ABSTRACT

Self, Stigma, and Identity Work in the Pentecostal Experience of Illness

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I examine the religious behaviors and interactions of ill Pentecostals and charismatics as they engage with a religious group and belief system that teaches that God wants to heal all believers in this life. I use the Baylor Religion Survey (2010) to model OLS regressions of how attendance and prayer are affected by the experience of illness and Pentecostalism, and I also analyze 18 interviews with ill Pentecostals for themes of private and public religious interactions. I find that being both ill and Pentecostal has a negative effect on church attendance compared with no effect on attendance for other ill persons. However, ill persons and Pentecostals both pray more often. My interview data suggest that while Pentecostals engage in accepting internal interaction rituals like prayer, their external interactions may be characterized by challenges to moral status that provide limited opportunities for acceptance of a personal identity characterized by illness.

Self, Stigma, and Identity Work in the Pentecostal Experience of Illness

by

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CHAPTER ONE

Introduction

Pentecostal and charismatic religious groups historically have shared the belief that miraculous healings should be an expected part of contemporary Christian experience (Synan 1997). They affirm that God offers believers a baptism in the Holy Spirit that is accompanied by such spiritual gifts as speaking in tongues and divine healing, and that based on the atoning work of Jesus Christ deliverance from both sin and illness is available to believers. But while Pentecostals often have a normative expectation of miraculous healing for every illness, individual Pentecostals still sometimes experience on-going illness that does not yield to faith and prayer. How such individuals interpret and respond to intransigent illness merits empirical investigation. Since the ill individual must interact with a larger Pentecostal community that shares the expectation of healing, the individual's physical state of illness may also pose interactional and identity challenges for them within their group context. Where the religious group is dramaturgically enacting public healing rituals in services, and preaching healing as the evidence of God at work in a person's life, the ill individual may face feelings of stigma when interacting with others in that context, and may question their own personal religious identity.

Using a mixed methods approach, I explore the ways in which charismatics and Pentecostals who experience on-going illness engage with their religious groups and interpret their experience. Using national survey data I examine the impact of chronic illness on religious attendance and prayer. I find that, while the attendance of

Pentecostals is negatively affected by physical illness or disability to a greater degree than for others, their frequency of private prayer is higher. In order to explore the reasons for this dissonance between the private and public religious engagement of ill Pentecostals and charismatics, I conducted semi-structured interviews of chronically ill or disabled Pentecostals. I describe specific interchanges where the social identity of these individuals is challenged by other Pentecostals. I then proceed to explore: 1) How their religious personal identity is reoriented within their internal interactions with God, 2) How they present this personal religious identity to their Pentecostal group, and 3) Specific social situations in which they encounter acceptance for their presentation of personal identity. This grounded analysis complements the survey data by providing a theoretically sound explanation for why Pentecostals and charismatics may withdraw from public religious interactions while maintaining an engaged private religious life.

CHAPTER TWO

Literature Review

Background of Pentecostal Healing Beliefs and Practices

Healing has been central to the Pentecostal church since its beginnings in 1901. Before Joseph Parham began to assemble the distinctive Pentecostal doctrine linking spirit baptism to the evidence of speaking in tongues, he was in fact a faith healer. He formed a "healing home" as early as 1898 where sick people could come and be prayed for (Synan 1997:90). Parham was not the only leader in the early Pentecostal movement who believed and preached divine healing. Mary Woodworth Etter and Alexander Dowie, who came to identify with the Pentecostal movement, led healing campaigns during this time in Florida and Illinois (Synan 1997:192). Joseph Parham's student, William Seymour, taught both spirit baptism and divine healing in Los Angeles during the Azusa Street Revival, beginning in 1906. Through these leaders, the expectation of divine healing became a central doctrinal position of the Pentecostal movement as it spread. In time, this movement solidified into different denominations like the Assemblies of God and the Church of God in Christ. It is these denominationally affiliated groups that are referred to today as Pentecostal. Charismatic groups emerged in the latter half of the 1900s, as individuals from mainline denominations remained in their churches, but began to practice spirit baptism, speaking in tongues, and healing (Poloma 1982:11). Neo-charismatics showed up in the 1970s, when certain nondenominational churches began to display these same characteristics, but rejected the "Pentecostal" or

"charismatic" label (Robbins 2004:121). For the remainder of the paper, when referring to all three groups, I will use the abbreviation of P/C. Today, the P/Cs movement is estimated to account for 23% of the U.S. population (Lugo, et al. 2006).

The theology of P/C groups revolves around a particular kind of relationship with God. It is believed that through the atoning sacrifice of the Son of God, in His death and resurrection, anyone who repents of their sins and believes in Him can be fully reconciled with God. This sacrifice and reconciliation covers not only the spiritual sins of believers, but *also* provides healing from physical illness and disability (Blumhofer 1993:5; Synan 1997:89). Thus, divine healing is a holistic activity in which believers are reconciled with God in all areas of life: spirit, mind, *and* body. This holistic approach to healing has fostered various interpretations of the causes of illness in different P/C groups. Some groups pray for deliverance from negative or malevolent spiritual influences which are thought to be causing the illness or simply preventing healing from occurring (Robbins 2004:122). Others consider sin or unresolved inner conflict to be a barrier to healing (Poloma 1982:96). Finally, prosperity gospel groups believe that the ill person must consistently confess in faith that they are healed in order for divine healing to take place (Bowler 2013:147). In each case, illness is not simply a physical problem; it is dependent on having a right relationship with God, who, through the power of atonement, provides healing for spirit, mind, and body (Poloma and Green 2010:123). Thus, lack in any one of these areas may be interpreted as indicative of a rift with God that must be rectified.

These theological beliefs about healing are lived out within religious groups. They form part of a collective identity that differentiates Pentecostals from others and that situates them in relationship to God. This collective identity is reinforced through

religious rituals that church members participate in together. Church sermons may serve as a space to recount stories of miraculous healings. In the weekly Sunday service, there is often an altar call in which the leader invites people to come forward for prayer for physical or spiritual problems. The leaders may lay hands on a sick person and pray for their healing while the congregation agrees in prayer (Poloma 1982; Synan 1997). Special services may even be dedicated solely to prayer for divine healing. Charismatics who attend mainline churches may not experience these rituals of structured prayer, but are likely to have informal relationships with others who share a belief about healing. In both structured settings and informal gatherings, rituals of healing prayer reinforce a specific part of the collective Pentecostal identity that situates the group as believers in relationship with a God who readily provides physical healing to those who ask and have faith.

It is important to note that although the early Pentecostal movement eschewed the use of medical treatments, today many Pentecostals believe that God can also act to heal through medical procedures (Synan 1997; Williams 2013). So, while prayer for physical healing may ask for a successful medical procedure or for immediate divine healing, the focus of the prayer is that *God* is the one who is acting to bring about this healing regardless of how that occurs (Williams 2013). In either situation, *God acts primarily through healing, not through illness*.

Of course, many P/C believers do in fact experience medical problems and disabilities such as Alzheimer's disease, cancer, diabetes, and Rheumatoid arthritis. It is also empirically the case that many of these P/C believers do not experience healing from these conditions through either natural or supernatural routes. Given the central

importance of healing for P/Cs, illness that does not in some way yield to healing poses a challenge to both the collective religious identity of the group and to the ill or disabled individual's personal identity as a believer in healing. If God reconciles believers to himself through healing in all areas of life, what is the implication of persistent illness for someone who prays and believes, but does not receive physical healing? Do they lack faith or are they mistaken in who God is?

Recently, several Pentecostal theologians have attempted to address the issue of what role the ill and disabled can find in a church where there is a clear, normative expectation of healing (Ma, Menzies, and Spittler 2004; Mittelstadt 2004; Yong 2007, 2010). While they suggest that ill or disabled Pentecostals may theoretically find meaning in their suffering or in a new identity, they do not empirically describe any Pentecostal settings in which such an alternative framework for identity is being actively articulated. Instead, these very publications demonstrate an implicit understanding that the normative expectation of divine healing present in Pentecostal settings today marginalizes people in the church for whom healing does not occur. While the work of these theologians is not empirically oriented, the presence of this discourse amongst theological leaders of the Pentecostal community highlights an area of the human experience within these groups that warrants further investigation.

The growing body of empirically based literature about the Pentecostal and charismatic movement does not sufficiently address how P/Cs experience illness within their religious context. The literature tends to focus on descriptions of healing rituals and historical accounts of the theology produced and practiced by healers and leaders in the P/C movement (Bowler 2013; Csordas 1997; Hardesty 2003; Poloma and Green 2010;

Synan 1997; Williams 2013). The problem with this approach is the tendency to treat the P/C experience as homogenous within each congregation or group. Healing experiences are sometimes described in great detail, but often lack description of any but *one* type of experience. Scholars who focus on tracking the history of the movement from the perspective of leaders and within the context of theology (Bowler 2013; Hardesty 2003; Synan 1997; Williams 2013) tend to provide accounts that are divorced from the interactional context within which lay believers operate when they seek healing for a physical problem. Csordas (1997) focuses in more detail on the interactions and beliefs of the ritual context of healing, but he groups in physical illness with the spiritual and emotional problems that other believers encounter, providing no reflection on how these experiences might differ. Instead, all healing is treated as fulfilling the same function in the group. This approach ignores an obvious differentiating characteristic for the chronically ill or disabled: they often exhibit visible symptoms of their physical problem. In a context where the religious collective identity assumes a healing God who listens and responds to prayers, visible symptoms of continuing physical problems could be expected to create interactional challenges and potential stigmatization for the ill or disabled individual. No current empirical research systematically considers the potential marginalization of the ill within this unique belief context.

Kate Bowler provides limited insight into what the experience of illness may involve for P/C believers. Almost as a side note, she describes several difficult interactions she had during fieldwork in one congregation (Bowler 2013). This particular church emphasized the importance of positively confessing one's healing. Some church members refused to be interviewed because symptoms were still persistent. Others said

that they were healed despite what appeared to Bowler to be clear physical markers of persistent symptoms of the very illness they were claiming to have been healed from. She notes that leaders in the church discouraged certain members from coming forward for healing if they continued to be ill for an extended amount of time. Bowler's research provides a start in the direction of understanding how some P/Cs respond to persistent illness within their religious group. However, there is a need for empirical research that *centrally* examines how chronically ill or disabled individuals participate in a collective identity of relationship with a healing God. In short, this paper is an attempt to remedy this deficiency.

Theory: P/C Experience of Illness, Identity, and Internal Interaction

In the lives of most people, such possibilities as pain, suffering, and death are distant or limited to the lives of others; a personal experience of chronic illness or disability bring these things into the world of the real, and disrupt not only the physical reality of that person, but their moral foundations as well (Bury 1982). While a religious person may lean on their faith to provide an explanation and emotional support for what is happening to them (Berger 1990; Stark 2000), it may be difficult for P/Cs to reconcile their belief in a healing, responsive God with physical symptoms that do not abate. After all, it could be asked, if God does indeed heal immediately in response to the prayers of faithful believers, why hasn't it happened for me? Leon Festinger suggests that when a person undergoes this kind of discontinuity between their experience and beliefs, it results in negative feelings that prompt them to reestablish continuity between the dissonant parts of their experience (1957). An ill or disabled P/C believer could remedy this by simply rejecting their beliefs, but someone with longstanding religious affiliation

would be abandoning more than just healing belief. They may be leaving crucial networks of potential physical support at their church, as well as moral foundations that extend beyond physical healing to define their eternal salvation and provide the emotional support and identity of a personal relationship with God. So, how else might a P/C maintain their religious beliefs when they experience a physical reality that comes into such conflict with it?

Often, individuals who find themselves in a position of such cognitive dissonance may find ways to redefine God's motives or activities, reorienting their personal identity so their experience and beliefs are continuous (Sharp 2013). The internal work that an ill or disabled person does to reestablish continuity may not necessarily bring them closer to the collective identity of their group. If they publicly reject any part of the belief in divine healing, their social identity as a P/C believer—as a moral person in good relationship with God—may be seen as less legitimate when they interact with other P/Cs. And if they display visible symptoms of ongoing illness or disability, others may simply assume that they are not in right relationship with God, since he would have healed them if they were. In either case, the ill or disabled person is seen as not fully participating in a P/C collective identity that situates believers as people in good relationship with a healing, responsive God. Indeed the interactional context is constantly producing challenges to someone with a social identity that does not reflect this particular belief in divine healing, since the religious group enacts and reifies, often on a weekly basis, the very healing beliefs that are so dissonant with the lived experience of a chronically ill or disabled believer.

In this context, ill or disabled individuals face stigmatization; their physical problem is a marker of spiritual deficiency, calling into question their identity as someone in good relationship with God (Goffman 1963). Thus, the ill or disabled P/C is left to manage both their *self-concept,* as they internally come to terms with what their illness means for them as a religious person, and their *social identity,* as they negotiate their place in their religious group in light of this stigmatized identity. To define these terms more clearly: the self-concept can be thought of as the person's total view of themself as a moral, social, and physical individual. When they interact with others in a social context, and those other people attribute certain characteristics and meanings to them, that is their social identity. Finally, the individual draws on parts of their self-concept in order to present a particular picture of themself for others; this presentation of self is their personal identity. As a whole, they are engaging in identity work from start to finish of this process. They develop a certain self-concept internally, and present parts of that to others through their personal identity. Finally, other people observe their presentation of self and any visible characteristics like illness or disability and attribute a certain social identity to them (Goffman 1963; Snow and Anderson 1987). As the person engages in this identity work, they operate on two fronts: backstage and front stage. In their backstage activities, they develop a self-concept that makes sense of their experiences. In their front stage space, they draw on this self-concept to present a particular personal identity to others as they negotiate the stigmatized social identity that others have for them (Goffman 1963).

The unique element of backstage activity for P/Cs is that it too is an interaction—each P/C has an intimate, personal relationship with God that is expected to influence the

development of their self-concept. Tanya Luhrmann describes the way this personal God relationship functions for "soft charismatic" Evangelicals (Luhrmann 2012). They are taught to perceive God as an acting and communicating participant in their everyday lives. He becomes an internal significant other who the P/C interacts with through the mediums of prayer and scripture. He influences their self-concept as a religious person in the same way another significant other might be expected to. In fact, the religious group fully expects God to transform the self-concept of each believer as He brings them into closer relationship with Himself—reconciliation with God is, for Pentecostals, the entire purpose of the atoning sacrifice of Jesus.

While the group's beliefs clearly influence how each individual expects God to interact with them, when they hear from God, it is in the private, backstage space of their own mind, where an ill person does the work of evaluating how to reconcile their religious identity with their physical symptoms. This space is separate from the front stage enactments of public rituals of healing. What they hear from God need not necessarily be constrained by the structure of external social interactions that reinforce a stigmatized identity. The individual draws from P/C resources like scripture and the group's teachings about God's identity, but they evaluate these internally. The internal interaction rituals they have with God could provide unique opportunities for the individual to develop a religious self-concept that, while it may not find acceptance from the religious group, receives the legitimizing authority of confirmation by God.

