THE SERVICE OF HEALING AS PASTORAL CARE: A DISCOURSE-INFORMED, COMMUNAL-CONTEXTUAL INTERPRETATION

By

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CHAPTER I

INTRODUCTION

Case Study

Joan is a single woman in her thirties who has undergone both medical and therapeutic treatment for chronic, recurring depression since she was in college. Joan worshipped at her local Episcopal church until she left for school, and when she began feeling despondent and unhopeful as a sophomore, she wondered if her spiritual life was connected to her deepening sadness. Joan began withdrawing from social activities, and her grades began to decline. She lost interest in her personal appearance and in making a strong impression at her part-time job. When her low grades began to endanger her academic scholarship, Joan began visiting the school counselor who, after several sessions, recommended she be evaluated for treatment with medication while continuing therapy sessions. The combination of therapy and medicine made a positive difference for Joan. In time she learned how to manage her depression while also working toward her academic goals and maintaining relationships with co-workers and friends, but the symptoms never entirely went away. The threat of depression, as well as its real, regular symptoms, became a chronic presence in her life, requiring daily attentiveness and vigilance. Her doctor and therapist both assured her that medicine and therapy will probably be a permanent part of her life.

During her initial recovery, Joan began attending a local Episcopal service, and noticed the regular service of worship included an optional service of healing. For months Joan watched individuals, after they had taken the Eucharist, move from the altar to a smaller
chapel, stay for a few minutes, and then return to their seats in time to sing the final song and receive the benediction. She thought of the stories of healing in the New Testament that described desperately suffering people going to great lengths to be touched by Christ: the crippled man, the woman with the issue of blood, the parents of a child who had already died. The people coming out of the small chapel didn’t look that desperate; in their dress and their manner, they looked to Joan like normal, average people. She wondered what the extra service of healing gave to these folks, and if her own suffering was enough to allow her to go into that little chapel and ask for relief. One Sunday she decided to find out. With the taste of bread and wine still on her tongue, she rose from the kneeler, turned toward the small chapel, and took her place in the line that had formed.

Upon entering, Joan saw two robed ministers standing side by side in the front of the room. In front of both was a parishioner; one knelt with his elbows on the rail and knees on a padded cushion, and the other stood. Joan watched as one of the ministers bent her ear toward the kneeling man while covering his hands with her own. After a moment she nodded and reached for a small, round container that disappeared in the palm of her hand. With her forefinger she applied some of its contents to the forehead of the kneeling man, and then laid both of her hands, palms down, on his entire head, praying aloud, intensely but quietly, for several moments. Eventually the man rose and left the chapel, and it was Joan’s turn to approach and kneel.

As she knelt, Joan clasped her hands on the altar in front of her, and the robed woman covered them with one of her hands. She placed the other hand on Joan’s shoulder, and Joan felt the warmth of her palm on her skin through her clothes. Joan wondered how long it had been since she had been touched by someone other than a nurse during the regular blood-
pressure check she had to have because of her particular combination of prescription medications.

“What is your name?” the woman asked.

“Joan.”

The woman moved one hand to the top of Joan’s head, and with a finger, drew a cross onto Joan’s forehead with oil. Joan smelled something earthy and sweet, and thought of moss.

“Joan, I anoint you with this oil, as an outward and visible sign of God’s love for you, in the Name of the Father, and of the Son, and of the Holy Spirit, beseeching our Lord Jesus Christ to sustain you with his presence, to drive away all sickness of body and spirit, and to give you that victory of life and peace which will enable you to serve him both now and evermore.”

The woman continued to pray over Joan with such clarity that Joan felt she must know more about Joan’s condition than she realized. Joan found herself nodding her head, believing in that moment that everything the woman prayed on Joan’s behalf would come true, and wishing she could think so clearly herself when she knelt alone to pray to God.

“Amen.”

