, good shepherd, landlord, vine-grower, healer, a woman searching for a lost coin, a woman kneading bread, a father looking for a prodigal son, a mother hen sheltering her chicks. Unknown to many Christians today, several of the early writings of the Christian movement incorporated both feminine and masculine images for God. In homilies and theological reflections of the first Christian centuries, the motherhood of God was freely acknowledged along with the fatherhood of God.

The earliest existing artistic representation of the Trinity, found on a sarcophagus now in the Lateran Museum in Rome, shows three bearded men fashioning a tiny Eve while Adam sleeps nearby. Chronologically, the next representations of the Trinity were images of three identical male figures, the visitors of Abraham and Sarah. Another early image portrayed a hand representing the Father, a dove representing the Spirit, and a lamb representing the Son. Manuscripts of
eleventh-century England contain a variety of images of the Trinity, such as three masculine persons enthroned side by side surrounded by angels, or two seated masculine figures with a dove above them, or the enthroned Christ crowned with a wreath by the hand of the Father and a dove (Raw, 78–149). In the East, Russian iconographer Andrei Rublev (d. 1430) gave the world its most famous and enduring picture of the Trinity in his icon of the three angels sitting at table as guests of Abraham and Sarah.

Feminine representations of the Trinity were rare, but not totally absent. The twelfth-century mystic Hildegard of Bingen records an image of a circle of rays with the Holy Spirit in the form of a woman in the center. From the Middle Ages a unique representation found in a church in Urschalling, Bavaria, shows the Trinity as two men, one with dark beard and one with white, with a young woman between them representing the Spirit. A seventeenth-century painting, commissioned for a Black Forest church, even depicts a totally female Trinity—three seated women clothed in bright colors (Moltmann-Wendel, 46–103).

**Theological and Political Message of Images**

This rich, if sparse, tradition of various imagery for the Trinity is not known to most Christians. For the architects of theology have persistently presented a trinitarian model of God as Father, Son, and Holy Spirit, with the most common visual representation being two bearded white males and a dove. This predominant image asserts a powerful theological message about the identity of God. In addition to masculinity, this image reflects a static, remote triune God who watches the world and its affairs from a distance, granting mercy, passing judgment, or bestowing favors on the humans struggling for life on earth, far beneath the heavenly throne. The enthroned, all powerful king and his prince son, seated under the insignificant white dove, manifest royal authority as monarch, judge, and benefactor for the world below. Furthermore, they are represented as white European males, thus unabashedly proclaiming the divinity and superiority of the white race.

This sovereign Trinity exerts kingly power and does not tolerate any challenges to authority. On the other hand, this God is a persuasive and beneficial ally for men seeking power and dominion on earth. History confirms that human rulers have assumed that the heavenly monarch, like earthly kings, supports and awards violent military campaigns to win more subjects and more territory for his kingdom on earth. At the same time this king is considered to have little concern for the violence perpetrated on the so-called unbelievers who supposedly deserve the punishment given to them by the king's loyal subjects.

This pervasive image of the Trinity continues to influence the faith and behavior of Christian men and women today. Either consciously or unconsciously
the images we carry of God determine the manner of our relationship with God and one another. The image of the heavenly king and his son portrays as divine the qualities of power, strength, domination, might, authority, control, prestige, superiority. Those humans who can identify with the bearded white king or who see themselves as other sons of the king, attempt to incorporate these divine qualities into their own life. At the same time they often seek their appropriate place of power in this world and appeal to this God to legitimize their authority. For those persons who cannot identify with this king or his princely son (because of sex, race, or class), the virtues of humility, meekness, obedience, silence, submissiveness, and passivity are expected and even demanded—not only toward the heavenly king but also toward those humans who claim to be his earthly representatives.

The suspicion arises that the predominance of this imperial image of the Trinity for hundreds of years may have been inspired by political motivation. In Eurocentric cultures where Christianity has been the most successful, it is not difficult to find evidence that some segments of this culture have benefited from promoting this image to the exclusion of other images. One might surmise that this image was not promulgated mainly as pious art for religious inspiration but to serve another purpose, more closely allied to the aggrandizement of human power and earthly kingdoms. “The idea of a divine monarchy, projected out of the earthly monarch, was used to justify all kinds of hierarchy and domination: religious, moral, sexual, political” (LaCugna, 1991, 393). Images, especially those of a religious nature, are expected to express the truth of reality, but whose truth do they represent? Perhaps the answer to this lies in a further question: Does one class of a culture reap specific benefits from a particular religious image more than other classes do?

Either consciously or unconsciously the images we carry of God determine the manner of our relationship with God and one another.

The Power of Images

An objection might be raised that these visual and verbal images do not actually have such a powerful impact on the ordinary person’s understanding of God and God’s relationship with humanity. Yet, recently in an adult education situation, an elderly woman asked me in all sincerity, “Is God the Father
really a heavenly male with a long white beard?” Her intuition told her this could not be so, but this is the image she had heard/read/seen since youth in catechisms and biblical art. In another adult education class I taught a few years ago, I explained that God could be referred to as “She” as well as “He.” One woman got up from her chair, and with alarm said, “I could never do that. What if he doesn’t like it.” She walked out the door and never came back to class. The dominant masculine image had infiltrated her religious understanding and was total reality to her.

Another illustration on the influence of images comes to my mind from an occasion when I was attending Mass in my friend’s parish church a couple of years ago. The youth group had just returned from an experience of evangelization in Central America, where they used song and drama to portray the Christian message. They wanted to share one of their pantomimes with the parish that day. There were five actors, two boys and three girls, who would represent the five characters of Jesus, an innocent youth and the temptations of the world, the flesh, and the devil. My fears were verified when the three girls played the parts of the three tempters, while the boys represented Jesus and innocence. The most painful aspect of this experience for me was that no one in the parish noticed the underlying message for the girls and women. Elizabeth Johnson explains the theory working behind these examples: “The evocative power of the deeply masculinized symbol [of the Trinity] points implicitly to an essential divine maleness.” This has the “effect of casting men into the role of God while women stand as dependent and sinful humanity” (Johnson, 193), not to mention as the devil herself.

From these and other experiences, I can verify that images of God have a powerful and often unconscious influence on our faith and praxis. Margaret Miles provides an in-depth study on the history of Christianity as revealed through visual images. Miles found that the study of images through the centuries supplements the historical and theological texts and provides a new access to the religious ideas, attitudes, and values of ordinary folks. By analyzing the visual images used in worship spaces, insights can be gained into the religious world. “We must reconstruct on the evidence of the images themselves the spectrum of messages that were likely to be received by the worshipers who lived with them” (Miles, 7).
A more focused study by David Morgan reveals the impact on people of the popular painting *Head of Christ* by Warner Sallman. As a result of his study he claims, “I will argue that the act of looking itself contributes to religious formation and, indeed, constitutes a powerful practice of belief” (Morgan, 3). By looking at religious pictures people claimed they felt the presence of God, received comfort, strength, and courage, felt called to pray, and were confirmed in their concept of God. The author concluded that the religious world of people is constructed by images. “Language and vision, word and image, text and picture are in fact deeply enmeshed and collaborate powerfully in assembling our sense of the real” (Ibid., 9). A visual image often seems to embody the real presence of God for the viewers and infiltrates into their faith and practice. Morgan also discovered that as an image becomes anchored in the mind, it influences the way a biblical text is interpreted, and then the interpretation of the text confirms the pre-existing image.