Front stage interactions are dominated by the process of facework, as individuals engage in a give and take of verbal and non-verbal communications that convey one's personal identity to others, and engage or contest the stigmatized social identity that

others perceive (Goffman 1955, 1963). Each person naturally wishes to be perceived by others in a positive light—to present a personal identity that others see as acceptable—and in the best-case scenario they present themself in such a way that this occurs. However, when an ill or disabled person tries to communicate their personal identity as a believer in good relationship with God, they are undermined by the discrediting characteristic of their illness or disability. Instead of interacting with the ill person based on any actual spiritual characteristics, they may assume that the person is not in good standing with God, and communicate with them accordingly. This interaction challenges the positive identity that the discredited individual is trying to present. Goffman suggests that a stigmatized person may respond to the interactional challenge by withdrawing their claim or by presenting a new interpretation of the situation (Goffman 1955). If an ill or disabled person has developed a self-concept in their relationship with God that does not align with the stigmatized identity that says they are spiritually needy, they may respond to an interactional challenge by presenting this different interpretation of their personal identity. The challenger may choose to accept this interpretation or not. It may be easier, when encountering an interactional challenge of this sort, to withdraw from those interactions than to present this different interpretation of their identity, particularly if previous engagements have taught them that their presentation of self will not be accepted by other P/Cs.

In sum, several questions arise as to how ill and disabled P/Cs maintain positive self-concept and manage a positive social identity in an interactional context where their physical problem is viewed as discrediting to their moral status. In this paper, I provide an empirical exploration of these interactional dynamics. If public religious interactions

do in fact prove challenging to the ill or disabled individual's social identity in that group, we could expect that they may withdraw from interactionally challenging situations such as church services or interchanges with people they know will not communicate acceptance of a positive personal identity. The belief context would seem to also create a significant level of cognitive dissonance for ill or disabled P/C. However, private religious interactions may provide a space for them to reorient their self-concept, providing legitimation for their personal identity that is not available through external interactions with their group. If this is the case, we could expect higher levels of participation in prayer and descriptive evidence of this in interviews. I begin with an analysis and discussion of the quantitative trends in P/C attendance and prayer for those who are frequently ill. I then explore the qualitative evidence for a theory of interactions for the ill and disabled in the Pentecostal context.

CHAPTER THREE

Survey

The two dimensions of religious practice that are important to quantitatively evaluating how a P/C experiences illness or disability are public and private religiosity. Prior scholars have evaluated levels of public religious engagement through attendance. While P/Cs have been shown to have high rates of church attendance (Dougherty et al. 2011), the functional limitations associated with illness can reduce attendance overall (Ainlay, Singleton, and Swigert 1992). These functional limitations could be expected to reduce attendance in a similar way for both P/Cs and non-P/Cs. However, despite the fact that attendance is generally higher for P/Cs, if the P/C healing belief produces a significant challenge to the social identity of an ill person through interactions, we could expect the attendance of ill P/Cs to decrease to a greater extent as they withdraw from the context of public religious interactions.

The second dimension of a P/C's religious experience that may be affected by illness or disability is private religiosity. Since personal relationship with God is experienced through interactions with Him, we could evaluate the frequency of prayer to explore what effect illness or disability may have. Generally, P/Cs pray more frequently than other religious people (Lugo et al. 2006). In addition, poor physical health tends to increase prayer as people reach out to a supernatural power for comfort and support (Elizabeth Rippentrop et al. 2005; Haley, Koenig, and Bruchett 2001; Koenig et al. 1997). This would seem to indicate that ill P/Cs would pray more often than both healthy

P/Cs and all non-P/Cs. Testing whether this is the case allows us to examine whether the challenge that healing belief produces results in withdrawal from one's relationship with God, or engagement in this relationship as they reorient their self-concept.

In sum, the questions I propose to explore through quantitative analysis are the following:

1. How does the frequency of attendance for ill P/Cs compare with that of other groups?
2. How does the frequency of prayer for ill P/Cs compare with that of other groups?

Methods

Survey data for this study come from the third wave of the Baylor Religion Survey, which was conducted by the Gallup Organization in the fall of 2010. The survey employed a national random sample of 1,714 adult respondents. These data are uniquely suited to this analysis since questions ask about both P/C identity and physical health.

Dependent Variables

Attendance. Attendance is used to gauge the public participation of P/Cs in their religious context. Respondents were asked, "How often do you attend religious services at a place of worship?" Possible responses included: "Never," "Less than once a year," "Once or twice a year," "Several times a year," "Once a month," "2-3 times a month," "About weekly," "Weekly," and "Several times a week." I treat the variable as a scale with "Never" coded as 0 up to "Several times a week" coded as 8.

Prayer. To evaluate private religious engagement, I use a question about personal prayer. Respondents were asked, "About how often do you spend time alone praying outside of religious services?" Possible responses included: "Never," "Only on certain occasions," "Once a week or less," "A few times a week," "Once a day," and "Several times a day." This variable is also treated as a scale with "Never" coded as 0 up to "Several times a day" coded as 5.

Independent Variables

Pentecostal/charismatic identity. Pentecostal or charismatic identity has been measured in previous Baylor Religion Surveys using one of the following: denominational affiliation, speaking in tongues, and self-identification (Dougherty et al. 2011). This particular wave of the BRS does not include a question about speaking in tongues, so I have used self-identification as my variable for identifying Pentecostals and charismatics. This assumes certain knowledge on the part of respondents as to what these terms mean, but it presents a measure that is inclusive of those P/Cs who may not identify with a Pentecostal denomination. The self-identification question reads: "How well do the following terms describe your religious identity?" Respondents are asked to respond to a set of identification terms on a 1 to 4 scale of "very well" to "not at all." For the purposes of this study, if the respondent answered that "Charismatic" or "Pentecostal" described them "very well" or "somewhat well," they are coded as 1. If they answered for both identifiers that it described them "not very well" or "not at all" they are coded as 0.

Frequent illness. To analyze the presence of frequent illness, I created a dichotomous variable based on three items pertaining to physical health. These items are

part of the Healthy Days measure developed by the U.S. Center for Disease Control. The three questions are: "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?" "During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?" Possible answers for each question were: "none," "1-10 days," "11-20 days," "21-29 days," and "all 30 days." In previous work, frequent illness is categorized as 14 or more days (Chowdhury, Balluz, and Strine 2008). Since this response category is not available on this survey, if a respondent answered that they had been sick "21-29 days" or "all 30 days," on any of the three questions, I coded this individual as 1 for frequent illness. All others were coded as 0 for frequent illness.

Frequent illness x Pentecostal/charismatic identity. To explore how the attendance and prayer of ill P/Cs compares with that of other groups, I have created an interaction term between the two variables, P/C self-identification and frequent illness. This will test whether there is an effect specific to the ill P/C group that uniquely affects their rate of attendance or prayer.

Controls

Controls include various demographic and religious characteristics. Dichotomous variables include sex (Male=1), marital status (Married=1), race (White=1), employment status (Employed=1), region (South=1), and children (Has children under 18 living at

home=1). Age ranges from 18 to 108. Education and income are controls. Education is coded from 1 to 7: 1=8th grade or less, 2=9th-12th grade (no high school diploma), 3=High school graduate, 4=Some college, 5=Trade/Technical/Vocational training, 6=College graduate, and 7=Postgraduate work/Degree. Income is a 7 point scale from 1=$10,000 or less in annual earnings to 7=$150,000 or more.

Because this analysis primarily relates to types of religious engagement, several religious variables are included as controls. A system of dummy variables is included for religious tradition, including Evangelical, Mainline, Black Protestant, Catholic, Jewish, other, and none (Steensland et al. 2000). None is the exempted category for these analyses. Finally, a control is included for belief in an engaged God. This is important to include since Pentecostal identification is closely linked to engaged God belief, and we want to know whether Pentecostal identification, and not just one associated belief, is responsible for the effects on attendance or prayer when interacted with health. The engaged God variable is composed of four statements in which the respondent is asked "Based on your personal understanding, what do you think God is like?" The four statements are "Concerned with the well-being of the world," "Directly involved in world affairs," "Concerned with my personal well-being," and "Directly involved in my affairs." Each is a 4 point Likert scale from strongly agree to strongly disagree, and they show a .90 Cronbach alpha when combined. These questions have been summed to create the engaged God variable for this study. This measure is based on the core questions that comprise the "engaged God" belief used by Froese and Bader (2010).

Plan of Analysis

To examine how illness affects public and private religious participation of ill P/Cs, I conduct two OLS regressions. The first explores attendance as an outcome, and the second examines prayer.In each of these models, I evaluate how P/C identity and illness each independently affect frequency of religious engagement. Also included in each final model is the interaction term between P/C identity and frequent illness that shows how ill P/Cs are uniquely different in their rates of attendance and prayer.

Results

The average characteristics of the individuals in this survey are displayed in Table 1. Several clear disadvantages appear to be connected with both frequent illness and P/C identity. Both groups show lower income and education levels. While the frequently ill are less likely to be employed or to have the social connections of marriage or children at home than the average person, P/Cs are more likely to identify as non-white. The intersection of these two groups, represented byfrequently ill P/Cs, would appear to experience a higher degree of disadvantage in day-to-day life than others.

Religious characteristics are as expected for P/Cs. They display very high rates of attendance and prayer compared to the overall sample. Half of all P/Cs report attending weekly or more often, and their average attendance is between “2-3 times a month” and “about weekly.” In comparison, the average attendance of the total sample is less than once a month. Reported frequency of prayer is also significantly higher for P/Cs. 71.2% pray daily or more often, whereas the average person from the overall sample prays just short of “a few times a week.”

Comparatively high rates of attendance and prayer for P/Cs may reflect a social desireability bias in the way they choose to answer these questions. Because people prefer to present themselves well in relationship to others, if they think prayer or attendance characterizes a person of their particular religious beliefs, they may report higher levels of attendance or prayer than they actually have (Hadaway, Marler, and Chaves 1993). While P/Cs could be expected to reflect this trend in over-reporting prayer

Table 3.1 Descriptive Statistics by Pentecostals and Frequent Illness[1]

Variables	Frequently Ill (n=148) % or Mean	P/Cs (n=281) % or Mean	Total Sample (n=1,397) % or Mean
Male	54.7%	42.1%	46.4%
White, Non-Hispanic	73.0%	66.9%	74.9%
Evangelical	22.6%	41.2%	30.6%
Children under 18 at home	16.8%	29.9%	27.4%
Employed	44.8%	60.1%	64.2%
Age	57.95	53.56	53.91
Married	53.5%	60.5%	64.7%
Income	3.60	3.84	4.39
Education	4.17	4.37	4.76
Attendance	3.11	5.23	3.78
Prayer	3.16	3.93	2.93
Southern	28.4%	26.0%	24.5%
Pentecostal	26.4%	-	20.1%
Frequently Ill	-	13.9%	10.6%

or attendance, social desireability bias could also be expected to similarly affect the responses of other religious individuals since valuing prayer and attendance is common for other Protestant Evangelicals, and Catholics and Mainline believers as well. Given these commonalities, the difference in the reported frequency of prayer and attendance is

[1] Note: Missing cases of Frequently Ill and Pentecostals are excluded.

Table 3.2 Regression of Attendance on Frequent Illness and Pentecostalism[2]

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Intercept	3.50***	0.85	-1.66***	-5.02***	-5.09***
	(0.09)	(0.51)	(0.50)	(0.53)	(0.53)
Frequently Ill	-0.88***	-0.80**	-0.76**	-0.69**	-0.22
	(0.25)	(0.27)	(0.24)	(0.23)	(0.27)
P/C Identity	1.85***	1.89***	1.34***	0.57**	0.80***
	(0.19)	(0.20)	(0.19)	(0.18)	(0.19)
P/C Identity*Frequently Ill	-	-	-	-	-1.80***
					(0.51)
Child at Home		1.22***	0.94***	0.67***	0.65***
		(0.21)	(0.19)	(0.18)	(0.18)
Employed		-0.12	-0.11	-0.16	-0.18
		(0.19)	(0.17)	(0.16)	(0.16)
Age		0.04***	0.02***	0.02***	0.02***
		(0.01)	(0.01)	(0.01)	(0.01)
Married		0.67***	0.56**	0.48**	0.45**
		(0.19)	(0.17)	(0.17)	(0.17)
Income		-0.15*	-0.10	-0.07	-0.05
		(0.06)	(0.06)	(0.06)	(0.06)
Education		0.17**	0.16**	0.23***	0.23***
		(0.06)	(0.05)	(0.05)	(0.05)
South		0.43*	0.30	0.25	0.26
		(0.19)	(0.17)	(0.16)	(0.16)
Male		-0.11	-0.01	0.26	0.27
		(0.16)	(0.15)	(0.14)	(0.14)
White		-0.42	-0.31	0.04	0.07
		(0.23)	(0.21)	(0.20)	(0.20)
Religious Tradition					
Evangelical			3.88***	2.12***	2.12***
			(0.25)	(0.30)	(0.30)
Mainline			3.81***	2.16***	2.18***
			(0.25)	(0.30)	(0.30)
Black Protestant			3.56***	1.84***	1.75***
			(0.55)	(0.54)	(0.54)
Catholic			3.65***	2.06***	2.06***
			(0.26)	(0.30)	(0.30)
Jewish			2.77***	1.53**	1.52**
			(0.57)	(0.57)	(0.57)
Other			3.75***	2.26***	2.23***
			(0.38)	(0.40)	(0.40)
Engaged God Belief				0.38***	0.38***
				(0.02)	(0.02)
r^2	.07	.14	.31	.40	.40

*p<.05 **p<.01 ***p<.001

[2] Note: VIF less than 2 except for system dummies Evangelical, Mainline, and Catholic. "Nones" are the comparison group for religious tradition.

likely to be affected in a similar way for both P/Cs and non-P/C religious persons, and is not expected to discount the differences between these groups.

The religious characteristics of those who are frequently ill are also as expected, but the differences from the overall sample are less marked than for P/Cs. Those who are frequently ill do attend slightly less often than the average person, but pray slightly more.