Joan stood, turned toward the door, and walked back to her seat in the larger chapel. The final song was being sung; she made it back in time to join in the last two verses and to genuflect with the rest of the congregation in response to the priest’s blessing:

“Go in peace to love and serve the Lord.”

“Thanks be to God,” Joan responded with the congregation.
The Service of Healing as Pastoral Care

In *Christian Liturgy: Catholic and Evangelical* (1997), Frank C. Senn writes the “anointing of the sick … reentered mainline Christian practice in the twentieth century through the Episcopal churches” (671). Both leaders of and participants in such services should be able to explain the role and efficacy this service has both for individuals and for the larger Christian community. In a series on the seven sacraments, *Alternative Futures for Worship: Anointing of the Sick* (1987), ritual editor and contributor Jennifer Glen explains the need for careful reflection on the service’s personal and theological meaning in order to understand its intended benefit. “Detached from contexts,” Glen writes, this ritual “can denigrate into magical prescriptions for care, hastily sketched amulets against despair or simply empty, pious platitudes with which to cloak the anguish of sickness and death” (Glen 34). This thesis proposes that one way of returning context to the contemporary ritual of anointing in the Episcopal tradition is through examination of the ritual as an act of pastoral care as understood through a communal-contextual paradigm of pastoral care informed by feminist discourse theory. By examining the ritual in this way, both caregivers and care receivers will understand the ritual as a combination of texts, words, sounds, smells, and touches that combine to send a holy, distinctively Christian message about personhood, suffering, community, and healing.

The dominant pastoral care paradigm at the turn of the twenty-first century, the communal-contextual paradigm, continues to pursue the historical goal of pastoral care: the shepherding of souls (*DPCC* 836). The most basic and simplified definition of pastoral care, articulated by Liston Mills in the *Dictionary of Pastoral Care and Counseling*, links pastoral care to “the biblical image of shepherd and refers to the solicitous concern expressed within
the religious community for persons in trouble or distress” (836). Persons seeking care in the
Christian tradition will have heard many stories and seen images of how God cares for
humans as a shepherd cares for sheep, guiding them, looking for them when they have gone
missing from their flock, and rejoicing when they are found and restored to that flock. Jesus,
as the embodiment of God on earth, is often referred to as the ultimate Shepherd.
Consequently, Christian caregiving will include members performing this shepherding
function to members of the Christian community who are suffering or wandering, and thus in
danger of harm, possibly by becoming separated from the larger community of believers.

Later in his introduction to the concept of pastoral care, Mills makes three other
points about the uniqueness of pastoral care that holds significance of this examination of the
service of healing as pastoral care: the meaning of pastoral, the meaning of care, and the
need of the person seeking care. First, Mills explains that the word pastoral may refer to
anyone acting on behalf of the community of believers. This includes both lay and ordained
ministers of the Christian community. For the second and third points, Mills references the
understandings of Hiltner (1958) and Clebsch and Jaekle (1964): the word care “may refer to
any pastoral act motivated by a sincere devotion to the well-being of the other(s),” including
“the pastoral functions of healing, sustaining, guiding, and reconciling” (836); and finally,
pastoral care is given in response “to instances in which there is some sense of individual
need and willingness to accept help.” Specifically, Clebsch and Jaekle “insist that the care
must include matters of “ultimate concern,” i.e. the troubles must be meaningful in relation to
Christian faith in that they foster a deeper faith and relation to God” (837). In making these
points, Mills clearly is stating the “cure-of-souls” nature of pastoral care. The meaning is
clear: the forces that initiate a person’s desire for pastoral care may arise out of one’s
experience in the physical, secular world, but the work of pastoral care is for the sake of restoring the sufferer’s relationship with the Creator, so that the sufferer can find spiritual means to continue his or her earthly existence in full relationship with God. It is this interdependent relationship one has with the world around her that makes the communal-contextual paradigm of care promising for persons in need, but there is an additional approach to this paradigm that can help articulate more about the impact of this relationship: feminist discourse theory.