In regard to visualizing God, the process works in this way: a picture of a kingly God on a throne is presented to illustrate the words, “Our Father who art in heaven,” and these words in turn confirm the image of God seated majestically on a throne in what is pictured as heaven. Morgan explains the process:

This is a powerful means of corroborating religious belief because it naturalizes the biblical text—or what believers take to be the text, but is actually their preconception of what the text itself means. What we come around to in the hermeneutical circle is the dogma, church practice, social order, and conceptions of gender, authority, and race that tell believers what the Bible means. These *pre-texts* constitute the ideological structures that guide the believer’s reading of the Bible and predispose him or her to interpret it in a particular way (140).

**Necessity of Human Images for God**

If verbal and visual images can be so perilous to God and humans, should all images be abolished in a new iconoclasm? That would be impossible according to David Freedberg, for “whether we have an image before us or not, the mind can only grasp the invisible by means of, or with reference to, the visible. . . . Thus we form images in our mind from our memories or from some image before us. The mind has no choice” (Freedberg, 191). If images are essential to human understanding, even of the divinity, then it seems many more images are needed to represent the fullness of the Trinity. If we truly believe Genesis 1:27 that both male and female were created in God’s image and likeness, then God must be represented by both the masculine and the feminine. If all the peoples on this earth
are created in God’s image, then representations of God must not be limited to white-skinned figures.

An escape from this dilemma of representation could be found by the use of only inanimate images for God, such as light, energy, rock, wind. These are certainly available to us from Scripture itself, yet Sallie McFague presents two excellent reasons to continue using the image of humanity. The first reason is that God was incarnated in humanity, with Jesus being the prime image of God. The second is that humans, male and female together, do reflect the divine image. “We were made in the image of God (Gen. 3:27), so we now, with the model of Jesus, have further support for imagining God in our image, the image of persons” (McFague, 1982, 20).

A New Down-to-Earth Image

Since images are essential to the human thought process and to the Christian sacramental view of reality, I suggest that we need to consider new visual and verbal images to replace the distant monarchy. We need an image which brings a loving, caring, relational God to earth, perhaps an image that depicts the Trinity walking among us, as Genesis 3:8 portrays God “walking in the garden at the time of the evening breeze.” A new portrayal of the Trinity (to be created or to be discovered in the archives of the world) could be similar to the famous icon of Andrei Rublev which features three angelic figures sitting at table as guests of Abraham and Sarah. The three figures are arranged around the table non-hierarchically, are not specifically masculine in form, and invite participation. The three angels, understood to represent the Trinity, invite the viewer to sit at table with them, to dine with them, to share their meal, to be in relationship.

To return to my introductory remarks, one example I would propose for consideration for a new image of the Trinity would be (or would closely resemble) the painting of The Gleaners. In this harvest scene the three stooped, walking figures are presumably women peasants, but their sexuality, age, and race are not pronounced since the figures are stooped and their faces do not show. These gleaners, wearing the simple garb of peasants, reach to the earth to gather grain that the harvesters have left behind. They value the insignificant, the negligible, the leftovers not considered profitable by those who reaped the choice portions of the harvest ahead of them.

This image of the Trinity gleaning among us on our earth would invite us into a dynamic, vibrant, working relationship with God, who chooses to walk with us in our daily lives. Rather than sitting on a jeweled throne in the distant sky, wearing spotless royal robes akin to the outmoded kings of the earth, God takes up residence on earth, even tenting among us according to the Gospel of John, “The Word became flesh and set his tent among us” (John 1:14). God works, cries,
laughs with humanity, day in, day out, at office, school, sick bed, kitchen sink, dinner table, field. We do not struggle alone but always in companionship with God, who desires to share our whole life with us.

The three gleaners also invite us to become gleaners, to come into the field with them, to walk and work with them, to gather the valuable resources of the earth bit by bit in order to provide bread for all humanity. The God who cares passionately for the people of the earth, provides for us the fruit of the earth, has also promised: “I will feed you with the finest of wheat” (Ps 81:16). The God of Jesus is like a woman taking yeast and mixing it in with three measures of flour until all of it was leavened and ready to be baked (Matt 13:33). God gathers the grain, bakes bread, and blesses, breaks, and distributes it at the Eucharist. God is busy gleaning side by side with us each day so that all children of earth may be fed with daily bread for body and soul. “I am the bread of life. This is the bread that comes down from heaven for [you] to eat and never die” (John 6:33,50).

This image of the Divine Gleaners also speaks to the current, urgent concern for the health and preservation of the environment of our earth. It is common knowledge that the natural resources of our earth are being exploited for the sake of financial profit. Air, land, and water are polluted by the careless disposal of wastes, from the small individual littering of garbage to the corporate dumping of toxic products. The God on the distant throne seems to be too preoccupied or too distant to be concerned. But the Gleaner God stoops with us (emphasis on
with us) to search for unexploded land mines, to pick up discarded trash, to plant flowers in the cracks of cement, to raise a hand to stop the progress of the bulldozers, to heal the wounds of the earth.

The Gleaner God is the divine administrator of justice who expects us to care for the neglected children, the homeless aged, the unemployed welfare mothers and fathers who live on the perimeters of society, on the edge of the field of plenty. “When you reap the harvest in your field and overlook a sheaf there, you shall not go back to get it; let it be for the alien, the orphan or the widow, that the Lord, your God, may bless you in all your undertakings” (Deut 24:19). God is the advocate of those who can find no human advocate, the healer who reaches out to soothe the wounded of heart, the listener who hears the feeble voice of the refugee, the one who keeps vigil through the night with the dying.

The Gleaner God walks quietly and softly at our side, asking us to tread lightly upon our earth which sustains us, to revere what it surrenderers for our use, and to bless it gratefully with our hands. If this image of God were imbedded in our minds and hearts, we would not dare continue the multiplication of lethal weapons, the greedy exploitation of the treasures of our planet, or the oppression and domination of the weak with whom God walks.

With this proposal for new images of the Trinity I am not intending to address the refined points of trinitarian theology, with all of its carefully crafted distinctions. I would remind those who may object that The Gleaners does not adequately represent Trinitarian theology, that surely two men and a dove are no improvement. But just as that image supposedly served a purpose in its time, other more meaningful images can take its place in a new time. The role of a new image would be to assist the belief of people who are struggling to find and claim a faith for themselves.

**Theo-Fantasy to the Rescue**

Perhaps what I am proposing with the image of *The Gleaners* is what Elisabeth Moltmann-Wendel calls theo-fantasy. She remarks that women, and I would add many men too, often find more meaning in their imaginations than
the scholastic tradition and language of theology. “For us, therefore, theo-fantasy takes its place alongside theo-logy and frequently reexcavates the buried sources” (Moltmann-Wendel, 119). Theology has been primarily the work of scholastics who have focused on their limited knowledge and experiences as well as the nuances of the written word, whereas life is more rich and colorful than any theological treatise.

Theo-fantasy calls upon the gift of human imagination to bring to our awareness those aspects of God that can easily slip unobserved between the planks of ponderous theological words. Theo-fantasy awakens our mind to glimpse new aspects of God in all of God’s wondrous creation and even in human creation, including art. “Sometimes we recognize that artworks have the capacity to transform the structures of our thought, to turn things upside down and literally to change the way we see” (Pattenden, 34).