Public religious engagement is examined in Table 2, with an OLS regression of illness and P/C identification on attendance. Added in progressive models are demographic variables, religious traditions, engaged God belief, and finally, the interaction term of frequent illness x P/C identification. P/C identity is associated with higher attendance in all models. Frequent Illness is associated with lower attendance in Models 1-4. However, when the interaction between P/C identification and frequent illness is added to model 5, frequent illness loses its significance; instead, the interaction term, frequent illness x P/C identity, shows a significant negative effect on attendance. This indicates that, when you account for all the other variables in model 5, the negative effect of poor health on attendance is only meaningful for P/Cs. Although P/C identity has a positive overall effect on attendance (.80 in model 5), the added interaction effectively cancels this out. Attendance drops 1.8 for ill P/Cs, below that of well Pentecostals and all non-Pentecostals too.[3]

Figure 1 illustrates these results by displaying the average attendance expected for each of four groups: Healthy non-P/Cs, Ill non-P/Cs, Healthy P/Cs, and Ill P/Cs. In this

[3] It should be noted that although engaged God belief has a consistent, significant positive effect on attendance across all models in Table 2, an interaction (not shown here) between engaged God belief and health was not significant and did not change the effect of frequent illness on attendance. This demonstrates that Pentecostalism is not simply a mediator for the effects of engaged God belief.

chart, all other variables were set at average levels to demonstrate the differences in attendance between each of these groups when other characteristics are held constant. At these average levels, healthy P/Cs have an attendance of 2-3 times a month, other religious persons attend just over once a month, and ill P/Cs only attend several times a year.

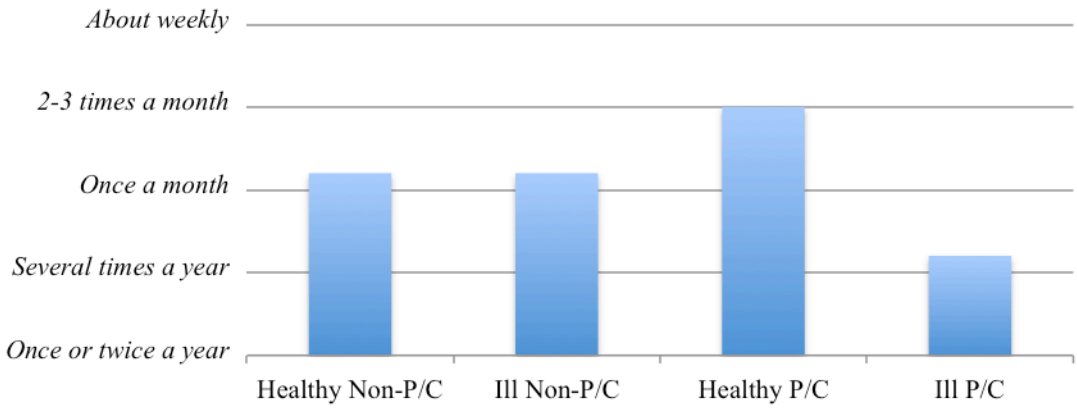

Figure 3.1 Frequency of attendance expected for an average person[4]

Factors that may affect frequency of prayer are explored in table 3, which displays an OLS regression of prayer on the same variables tested for attendance. Frequent illness has a significant positive effect on frequency of prayer only in the final model. This relationship does support the literature on health that suggests that frequently ill persons do pray more often. P/C self-identification has a significant positive effect on the frequency of prayer in every model. Although there is no unique effect that influences prayer for P/Cs who are frequently ill, they do tend to pray the most when compared to non-P/Cs or any healthy P/Cs.

[4] Levels for other variables are held constant as the following characteristics: married, 55, evangelical, some college, no child at home, average engaged God belief.

Table 3.3. Regression of Prayer on Frequent Illness and Pentecostalism[5]

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Intercept	2.659***	2.734***	1.045***	-1.227***	-1.242***
	(0.055)	(0.318)	(0.308)	(0.304)	(0.305)
Frequently Ill	0.169	0.158	0.198	0.208	0.312*
	(0.155)	(0.167)	(0.150)	(0.133)	(0.153)
P/C Identity	1.243***	1.182***	0.837***	0.266**	.317**
	(0.119)	(0.125)	(0.116)	(0.103)	(.120)
P/C Identity*Frequently Ill					-0.393
					(0.293)
Child at Home		0.462***	0.294**	0.130	0.125
		(0.128)	(0.116)	(0.103)	(0.103)
Employed		-0.007	0.007	-0.069	-0.073
		(0.116)	(0.105)	(0.094)	(0.094)
Age		0.014***	0.007	0.006	0.006
		(0.004)	(0.004)	(0.003)	(0.003)
Married		0.269*	0.191	0.052	0.045
		(0.117)	(0.106)	(0.095)	(0.095)
Income		-0.116**	-0.075*	-0.036	-0.034
		(0.039)	(0.036)	(0.032)	(0.032)
Education		0.041	0.030	0.087**	0.087**
		(0.034)	(0.031)	(0.028)	(0.028)
South		-0.052	-0.141	-0.222*	-0.222*
		(0.115)	(0.105)	(0.093)	(0.093)
Male		-0.625***	-0.547***	-0.382***	-0.381***
		(0.100)	(0.091)	(0.081)	(0.081)
White		-0.653***	-0.621***	-0.364**	-0.357**
		(0.141)	(0.131)	(0.117)	(0.117)
Religious Tradition					
Evangelical			2.541***	1.044***	1.043***
			(0.153)	(0.173)	(0.173)
Mainline			2.383***	0.972***	.974***
			(0.156)	(0.174)	(0.174)
Black Protestant			2.092***	0.662*	.644*
			(0.336)	(0.309)	(0.309)
Catholic			2.293***	0.928***	.927***
			(0.157)	(0.174)	(0.174)
Jewish			1.866***	0.717*	.714*
			(0.352)	(0.328)	(0.328)
Other			2.319***	1.045***	1.038***
			(0.234)	(0.230)	(0.229)
Engaged God Belief				0.277***	.277***
				(0.013)	(0.013)
r^2	.07	.15	.32	.46	.46

*p<.05 **p<.01 ***p<.001

[5] Note: VIF less than 2 except for system dummies Evangelical, Mainline, and Catholic. "Nones" are the comparison group for religious tradition.

In sum, these results show that ill P/Cs are more privately religious than others, but less engaged than others in the communal religious activity of attending services. Only P/Cs show lowered attendance with illness, which seems to indicate that this religious group presents a unique interactional challenge for the ill person. However, a higher rate of prayer amongst ill P/Cs suggests that the social challenge that P/Cs encounter at church does not cause individuals to withdraw from their internal interactions with God.

These findings raise the question: *Why* do ill P/Cs tend to disproportionately drop off in church attendance while still maintaining a vibrant personal spiritual practice? Although I have proposed a theoretical approach for P/C identity work above, I explore the empirical evidence for this using interviews with ill and disabled Pentecostals.

CHAPTER FOUR

Interviews

Methods

I conducted semi-structured interviews with 18 chronically ill or disabled adults who attend Pentecostal churches. Every church that was included supports belief in divine healing as provided through the atonement. Participants were from five churches located in three Midwestern states. Eight of the adults attended Assemblies of God churches, and 10attended non-denominational churches. I made contact with pastors through personal connections, and requested that each pastor put me in touch with five individuals from their congregation who experience an "ongoing illness or disability" and who might be willing to be interviewed. Each pastor emailed me a list of individuals, and I contacted them myself. I was able to schedule 18 interviews, which I conducted between May and June 2013. With the exception of one phone interview, all were conducted in person.

Because I was interested in understanding social mechanisms involved in the public and private religious experiences of an ill or disabled Pentecostal, questions revolved around these topics. I asked interviewees to relate the history of their health problem and then to answer a series of questions about their church involvement and personal spirituality. Although I began and ended with approximately the same general questions, I followed the precedent set by grounded theorists for modifying the interview script based on new patterns that emerged during the course of interviewing (Gubrium and Holstein 2002:676). The interviews were semi-structured to allow for interviewees to

lead the narrative in the direction most relevant to them, however, any question that was not answered by the interviewee in the course of their own narrative was asked later. Interviews lasted an average of an hour, with some as short as half an hour and others almost two hours in length. I personally transcribed all of the interviews with particular attention to pauses, emphases on words, and emotive expressions such as crying and laughter.

Although I asked questions specifically to elicit responses about certain topics, I use grounded theory coding in order to derive codes from the meaning interviewees sought to convey. I explored the interviews through rounds of initial, focused, and theoretical coding. In the initial coding stage, segments of the text were evaluated for their analytical import on a line-by-line basis. Codes that were particularly useful in the initial round of coding were compared across interviews and other sections of text, and were refined to become the basis for a second, focused round of coding. A final, theoretical round of coding was used as I combined the disparate codes under theoretical concepts that could be used to categorize the data for analysis.

Through the exploration of interviews, I attempt to provide a description of the P/C experience of illness grounded in the subjective experiences and meanings communicated by individuals in this context. The methods I chose for this endeavor are guided by feminist theory of qualitative research. Specifically, I wished to avoid exploiting the interviewees as conduits for data; instead, to use the language of Ann Oakley, I hope "to be a tool for making possible the articulated and recorded commentary of [Pentecostals] on the very personal business of being [ill or disabled] in a [healthy social group] (Oakley 1997:48–49). While Oakley spoke about women in a Patriarchal

society, I believe the ill and disabled are a minority group who desperately desire to be heard—to have their *own* stories told—and who so often do not have the resources or even the ability to communicate that story to others. Being guided by this methodological approach, I use grounded methods throughout the research process. I also consider the qualitative interview not as hierarchically separated scientist and subject, but as a dynamic relationship occurring between two subjectively positioned individuals (Ellis and Berger 2002). By employing collaborative work to an extent with interviewees, and engaging in self-disclosure when asked, I honor this relationship and communicate that I value my interviewee as a person experiencing a very real and often difficult reality. I do not believe I could have done otherwise when engaging with individuals who shared with such vulnerability these experiences with me.

My interviews included a degree of collaborative theory building, and a definite element of self-disclosure. I requested feedback about my quantitative findings from each interviewee, asking them if they had any thoughts about why this is something I might be observing. I placed this question at the end of the interview so it would not influence their account of their own personal experience of illness. However, this question allowed the interviewees to be collaboratively involved in the meanings elicited from this data. Several interviewees, when asked this question, recounted stories of people they had known who had had challenging illness experiences with a Pentecostal group. Others took the opportunity to critique certain trends in Pentecostal churches. It also provided a chance for me to hear an insider's check on the interpretation that I as the researcher placed on their experiences. Some clearly rejected the finding as not being representative

of their experience. And several suggested alternative frames for understanding these results, which helped guide my later interviews and my final analysis.

Various scholars, and especially feminist researchers, emphasize the importance of self-disclosure as facilitating rapport with the interviewee and validating their subjective experiences (Denzin and Giardina 2006:182; Oakley 1997:49). Although I had a certain amount of rapport with interviewees because of the known support of each pastor, at times my disclosure about myself extended beyond this. I tended to give minimal information about my own religious background up front, but because the pastor had referred me to these contacts, many simply assumed I was Pentecostal. In one location, members knew my religious background because of my previous interactions with the church. In the two cases where interviewees directly asked about my religious beliefs, I disclosed that I have a family connection to a Pentecostal church and that I myself have spoken in tongues. Although I had not been asked this specifically, speaking in tongues is an insider/outsider boundary marker for P/C believers, and this was the most direct way to situate myself in relation to the interviewee in a meaningful way. Also, outsiders often view this practice negatively: at the best, it is seen as an affectation, and at the worst it is seen as a sign of mental instability. I believe that this self-disclosure helped to build rapport with interviewees, and allowed them to feel fewer reservations about disclosing their own religious experiences.

It is important to note here certain limitations to this study. Although my quantitative analysis evaluates the experiences of individuals who *identify* as charismatic or Pentecostal, this qualitative portion explores the experiences of individuals who *attend* Pentecostal churches. Because of this, in comparison to the survey findings, the interview

analysis may privilege the importance of social interactions with others who hold healing beliefs. However, even P/Cs who attend a non-P/C church may maintain relationships with others who share their beliefs. In this sense, these interviews are representative of one process that could be expected to affect the experience of ill or disabled P/Cs: interactions with those who share their P/C beliefs. There may be different processes involved in the interactions a charismatic has with their non-Pentecostal church that I am not able to address with the limited scope of this project. Because of this, the interviews theoretically complement rather than directly illustrate the survey findings.

Although these interviews cannot be treated as representative of the full spectrum of experience for all ill Pentecostals, they do provide rich data that contributes to the formulation of valid theory. Because contact was made through church leadership at specific locations, the interviewees who were suggested to the researcher tended to be members in good standing, and were frequently highly involved at their church despite their illness—many of them even holding leadership positions. However, even in this comparatively active group, several individuals reported periods of low attendance or even disaffiliation during the course of their illness in the past; periods not related to physical capacity, but to interactional challenges. These interviews provide a window into the experiences of those whose attendance may diminish with the occurrence of chronic illness or disability. But it also suggests that peripheral members might experience these challenges to an even greater extent—if members who are so centrally located in a church experience difficulty interacting with their group when they become ill, how much more so might someone who has a smaller network of support? Interviewees who do not report periods of low attendance due to non-physical reasons are

also valuable to this theory building. By understanding the experiences and particular mechanisms that have facilitated continued participation for these individuals, we can consider how the absence of these situational factors may induce lower attendance in others who inhabit more peripheral roles in the church.

Plan of Analysis

I have described the lack of empirical research about Pentecostals and charismatics who experience illness or disability on an ongoing basis. Rituals of healing seem to captivate the academic community, and encourage fieldwork and other research that makes sense of this exotic religious world. However, this project of developing a unified picture of P/C beliefs and practices as a functional culture seems to have distracted scholars from devoting attention to the differences experienced by individuals within it. Given this lack of research on the chronically ill and disabled within the P/C context, I approached this topic with an interest in developing theory that was grounded in the lived experiences and meanings of interviewees. I paid special attention to the interchanges these individuals described with others in their religious group, and I inquired about how they reconciled their interactions and beliefs with their experience of illness or disability.

Out of the grounded analysis of these interviews, it became apparent that theories of facework and identity work were particularly appropriate for use in describing the external and internal social processes that interviewees engaged in. These theories complement each other, and neither can be used exclusively to describe what ill or disabled Pentecostals experience. Thus, as I explore the experiences that interviewees shared with me, I use a framework that includes central elements of both facework and

identity construction. I describe: 1) individuals' experiences of interactional challenges to religious social identity, 2) how these individuals develop personal religious identities backstage that make sense of their experience of illness or disability, 3) specific examples of how they present their personal religious identity in external interactions, and 4) social encounters in which this presentation of identity receives acceptance.