Feminist discourse theory refers to the examination of communications systems from a point of view come to be known as the feminist one. For example, a feminist discourse approach to the contemporary health care system would examine verbal and nonverbal communication systems so see how they do or do not empower the vulnerable, support shared access to resources, or reflect a system of care that focuses on healing for the overall person rather than a single bodily organ. A person operating from a feminist, discourse approach sees significance in a final comment Mills makes about pastoral care: both the need for and the delivery of pastoral care are “rooted in the historical, political, and social fabric of a given time and place” (837). Mills emphasizes that “the political climate, cultural values and ideals, economic factors, and various forms of secular knowledge enter to determine in part the shape and intent of pastoral care” (837). What Mills is insisting upon here is that when providing pastoral care, the caregiver must take into consideration the context in which the person is embedded. It is this need to include context in the “shape and intent of pastoral care” that characterizes the prevalent model of pastoral care at the turn of the twenty-first century: the communal-contextual paradigm, but it is feminist discourse theory that will help
us understand more about how that paradigm impacts the giving and receiving of pastoral care.

The communal-contextual paradigm of pastoral care emerged as an expansion of the clinical-pastoral model evinced in the twentieth century, and its methodology views both the suffering and the potential healing of an individual as being in concert with particular context and community. Where the clinical-pastoral model understands the individual as a “living human document” (Boisen, 1944; Gerkin, 1984) on whom social scientific tools can be deployed to facilitate understanding and healing of one’s perspective or worldview, the communal-contextual paradigm instead embraces the description of the individual as part of a larger “living human web” (Miller-McLemore, 1993) that must be understood and examined to provide more adequate, holistic understanding and healing. A caregiver operating from a clinical-pastoral model would consider the individual sitting in her office as the focus of care, and would employ pastoral care activities that include understanding the individual’s personal narrative of meaning while employing interventions attempting to understand her suffering as psychological or spiritual bondage (Ramsay 1353). Alternatively, a communal-contextual paradigm of pastoral care considers that same individual’s suffering and healing to be connected to the larger context and community in which the individual lives and moves. Pastoral care under this paradigm would move beyond working only with the suffering individual, but will also examine relationships with other people and institutions that may be contributing to the suffering of the individual. The communal-contextual model utilizes a more postmodern understanding of human identity and interdependence, and emerged from the contributions of women and other previously marginalized voices of
suffering and experience, voices that supported merging particular postmodern theories with the actual practice.

The next section of this thesis, Chapter Two, will provide more detailed comparisons and contrasts of the two models that allow the reader to see how the communal-contextual paradigm developed to allow both Joan and her pastoral caregiver to explore aspects of her suffering and healing that take into account the larger web of relationships and influences in which she is a participant. But the communal-contextual paradigm alone will explain neither how those relationships are critical to Joan’s feeling of wholeness nor how the regular service of healing can be a way of providing “healing, sustaining, guiding, and reconciling” (Mills 837) for Joan and others. That understanding requires the addition of another social scientific tool to the communal-contextual paradigm: feminist discourse theory.

While the communal-contextual model responds to the growing understanding that people are interdependent beings whose responses are intertwined with those around them, it doesn’t quite explain how certain elements of care, like the service of healing, can act as a powerful form of pastoral care without creating an expectation of miraculous healing (Senn 671). In her work, “Feminist Discourse Theory and Pastoral Care” (1999), pastoral theologian Susan Dunlap argues how the use of feminist discourse theory within the communal-contextual paradigm forces pastoral caregivers to consider three specific aspects of a sufferer’s experience: subject position, embodied reality, and competing discourses. Chapter Two, therefore, also will explore how this lens on the work of the communal-contextual paradigm helps us move toward a clearer understanding of not only how human suffering, particularly related to effects of illness, manifests itself in one’s personal
experience, but also how certain acts of community provide distinctively Christian relief from that suffering.