Since we have become accustomed to seeing the Trinity mainly in one artistic form, that form needs to be turned upside down and inside out to inspire us with fresh insights into the unfathomable and unlimited mystery of God. Changing the way we see and consequently the way we understand and assimilate doctrine will enrich our relationship with God. As LaCugna reminds us, doctrine must insert God into our daily lives, rather than imprison God in an intradivine realm. “Preaching and pastoral practice will have to fight a constant battle to convince us, to provide assurances, to make the case that God is indeed present among us, does indeed care for us, will indeed hear our prayer, and will be lovingly disposed to respond (LaCugna, 1991, 411). After all, deepening our relationship with God is the purpose of our religious images as well as the doctrines they attempt to illustrate.

References


On the Theoretical Demands of Real Life

A Review Essay

William McDonough

... the ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed, the world is ruled by little else. Practical men, who believe themselves to be quite exempt from any intellectual influences, are usually the slaves of some defunct economist. Madmen in authority, who hear voices in the air, are distilling their frenzy from some academic scribbler of a few years back. ... But, soon or late, it is ideas, not vested interests, which are dangerous for good or evil (Keynes, 383–84).

Academic scribbler Alasdair MacIntyre’s new book Dependent Rational Animals: Why Human Beings Need the Virtues is astoundingly good. It is his best and most important book so far, in that it demonstrates John Maynard Keynes’s point above and gives contemporary practical morality a less defunct idea from which to start than the reigning sociological half-truth that morality belongs to and is made possible by groups.

MacIntyre himself has long insisted on the connection between ideas and practical life. He had articulated the Keynesian point in his A Short History of Ethics:

Philosophy leaves everything as it is—except concepts. And since to possess a concept involves behaving or being able to behave in certain ways in certain circumstances, to alter concepts, whether by modifying existing concepts or by making

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new concepts available or by destroying old ones, is to alter behavior. . . . It is important to allow the history of philosophy to break down our present-day preconceptions, so that our too narrow views of what can and cannot be thought, said, and done are discarded in face of the record of what has been thought, said, and done. (MacIntyre, 1966, 3–4).

Already in 1966, though, MacIntyre saw that the influence of ideas and practical life was more mutual than Keynes had articulated: “It is all too easy for philosophical analysis, divorced from historical inquiry, to insulate itself from correction” (MacIntyre, 1966, 3). In his new book MacIntyre has allowed his moral theory to be corrected by what he calls our “animal identities and animal histories” (MacIntyre, 1999, 82; all subsequent parenthetical references containing only numbers are to pages in MacIntyre’s new book). MacIntyre has allowed himself to be corrected by real life, and we should welcome his move as helpful to us all.

This essay comprises three sections and a brief conclusion. First, I explain a fundamental shift MacIntyre has made in his moral theory; the move can be summarized as a shift from sociology to biology as the ground of morality. Second, I briefly demonstrate the fruitfulness of this shift for practical thinking in economic, medical and sexual morality. Third, I show that this shift is welcome news for practical church ministry, which needs help rethinking its identity and purpose. The conclusion returns to the mutual relationship between the theory and practice in morality.

**MacIntyre’s Shift from Sociology to Biology as the Ground of Morality**

Dependent Rational Animals begins with an admission of theoretical error: “In After Virtue I had attempted to give an account of the place of the virtues . . . within social practices, the lives of individuals and the lives of communities. . . . I now judge that I was in error in supposing an ethics independent of biology to be possible” (x). MacIntyre’s admission about the error of his earlier and very influential volume is made dispassionately, but it has far-reaching implications.
He and, with him, much of contemporary morality have been wrong about where morality comes from. Below I will say more about the practical effects of this theoretical error and the promise held out by its correction; but, first, what does it mean to say that MacIntyre now wants to ground morality in biology and not sociology?

The opening page of Dependent Rational Animals claims that two biological facts are “of singular importance” for moral thinking: first, human beings are born vulnerable and subject to affliction; second, we are dependent on others for our very survival (1). Next, after claiming that these facts have been almost ignored in the history of moral philosophy, MacIntyre gives his book’s “central thesis”: “. . . the virtues we need . . . (are) the distinctive virtues of dependent rational animals, whose dependence, rationality and animality have to be understood in relationship to each other” (5).

The most basic truth about every human being is a biological one: “from the outset she or he is in debt” (100). Dependence is universal and “. . . there is a scale of disability on which we all find ourselves” (73). In what may be the most beautiful prose of the book, MacIntyre writes:

It matters . . . that those who are no longer children recognize in children what they once were, that those who are not yet disabled by age recognize in the old what they are moving towards becoming, and that those who are not ill or injured recognize in the ill and injured what they often have been and will be and always may be. It matters also that these recognitions are not a source of fear (146).

We make a theoretical error (with devastating practical results) about who we are unless we acknowledge these “facts of affliction and dependence” (6); for morality is reasoning about human flourishing, which “is in itself a question of fact” (64). I multiply MacIntyre’s references to fact to show how far he has moved away from his very odd 1988 claim (and its sweeping corollary) that “facts, like telescopes and wigs for gentlemen, were a seventeenth-century invention.... There are in fact no nontrivial statements which have appeared evidently true to all human beings of moderate intelligence” (MacIntyre, 1988, 357, 251).

But now it seems facts exist after all, nontrivial biological facts that carry with them far-reaching practical moral implications. From these facts MacIntyre begins to sketch a universal morality of what he calls “the virtues of acknowledged dependence” (119). To thrive as a human being is to acknowledge dependence, which itself entails at least two practical habits. First, we must learn to practice “just generosity” (129). Second, we must develop in our lives an “elementary truthfulness” that disallows us from taking a final stance of ironic detachment in relation to ourselves or others (150–52).
I will say more about justice below, but first more on truthfulness. Where contemporary moral philosopher Richard Rorty defends ironic detachment as a “realization that anything can be made to look good or bad by redescription” (151), MacIntyre sees it as a denial of the facts of human vulnerability. Like dolphins, we are born vulnerable and in need of protection; but unlike them we are “able on occasion to ignore or to conceal from (our)selves this fact, perhaps by thinking of (our)selves instead as Lockean persons, or Cartesian minds or even as Platonic souls” (82–83).

MacIntyre had critiqued these theorists in the past: he saw Plato’s aristocratic idealism as “irrelevant” for the practical lives of real human beings (MacIntyre, 1966, 60); he thought Descartes was responsible for generating a whole genre of falsely objective moral encyclopedias (MacIntyre, 1990, 58–60); and he thought John Locke’s theoretical idea of “entitlement” served as a moral cover for property holders unwilling to acknowledge that the lands they held had been stolen from someone else (MacIntyre, 1981, 251).

It was a largely negative critique posed in sociological terms: MacIntyre claimed that, in trying to account for everything, these thinkers were not self-critical about where they themselves stood. Trying to explain everything, they ended up standing nowhere. After Virtue took this negative critique furthest: in practice, such moral reasoning from nowhere has broken down our moral communities leaving us with protest as our only remaining moral language (MacIntyre, 1981, 71). The book concluded with the melodramatic and vague claim that we are in the “new dark ages . . . (and) what matters at this stage is the construction of local forms of community” where moral reasoning might again be possible. “We are waiting . . . for another—doubtless very different—St. Benedict” (MacIntyre, 1981, 263). In response to a flawed and self-interested moral sociology, MacIntyre proposed instead localized, authority-driven communities. Dreamy moral sociology was offered as a way out of self-justifying moral sociology.