Results

Interactional Challenges to Social Identity

For a Pentecostal, the central element of their religious identity is their relationship with God; salvation is about reconciliation with God. In Pentecostal theology, even healing is focused on bringing the person into right relationship with God. So, when a Pentecostal person interacts with other Pentecostals, their social identity in that religious context hinges on whether the other people perceive them as being in right relationship with God. However, this internal relationship is not a visible trait. It can be attributed to others regardless of the actual characteristics of their relationship with God. If a person has a chronic illness or disability, this is often commonly known to other churchgoers either because of visible symptoms or because of that person's participation in corporate prayer for their physical problem. This illness or disability can come to negatively define a Pentecostal's religious social identity by discrediting their relationship with God.

The types of responses interviewees encountered from other Pentecostals in response to their illness were many and varied, but all centered on a lack in the individual's relationship with God: "There's something spiritual going on"; "You just

don't have enough faith"; "There's gotta be sin in your life"; "you've got unforgiveness in your heart"; "sin in your life or your family or... or your... generational something..." One individual even reported that a woman she had never met wrote her a letter communicating that: "God told her that I was ill because of sexual abuse that I had experienced in my past." In every case, the reason given for the continued illness or disability is a perceived problem with their relationship with God that needs fixing. If they were in right relationship with God, they would have been healed.

Individuals are repeatedly encouraged to participate in prayer for healing, and are expected to focus on healing in their relationship with God. In informal interactions with other churchgoers, they are encouraged to "Keep believing. Keep persisting. Keep knocking [for healing]." Others say that church acquaintances commonly tell them, "I'm praying for you. God's going to heal you." These sorts of interactions do not necessarily cause the interviewees to *feel* that their religious social identity is being challenged. However, it does communicate that healing is the ideal outcome for their situation—that to be healed would be better, and that God *wants* to heal them. Through these interactions, other people encourage them to persist in believing and praying for healing so that they can move from a negative identity as ill to a positive identity as healed.

At the altar: public prayer as a challenge to identity. One formal way that the Pentecostal church responds to illness is with the structured interaction of public prayer for healing. During an altar call, the pastor publicly invites people to come up to the front for prayer for physical healing or other problems. Participation is expected of those who have physical conditions, and interviewees were commonly encouraged by other churchgoers to go up for prayer. One churchgoer told an interviewee who has cancer:

"You should be going forward cause you can't get healed if you don't." In this case, the public ritual of healing prayer is seen as the primary space for healing to take place. Participation is perceived as a spiritual obligation for the ill or disabled person since, if they do not participate, it throws doubt on their faith and desire for healing. Because other Pentecostals are concerned about the perceived spiritual well-being of the ill person, they encourage them all the more to go forward and be prayed for. The result of this is, for many interviewees, feelings of marginalization. One woman, who I will call Joanna[1], has experienced a disability since her childhood. She described her interactions at church during her teen years in this way:

> The minister would say, "If anybody, you know, needs a touch from God or whatever, please stand." And I never wanted to stand. I wouldn't stand actually. *laughs softly* And here and there someone would come over and say, "Hey, you need to stand up. You've got, you know, your [disability]. You need to stand up for healing." And I hated when people would do that. It made me feel very singled out. It made me feel like something was wrong with me.

When church members communicate to Joanna that she needs to get up and go forward, it is an interactional challenge that makes Joanna feel that there is something different about her—a negative characteristic that she needs to resolve. Physical illness or disability act as a stigma that discredits her social identity in that it indicates to other Pentecostals that her relationship with God is in some way lacking something that must be remedied by participation in healing prayer.

If the ill or disabled person does go up to participate in public prayer for healing, and if they do not experience healing at that time, this can present another social challenge to their identity. Alex, who has suffered from an illness for most of his life,

[1] Pseudonyms are used for all interviewees.

described his feelings when he failed to experience healing on the last occasion he attended an Evangelistic healing service:

> I was extremely, extremely devastated. Extremely. Especially because like, someone in front of me was, um, you know, rejoicing over *their* healing, and that was tough. That was really tough to bear. Um, because uh, you know, God was still withholding from *me*. And so I was crushed—extremely crushed. And so that was probably one of the last times that, that I've allowed myself to do that, um publicly at, at an altar. [Alex's original emphasis]

Alex's participation in the act of prayer for healing in this public setting was a devastating interactional challenge to his religious identity as a person in good relationship with God. He emphasizes the juxtaposition of his own experience and the other person's: *they* rejoice over their healing, while *his* healing has been "withheld" by God. Although there is no direct interpersonal challenge in this interaction, the structure of the ritual of healing prayer provides a space for the legitimization of the religious identity of someone claiming healing, but not of someone who remains unhealed. Based on the common discourse and rituals of his group that revolve around God as healer, Alex interprets his own position as being distant from God, his personal identity as being discredited by his continuing illness.

Chronically ill and disabled people may also have physical conditions that limit their ability to even participate in the legitimizing activity of public prayer for healing. Lisa, a woman who experiences intense chronic pain, went up for healing from a visiting minister and says she was "whacked" [hit] by him when he prayed for her. Other times, Lisa says the person praying for her might "push [her] too hard." "Every time I would go up to get prayed for I would come out in more pain than I went up. So I would be in such fear to go get prayed for." Her ability to even participate in the healing activity that

would rectify her stigmatized identity in the eyes of other group members is limited by the tactile form of its administration.

In each of these ways, the structured ritual of prayer at the altar call provides a space that publicly legitimizes the identity of those who receive healing, while throwing the experiences of those with ongoing illness or disability into stark relief. One group is publicly attributed a positive religious identity, characterized by an experience of closeness with a healing God; the other has restricted access to this identity either by their inability to participate or their inability to experience a remission of their symptoms.

Scripture as a challenge to identity. Pentecostals interact with God through prayer and scripture; scripture has authority as the word of God, and as such it can become a resource in social interactions between Pentecostals. Bible verses about healing become part of the public discourse that shapes the collective identity of Pentecostals, and in the same way that churchgoers encourage the ill and disabled to participate in public prayer, they use these healing scriptures to encourage ill or disabled individuals to have faith for healing.

Ann, a woman who has experienced a functionally debilitating condition for most of her life, describes the verses that church members have shared with her: "There's *always* someone that has a verse for me or a scripture reference or something they want to give me," she says [Ann's original emphasis]. When I asked her for an example, she told a story of Peter and Paul going to a temple to pray for a paralyzed man: "As they went by he was healed. Paul said, 'In the name of Jesus Christ, rise up and walk.' And they've used that one for me." As other churchgoers draw on these scripture verses to apply to Ann's situation, they communicate that her condition needs to be healed, and

that God is able to provide this. In this case, scripture provides an authoritative resource for legitimizing the claim that a healed identity is the ideal.

Ann also cited the verse Exodus 15:26 as one she is frequently given in interactions with others. She encouraged me to take the bible she keeps near her and read the verse aloud: "If thou wilt diligently harken to the voice of the Lord thy God and wilt do that which is right in his sight, and give ear to his commandments and keep all his statutes, I will put none of these diseases upon thee which I have brought upon the Egyptians, for I am the Lord that healeth thee." When I finished reading, she reflected, "Yeah. For I am the Lord that healeth thee. That is one they *always* give me." The verse she is given directs believers to be in right relationship with God, and promises healing to those who do this. However, Ann focuses on the last line of this verse, repeating, "For I am the Lord that healeth thee." The crux of the discourse being communicated to her is the identity of God as healer. If Ann participates in receiving healing, and claims a healed religious identity, it validates this collective belief that God heals.

Other interviewees reported being given similar verses by churchgoers; verses that centered around God's ability and desire to heal. These verses provide an authoritative resource for asserting a particular religious identity. They define God's activity in relationship to believers. And they define the promises that believers can claim in relationship to God. However, for someone continuing to experience illness or disability, they also construct a religious identity that is potentially inaccessible to those individuals.

Direct challenge to religious social identity. Perhaps the most direct interactional challenge that interviewees experienced to their religious social identity was when other

people would directly ask the ill individual to explain why they have not been healed. When I asked one chronically ill woman to describe anything that had been helpful to her spiritually in coping with her symptoms or understanding what her illness meant to her, she began crying as she described what it had been like growing up in an environment that taught that God can heal. "My spiritual walk has been… the life blood of me and what keeps me going in this journey," she said. "But um, at times it's, in a weird way—and I don't mean this to sound sacrilegious or disrespectful—it's almost been a burden though, because you always get the question, and always, of why hasn't healing come for you?" Later she continues: "Well-meaning people don't realize that that can be a burden on people, because it almost comes off like, 'What's wrong with you?' Like, 'Why isn't this happening for you?'" For her and others who were asked this question, the onus is being put on them to explain why God hasn't healed them. It implies there is something wrong with her relationship with God, and presents a deeply personal challenge not just to her social identity, but also to the very heart of her self-concept as a Pentecostal—the state of her internal relationship with God.

The person who directly challenges the religious identity of an ill or disabled person in this way is almost always someone who is not ill or disabled themself. This is illustrated by Dave's experience. A man at church who had experienced complete divine healing of epilepsy when he was younger asked Dave if he had ever asked God why He hadn't healed him. The man who challenged Dave possesses a social religious identity as someone who has been healed by God. Other individuals may possess this positive identity because they have been exposed to a close friend or family member who has experienced healing. Either way, the challenger is someone who experientially knows

that healing is possible; they participate in the collective identity that God heals. This healthy person's experience of healing is legitimized by the ritual structure and discourse of the church. They may have high moral status because of an experience of healing. In contrast, the ill person is excluded from claiming a legitimate healed identity by their ongoing physical symptoms. Even if a person believes in a God that heals, lack of healing experience imputes a lower moral status in a group that shares these beliefs. Because of this, they will have fewer legitimate resources to draw on when they are confronted by an interactional challenge by someone with a healed identity.

Unique interactional challenges in leadership. Since some of the interviewees held leadership positions at their churches, the dynamics of maintaining a positively perceived social identity was somewhat different for these individuals. Leaders who were less socially embedded in their churches experienced interactional challenges to their identity more often than those who had longstanding relationships with other church leaders and members. Sarah and her husband were involved in an evangelistic ministry at a time when she was struggling with serious physical symptoms of her illness. "People knew me as one-one dimensional almost," she says. "They saw us come and speak at their church. They saw that I was sick, and that was all that they saw." When Sarah and her husband would travel to different churches, leading worship and preaching at each one, people would regularly want to pray for her illness. "When [I] show up to church, [I] show up as almost a project, almost a, something that needs to be done." Sarah's social identity was completely defined by her illness in these churches. She occupied a central, visible position of leadership that put her physical condition in the limelight. However, she was not well known as holding a previously established religious social identity in

each church. Given these conditions, her social identity became completely defined by her illness, and she represented the focus of the groups' healing efforts when she would visit each church.

Sarah's experience is an important window into the treatment of individuals who are more peripheral to a group. While she came into each church in a leadership position, the virtual social identity that members perceived for her was not tempered by any knowledge beyond that of this discrediting characteristic of illness. She was "one dimensional" to them. Because people only knew her by her illness, they more openly challenged her identity, communicating that she needed healing and questioning her relationship with God. It was Sarah who received the letter from the woman she did not know communicating that she needed to resolve her past experience of sexual abuse. While Sarah's position as a leader made her more visible than she may otherwise have been, ill individuals who, like Sarah, are not embedded in close relationships within a congregation—relationships that define their religious identity more broadly than their illness—may also experience particularly difficult challenges to their identity as a religious person.

Church leaders who had longstanding relationships with other leaders and members of their congregations tended not to face these same kind of challenges to their social identity. Glenda, who is on the pastoral staff at her church, said, "You know, just, they might say, 'Hang onto your faith. Don't give up on your faith, because God is the healer.' But I don't think any of them had to say that to me because they knew that I had enough faith to hang onto my faith *laughs*." People at church know Glenda as a spiritual leader who holds an elevated moral status and legitimate religious identity in

that congregation. Her relationship with God has been publicly established through her longstanding role as a spiritual leader in that church. As such, she is not questioned as others at church may be.

Another longstanding church leader, Amy, has also not experienced interactional challenges to her religious identity from others since she became ill. She was asked, "Has anyone ever told you that if you had more faith, or if maybe there wasn't a certain sin in your life this wouldn't be happening or… *Amy shakes her head* you never had that experience?" Amy replied, "No, because I haven't, I'm not around… unbelievers that I'm close to, that I hang out with or anything." Although her religious social identity has never been challenged in this way, and she feels that only "unbelievers" would have asked her anything of the kind, later in the same interview, she reveals that *she* used to present this kind of interactional challenge to the religious identities of others:

> "I don't think I had enough compassion. And I apologize to the lord and ask forgiveness. Because some of the things that I have said to people in my prayer time with them, it… not intentionally, not knowing, in ignorance. And I have asked the lord to forgive me and I will never do that again. "Get up!" You know, "God's with you. You can do this." You know, not knowing, because I had never experienced anything like this my-*self*. And I was: "I'm strong, and I'm in the lord, and I'm gonna tell ya." And for me it's been so much of a learning experience… and to love people more. Not to judge, because you don't know what's goin' on. Love 'em where they are. Encourage them. Give 'em a word of encouragement, and no matter what, love 'em. Tell 'em God loves 'em, and it's gonna be alright. I think a lot of the, what I'm goin' through that I can experien—what I've experienced, that I can know how to treat people who are ill *better* and encourage them and not think, "Well, what you are…" Who am I to do that? Father forgive me… because I didn't have the right attitude. Not intentionally. Just didn't know any better. And you can't know if you haven't experienced it. And I've experienced it buddy now, and I *know*. And my attitude has changed." [Amy's original emphases]

Amy used to feel that she held a position of higher moral status than the ill person: feeling "strong," like she was "in the lord," and like she could "tell" them to get up and

be healed. She emphasizes that through her own experience of illness she has learned not to judge other people because "you don't know what's goin' on" for them. Amy used to reduce the ill person to their illness—and all the disreputable spiritual traits associated with that. She would question the individual when they did not recover: "Well, what you are…" These interactions were challenges *by* someone in a position of higher moral status *to* someone who was reduced by their physical condition to a position of lower moral status. At the time, she was able to participate in the collective identity of orientation toward a healing God because of her status as a healthy person. Although she does not recall being challenged about her religious identity, she used to occupy a position of higher moral status that allowed her to do so toward other people. Now, as a person experiencing chronic illness herself, she cannot operate in the same way. She feels obligated to change this hierarchical dynamic in her interactions with ill people in her church—to communicate that she loves them "no matter what," and that God loves them too. In doing this, Amy now communicates that their physical condition is *not* a stigma that singlehandedly attributes a diminished moral status to them.

For church leaders like Amy and Glenda, embeddedness in longstanding relationships allow them to benefit from attributions of higher moral status as they present a religious social identity that includes physical symptoms of illness. Other churchgoers do not challenge their social identity in the same way they would someone else's because they know this leader as someone who has an established right relationship with God. However, when the churchgoers' knowledge of a leader's moral status is not previously established through a standing network of close relationships, the leader's illness may become their master status in that context, dominating the religious social

identity that others attribute to them. It is likely that similar dynamics may be observed in the interactions of lay members of Pentecostal congregations; peripheral members may be expected to encounter more frequent interactional challenges to their religious identity than members embedded in networks of close relationships with other churchgoers.