Chapter Three details how, particularly, the Episcopal service of healing addresses suffering related to illness, explaining how, throughout time and without even understanding how, the myriad of actions and messages contained within the service of healing restores hope and provides strength to individuals who not only find their identities and their bodies impacted by the realities of illness, but also find themselves subject to competing narratives of meaning regarding those realities. Through a feminist, discourse theory-informed, communal-contextual understanding of pastoral care, the Episcopal service of healing provides an effective framework to acknowledge a person’s embodied suffering, affirm her identity as a sister in Christ and a Child of God, and strengthen her for her journey by providing an alternative narrative for her suffering that overpowers despair and affirms hope as she continues to navigate her experience.
CHAPTER II

A METHODOLOGY FOR INTERPRETING THE SERVICE OF HEALING

Introduction

A feminist, discourse-informed, communal-contextual pastoral methodology incorporates the core elements of pastoral care with emerging understandings of human experience. The combination of these two theories is unique to this thesis; the resulting approach gives pastoral caregivers and leaders a new lens with which to view our behavior. In other words, this approach identifies how particular actions restore wholeness to the brokenness that can emerge when dealing with pastoral issues of ultimate concern (cf. Clebsch and Jaekle; Tillich) in ways that support healthy formations of personal and communal identity and distinctively Christian narratives of meaning. This section has three parts: part one more fully develops a comparison and contrast of the care of Joan through the clinical-pastoral and the communal-contextual paradigms of pastoral care. Part two applies pastoral theologian Susan Dunlap’s “challenge of feminist discourse theory” to the communal-contextual paradigm, highlighting areas of Joan’s experience of suffering related to illness that can be addressed by incorporating a discourse approach to care. Part three concludes by asking what questions a feminist, discourse theory approach to the communal-contextual paradigm of care should ask about the pastoral functions of healing, sustaining, guiding, and reconciling available through the Episcopal service of healing for our sister Joan.
Regardless of pastoral methodologies that emerge to meet the needs of suffering people, the particular suffering accompanying illness often causes issues of ultimate concern that leads individuals to seek pastoral care. When discussing the connection between illness and the service of healing in *Alternative Futures for Worship*, Glen refers to Orlo Strunk’s contention that the experience of illness reflects one’s political, cultural, and economic landscapes: “The nature and severity of the illness,” Glen writes, “the cultural and personal history which forged the sufferer’s personal world, the socioeconomic circumstances which condition it, and the religious convictions which sustain it all have a part to play in shaping the way sickness is experienced and the response it elicits in the concrete” (Glen 39). Essentially, the same elements Mills names as determinants of the “shape and intent” of pastoral care are also, Glen explains, powerful influences on how a person responds to illness.

Articulated through a variety of metaphors, imagery, and language, the impact of illness, the need for pastoral care, and the use of the service of healing have remained present throughout Christian history. Writers of both historical and contemporary pastoral care describe the impact of illness as “destabilizing” (Philibert 1), “disruptive” and “threatening” (Glen 39), a “betrayal” (Glen 39), a “crisis,” and “overwhelming” (Louw 1). It makes people “vulnerable” (Lysaught 165). Gisbert Greshake argues that the reality of illness is so powerful that “the whole of the person is shaken. Men and women react with anxiety, hopelessness and despair or with impatience and rebellion” (Greshake 86). The *Dictionary of Pastoral Care* echoes this understanding of sickness as it relates to pastoral care giving, and reminds readers that these feelings may also spread to the sufferer’s friends, family, and immediate community (1166).
If one believes the descriptions of the impact of illness above, the Christian provision of pastoral care must include attention to the powerful impact that illness has on people’s lives. More importantly, if Strunk and Glen are to be believed, that attention must include the role one’s political, cultural, and economic landscapes play in that impact. The natural question arising for the pastoral theologian, then, is how well do the different paradigms of care interpret or describe how communities of believers meet pastoral care giving needs related to illness?