Dependent Moral Animals, at last, offers both a clearer negative critique and a coherent positive alternative to the reigning moral sociologies. Negatively, Plato, Descartes, Locke, and so much of the rest of moral philosophy went wrong by failing to tell the truth about human biological vulnerability: we are going to die, and no moral philosopher can think this truth away. Positively, MacIntyre now
sees the seeds of an at least partly universal morality in any moral theories that take our biology seriously. Feminist (3, 164), Native American (120), Confucian (123), ancient Greek tragic (123), and Augustinian-Thomistic (124) theory and practice have in common an acknowledgment that morality is not learned “by theoretical reflection, but in everyday shared activities and the evaluations of alternatives that those activities impose” (136). They also know that moral teachers are more like parents and mentors than like professors (89). In a word, they ground morality biologically and not sociologically.

Just here, we can notice the depth and promise of his shift. The same MacIntyre who had held us incapable of talking to each other now finds every single human being with an inborn capacity—which we must learn to exercise—to grasp our “initial directedness to certain goods,” namely those of caring for and being cared for by others (72). This truth is built into dolphins, gorillas, bats, and other creatures whose biology is destiny (59, 82). It is built into us also, but deeply enough buried that we will learn it only from parents and mentors who “have in significant measure the habits that they try to inculcate” (89–90). If we did not have such teachers early on, “analysts” can help us find a “sense of self sufficient for an increasing degree of independence in practical reasoning” (85).

The effects of this honesty will be a growing sense of justice, MacIntyre’s other central virtue. For we will have learned the biologically-grounded fact that “the good of the individual . . . (is neither) subordinate to the good of the community nor vice versa” (109). In saying this MacIntyre stands on theoretical ground previously held by Aquinas: nothing that is truly good is in conflict with anything else that is good. It is a simple truth, not contradicted by how hard it is to live: afraid ourselves and surrounded by others who are afraid, we most often speak not our own moral “voice but an echo” (148); and we do each other great harm.

Our shared biological vulnerability, not communal practices, ground MacIntyre’s two virtues of truthfulness and justice. The same MacIntyre who before called for the construction of local forms of community now warns against what he calls “the communitarian mistake” with its “cult of the local community” (142). Communities, he sees, are all too often the places where scared humans gather to insulate themselves from the truth about themselves as well as from the needs of other human beings, and thereby “continue to lead distorted lives” (137).

We could hardly be further away from the concluding lines of *After Virtue*. It is not St. Benedict we are searching for, but “ordinary, good” parents and teachers (89). Such parents and teachers can be found anywhere human vulnerability is being acknowledged and practically responded to; we have no more important task in our lives than to find these teachers for our own sakes and to become more like them for the sake of others.
Some Practical Implications of MacIntyre’s Shift: economic, medical and sexual

MacIntyre’s abandonment of sociology for biology is timely: contemporary sociologically grounded ethics has been a practical disaster on every front. In this section of the review, I first explain this bold claim and then demonstrate the helpful alternative MacIntyre’s theoretical move is for us by applying his logic to three practical issues in morality.

My claim is that sociologically-grounded ethical approaches have not worked. Postmodern secular ethics has retreated from a search for shared human value, while so much religious ethics has become either boring and irrelevant or punishing in its attempts to impose practical moral uniformity within communities of faith. Catholic theologian and bishop Walter Kasper summarizes well where Catholic concern for our own communities has landed us:

Most of our inner-church struggles are of little interest to the great majority of human beings. They are the more or less esoteric concerns of insiders. Most human beings have other, more pressing concerns. In fact while the house is burning down, we are fighting about which picture frames should be dusted first, by whom and how. We forget that the church is not here for itself (Kasper, 44).

It is not that morality can do without well-ordered communities: MacIntyre makes a very good case that only “communal relationships that engage our affections” will enable us to become practical moral reasoners (126). But, where MacIntyre’s sociologically-grounded communitarian ethic was romantic and self-referential, his shift to biology gives a clear and non-romantic criterion: no community is worthy of our allegiance that does not teach the virtues of acknowledged dependence. Neither Rorty’s loosely affiliated liberal community nor a sectarian religious one passes the test: neither demands or makes possible that we should give “hospitality to passing strangers” (126).

I now suggest the practical work MacIntyre’s theory could do for us, by looking at issues in economic, medical and sexual morality. First, MacIntyre works out the practical implications of his theory most directly for our economic life. In doing so, he lands a mortal blow to Adam Smith’s free market ethics which, MacIntyre shows, is based on a theoretical mistake. That defunct economist Smith, it turns out, acknowledged that it is a “deception which rouses and keeps in continual motion the industry of mankind” (2). That is, Smith saw that wealth and greatness simply do not address the deepest longings of vulnerable human beings. But he found this deception useful, at least for the short run of life in which (some) human beings are able to ignore their mortality.
MacIntyre points out where we are led practically by Smith’s half-truth that “it is not from the benevolence of the butcher, the brewer or the baker, that we expect our dinner, but from their regard to their own interest.” Glosses MacIntyre:

But if, on entering the butcher’s shop as an habitual customer I find him collapsing from a heart attack, and I merely remark ‘Ah! Not in a position to sell me my meat today, I see,’ and proceed immediately to his competitor’s store to complete my purchase, I will have obviously and grossly damaged my whole relationship to him, although I will have done nothing contrary to the norms of the market (117).

Actually, I will have harmed also my relationship to myself. For Adam Smith offers human beings something we do not really want, and if I take it I will get more and more deceived about the meaning of my own life. To be less deceived about who I am, I must rather seek that “there should be relatively small inequalities of wealth” (144). I must seek some “settings—households, workplaces, schools, parishes—in which resistance to the goals and norms of a consumer society is recurrently generated” (145).

Next, MacIntyre’s virtues of acknowledged dependence offer something to our stalled conversations in medical and sexual morality. MacIntyre develops the particular implications of his theory less in these areas, but significant practical conclusions flow from a claim near the heart of his biologically-based morality. He connects two human needs, arguing that the first is most fundamental but that a second follows immediately after:

What someone in dire need is most likely to need immediately here and now is food, drink, clothing and shelter. But, when these first needs have been met, what those in need then most need is to be admitted or readmitted to some recognized position within some network of communal relationships in which they are acknowledged as a participating member of a deliberative community, a position that affords them both empowering respect from others and self-respect (127).

In medical morality these connected human needs add up to two related practical norms: I must care for you, and I must not promise more care than one dependent rational animal can give to another.

So I must know that you will be there, at times when you have promised to be there. I must know that you will not make promises that it would be unreasonable for you to make. I must know that in emergencies you will do what is needed and that you will not flinch when some task for which you have taken responsibility turns out to be much more unpleasant—coping with vomiting or persistent bleeding or screaming, for example—or much more burdensome than expected (110).
Though he mentions neither of the following issues, MacIntyre’s theory exposes the folly both of physician-assisted suicide, which is a failure to be present to another human being; and of a no-holds-barred intensive care vitalism, which makes unreasonable promises to human beings who are dying. MacIntyre’s insights about our mutual needs to care and be cared for should lead us to support and participate in forms of healthcare that promise neither too much nor too little to dependent rational animals.

Third, in family and sexual morality, MacIntyre’s shift to biology again brings clarity to real-life practical debates. “All happy families are not alike,” says MacIntyre (134); and he adds a practical criterion for judging when a family exists: the purpose of a family is to give a child “unconditional care (as a) human being as such, whatever the outcome” (100). Could same-sex partners lead a family? MacIntyre’s criterion suggests we are once again at a question of fact: if children can flourish in such an environment, a family is present.