These interviewees' experiences reveal how the interactional setting at Pentecostal churches presents specific social challenges to the religious identity of ill and disabled members. The collective shared identity expressed through healing rituals and public discourse orients believers in relationship to a God who heals. Healthy individuals of higher moral standing encourage the ill or disabled person to also orient himself or herself toward a healing God by participating in praying and believing for healing. However, when that person continues to experience a physical problem, they are asked, "why hasn't God healed you?" and their relationship with God is called into question. In this public setting, the rituals of prayer and discourse of the collective identity of healing legitimize the social identity of the healthy or healed believer, but encourage interactions that challenge the social identity of an ill or disabled person.

Backstage Development of Personal Identity

Ill and disabled Pentecostals experience interactional challenges within the structure of the religious service and interpersonal interchanges that call into question their religious identity in their social group. Their illness imputes certain negative characteristics on their identity that relates to their personal relationship with God. In this way, the frontstage challenge presented in these external interactions, has backstage ramifications for their internal interaction with God, and their self-concept as a religious person. How can they, as an ill or disabled person, maintain a personal relationship with a

God that heals? How do they make sense of a situation that contradicts their religious identity?

When Ann is confronted with scriptures about healing, it causes her to question the very foundations of her relationship with God. She says,

> It used to really please me [hearing those verses], and I was very encouraged, but after so many years of sitting in a wheelchair, it kind of loses some of its, um, strength or whatever. I still believe in healing, and I still pray for it, but um… know I probably won't get it this side of heaven. It just causes me to wonder, is it really what God wants or is it not what God wants, or um, and why doesn't God want it for me if… If it's true that I'm not gonna be healed this side of heaven, then why not? I still question that kind of a lot. Like, why God? I'm [calm?], but it's been so long now. Surely you can heal me. Speak the word. I'll be healed. And yet at the same time, I kind of have lost some, some of the faith that I once had back when I first got hurt. And it's hard not to lose when you can't get up, can't do any, hardly anything for yourself. Um, it's kind of hard to keep believing that I'm gonna be healed one of these days."

Ann struggles with maintaining a faith that seems to contradict the experiences of her own life. She still believes that God can heal her, but says she has lost some of her faith that he will do so. And she questions God internally about this: "Why God? …It's been so long now. Surely you can heal me."

External interactional challenges do not provide an ill or disabled person like Ann with any resources to make sense of their situation. However, as Ann goes backstage and considers how her disability makes sense in light of her Pentecostal beliefs, she begins praying about it. It is within this personal relationship with God that Ann and other Pentecostals do their internal identity work to resolve this cognitive dissonance. Because the Pentecostal collective identity, regardless of whether one is ill or healthy, invests central authority in a personal relationship with God, an ill or disabled person can potentially draw from this relationship as a legitimate resource to support a reoriented self-concept that may or may not align with a group belief in healing.

This internal relationship with God thus becomes central to the way these interviewees articulate their personal religious identities. The internal question creating cognitive dissonance between experience and belief, "How do I resolve what I know of God with my ongoing experience of illness?" comes to define their relationship with God, and thus their personal religious identities, in different ways. Specifically, this backstage work results in three distinct themes among the people I interviewed: expectancy that God will heal, a purpose to the suffering, and a focus on God's *other* provisions in life.

Expectancy of healing: "It is *God's will to heal!"* While almost all the interviewees expressed that they do believe God provides miraculous healings, a subset believe that he wants to provide physical healing for all believers in this life. Kay, a woman who experienced a chronic health condition since childhood, said, "I always said to my family, or my roommates, 'If I die, and an invalid, don't go around saying, 'Well, Kay was a saint, and she died without healing.' Go around saying, 'Kay believed that there was healing in the atonement.'" Kay clearly positions herself as a believer in a healing God, and orients her entire religious identity toward her belief in "healing in the atonement." When I interviewed her, Kay brought out a journal of scriptures about healing that she and a friend had compiled over the years. She indicated the journal and said, "People don't bel-, they pray all the time, 'If it be thy will…' It *is* God's will to heal!" [Kay's original emphasis]. From these scriptures, she described various reasons why God withholds healing, including individual or corporate sin, and lack of personal or corporate faith. In this way, if someone does not experience healing, it is because

something spiritual is causing that breach. To Kay and others who orient their religious identity around healing, God's singular activity in relation to illness *is* healing.

Although articulating a healed identity may seem paradoxical for a person who still experiences chronic pain or other health issues, healed identity is, for these individuals, as much about the orientation of one's spiritual attitude as the remission of one's physical symptoms. Because Jesus is considered to have *already* provided healing through his atoning sacrifice, individuals who claim a healed identity are, on a very conscious level, claiming that they are healed *regardless* of their physical symptoms. Betty, who has experienced chronic illness for years, says, "God is my healer re-*regardless* if it's 100% gone, if I'm still on medication, I still will say, 'He's my healer today'" [Betty's original emphasis]. Betty situates herself as expecting healing from a God who will provide it, despite the fact that she is not without physical symptoms of illness. The important thing for her is that she is oriented in right relationship to God—and that God is very *clearly* defined as a healer. By orienting herself in this way, she identifies herself to God and other people as a believer with a claim to healing. In a sense, it is through this activity of declaring a healed identity that one can come to expect healing. Amy says:

> [I'm] believing and trustin' the Lord. Period. He's not a man that he can lie. Jesus paid for my healing. It's finished. Completed. And I want it. And I've drawn a line in the sand and I'm not backing up. I'm trusting the Lord Jesus and my father God. And I'm getting better, daily.

Amy affirms belief in God's identity as healer. She clearly articulates that healing is readily available through the atonement. When she says, "I'm getting better daily," she is not just describing her symptoms; she is articulating an identity as healed—situating herself as a healed believer in relation to a God who has already provided that healing

through the atonement. In a sense, the orientation of her spiritual identity is more important than the physical reality she engages with. By affirming God as healer, she puts herself in right relationship with Him. And maintaining this right relationship as a believer to a healing God is what gives her access to that healing. Claiming healed identity thus becomes not just an articulation of how one makes sense of one's situation, but it is part of the very process of healing.

The use of discourse that speaks about healing as a process allows the individual to reconcile an identity that expects healing from God with their persistent physical symptoms. "Healing has, for me, always been a process," says Kay. "It has never been instantaneous." This use of "process" for making sense of healed identity was particularly common at one church where I conducted interviews. Individuals consistently used language of process there: "I'm walking into my healing;" "One thing at a time, it's-it's a comin'." Glenda says, "Sometimes healing comes instantly, and then sometimes you've gotta walk it out by faith. And so if I'm not healed instantly, I know it's on the way. I'm in God's recovery room. And God is working on me. And so, it doesn't bother me, just as long as I get healed." This interpretation emphasizes that healing can sometimes be a process that takes time. Whether it is immediate or not, God will heal because that is his obligation in relation to believers. However, the language of "walking it out by faith" implies that the ill or disabled believer also has an obligation. They are not passive in the "process" of healing, but must continue in faith that God *will* heal them for it to take place. God is expected to heal, but Glenda articulates an obligation of her own to have faith for healing.

While a healed identity focuses on the *internal* orientation of the ill or disabled person toward a healing God, they also look for *external,* physical evidence that confirms God's identity as healer. This may mean attributing the alleviation of their symptoms to God, whether it involves a medical procedure or a ritual prayer service. Lisa describes attending a healing service when she had a broken tailbone: "[the pastor] said, 'You've got a broken coccyx.' And um, I went up and got prayed for, and then I didn't have any pain whatsoever." She continues, "So, I don't have any trouble with my tailbone anymore at all, but now I've got the other issue. So, no, but we've been healed from many *other* things. So that's been awesome. So I know God can heal, so I'm just waiting." Lisa's previous experiences of healing are a resource that she draws on for maintaining a healed identity. She has observed God's healing before, so she continues to believe she will be healed of this health problem.

Lisa's family members have also experienced healing, and she draws from these narratives as a resource for her religious identity as well. Lisa and her husband Chuck both experience symptoms of chronic illness. Lisa's son, Paul experienced several strokes when he was an infant, and when the doctors told her that he would be completely functionally impaired on his left side, including being unable to see out of his left eye, she rejected this diagnosis:

> Lisa: All of the sudden I felt a hand on my back, and I looked over at Chuck and I said, "You didn't touch me?" And he said, "No." And I said, "Cause I just felt something touch me," And I said, "He's gonna be alright." And he said, "Yeah." And so I looked at the doctor when he gave us this report and I said, "Okay, I understand what you're telling us, but he's gonna be okay. God's gonna heal him." And so, doctors looked at me like I was a nut. I said, "Okay." So, we're, we got back to the room and we're sitting back there that night. This was on a Tuesday. And uh, the, the nurse comes in and she's walking around the bed and she looks at me, she goes, "That baby's looking at me out of his left eye." "Yeah, he's gonna be alright." And so then pastor comes in and pastor prays. Everybody

in the church is praying. They sent us home on Friday morning from the I-, from the ICU, which they do not do. They, they will send you from ICU to a…

Chuck: Transitional.

Lisa: …transitional, and then to your regular room, and then they will send you home. They never do that. They released him from Phenobarbital within six months, which they do not do. Paul is left handed. He sees greater than 20-20 out of his eye.

Chuck: His left eye.

Lisa: Yeah.

Chuck: His right eye's normal, and his left eye is better than normal.

Lisa: Left eye is better than normal. And uh, so every time, and he, um, he plays the bass. He plays it left-handed. And people are just amazed that he plays the bass left-handed. They're like, "tell him to switch," and I'm like, "No." Because that's my miracle.

Chuck: And he's also an athlete, and he's good left-handed.

Lisa: He's very…

Chuck: Does everything left-handed.

Lisa: …everything left-handed.

Chuck: Well, he's actually kind of ambidextrous…

Lisa: Yeah.

Chuck: But, but left is, he's better on the left.

Lisa: But he's a miracle. He's a walking miracle. And so that's just, but he's our miracle. He's God, that he is just, that's just what God does. We have got so many miracles in our family of healing. And so we're just, you know, these little things that we're going through, we just know God's just gonna touch 'em. We may go through small things every day, and even though what I'm going through may seem large at the moment, it's nothing compared to what we could've been going through. So I'm just thankful.

Each time in the narrative when Paul's physical symptoms don't follow the trajectory that the medical professionals projected, it is interpreted by Lisa and Chuck as

affirming God's activity of healing Paul; such as when he first seems to recover his eyesight, and when he goes directly home from the ICU instead of into "transitional." Paul's experience of healing becomes part of a discourse that the family rehearses, as they encourage him to use his left hand for various activities, and emphasize how his injured side is even better now than it was before. They claim this story of healing: "he's our miracle," Lisa says. The narrative affirms God's identity as healer: "that's just what God does," she says. And it affirms their personal identities as believers in relationship with a God who does heal in observable ways. In this way, healing stories become resources for the identity work of an individual who continues to experience illness or disability of their own. Whether it is the interviewee or a close significant other that experiences the healing, the internal and external rehearsal of these narratives help the individual maintain a religious identity that expects healing despite their own current illness.

Scriptures also serve as an important resource for these individuals as they maintain an internal orientation of expectancy for healing from God. Glenda experiences a chronic illness and describes several other unrelated health problems she has had over the years. When she experiences physical problems, she says, "I just remind—put God in remembrance of his word, because he says, 'you can do that. You can put me in remembrance.'" She goes on to describe these passages of scripture:

> "My son or my daughter, attend to my words. Incline your ear to my sayings. Let them not depart from your eyes. Keep them in the midst of your heart, for they will bring *life* to those who find them, and *health* to all their flesh." So, I said, "Okay God, here it is. You promised." And also I used another one that is found in the Old Testament, and uh, I think it's in Exodus. The Lord said if we would ask *him* to bless our food and our drink, he would take sickness away from us. So I began doing that. [Glenda's original emphases]

Scripture is central to Glenda's interactions with God. She uses scriptures that relate to healing to "remind" God of his role as healer. God is felt to have an obligation to heal those who believe. Other interviewees would also draw from scriptures as an authoritative resource in claiming healing from God. In this way, scripture is used in these internal interactions as a legitimate resource for maintaining a personal identity that expects healing.

When physical symptoms remain, persistence becomes an important part of belief in healing. Betty says, "I didn't have any, uh, relief at the time. I didn't have any proof that… that my confession was working. However, it was a decision that we decided to do—still just believe for healing." Although she prayed continually for healing, Betty's belief for healing also prompted her to discard the information that doctors had given her about how to prepare for later stages of her degenerative condition. She felt that God was leading her to not accept that diagnosis. She also stopped talking about her symptoms to her family and other church members, seeing her verbal expression of that as a form of negative confession. Betty expends an incredible amount of personal effort to manage all her interactions, both external and internal, around persisting in a belief for healing of her condition. Everything was invested in maintaining the identity of expectancy for healing. Internally, she completely oriented herself toward God as healer, and externally she presented herself as healed (or expectant of healing) in her interactions with others, by not talking about her symptoms at all.

It should be noted that a personal identity of expectancy for healing is not necessarily mutually exclusive to the personal identities that follow. Other individuals, who do not necessarily believe in healing in the same way as those described above, do

draw from some of these same resources for identity construction. For instance, nearly all the individuals I interviewed reported having had either a personal experience of divine healing or a nuclear family member who had experienced divine healing. This may go some way to explaining why these interviewees have remained in Pentecostal churches despite currently experiencing a physical condition that is difficult to reconcile with belief in healing. In the past, these previous healing experiences have served as resources for these individuals by facilitating participation in the collective Pentecostal identity of relationship with a healing God. While an individual may no longer *completely* accept this view of healing, they are still invested in a religious identity that includes a God who is at least *able* to heal.

Transformed identity: "I like who I am." As interviewees seek to understand why they continue to experience illness despite belief in a healing God, many express uncertainty about whether God really wants to heal them. Paradoxically, this uncertainty comes with a degree of comfort or peace with their situation. God can choose to heal, but He has the right to do what He wants with one's life with no particular obligation to provide healing. Often the interviewee focuses on the new and sometimes better purpose that God has for their life—God is seen as changing one's self in a way he could not have done without the illness or disability. Al draws from scriptures about God's sovereignty to explain his understanding of this:

> The bible says, "I have been bought with a price. I am not my own." If I belong to him, then he has the right to ask of me anything he wants to. And uh, it might not be what I want when I want or if I want. *laughs slightly* ...But I want to be able to exhibit a faith in the Lord and trusting him, cause he's all wise, all powerful. And uh… I'm in pretty good hands.