Specifically, early Christian texts illustrate distinctive responses to persons seeking relief from the effects of their illnesses, and as Christianity formally developed, so did a service of healing based on the early use of communal gathering, scented oil, intentional touch, and specific prayers for those suffering from illness. In examining the emergence of the feminist, discourse-informed, communal-contextual paradigm as a response to the clinical-pastoral paradigm and communal-contextual models of pastoral care, this section will make two arguments: first, the effectiveness of the early Christian communities’ response to persons suffering from illness currently can best be understood through a discourse-informed, communal-contextual understanding of pastoral care; second, it is the discourse-informed, communal-contextual paradigm that allows caregivers to interpret not only the re-emergence of the service of healing in Episcopalian churches in the twentieth century, but also the work of pastoral care the service provides to individuals, like Joan, who suffer from the effects of illness.

The New Testament books of Mark and James provide origins of activities that become formal parts of services of healing – origins that likely incorporate both Hebrew and Greek uses of touch and oil. Significantly, in these New Testament sources both the
community and the individual act in ways that demonstrate their belief that God, through Christ and the Holy Spirit, is a source of care – or cure – of the individual’s suffering. Early in Mark 6 Jesus begins sending his followers out in pairs, and verse 13 tells us “they were casting out many demons and were anointing with oil many sick people and healing them.” In James we see the older apostle giving instructions to a community (cf. Lysaught, 2006), and verses 14-16 of the final chapter contain specific instructions for anyone who is sick: “Then he must call for the elders of the church and they are to pray over him, anointing him with oil in the name of the Lord; and the prayers offered in faith will restore the one who is sick, and the Lord will raise him up, and if he has committed sins, they will be forgiven him” (James 5:14-15). In both of these passages we see Christ’s early followers, acting on his instruction and through the power of the Holy Spirit, continue to have conversations about and actions related to suffering and healing that mimic the work demonstrated by Christ.

The presence of similar acts, characterized by intentional inclusion of the suffering in the Celebration of the Eucharist, anointing, and prayer, continues as the early Christians formalize their religion. The Middle Ages brings a shift in the meaning and intent of the act: anointing of the sick becomes “last rites” or “extreme unction,” an act of anointing for someone who was dying. But Lutheran church orders in the 1500s restore activities “provided for ministry to the sick” that are distinctly different from last rites (Senn 353), and the first Book of Common Prayer, produced in 1549, contains instructions for visitation of the sick, providing specific guidance for anointing and communion. Many of the words and actions of contemporary Episcopal services of healing directly link back to the earliest actions taken by early Christian communities on behalf of individuals suffering from the effects of illness. Indeed, the model of care evinced by the Mark and James stories on which
the contemporary services of healing are based demonstrate a model of pastoral care that can be effectively interpreted via a discourse-informed, communal-contextual model.

To use the discourse informed, communal-contextual model to understand the work and endurance of this powerful service, it is helpful to contrast both the service and the care Joan would receive under the model that communal-contextual, and the proposed discourse-informed, communal-contextual, replaced: the clinical-pastoral paradigm. The next several pages of this section will illustrate how Joan may have been cared for under the clinical-pastoral model, highlighting how that model provided care of issues of ultimate concern related to illness according to twentieth century understandings of human development, as well as how issues that went unaddressed were identified by the consequential development of the communal-contextual approach. At that point Susan Dunlap’s challenges of discourse theory will be introduced, allowing the reader to then use a discourse-informed, communal-contextual approach to the service of healing to examine how it functions as pastoral care of persons suffering the effects of illness.