Though he says nothing at all about the subject, MacIntyre’s biologically-based truth that “having been cared for, (we) care for others” (82), is the ground from which we could think more deeply about homosexual sexuality. After making the point about care cited just above, MacIntyre immediately rejects as a mistake the Stoic idea that human beings are able to offer “disinterested friendship” to other human beings (82). To be a dependent rational animal is to be incapable of disinterest in relation to others. What matters and is humanly possible is that others take an interest in us so that we become capable of caring.

Just here, the Roman Catholic Church would do well to think further, for in its Catechism (par. 2359) it calls on homosexual persons to renounce sexual relations and “by the support of disinterested friendship . . . resolutely approach Christian perfection.” The teaching rests on a theoretical mistake made by the Stoics; to follow it means to seek happiness outside of one’s own life, another triumph of sociology over biology.

I do not know that MacIntyre would join me in these practical conclusions. They are, however, extensions of his remarkable theoretical shift in seeking a more biological ground for morality. How helpful for us if we thought further about the practical look of a morality that arises from our mutual vulnerability.

MacIntyre’s Shift as a Practical Challenge to the Churches

Here I suggest MacIntyre’s great relevance for thinking about theology and ministry in our churches. In a recent article, theologian Gilbert Meilaender critiques MacIntyre’s philosophical stance as ultimately unhelpful to Christian believers. Meilaender writes that, while philosophers may understand morality in terms of mutual responsibilities and obligations, believers know it is founded
in self-surrender and self-sacrifice. Citing MacIntyre’s critique that self-sacrifice “is as much of a vice, as much of a sign of inadequate moral development, as selfishness,” Meilaender responds: “When a Christian writer makes such a statement, I think we may safely say that something has gone awry” (Meilaender, 54).

But Meilaender’s rejection distorts MacIntyre’s point and could short-circuit the very self-reflection to which we in the churches should be led by Dependent Rational Animals. MacIntyre is right to dismiss self-sacrifice as a mistake: human vulnerability and dependence are common to all of us, so the deepest good of one dependent rational animal cannot be gained at the cost of another’s self. To be a believer is not to sacrifice one’s self; it is rather to try to practice in one’s living what one holds as true and good for all human beings.

The same MacIntyre who rejects self-sacrifice makes clear that he is calling for something at least as demanding as what Meilaender sees at the heart of Christianity. To live the “just generosity” that is fundamental to MacIntyre’s morality will make the following demand on me: “I will have learned to act without thought of any justification beyond the need of those given into my care” (159).

Far from having gone awry, MacIntyre’s claim is clarifying for us in the churches. Indeed, do our churches exist for any other reason than to help us see we are more deeply “given into (each others’) care” than most of us realize most of the time? The perfectly coherent, if difficult theoretical philosophical claim that we are equally vulnerable and in need of care gets extended, not negated by theology. Theology and the churches want to demonstrate how (infinitely) far we have already been given into the care of others (and of Another). To universalize this theoretical philosophical point we in the churches need only practice ever-broader care.

Where Meilaender wants theology a priori to win a theoretical argument, MacIntyre shows that the problem lies elsewhere. There is something “deeply awry,” but it is in our own practices and not in MacIntyre’s theory. Above I quoted Walter Kasper to argue for MacIntyre’s relevance in re-thinking communal life in the churches. Here I specify the point: our church teaching and ministry has gone awry in a way MacIntyre’s theory can help us see. MacIntyre criticizes a “blandly generalized benevolence”:

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To be a believer is not to sacrifice one’s self; it is rather to try to practice in one’s living what one holds as true and good for all human beings.
The limitations and blindnesses of merely self-interested desire have been catalogued often enough. Those of blandly generalized benevolence have received too little attention. What such benevolence presents us with is a generalized Other—one whose only relationship to us is to provide an occasion for the exercise of our benevolence, so that we can reassure ourselves about our own good will—in place of those particular others with whom we must learn to share common goods, and participate in ongoing relationships (119).

Something like this has crept into ministry and teaching in our churches. Once we forget our own dependence, ministers and teachers can easily (mis)understand ourselves as Platonic rulers; or as Cartesian minds giving principles and directives for others; or as entitled Lockean holders of intellectual property. But to become in practice any of these is to undo with our lives the central theoretical truth claim of the churches.

Conclusion:
On the Theoretical Demands of Real Life

I conclude by noting a further theoretical reflection I want from MacIntyre. It is a reflection on the universality of the problem of coming to have a voice. MacIntyre should name more clearly and think through more rigorously that none of us yet fully has a voice; we are all echoes more or less on our way honestly to acknowledging our dependence.

A text from the opening and one from the closing pages of his book support this claim. In the book’s beginning, MacIntyre says some human beings, for example, women and physical laborers, often find themselves in positions in which the universal human “facts of affliction and dependence are most likely to be undeniable” (6). Such people as these are dependent, but is it really an acknowledged dependence? Does not a lack of voice in the form of discouragement or depression or marginalization more often than not characterize the very people who know in their bodies the facts of dependence? Acknowledgement is the problem here.

In the book’s closing, MacIntyre deals with the many of us who need to be taught these “facts.” To men with well-paying jobs who are able for a time to deny the facts of our dependence, MacIntyre says: “. . . what we should have learned from the virtues of acknowledged dependence is that this is a respect in which men need to become more like women” (164). But the truth is we have not yet learned it. And ours is the flip side of the problem of the marginalized voiceless: we who have voices, or who are at least making the loudest sounds, are not anxious to talk about our dependence. Dependence is the problem here.

I am pointing out that human voices are universally distorted by echo. MacIntyre knows this, but needs to be more rigorous in thinking it through. In a word, he
needs to think further about the fact of exploitation, which is the corollary of unacknowledged dependence. The term exploitation is used only once in the book as far as I can tell (102). In theology, exploitation and its universal effects go by the name of original sin. Whatever it is called, its long history of damage has deprived all human beings of voice, exploiters no less than the exploited: it “debase(s) perpetrators more than victims,” said Vatican II’s Pastoral Constitution on the Church in the Modern World (par. 27).

I end with this not to undermine the welcome and ordinary changes MacIntyre’s morality of acknowledged dependence is asking of us, but to highlight that we are all scared and need each other in the tasks we face. Alcoholics Anonymous has good words for what I would like more help from this academic scribbler in thinking about: our challenge may be simple, but that does not at all mean it will be easy.

References


The U.S. Census Bureau is releasing a steady stream of information concerning the results of Census 2000. This most recent comprehensive survey provides a "family portrait" of who we are as Americans. These numbers will be the subject for analysis, discussion, and debate for years to come. But one thing is beyond dispute: American society is now more racially, ethnically, and culturally diverse than ever before in living memory. To take but one example: those Americans who indicated that they were "white alone" (I hasten to note that this category is not mine, but that of the Census Bureau)—that is, who stated they belonged to just one racial group designated as "white"—number only 62.6 percent of the population. Given the commonly admitted undercounting of certain groups, including Latinos and African Americans, it is reasonable to assume that at least four out of every ten Americans are, in the convoluted language of U.S. bureaucracy, "Latino or non-white."