Using scripture as a resource, Al illustrates that the act of atonement confers ownership of his life to God. He interprets this that God is not obligated to act in a certain way with regard to his illness, but has the right to do whatever He wants with him. This does not mean that God acts arbitrarily though. "He's all wise, all powerful, and I'm in pretty good hands," says Al. In his personal relationship with God, Al positions himself as completely subject to the will of a good God who has a plan for him, even though it may not be what Al wants or expects. The personal religious identity that Al develops orients himself not primarily toward a God of healing, but toward a God who has the right to direct the lives of his believers in other, and better ways.

Reflections on why God has not healed often turn toward this emphasis on seeing God's identity as not limited by an obligation to heal. Alex asks, "Is there a difference between what it means for, uh, a faith that confesses that God *will* versus a faith that confesses that God is *able?*" [speaker's emphases] He goes on to describe a bible story that elaborates on the point he is making. Three men, Shadrack, Meshak, and Abednigo, face the threat of being thrown into a fire, but, Alex says,

> They make this-um-this radical faith claim that-um-that God is *able* to-to rescue them. And um, and I just, I really felt, um, I really felt liberated from-from their display of faith. This idea that they had no idea what-what was gonna happen… [but] they don't revert to that kind of, uh, language of like, you know, "Of course we're people of faith. God *will* save us" [speaker's emphases].

Alex identifies with these bible characters, who, when faced with death, claim that God is able to save them, but never make the claim that he must or will do so. For Alex, this story provides the legitimate authority of scripture to reject the claim that God is obligated to heal. One other interviewee, from a church in another state, drew from this same bible story to make exactly the same point—that God is able, but not obligated to

heal. It seems that across different specific locations, the same scriptures are used as resources for identity construction that reject a God who is obligated to heal. However, it is also possible that these individuals found a common discourse to draw from that used this scripture in this way—both had seminary training and reported being exposed to non-Pentecostal authors on the subject of illness. Either way, scripture is the primary basis from which this discourse emerges, providing the authoritative resource to draw from in constructing identity.

The idea that God need not heal is accompanied, for Alex and others, by the articulation of a transformed identity through the experience of suffering. Alex believes his relationship with God has been altered in a positive way. He says, "Even in the worst times when-when healing is not being produced, intimacy is still being, um, produced." He again draws authority for this positive identity of closeness to God through suffering from scripture:

> In the book of Job I found a… a companion in suffering. Um. And-and it wasn't so much that-that um… he was suffering that helped me find some sympathy. It was the fact that he-um-he was considered to have such an intimate relationship with God.

Later Alex continues:

> I didn't have any, um, have any prayers that, that would help make sense of my suffering. And so, so just kind of, uh, leaning on that companionship in Job, um, really, really helped me, helped me find uh, strength in being able to keep my identity as a person of faith.

And again later:

> Just seeing what it looks like for, for someone to be considered a person so close to the heart of God to have gone through this thing, extremely similar, uh, kept me, kept me sane through it.

Because Alex sees Job as someone who is "considered to have an intimate relationship with God," he considers his own similar experience to have brought him closer to God. The very experiences of suffering, doubt, and uncertainty are seen as bringing him into closer relationship to God. The product of his chronic suffering is positive personal identity change.

In a sense, Alex and other similar interviewees articulate a personal identity of transformation through suffering as they find spiritual meaning in the difficulties they experience. That is to say, there are elements of their experience of suffering that they come to consider invaluable to the development of their personal religious identity. Diana leans on the confirmation of her internal interaction ritual with God to describe her transformed identity. She says, "I feel such a peace, and I really do. I feel like God has said, 'This is where you are.' And I feel like I am surrounded by his hands." In her internal interactions with God, Diana has come to feel a peace about her situation that validates a personal identity that does not include healing. Diana is not expectant that God will heal her; rather, she feels at "peace" with her experience of illness because God is felt to be present with her in that experience. In this way, her internal interactions with God validate her personal identity.

Like Alex, Diana not only believes that God has no obligation to heal her, but she believes that her suffering has transformed her identity in a positive direction. "I like who I've become," she says. Diana feels that she is more compassionate toward other people now, making time to have real personal connections with others rather than having a task orientation to ministry as she did before. The experience of suffering, for Diana has caused her to reorient her identity in relation to God and other Christians. She says the

illness has made her "slow down" and engage in more significant interpersonal connections both with external others and with God, internally. She feels that her personal religious identity is now better than it was before, because of her physical condition.

Diana uses scriptures about suffering as a resource in defining how God works through her physical condition to transform her identity:

> "You will continue to experience difficulties, but take heart, take heart I've overcome the world." "Don't run from suffering. Embrace it." Okay, had I read that before? I'm sure I had, but I didn't… I didn't embrace it. You know. That wasn't something that grabbed a hold of my head. So, it's like scripture is so new to me all over again. Um. Yeah. He, he doesn't promise us perfection here, but he promises he'll see us through it. He's with me through this, and I feel that. There's no doubt in my mind.

Scripture becomes the basis for Diana's interpretation of how God interacts with a person experiencing illness. Suffering is not something to be avoided. God does not abandon those who suffer. Instead it is regarded as an opportunity for closeness with God. Using these scriptures as a resource for identity construction, Diana is able to legitimately articulate a personal identity that says that God is close to those who suffer and because of this closeness, there is positive spiritual transformation through suffering.

The chronically ill or disabled often experience a level of uncertainty about the particular trajectory of their lives. Andrew experiences a degenerative disease that leaves him feeling a lack of control over his own life. Although he initially felt betrayed by God when he did not experience healing, his relationship to God as sovereign has become particularly important to his personal religious identity. A painting hangs above the chair where he spends most of his time. It is a depiction of a person standing on a dark

beachscape. The figure is holding a handful of cords that extend up into the air and are attached to a bird flying at the end of each one. He says:

> I think that [this painting] symbolizes exactly what I'm talking about, because you don't know what's happening outside the canvas. You can't read the face of the person who is holding the strings, um, of the birds. And you don't know if the birds are being held back or protected. You don't know if the person is benevolent or harmful. And um, the picture to me came to really represent what I needed to remind myself on a regular basis: that I need to be able to look to the holder of the line, God, and say, you know, "yeah, I'm on the string here. And your kingdom come, your will be done. What you will. Not what I will. Cause I'm not the one in control."

Surrender to an all-powerful, all-knowing God is crucially important for the personal religious identity of those with a suffering identity. In order to reconcile their physical reality with belief in a healing God, they reject the assumption that God is *obligated* to heal them, and instead maintain belief in a God who can heal but is not constrained by this obligation. They find comfort or peace in their internal interaction with God, and through the legitimizing authority of this internal interaction and scripture, they support a personal identity that believes God is not obligated to heal.

Denise quotes a favorite song of hers that illustrates what she sees as the effect of suffering in her life:

> Jason Crab is-is my favorite, my favorite musician right now. He's got a song that he does, Through the Fire. "And he'll take you through the fire again." And I think as we go through that fire, that's where we are, where our nasty… stinking flesh gets burned off, and our stinking thinking attitudes and our stinking thinking habits, they get burned off in the fire. And we come, and we come forth at the end of this as pure gold. You know? That-that this is part of the, part of the process I think that um… I'm going through. It's just understanding, you know, Christ's suffering. And as we go through suffering I think we become more compassionate and have more compassion for other people. That we can now relate to the hurting a little better than those that have never had any struggles.

Like Diana, Denise says she has gained more compassion for other people who are "hurting." She also feels that she has been brought into a closer position of right

relationship with God, as her attitudes have been "purified" through the process of suffering. Finally, her personal religious identity is also situated more closely with God because of her ability to align with the *suffering* of Jesus. This is perhaps the personal identity in the most conflict with a healed identity. While Denise situates her identity in relation to a God that suffers, the healed identity is oriented toward a God that heals. Both of these aspects of God arise from the Pentecostal collective beliefs about the crucifixion and atonement—Jesus *suffers* to provide *healing*. But Denise's personal identity focuses on the aspects of the atonement related to suffering whereas the healed personal identity orients itself toward the aspects of atonement related to healing.

Focusing on God's other provisions. The final theme in these interviews of how these ill and disabled individuals made sense of their religious identity in this context is by focusing on God's other provisions in their life. Often interviewees would affirm healing and may even continue to pray for it, but their focus in their internal relationship with God shifts to other things besides healing. They may see God acting as a provider that meets physical or relational needs in their life. Through prayer and scriptures, He may be seen as providing personal strength or support throughout their daily experience of pain or fatigue. Ann, a woman who lives with severe functional limitations, says, "Without my faith I wouldn't even be here at all. I would give up on life years ago. But because I have faith in God, then that's what keeps me going. It's the only thing that kind of may give me a reason to live." Healing is not the element of primary importance for Ann as she interacts with God throughout the day. Instead, she focuses on God's provision of spiritual or emotional strength on a day-to-day basis that has enabled her to

continue persevering despite her physical difficulties. God's provision in this area is what defines her personal religious identity.

Some interviewees emphasize God's provision in financial or relational areas of life. Jane's internal focus on God's role as provider in these areas is what helps her get through day-to-day struggles. She reminds herself of how she has been blessed in these non-healing areas of life. Jane says:

> I-I do… pray for [healing], but I… I don't let it trouble me. You know, I figure… I-I-I instead take on what I feel to be, and the reason emotionally I think I can handle it, is I-I will take on a grateful heart, a grateful, um… you know… grateful in my spirit for the fact that I have *many* things that um are-are… you know, that I'm blessed with. *Many* things. [speaker's emphases]

Jane goes on to elaborate about the ways she has been blessed. She says the fact that she doesn't have to work has been practically helpful since it leaves her with time to attend all her medical appointments. She feels blessed that her children are Christians and that her church is supportive of her. The types of things she is grateful for vary, but each one becomes part of how she internally orients herself toward God as provider in these different areas of life. Rather than focusing on her illness that has not been healed, she "takes on a grateful heart," and focuses on the other areas of life in which God *has* provided.

Jane and other interviewees sometimes even interpret this provision as a substitute for physical healing. Although God does not provide healing for Jane's primary health problem, and she does not necessarily expect him to provide that, she says, "I just plain believe that my healing has come in-in other ways. You know what I mean? I just do. I believe that." Throughout the interview she talks about how she has experienced emotional and spiritual healing and growth through her experience of illness. God's

provision in those areas of life is interpreted as a type of healing that is equally as important as her physical state. Her identity in relation to God positions him as a provider of these other types of "healing."

Older interviewees or those who experience intense chronic pain tended to focus on God's eternal provision of a place where ultimate physical healing will be experienced. Dave says:

> "Ask and then you shall receive." *Voice breaking* I don't think people realize when they ask they don't receive in a month or a year or two years or whatever. You know, I mean… when you think, you go to heaven, it's eternity. How long is that? *laughs softly* You know, I mean this is nothing compared to later.

Dave reinterprets a scriptural reference about asking and receiving that would commonly be used in Pentecostal discourse to support an identity that situates believers in relation to a healing God. However, Dave reflects instead on the healing that will be provided in heaven. By focusing on this aspect of God's eternal provision throughout the day, it alleviates some of the emotional difficulties of his daily experience.

Each of these interviewees internally reorients their religious identities in such a way that they situate themselves in relation to a God of provisions *other* than healing of their chronic illness or disability. While each of them acknowledges that God is able to provide healing, they tend to avoid focusing on this in their internal interactions with God. They instead reflect on how God provides in other ways: comfort, finances, relationships, eternal salvation. Most of these are observable elements of their lives—God confirms his role as provider through this observable evidence. It is through these internal confirmations of God's role as provider, and through the confirmation of scripture, that these interviewees draw legitimate authority for their personal identity in relation to a God who provides.

Boundaries and intersections of identities. Each identity described above—healing, suffering, and provision—are not mutually exclusive. Instead, they intersect at certain points and diverge at others. Figure 2 demonstrates how each of the three identities is an input in constructing a response to the original dilemma of maintaining a Pentecostal religious identity in the face of ongoing physical problems. The identity oriented toward God as provider occupies a sort of middle ground between the identities of healing and suffering.

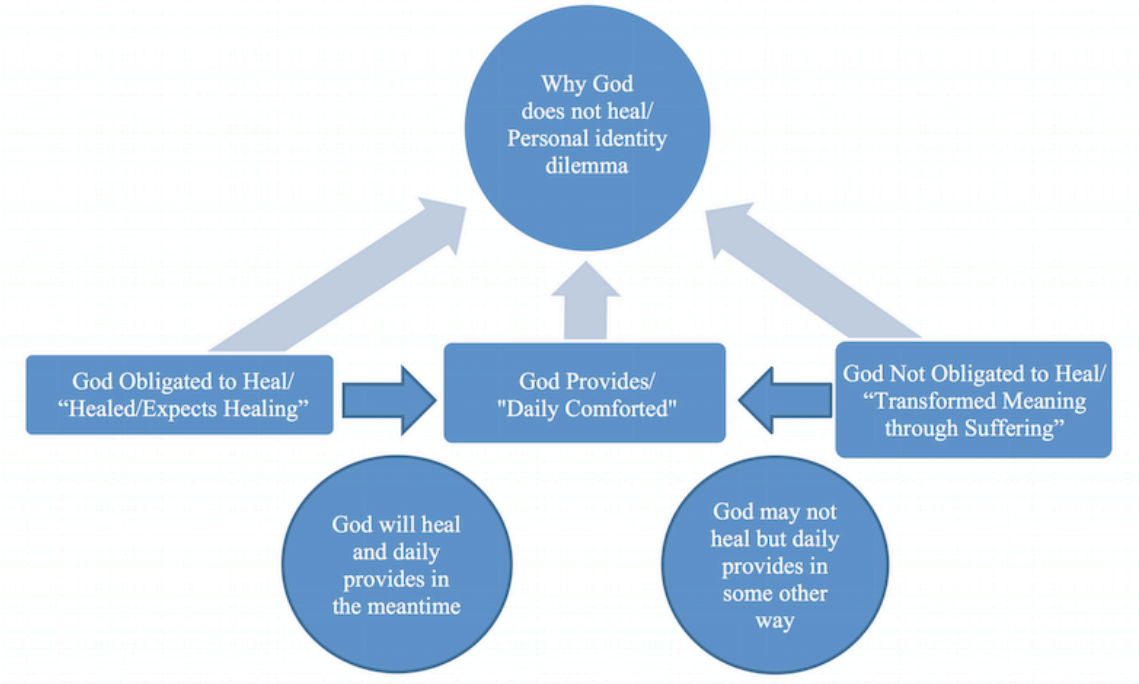

Figure 4.1 Process of Pentecostal Personal Identity Construction

It is common for individuals from both healing identity and suffering identity to emphasize God's role as a provider in everyday life. An example of this is God's physical provision for the alleviation of day-to-day symptoms. This physical provision is not the same as belief in God's obligation to heal, because it is limited to a particular element of

daily life. However, this daily provision can be *interpreted* as supporting either healing or suffering identities. The individual in either case prays for a specific symptom to be alleviated. Dave says, "Sometimes I ask… when I get some good spasms through that or something, if I'm sleeping or something, I… I may say something, pray something to give me a little bit more rest. You know. And you know, I might get half an hour or so more." Amy says: "I would get to that point that I would say, *Crying* 'Jesus, please help me. I can't stand this anymore. I'm hurting so bad. I can't stand this pain. Please help me.' And it would lift, and I would go to sleep." Both Dave and Amy experience intense chronic pain related to their conditions that prevent them from sleeping. Both pray for alleviation from this pain, and both receive limited provision from God in their daily experience. However, Amy follows this with "And uh… so… gettin' better," placing this daily provision in the larger narrative of expectancy for complete healing. For Dave, this is simply a recognition that God provides alleviation of day-to-day pain when he needs it most. In Dave's larger narrative, he emphasizes very clearly that God is not obligated to heal. In this example, individuals from both a healing identity and a meaning through suffering identity may focus on God as provider, but the interpretation of the provision can go either way depending on the particular healing or suffering identity they have developed through their internal interactions with God through prayer and scripture.