Clinical-Pastoral Care of Suffering Related to Illness

The twentieth century clinical-pastoral approach to care facilitated the “cure-of-souls” through client-patient behavioral health interventions influenced by the particularly western fields of psychology and medicine. Under this paradigm, Joan’s clinical-pastoral caregiver would understand Joan primarily as an individual suffering from an illness best diagnosed through the western medical model, from which the clinical-pastoral nomenclature gains the word “clinical.” According to this model, Joan’s primary problem would be best described by her diagnosis: chronic major depression. Western medicine tends to look for fixed,
biological causes of illness; one study explains how, in the western medical model, disease, illness, and sickness are three different concepts: disease “is the pathological process, deviation from a biological norm. Illness is the patient’s experience of ill health, sometimes when no disease can be found. Sickness is the role negotiated with society” (Boyd 10). The western medical model has found much success in focusing on parts of the human body that have been identified as causing illness, and a physician providing primary care for Joan in this model would seek such causes for Joan’s suffering. If no biological cause can be identified, western medicine incorporates the expertise of mental health practitioners, who would then work with Joan to manage her symptoms through behavioral and/or pharmacological approaches (although physical treatments like lobotomy and electric shock once were utilized). Psychological care would be heavily influenced by Freudian understandings of human development, a modern perspective not in use until the nineteenth century; this perspective would understand Joan’s situation in terms of theories about drives and early childhood experiences, neither of which Joan would be able to control nor change as an adult. Treatment would consist of uncovering and noticing the effects of those drives and those early childhood experiences on Joan’s psychological, emotional, and spiritual makeup, and then learning to adapt to those awarenesses. Joan’s chronic depression would likely require ongoing therapy and pharmacological treatment, both often characterized in the twentieth century as more art than science. Overall messages Joan would receive under this model of care would include the following: something is wrong with you. That something is permanent. You can learn to live with your illness, but it will never go away.

In many ways, the clinical-pastoral model is just what the words demonstrate: the word “pastoral” added after the word “clinical.” The religious community’s response to
suffering related to illness in the twentieth century followed – although some would argue “colluded with” – the perspective of the medical model (Sutherland 274). Further, since the medical model forces both etiology and treatment of suffering to be understood as personal, private affairs, there is no obvious relationship between treatment and pastoral care. Rather, the work of recovery is limited to the doctor, the patient, and the patient’s insurance company. Consequently, people suffering the effects of illness become isolated, and if they choose to seek pastoral care it will be for the issues of ultimate concern that emerge out of the effects of illness rather than for relief from the illness itself. In other words, pastoral care and counseling under the clinical-pastoral model can simply be seen as clinical care provided with Christian terminology. Under this paradigm, a service of healing could reinforce the medicalization of suffering in at least two ways: first, the aim or goal of the service would be the elimination of pathology, or in other words, the expectation of miraculous cure of symptoms, and second, the scheduling of such services at different times from regular services of worship or in different places from the larger, un-afflicted community members would reinforce the idea that illness is a private, individualized experience, and likely would not participate.

In the second half of the twentieth century, responding to theoretical advances in personal development and identity formation particularly in areas of psychology and linguistics as well as different forms of liberation theology, pastoral care of Joan under the clinical-pastoral paradigm may have recommended the service of healing to Joan as part of an overall hermeneutical approach to pastoral care. Under this model of care, regular sessions between Joan and her pastoral therapist would work to reinterpret Joan’s experiences “within the framework of a primary orientation toward the Christian mode of interpretation in
dialogue with contemporary psychological modes of interpretation” (Gerkin 20). This understanding of the individual as a “living human document” would pair the suffering individual and the pastoral caregiver together to re-appropriate the care receiver’s narratives from stories of suffering to those of healing, and it combines strengths of the clinical-pastoral model of care with social scientific and theological advances. In this therapeutic approach, the service of healing could function as an opportunity for engaging the “milieu” of “images and symbols” Joan has historically used to construct her distinct, personal narrative (Gerkin 26). Again, though, it would be seen as an experience provided by specialized members to the suffering members of the religious community.