Not only is American society becoming more multiracial and multicultural, it is also more religiously diverse. The Census Bureau is prohibited from asking respondents about their religious affiliation. However, a recent (May 2001) report on National Public Radio notes that there are now more Muslims than Jews living in the United States. Indeed, the Muslim population is more numerous than the Episcopalian—a denomination which has had significant influence in American life. This same source further reports that Hindus and Buddhists also are an ever-more significant presence in our social life. It is thus increasingly difficult, and even false, to assert without qualification that the United States is a "white Christian nation."

Moreover, it is likely that these demographic shifts will only accelerate and become more pronounced as this new century—indeed, this decade—progresses. Currently people of color, women, and immigrants comprise 53 percent of the workforce; many believe that by 2005, 85 percent of those newly entering the workforce will be women, people of color, and immigrants. Hence the landscape of American society is being, and already has been, decisively altered. Our schools, workplaces, parishes, religious congregations, and dioceses are more racially, linguistically, and culturally diverse than many might ever have imagined or dreamed possible—or desirable.

This momentous, even unprecedented, demographic shift is one of the chief "signs
of the times” which demands deep reflection. It has major implications for social ethics and pastoral planning. This is all the more the case because as a nation we have little historical experience from which to gain the wisdom needed to negotiate this shift successfully. Our previous approach to the issue of diversity was expressed in the metaphor of “the melting pot.” That is, the goal given to previous social groups upon coming to the United States was to become as indistinguishable as possible from the “White Anglo-Saxon Protestant” dominant group. The solution to cultural diversity was a process of cultural assimilation. To a great extent, this homogenizing approach has been a success for Catholics whose ancestors hailed from Europe. However, the “melting pot” strategy now fails us. Its limitations become ever more apparent as we confront the fact that many social groups have not been, cannot be, and/or have no desire to be, culturally assimilated. We thus have little concrete experience for how to be a “stew,” or “salad,” or “quilt,” or “gumbo”—to name just a few of the metaphors being used to describe our new situation.

Furthermore, the demographic shifts of the present and near future force us to face the unfinished business of our nation’s past and current struggles for racial justice and equality. The ghosts of our legacy of racial inequality continue to haunt us. The April 2001 racial violence and protests in Cincinnati, the racial inequities in the criminal justice system, the continuing controversies over affirmative action, the popularity of “English only” initiatives, the presence of “gated communities,” the hate crimes perpetrated against those deemed different and dangerous provide ample evidence that managing our demographic transition and forging a new American identity will be neither easy nor smooth. We undertake this task burdened by a legacy of racial injustice, social intolerance, and cultural privilege.

What wisdom, then, can the Catholic faith and ethical tradition provide for living in the midst of such a deep cultural transition? How can we become communities that prize, rather than lament, our new family portraits? What resources do we have for forging what Martin Luther King, Jr. called “the beloved community,” that is, an inclusive community where difference is not a source of fear but a cause for celebration? In the brief space of this column, I cannot solve the numerous concrete pastoral problems posed by the demographic shift. These concerns include the practicalities of multicultural worship, vocation recruitment, seminary education, and evangelization. Rather, I will situate these practical concerns in a broader horizon or perspective. This fundamental faith vision is characterized by catholicity, conversion and humility, a concern for truth, and a respect for power.

Catholicity

In the corporate world, cultural diversity is “managed” by training employees in sensitivity and respect for those who are “different.” The goal is toleration, so that differences do not compromise an organization’s productivity, public image, or legal liability. Faith, however, takes a different approach. We begin from the premise that the range of color and culture in the human family is a holy gift of God and reflects the design of the Creator. Precisely because we are “catholic”—universally inclusive—the variety of peoples, languages, cultures, and colors among us must not be tolerated as an unavoidable fact, but cherished as a divine gift. In the light of faith, the current demographic shift is a passage toward becoming a more authentic and truer reflection of the human family in whom God delights. Any other approach is tantamount
to rejecting the way in which God chooses to manifest the Divine Image in human-kind.

Conversion and Humility

Accepting this faith vision entails a call to conversion. Ethnocentrism—the belief that one's own culture is central to reality and has a privileged possession of truth and presumption of rightness—seems endemic to the human condition. Once again, faith takes a different perspective. In the words of Gustavo Gutiérrez, evangelical conversion demands an on-going “break”: “We have to break with our mental categories, with the way we relate to others, with our way of identifying with the Lord, with our cultural milieu, with our social class” (Gutiérrez, 1973, 118, italics added). True conversion requires a never-ending struggle against whatever attitudes and vices are contrary to God’s creative wisdom manifested by the diversity of the human family. This means that the demographic shift, when viewed in the horizon of faith, summons us to a stance of cultural humility. This humility entails a paradox; we must both celebrate and relativize our cultural heritages. We prize the unique manifestation of God mediated through our own cultural histories, artifacts, and perspectives; we realize that our particular culture’s insight into and appropriation of the Divine are partial and limited; we then can gratefully respect and appreciate another people’s expression of the infinite reality that is God.

A Concern for Truth

A recognition of the valuable but limited insight of every culture into the reality of God means that faith communities are also called to be communities of conscience, that is, places where the truth is spoken about the ways in which particular cultures have both formed and malformed our public lives. As mentioned earlier, the successful resolution of our demographic transition is hindered by an oppressive burden of injustice. Actions and omissions of the past have built an enduring edifice of unequal social relationships between the peoples and cultures of U.S. society. Unless we honestly engage the past, we cannot heal the present and create a new future. As James Cone, a preeminent black theologian, so rightly notes, “Amnesia is an enemy of justice” (xi). Faith communities, then, are called to witness to the truth, celebrating the understated contributions made to faith and society on the part of many and confessing the unacknowledged harms done as well. Naming and confessing personal collusion, ancestral culpability, and institutional complicity will be, without doubt, disorienting, confusing, and challenging for many. Faith communities, by providing the strength and courage for facing difficult truths, can be important midwives as America gives birth to a new and more authentic national identity.

A Respect for Power

A final observation is that we cannot afford to be naive about the power relationships present in and challenged by the demographic shift. Indeed, Sunday worship all too often reflects, rehearses and reinforces the skewed power disparities of race, class, and ethnicity present in the wider society. For example, “power” is demonstrated and ritualized in worship through what is sung and in whose language, through who is active and who is acted upon at liturgy, and in the composition of the assembly (that is, who is present and who is absent).

On the other hand, Sunday eucharistic worship also has a prophetic edge. The Eucharist challenges and transforms our understanding of power. We gather in
memory of Jesus: a powerful person who taught with authority, forgave sinners, rebuked demons, and transcended cultural barriers. However, his power was not an exercise of coercive dominance; rather, his was a power shown in vulnerability and compassion, a power revealed in presence and accompaniment, a power expressed in silent suffering and tenacious fidelity at the cross. Hence, the Christian community can provide a vital service during this time of demographic transition by being a witness of alternative forms of power other than the coercion present in current social relationships.

**Conclusion**

The present and future demographic shift, while not without peril and challenge, is also an occasion of grace and opportunity. As we strive to honor and listen to the increasing variety of cultures and languages present in the United States, in our workplaces, and in our parishes, beneath the distressing cacophony of Babel’s tower we may well discover the harmonious melody of God’s spirit. Indeed, “what we might then begin to hear, above our own chatter, are possibilities we have never dared to dream” (Tracy, 79).

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Ten years ago in this same column I asked the question, “What Ever Happened to Mary?” This reflected the curious reality that Mary had almost disappeared from theological reflection and popular devotion in the early post-Vatican II church, at least in the United States. The column examined a number of reasons for this lapse of interest and drew attention to some initial motifs in a renewed interest in this central figure of Catholic tradition. Ten years later, I think it is safe to say, “She’s back!”