In contrast to the transitive nature of provisional identity, healing and suffering identities often are demarcated by clear boundary work. Certain individuals draw almost exclusively from one identity or the other, and on each end of this spectrum, they clearly articulate that their interpretation of God's activity in relation to illness is different and

better than the other side's. If an interviewee rejects that God is obligated to heal, they may describe the healing identity in juxtaposition to their own identity of suffering, reflecting on how their identity is *better* in some way. At one particular church, this demarcation of suffering identity boundaries was quite common. Jane, a leader at this church, reflects on the collective healing identity expressed by members of another church in town: "This particular church is *very* strong in believing that you, you know, should be healed and that you… name what you want to name and you should be rich and all these things…" [Jane's original emphasis]. She says, "I think it's taking scripture really too far, taking it in a context it's not meant to take." She goes on to articulate her own personal identity in contrast to this: "[I have] a lot better handle on what's important in life and, you know, learning how to really put my focus in trusting God the way it should be, and not in myself. And I think those are… wonderful lessons to be learning." Jane believes that her experience of suffering has provided an opportunity for her to develop a better relationship with God. She feels that she is oriented in right relationship with God, whereas those with a healing identity are seen as getting it wrong. She believes those others are interpreting scripture incorrectly as a resource to support a healing identity.

While Jane and some others at her church do clearly demarcate boundaries between their identity of meaning through suffering and the identity that assumes God's obligation to heal, many individuals articulate both these identities at different times in their interview. A person may believe that God *will* heal them and simultaneously articulate that they have learned things about their faith they would never have done if they had not been ill. Others may strongly believe that God has a purpose for their illness,

but also look for evidence of physical healing in their life to support the belief that God does heal. These identities, in practice, form multiple discourses that ill individuals draw from as they interpret their situation and their relationship with God. However, on each end of the spectrum of healing and suffering identities, individuals clearly articulate boundaries in the way that Jane does when she says that "It's taking scripture really too far," and in the way that Kay does when she says, "People… pray all the time, 'If it be thy will…' It *is* God's will to heal!" Each of them draws from the authority of scripture to do this boundary work, but they interpret that scripture in two divergent ways to support an identity of suffering or an identity of healing.

As interviewees engage in the backstage work of developing a specifically oriented self-concept in response to challenges to religious identity, they draw from scriptural narratives that are part of a single authoritative resource for Pentecostals. In their internal interactions with God, they develop vastly different orientations for their personal identity based on the same resources of prayer, scripture, and circumstantial confirmation like daily alleviation of symptoms. They emphasize God's divergent roles as provider, healer, and transformer through suffering. These discourses about personal identity are often not mutually exclusive, as individuals do the backstage identity work that makes sense of their experience. However, the social context of their congregation places constraints on which personal identities will receive legitimation in the frontstage sphere. This is explored in the following sections.

Frontstage Presentation of Personal Identity

In backstage identity work, ill and disabled individuals develop discourses of suffering, healing, and provision that make sense of their situation and orient their

personal identity in relation to God. Moving to the external presentation of personal identity, we enter back onto the frontstage activity of face-work. These individuals have often encountered numerous challenges to their social identity as a religious person in relationship with God. Since this relationship is not a physical characteristic that others can perceive, it is difficult for the individual to contest the closeness of their relationship with God in a context where other people assume that their physical symptoms indicate a spiritual problem. Given these dynamics, how the ill or disabled person chooses to present themself in their religious context often varies depending on exactly whom they are interacting with and what primary interpretation of God they identify with.

The successful presentation of a religious personal identity requires the validation of others in the individual's religious group. When the individual expresses a basis for religious identity that incorporates a familiar interpretation of illness, acceptance is easier to receive. Thus, a healed personal identity aligns more closely with the collective Pentecostal identity of healing. However, when an individual uses an unfamiliar basis for their religious personal identity, it could be more difficult to negotiate a successful interaction in which their self-concept is affirmed.

Presentation of healed identity. If an individual wishes to present a personal identity as healed or as expectant of healing, its alignment with the collective Pentecostal identity makes their interactions with their group fairly straightforward.. These individuals often participate in public prayer for healing for their own condition, and engage in discourse with other churchgoers about healing experiences that affirm belief in a healing God. It was a minority of the individuals I interviewed that presented a personal identity as healed when interacting with their group. Almost all were located at a

single church. In their interactions, these individuals affirmed an unswerving belief that physical healing is intended for all believers in this life. They would regularly participate in public prayer for healing, usually without reservation.

Part of the success of their presentations of healed personal identities in their group may possibly be due to the group's unique discourse about healing as a process. For someone who continues to experience symptoms of illness, the discourse of healing as process allows them to present a positive religious personal identity as healed despite their physical condition. It is the orientation of one's attitude rather than the immediate remission of symptoms that communicate this identity to others. It was common to hear statements like "I am walking into my healing," or "day by day I'm healed." They focused on consistent positive confession of their healing despite physical symptoms that didn't align with this—again indicating the importance of mental or spiritual attitude or orientation rather than physical manifestation. Practically, one is able to successfully articulate an expectation of healing in this setting without actually displaying a remission of those physical symptoms. It is the act of publicly declaring an identity as healed that becomes central to attaining a legitimate religious personal identity. The homogeneity of how these individuals articulated their identity was striking, and I suspect that more extensive fieldwork would reveal that these are lines commonly repeated in interactions between believers and within church services at this location.

Amy reports one particular interaction that indicates the common discourse at this church of healing as a process. She says:

> Four different people have spoken to me, prophets, and they've all said the same thing. And they don't know each other. They didn't know me. Said that I am walking in to my miracle. To my healing. And I am. It's a process. Some people get it [snaps fingers] that. Others is a process. And I don't understand it, but I trust

> the Lord, and I know it's gonna happen, but whatever happens, he's who holds me, and I know where I'm goin'.

Amy's personal identity as healed is confirmed by her interactions with other Pentecostals. These other Pentecostals are also "prophets," people of high moral standing, and therefore individuals who can speak with special insight and moral authority about a person's identity. They confirm that Amy is healed, and indicate a process of healing when they say she is "walking into her miracle." Although Amy still experiences symptoms of her illness, she is able to successfully articulate a personal identity of healing within her group. The direct confirmation provided by other believers also displays the central importance of group acceptance to the maintenance and presentation of healed personal identity for Amy and the other interviewees from this church.

It should be noted that interviewees who presented a healed identity still sometimes experienced interactional challenges at their church. When people tell Lisa or Chuck that there is something spiritual going on that they are not receiving healing, Lisa says, "We love 'em and go on." Lisa and Chuck defer to the other person in the interaction, possibly because they consider the other person as being outside the church's collective identity that defines healing as a process.

However, more often than not, interviewees with a healed identity reported no such challenges, instead they constantly affirm how supportive their church is specifically by providing prayer for healing and support for an expectant declaration of healed identity. Because these individuals are totally invested in the personal identity of expectation for healing, they do not interpret interactions of this sort as a challenge to their religious identity.

Presentation of alternative identity to healing. For someone who primarily orients themself toward a God that transforms or provides meaning through suffering, responding to interactional challenges is more nuanced. They do not personally share in the collective identity of healing in the same way as someone with a healed identity does. Depending on the particular social context, the most common actions that these interviewees would take to respond to an interactional challenge are: 1) deferring to the other person, or 2) asserting a different interpretation or presentation of one's personal identity.

In any interaction with another Pentecostal, each individual is invested in upholding the collective identity as Pentecostal that they both share. Even if an individual does not fully accept the group's beliefs about healing, they often try to support this in their interaction with another Pentecostal for the sake of that individual's inclusion in the group through relationship with a healing God.

With this in mind, some interviewees worry that their very condition of illness itself challenges the healing identity of other Pentecostals. Ben has been chronically ill for several years. Every time he would visit his parents and siblings at their home, they would gather round and pray for his healing. He says:

> I would listen to my younger siblings who would pray... fully expecting when they were done praying that like my hair was going to grow back in right there in front of their eyes and uh... you know, I wasn't going to look gaunt and... white and... sick looking. And... it didn't happen. And I would watch that... you know, just in their faces and in their... the way they gave me a hug when I was leaving and just different stuff like that. And uh... and I remember at-at one point in time o-on the visits, calling my parents in advance and saying "I don't want that to happen, because I don't want to hurt their faith."

For the same reason, Ben reported that there were also times he had avoided going to church on Sunday because he didn't want to encounter Pentecostal acquaintances who

would want to walk him up front and pray for him. As with his siblings, he withdrew from the interaction because he said he worried about the negative impact this interaction might have on their faith in healing.

This kind of indirect response of withdrawing or deferring to the other person in an interaction are the most common action that interviewees with an identity of meaning through suffering reported taking in response to others. When Ben is offered spiritual or practical advice about his condition, he says he often "humors" the other person rather than disputing their advice. Al allows other people to pray for his physical healing, but privately doesn't believe that this is what God wants for him. He does not reject the prayers offered for him, but defers in these interactions with other Pentecostals. Likewise Diana says, "I just smile and I just say, 'Oh, thank you so much.' And you know, in my mind it's like, pshaw [she makes a dismissive noise and facial expression]." For these individuals, they may be internally dismissive or upset by the suggestion offered by the other person, but their external response is to simply allow these challenges to pass.

Interviewees had different reasons for deferring in their interactions. While some, like Ben, didn't want to impede the other person's belief in healing, others were concerned about extending autonomy to them in their personal relationship with God. Dee describes interactions she has had with another woman at church who has told her that with enough faith she can be healed. She strongly feels that this is incorrect, but defers to this message rather than asserting her own understanding of it. The reason she gives for this withdrawal is grounded in a perception of the personal, private nature of relationship with God: "What God says to Kay is for Kay and what God says to me is for me," she says. Dee thus reserves autonomy for her own religious identity and extends it

to Kay by deferring. Diana says, “I don’t want to offend them, or make them feel that they’re less of a person because I’m not expect-… you know, I’m not jumping on board with them.” Again, deferring in this situation extends the other individual autonomy for their own personal identity. These interactions do not assert a *specific* personal identity for the ill or disabled person; they simply allow the challenger to maintain their own face in the interaction.

However, other interviewees asserted their personal identity more definitively when they withdrew from participation in public prayer for healing. When a man encouraged Jane to go up for healing, she replied, “I feel fine just sitting here, and I-I believe that God’s hearing my prayers when I’m praying myself here. I feel comfortable doing that.” In her response, she draws authority from her personal relationship with God to present a legitimate religious personal identity. Ben responds to interactional pressure to participate with, “The God I have isn’t limited to the front of a church.” He emphasizes God’s characteristic of sovereignty to make a legitimate argument for his presentation of personal identity in this situation. While neither person rejects that God can heal, they choose not to utilize the public space that showcases their illness. They elect to contest their identity within a face-to-face interaction, in which they can claim the authority of close relationship with God, rather than participate in the public ritual of healing prayer that necessarily highlights the discrediting element of their social identity. Neither Jane nor Ben is specifically asserting their transformed identity in this interaction, but they are claiming a generally positive social identity by articulating that their illness doesn’t separate them from God.

There are times when certain individuals respond directly to extreme interactional challenges. For example, when a churchgoer suggested that Ben wasn't being healed because he needed to correct the sin in his life, Ben responded, "Are you praying for me to get better?" When the man responded in the affirmative, Ben asked, "Well then how do I know it isn't something… *points at interviewer, implying "something *you've done*"*?" Ben said he didn't feel that this response had been very effective in any long-term change to how the man thought. These kinds of direct confrontations present a different interpretation of the situation from what the challenger is presenting; Ben suggests that it is actually the religious identity of the challenger that is at fault. Because it is not Ben, but the challenger who has the assumptions of the collective identity on their side, finding successful acceptance in this kind of interaction is likely rare.

Another avenue that interviewees use to take the public eye off the stigmatizing characteristic of illness is to control disclosures about the status of the illness. This may involve keeping updates off social media platforms, only notifying close friends and family about upcoming medical procedures, and only allowing close friends to pray for one's physical condition. This limits the access that acquaintances have to information about the ill person's physical condition. By controlling these disclosures, they limit their exposure to the sort of loose social connections who would only know them by their illness, and thus might be more likely to present interactional challenges.

Although it was uncommon, three of the interviewees left religious congregations they had attended at the onset of their illness because of the treatment they received regarding their illness. One of these was Sarah, the woman who resigned from a ministry position because the visible role she held attracted too much negative attention to her

illness—she was prayed for frequently and her illness dominated her social identity in that context. The other was Andrew, a man who experienced the sudden onset of very disruptive symptoms that prevented him from attending his church. He said that the church did not come to provide any physical support, and they came only once at his request to pray for his healing. He was very brief about this experience, but said, "I don't think that they really knew how to respond." He felt "isolated" and "rejected" after experiencing this silence on his condition, and he has not attended there since. Another woman, Kay, attended evangelistic healing meetings in her earlier life, but stopped attending after she was prayed for multiple times without results. In each of these situations, the barriers to acceptance of a personal identity that included illness were insurmountable. Each of these situations demonstrates the experiences of individuals who occupied relatively peripheral roles in these religious groups. The healing services Kay attended and the churches that Sarah ministered to were transient associations for them. Andrew had experienced a series of relational traumas in the years leading up to the onset of his illness, including divorce and the death of a close friend and family member. Given these conditions, each of these individuals possessed a social identity at church that easily became completely defined and discredited by their illness because of the lack of social relationships with others who knew them as possessing other, positive spiritual traits.