Early retrievals of theology of Mary, following the council, drew on themes of the council that asserted the unique mediatorship of Jesus, and Mary’s role in the Church as exemplary disciple. The council initiated a move away from the privilege-centered Mariology particularly characteristic of the nineteenth century to a theology of Mary that emphasizes continuity between Mary’s life and the lives of women today. Paul VI’s *Marialis Cultus* provided guidelines for a renewed popular devotion to Mary within the theological spirit of the council. Early theological explorations also drew on contemporary biblical scholarship and echoed the concerns of a developing feminist theology. Appropriately they reflected the entry into theology of significant numbers of women theologians from around the world. These theologians saw in Mary both a source of hope and a figure herself in need of liberation from past interpretations that saw her either as passive and docile, or as an idealized image of feminine virtue. Liberation theologians of the seventies and eighties both male and female saw in Mary, especially the Mary of the Magnificat, a powerful symbol of the liberating intent of God who stands on the side of the poor and powerless of society.

These initial explorations continue to form the basis for ongoing interest in Mary over the past ten years. The explosion of writing in this period not only indicates the deep awareness in the Christian churches that something is missing when we lose touch with Mary, but also that the figure of Mary is a complex and mysterious symbolic reality in Church life. Studies in the nineties both develop the theological direc-

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tions of the eighties and mine their insights for including Mary in a responsible ecclesial spirituality. Two major themes characterize recent works. The first focuses on the search for the “historical Mary” and the second emphasizes more her symbolic role in Church life and tradition. Probably the greatest danger in a theology of Mary is the loss of a creative tension between these two approaches that can lead either to unhealthy exaggeration or excessive diminution of her importance. Let me single out just a few representative works and authors.

Elizabeth Johnson continues to be an important voice in Catholic theology of Mary. Although she acknowledges the profound symbolic role that Mary has played in Catholic tradition and imagination, her focus is on getting in touch with the historical Mary, in spite of the difficulties posed by the paucity of information about her in the Christian sources. One avenue she suggests is new studies of life in first-century Palestine that open a window into the life of a poor, observant Jewish woman. Theologically, Johnson expands on feminist tendencies to stress continuities between Mary and other human beings by placing her firmly in the company of the saints, interpreted inclusively to include all human beings in a web of connections with the natural world. Mary is a friend of God and prophet in whom all those still on the journey can find hope and inspiration. Johnson’s book *Friends of God and Prophets* offers a feminist interpretation of the communion of saints that provides a context for rethinking Mary’s place in Christian tradition.

George Tavard’s work *The Thousand Faces of the Virgin Mary*, while not neglecting the historical, focuses more on the symbolic dimensions of the Mary tradition as a way to overcome the barriers to exploring Mary’s significance beyond narrowly Catholic or even Christian discussions. Tavard draws on his wide experience and involvement in ecumenical theology and intra-Christian and interreligious dialogues to provide an introduction to the place of Mary in these traditions. Although there is a reawakening of interest in Mary within many Protestant traditions, theoretically she remains a divisive figure. Agreements that have been reached on major church-dividing issues, such as justification, have not been able to be reached on Mary. Tavard attributes this to a narrow focus on Marian doctrines, particularly since the Reformation. His book contains a wide ranging discussion of the many images of Mary, starting with the young Jewish woman of the Scripture and moving to the symbolic importance of Mary as the female face of the divine which may make a connection with the religions of the east.

While Tavard’s work is driven by his ecumenical concerns, Sally Cunneen’s work *In Search of Mary* consciously attempts to bring together the many images of Mary in art, literature, and poetry in a very readable work that surveys the history of doctrine and devotion to Mary. She too notes that a search for Mary reveals many different versions and that each generation has found in her a way to touch the deepest truths we know about ourselves and about the divine. Cunneen suggests that today’s understanding of the symbol of Mary must be one that “is true to the Bible and church tradition, that fosters reverence rather than contempt for Jews, and that does not praise Mary by denigrating other women” (273). A good guideline!

The recovery and reclaiming of the symbol of Mary continues to be of particular importance for women theologians from many cultures and contexts. The image of the Mary of the Magnificat is a powerful emblem of the cry for liberation from all kinds of oppression voiced by
Latin American liberation theologians. “The image of the pregnant woman, able to give birth to the new, is the image of God who through the power of God's Spirit brings to birth men and women committed to justice, living out their relationship to God in a loving relationship with other human beings” (Gebara and Bingemer, 73).

Korean theologian Chung Hyun Kyung sees Mary as “both a model for full womanhood and of the fully liberated human being. As a virgin she is a self-defining woman; as mother she is giver of life to God and humanity; as sister she is a woman in solidarity with other women and with the oppressed” (King, 269). A paper on Mary that grew out of the Singapore Conference of Asian Women Theologians critiques the prevalent image of Mary as eternally young and will speak to many who experience their own aging.

The young woman who sings of revolution does age. The woman who stands, with other women, at the foot of the cross, and who is present with the community at Pentecost, is an older woman, a woman of wisdom and strength, who suffers, with God, the loss of her son... It is time for us to claim and celebrate the presence of the Spirit in old women. We need them (King, 273).

Many of these theological themes are woven into a lovely book called *Meditations on Mary* by the poet and essayist, Kathleen Norris. Beautifully illustrated with classical works of art, her meditative essays offer another window into the many faces of Mary and the points of continuity between her life of faith and the lives of women today. “When I brood on the story of the Annunciation, I like to think about what it means to be ‘overshadowed’ by the Holy Spirit; I wonder if a kind of ‘overshadowing’ isn’t what every young woman pregnant for the first time might feel, caught up in something so much larger than herself” (Norris, 31).

*Mary: Art, Culture, and Religion through the Ages* also makes central the theme of the many faces of Mary and the reality that her complex symbolic meaning is not easily or appropriately reduced to any one defining picture or image. Its sumptuous presentation of pictorial images through the ages gives visual credence to the theological themes we have been exploring. Mary has indeed revealed different facets of the divine-human relationship through history and continues to do so today. Although this work confronts us with the reality that our images of Mary, whether in art, music, literature, or theology have been predominantly produced by men, it introduces new images that reflect the transformation of Mary’s role through the enormous societal conflicts and changes of the twentieth century.

A final theme of the last decade has been a continuing interest in the phenomenon of apparitions, perhaps not surprising in the apocalyptic atmosphere of the turn of the century. While religious bookstores once again have shelves of books on Mary, closer inspection reveals that many of them deal with apparitions. What does this mean? The official church takes a cautious attitude to apparitions (National Conference of Catholic Bishops), and there is obviously in these phenomena the possibility of exploitation, and the danger of retreat into a privatistic spirituality antithetical to the spirit of Vatican II. A provocative work on the topic is Sandra Zimdars-Swartz’s *Encountering Mary*. Zimdars-Swartz points out that the tradition of apparitions usually involves the most marginalized in both
Church and society; the poor, especially women and children. However one evaluates the apparition events themselves, the tradition of apparitions can challenge the institutional church to take seriously the experiences and concerns of the world's poor and suffering.

This eclectic sampling of some recent approaches to Mary reveals that our generation too is fascinated by the figure of Mary and continues the quest for an understanding of Mary that will reflect and respond to the pressing questions and concerns of the twenty-first century.