The social niche: acceptance for alternative personal identity. When personal identity does *not* align as healed, close friends can provide a social niche for a reinterpretation of the situation. This is because these significant others provide a level of acceptance to the presented personal identity that cannot necessarily be expected of the loose associations with acquaintances at church. Ben describes his interactions with his

closest church friends as a space where he finds acceptance of his personal identity. He says, “there’s been many points in time when I have not relied on my own faith but others... uh... to sort of get from one moment to the next.” When his doctor told him that he would die soon, Ben questioned whether he should even keep praying that he would recover. He went to his wife and a few close friends and said, “I am struggling... to have my own level of faith that would allow me to not think 'I just need to give up.'” He said:

> Those individuals... uh... knew me well enough, and maybe knew how I react to stuff well enough... and had a strong enough faith base of their own to go... um... their-they-their jump into it wasn’t “well let’s just pray that you have faith to get through this.” It wasn't. It was more of a... just a different way of just coming alongside and saying “I understand what you’re telling me and you know, I feel for you. And... let’s talk about football, or you know, something different than this.” And um... you know, not saying “no that’s not true” because... I think a lot of them believed it probably was just looking at me at the time, and you know, I was not a healthy looking person. I was sick. I had... lost thirty something pounds and all those different things that go on with all those treatments. And... um... so it was those interactions... not going *to* church, but being part *of* the *family* of church that uh... pulled... through times when I was like... “I... can’t do this on my own.” [speaker’s emphasis]

Ben’s significant others provided a space for him to have his personal identity accepted, despite the fact that they did not necessarily agree with him at the time on his particular beliefs about whether he would be healed. These significant others extended inclusion to him as part of a collective identity of believers, but did not impose those particular healing beliefs on his personal identity. Instead they “came alongside” and aligned themselves with the way that they had learned that he interacted with God about his situation.

In another example of relationships of acceptance of personal identity, Denise wrote an essay for close friends about her illness, called, “What M.S. means to me.” In it, she articulates a personal religious identity that challenges the assumption that her

physical condition is the only thing that defines her. M.S., she says, stands for not just Multiple Sclerosis, but also My Sweetie (her husband), and My Savior (Jesus). By sharing this written account of her identity with other Pentecostals, she articulates a different basis for her personal identity in a public space. In this articulation, she contests the reduction of her religious identity to a physical characteristic. Instead she reminds others that she is defined by her relationship with Jesus as her savior, and by her status as a wife.

Diana provided me with a devotional that she had written for members of the church choir she participates in. This devotional included a list of verses about suffering and God's comfort and provision through that experience. She writes,

> I am a better person in every way because of all this. I've reached a depth of peace that isn't just amazing it's a miracle of grace. I never want to look back on this part of my life and regret the journey. I want to enjoy the memories and choose to forget the pain *unless its still there to keep me company*. We never really know what is best for our lives. But we are blessed that our creator does and he cares enough to walk this journey with us. What an awe inspiring thought.

By sharing this devotional with other choir members, Diana clearly presents her identity as transformed through suffering. She sees this experience as valuable for her spiritual "journey," and through this devotional she publicly orients herself in relation to a God that provides meaning through suffering. Diana's embeddedness within this ministry and close relationships at church allow her to have a platform for articulating this identity.

Finally, one other social niche that can provide acceptance for the personal identity of an ill or disabled Pentecostal is a position of leadership. In a sense, Diana's position as a member of choir is a leadership position that enables her to share her identity with others in a space of acceptance. It may seem counterintuitive for a leadership position to facilitate identity acceptance, given the negative experiences that

some individuals have with public displays of their illness. However, when an individual is invited to participate in leadership by other leaders, this can confer a status of moral authority to the ill or disabled person, providing confirmation of a positive social identity for the individuals invited into leadership.

While the few interviewees who were invited to participate in leadership still reported experiencing interactional challenges revolving around their illness, the invitation to participate in leadership allowed them to draw on their illness as a resource for ministering to others, as Diana did in her shared devotional. The position of leadership gives them an elevated moral status in particular interactions with the individuals they mentor or have close contact with through ministry. For example, Alex was invited to preach a sermon. He delivered a sermon he titled, "Why God? And the Bitter Answer." The content of this sermon revolved around Alex's struggles with doubting God that emerged from his experience of chronic illness. Toward the end of the sermon, he concludes that "faith is not defined by how I suppose God should respond to me but how I know I ought to respond to God—utter dependency." He articulates that God does not always provide what we want. He communicates that the important element of the experience of suffering is surrendering to God no matter the outcome. Through the sermon, Alex presents a particular personal identity of suffering very clearly, and this presentation is legitimized by the platform of leadership he has been given. Although this does not preclude individuals presenting that person with an interactional challenge to their religious identity, it is likely to create a social niche composed of the individuals that the person is closely mentoring which will not be characterized by challenges to their

presented personal identity. It also inserts into the public discourse of that church new, legitimized interpretations for ill identity that diverge from the expectation for healing.

It is important to note here that 12 of the interviewees held official positions of either leadership or membership in a church ministry or on the pastoral staff. This means that the interviewees I spoke with tended to be well embedded in the social network of the congregation. Their social identity as a person of good standing in relationship to God had for many of them been well established in the community they participated in. With these larger social networks, they also had more options for finding the right social niche for acceptance. It is likely that more peripheral church members experiencing chronic illness or disability would have less success in finding social niches for acceptance of the presentation of a positive personal identity that did not center around a collective discourse such as healing.

CHAPTER FIVE

Conclusion

Many aspects of my findings align with previous literature that maps the progression of a chronic illness or disability as a biographical disruption prompting identity work (Becker 1997; Bury 1982). Various scholars specify general trends in the identities that individuals develop as they reestablish continuity; these include: seeing the self as better than before, gaining a partially or fully restored pre-illness identity, having identity completely defined by illness, losing all sense of identity (Charmaz 1983; Yoshida 1993). While these identities loosely fit those articulated by my interviewees, my research demonstrates the importance of a specific belief context in producing identities that that are constrained by and respond to the interactional dynamics and available discourse within that social structure. Interviewees draw from common Pentecostal discourses about healing and illness to construct an identity that reestablishes biographical continuity in a way that reflects that social context. Becker calls these sorts of resources "cultural constructs" that individuals use to tell a new and continuous narrative of self after a biographical disruption. Identity work is thus constrained by the available cultural constructs.

However, my research also shows that cultural constructs can be used with great flexibility in developing identities. Scripture was used again and again by interviewees as an authoritative resource for identity construction. It provided the constructs that were used to build a narrative of self after disruption. But the constructs interviewees extracted

from the *same* cultural resource of scripture were vastly different, supporting identities that sometimes focus on achieving healing and, at other times, transformation through suffering. In this sense, interviewees retain agency within the social constraints of the available discourses.

The Pentecostal context in fact encourages this agency through the collective belief in a supernatural authority that is vested in each individual through a personal relationship with God. In a Weberian sense (Weber 1978:215), this "charismatic" authority of each individual could be considered a cultural construct that forms the crux of Pentecostal belief, and facilitates agency in applying other cultural constructs to personal religious identity. It allows individuals to legitimately make personal claims about the nature of God.

Luhrmann's detailed analysis of the God relationship reveals how interviewees are able to rely so heavily on the charismatic authority of this relationship for legitimate personal identity construction (2006). The questions one is encouraged to ask in order to "check" whether one is really hearing from God are: 1) Is it just something out of my own mind? 2) Is it something God would say (from the bible)? 3) Is it confirmed by my circumstances or the prayers of other people? And 4) Do I feel peace about this? (Lurmann 2006) The primary validations for what one "hears" from God are internal. Interviewees demonstrated that both scripture and circumstances could be interpreted as supporting very different claims about God.

However, charismatic moral authority for identity construction is also subject to social constraints. Successful presentation of self depends upon the acceptance of others (Goffman 1955). My research shows that, in the situation of chronic illness or disability,

this acceptance is dependent on certain factors. Illness itself encourages other Pentecostals to call into question the charismatic authority of the God relationship. But if one can align with the collective identity of healing, as did those who present a healed or expectant identity, the social group more readily provides interactional "confirmation" for that identity—one of Luhrmann's "checks" for hearing from God. However, this collective confirmation is present only in so long as the individual continues to align with the collective identity of healing. A clear, and often verbal presentation of self as "healed" thus becomes a crucial symbolic marker to external others that one is in right relationship with God.

On the other hand, an individual may feel that the personal moral authority of their God relationship supports a religious identity that deviates from their group; when this identity is not confirmed through the interactional acceptance of other Pentecostals in rituals of group prayer and in the common discourse about illness, this public setting disconfirms the legitimacy of their charismatic moral authority. The disconnect between personal and corporate moral authority results in the ill or disabled person using what some scholars of illness call a "calculus of friendship" to manage their relationships in such a way that the authority of the personal identity is challenged as little as possible (Clarke and James 2003). My interviews show that individuals who develop a different personal identity from the collective one tend to withdraw from social interactions with "loose ties," like acquaintances at church that may challenge their personal identity. They don't engage in interactions of ritual prayer as much, which also serve as a social space that challenges this personal identity. These trends are reflected, I believe, in my survey

data, as P/Cs who are frequently ill drop off in church attendance to a greater degree than other frequently ill people.

My interviewees were unique in that they were often embedded in networks of "close ties" with others in their group and often occupied leadership positions within their congregations. Although these characteristics are not necessarily typical, and may limit the generalizability of my findings, they do indicate potential spaces of interactional acceptance for ill and disabled Pentecostals. Individuals in positions of leadership are invested with a traditional source of moral authority that can offset the discredited charismatic authority of their personal relationship with God. This provides them with a space to change the common cultural discourses about illness as part of religious identity. Additionally, those who are embedded in close relationships with other Pentecostals have more options, as they engage in their "calculus of friendships," to find a social niche that responds with acceptance to their presentation of a personal identity that deviates from expectancy for healing.

In conclusion, my research suggests that social groups and meaning systems can be highly formative for how an individual resolves the discontinuity of their biographical disruption. For Pentecostals and other Evangelicals, the intimate, personal relationship with God is an internal interaction ritual for developing meanings that influence how they interpret their situation (Collins 2010). The Pentecostal's religious beliefs validate this relationship, investing the products of their internal identity work with charismatic authority. Cultural constructs about illness and healing are drawn from scripture and the common discourse of the group and are used internally to develop an independent personal identity that resolves the cognitive dissonance of the chronically ill or disabled

person's situation. However, this charismatic source of authority is publicly challenged because of their illness. The result is a calculated presentation of self that either aligns with the collective identity, or tends to defer and withdraw to social niches of acceptance when identity does not align. Traditional sources of authority can provide an opportunity for the ill person to contest their identity and introduce a new discourse about illness into the larger social group.

Further research in this area would be valuable as P/Cs are a large, understudied group. Qualitative research could explore the identity and interactions experienced by ill and disabled P/Cs in other contexts, such as those attending non-P/C congregations or those experiencing illness in different cultural settings. These contexts may present different kinds of interactional challenges to an ill or disabled individual's religious social identity, and they may provide different resources and discourse for that individual to draw from. This could facilitate the development of different sorts of personal religious identities that would need to be explored through further research. Ethnographic field study would be an invaluable tool for future research of this sort, as this could identify more clearly the collective discourses that P/Cs are exposed to regarding illness and healing.

Quantitative surveys rarely ask detailed enough questions about religious practice to single out Pentecostals and charismatics. Simple affiliation does not necessarily identify individuals who are charismatic or neo-charismatic, since these churches do not always clearly identify as Pentecostal. Since P/Cs comprise a relatively large percent of the U.S. population and represent a growing religious movement internationally, when studying religion, it is important to consider including survey questions that could

identify these individuals through beliefs and private and corporate religious practices that include speaking in tongues and divine healing *as articulated by P/Cs*.

It is also rare to find surveys that include both detailed questions about religion and adequate health measures. The subjective experience of a health problem, as this research has shown, is greatly influenced by the religious context a person operates within. To explore this further using the kind of quantitative analysis that would produce more widely generalizable findings, it would be necessary for such surveys to include detailed questions related to both these aspects of the experience.

In a very significant way, this study adds to the discussion of how specific social structures can influence individual experience of chronic illness or disability. The development of the personal identities of the interviewees in this study demonstrate that social structures both constrain human experience and give individuals the tools to act agentically within that. The central element of the social structure that allowed this to occur is the authority invested in internal interaction ritual with God. This and other such central elements of social structure that facilitate agentic activity should be explored.

APPENDIX

APPENDIX

Interview Script

Illness:

1. Could you please describe when and how you first experienced your condition/symptoms and how that has progressed for you?
2. How has it affected your day-to-day life?
    a. Has there been anything specifically that has helped you spiritually in coping with your symptoms or understanding your current situation?
        i. Bible reading, prayer, any books or other resources?
    b. Do you watch church services or religious speakers on TV? More so than before you became sick?
    c. Do you journal about your experience?

Church:

1. Were you going to your present church when this started?
    a. If not, what church? And why join this one?
2. Has this affected your attendance or other involvement at church? How so?
3. How did you let people at church know about your condition, and who all knows about it?
4. How have people at church been involved in your experience as your illness has progressed?
5. Have you relationships with church friends changed?
6. What have been the responses of people at church to your condition?

a. Could you describe any particular advice or comments you have gotten about this?
    i. Was this health advice, bible verses, spiritual advice, or what?
b. How did that make you feel, and did you do anything in response to that?
c. Has there been anything that was particularly helpful or encouraging that someone shared with you?
d. Has there been anything discouraging or less helpful to you that people have responded with? Why was it discouraging?

7. Do you know if your church has any program for people who have chronic illness?
    a. Are you involved in this? Why/why not?
    b. How exactly does your church help you out through this program or otherwise?
8. Have you been prayed for at church as an altar call or in the church service?
    a. Could you describe that for me? What is that experience like for you?
    b. Have you gone up for an altar call lately? Why/why not?
9. Have you been prayed for by friends from church outside of a service?
    a. What is that experience like for you? Positive?

Personal Spirituality:

1. Have you ever experienced healing by God?
    a. Is this something you pray for in your current situation?

2. Has what you pray for changed through this—and your relationship with God in that?
3. Do you feel like what you pray for and how you understand your situation is different in some way than other people at your church? How so?
4. Thinking of what you have said or adding to it, how would you say that your faith affects how you experience or understand your illness and situation in life?

Conclusion:

1. I have been studying some national survey data that shows that some Pentecostals who are chronically ill go to church less than other Christians with the same health problems. I am interested to know your thoughts about why this might be the case for some people.

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