**References**


Canned homilies—whether purchased by subscription or downloaded from the Internet—are the bane of authentic liturgical preaching. No, this is not the rant of another homiletic purist, but rather the challenge of the Roman Catholic understanding of the homily, from the Second Vatican Council onward. To better understand this challenge, I will review fifteen years of developing Catholic insight into one particular aspect of the homily, and then look at some practical implications of this development.

Adapting the Word

Insights into the nature of the homily came gradually. The homily was restored in 1963, in Sacrosanctum Concilium (The Constitution on the Sacred Liturgy, 35; cf. 24, 52). The next year, the Congregation for Rites began the process of unfolding the implications of the conciliar restoration. The Congregation wrote that the homilist should be “taking into account the particular needs of the listeners” (First Instruction on the Proper Implementation of Sacrosanctum Concilium 54 [ICEL: 100]). Liturgical preaching was not to be generic and timeless but rather suited to the particular identity of a particular assembly.

In 1965, the Second Vatican Council’s Gaudium et Spes (Pastoral Constitution on the Church in the Modern World) was adopted. In paragraph 44, it furthered the insight that all preaching must be adapted to its listeners:

The Church learned early in its history to express the Christian message in the concepts and language of different peoples and tried to clarify it in the light of the wisdom of their philosophers: it was an attempt to adapt the Gospel to the understanding of all men and the requirements of the learned, insofar as this could be done. Indeed, this kind of accommodated preaching of the revealed Word must ever be the law of all evangelization. (Flannery: 946, alt.)

Five years later, this general “law” was applied to homiletic preaching. The Third
Instruction on the Proper Implementation of Sacrosanctum Concilium (Liturgicae instaurations 24) insisted that the homiletic task is "to make clear to the faithful the proclaimed word of God and to make it fit the sensibility of our age" (ICEL: 161). Post-conciliar Catholic preachers were to master the skill of adaptation and accommodation of the revealed Word to the needs of the hearers.

Inculturating the Word

In 1979, Pope John Paul II contributed a new term to Roman Catholic understanding of the ministry of the word: "inculturation." The term comes from missiology, and would eventually be applied directly to liturgical preaching. A more generic use came first:

As I said recently to the members of the Biblical Commission: "The term ‘acculturation’ or ‘inculturation’ may be a neologism, but it expresses very well one factor of the great mystery of the Incarnation" (AAS 71 [1979]: 607). We can say of catechesis, as well as of evangelization in general, that it is called to bring the power of the Gospel into the very heart of culture and cultures. For this purpose, catechesis will seek to know these cultures and their essential components; it will learn their most significant expressions; it will respect their particular values and riches. In this manner it will be able to offer these cultures the knowledge of the hidden mystery (cf. Romans 16:25; Ephesians 3:5) and help them to bring forth from their own living tradition original expressions of Christian life, celebration and thought (Catechesi tradendae [Apostolic Exhortation on Catechism in Our Time; hereafter CT] 53).

Inculturation as a concept, then, combines the task of accommodation of the gospel with an explicit statement of its intended result—original expressions of Christian life.

John Paul II's description of this accommodation is a good one which could fruitfully be applied across the spectrum of the ministry of the word, from evangelization to acts of catechesis and of preaching:

a) they must be linked with the real life of the generation to which they are addressed, showing close acquaintance with its anxieties and questionings, struggles and hopes;
b) they must try to speak a language comprehensible to the generation in question;
c) they must make a point of giving the whole message of Christ and his Church, without neglecting or distorting anything, and in expounding it they will follow a line and structure that highlights what is essential;
d) they must really aim to give to those who use them a better knowledge of the mysteries of Christ, aimed at true conversion and a life more in conformity with God's will. (CT 49)

Finally, the direct application of this developed theology of inculturation to preaching came in a 1993 papal address, as John Paul II received and commended The Interpretation of the Bible in the Church, a document of the Pontifical Biblical Commission. The Pope said:

The Bible exercises its influence down the centuries. A constant process of actualization adapts the interpretation to the contemporary mentality and language. . . . [In order for it to have profound effect,
there must be inculturation according to the genius proper to each people. . . . In our day, a great effort is necessary, not only on the part of scholars and preachers, but also those who popularize biblical thought: they should use every means possible. . . . so that the universal significance of the biblical message may be widely acknowledged and its saving efficacy may be seen everywhere. . . . (De tout cœur 15).

Actualization and inculturation are here denominated as among the means by which preachers release the power of the word. The Pontifical Biblical Commission document itself explains these processes in some depth, and shows them to be at the heart of liturgical preaching (see IV[B], IV[C(3)]).

This brief survey of official documents highlights one important aspect of the journey of the restored homily. Early on, the Church understood that the needs of the homily’s listeners somehow needed to be taken into account. “Adaptation” and “accommodation” were shorthand for that concern. Ultimately, the much richer concept of “inculturation” became regnant. The authentic homily is an inculturated homily which at once incarnates the eternal Word in the language and symbols of a particular assembly and empowers that assembly to bring forth new expressions of Christian life in the world.

The Inculturating Preacher
The implications of inculturation for our preparation and preaching are manifold. I highlight some of the most important ones.

No Canned Homilies. As should be obvious by now, a homily written by someone other than the preacher, written for some non-existent, “generic” community, is a homily lacking in the necessary characteristic of inculturation. While it is possible to glean helpful elements from the homily of another, it is on balance more fruitful to study and pray over the scriptures with your particular assembly already present in mind and heart.

Local Images. Eminent homiletician David Buttrick wrote that “Homiletic thinking is always a thinking of theology toward images” (Buttrick: 29). The inculturated homily is one in which the images are drawn from the daily life of the particular assembly. For inspiration in this, the preacher need only reflect upon the preaching of Jesus, the master of thinking theology toward local images.

Local Knowledge. The preacher cannot accomplish the goal of inculturation, then, without knowledge of the assembly’s “significant expressions . . . particular values and riches” (CT 53); in short, the “real life of the generation [being] addressed . . . its anxieties and questionings, struggles and hopes” (CT 49). How do we accomplish this? Part of the answer lies in a commitment to awareness and to theological reflection. The sweet burden of the Word entails a dedication to watching and listening closely to the ebbs and flows of culture—national, regional, local, ethnic. Beyond such observation, though, we commit ourselves to theological reflection, the conscious act of bringing together the stuff of life with the stuff of our tradition.

But there is more that can be done. Leonora Tubbs Tisdale, in her book Preaching as Local Theology and Folk Art, suggests that a disciplined exegesis of the liturgical assembly is as necessary and as possible as an exegesis of the scriptural texts. She recommends careful attention to the “culture texts” of the congregation: its stories, archives, demographics, art and
architecture, rituals, events and activities, and prominent and marginalized people. Tisdale shows how these “texts” can reveal much of the assembly’s unique identity, including its views of God, humanity, nature, time, and the Church. The inculturating preacher is by necessity a cultural anthropologist and ethnographer.

Underneath all of the preacher’s efforts toward inculturation is nothing less than the mystery of the Incarnation. Just as the Son of God was born in a particular culture and at a particular time and yet revealed the eternal God, so too the words of the preacher, though drawn from a particular congregational culture, express the everlasting revelation of God in Jesus Christ.

References


Note

1 Flannery has “this kind of adaptation and preaching . . .”; the Latin has: “. . . accommodata praedicatio lex omnis evangelizationis permanere debet.”
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