In the field of pastoral care and counseling, as in most other fields, the advances Gerkin’s methodology demonstrates can also be characterized as the results of “attitudes or perspectives critical of central assumptions associated with modernity or Enlightenment thought” (Ramsay 1351), commonly known as postmodern. Postmodern thought forces caregivers to reconsider how they understood care of persons in several ways. Major challenges to concepts of self, text, and truth emerged as a result of emerging theories of identity formation and the inclusion of non-male, non-white, and non-western commentary on Christian theology. Work in psychology and linguistics demonstrated how the formation of a self is an ongoing experience dependent upon relations and interactions with others. Consequentially, the Freudian understanding of a fixed self developed in early childhood was no longer the only way to understand identity formation. This work lead to Gerkin’s hermeneutical approach described above, which tied its methodology to continuing theoretical advances in linguistics and psychology. These previously unheard voices held implications for identity development, relationality, truth, and meaning-making.
Communal-Contextual Care of Suffering Related to Illness

What we see in Gerkin’s hermeneutical theory, then, is indications of movement from the clinical-pastoral paradigm of care to what will become known as the communal-contextual paradigm of care. In applying emerging theories about meaning-making to the pastoral encounter, Christian pastoral theologians began identifying not only the possibilities but also the limits of change two people alone can engender. Simultaneously, theologians working from liberation perspectives to focus work on “the emancipation of the poor and oppressed from the sociopolitical structures of domination” (Moseley 645) and feminist perspectives to “empower women to personal creativity and self-confidence by enabling them to remember that they too are created in the image of God” (Zulkosky 433), were making convincing arguments about the relationship between issues of ultimate concern once considered private and social justice issues that were convincingly becoming public. The resulting impact of these theologies of the underside on the work of pastoral care is significant. As noted in updates to the Dictionary of Pastoral Care and Counseling (2005, originally published 1990), the field underwent a major shift: “the living human document” instead became “the living human web” (Miller-McLemore 1993), and instead of modeling pastoral care after the western medical model, one feminist theologian proposed the imagery of a “healing and transforming web” (Ramsay referencing Brita-Austern 1363). This shift reflects the practical implications of those theoretical advances in identity development, relatiornality, truth, and meaning-making – advances well-illuminated by several pastoral theologians, particularly feminist ones – and has specific implications for the provision of both giving and receiving pastoral care. The remainder of this chapter will detail some implications and characteristics of the communal-contextual approach to care, identify the
three challenges feminist pastoral theologian Susan Dunlap believes discourse theory brings to the communal-contextual paradigm, and explain how Joan’s experience of pastoral care would change under a communal-contextual paradigm informed by pastoral care.

The communal-contextual (Patton, 1993) approach to the pastoral care of illness broadens everything about the way Joan receives care, because it allows pastoral theologians, caregivers, and care receivers to re-interpret everything we think we know about the etiology, impact, and treatment of issues of ultimate concern. The communal-contextual paradigm utilizes the continuously emerging tools of behavioral sciences (i.e., ethnographic observation) that are helpful for understanding how people respond to and process information, and also incorporates previously unheard perspectives, experiences, and voices of suffering and care. It invites us to consider both the presence and impact of human interdependence and connectedness in both causing and caring for issues of ultimate concern. The “core values” identified in the communal-contextual approach “include: a priority for relationality and community; a more interpersonal than intrapsychic developmental perspective; appreciation for particularity and difference and recognition of ways asymmetries of power distort these differences in communities; and a goal of mutuality and reciprocity within communities” (Schieb in Ramsay 1363). Susan Dunlap argues effectively that these core values not only exist because of the theoretical foundation of discourse theory, but also that discourse theory offers three particular challenges to the communal-contextual model with implications for pastoral practice.

Where the clinical-pastoral paradigm understood both the etiology and treatment of illness as a private pathology manifesting itself within the body of the suffering individual and treated by someone able to excise or otherwise ameliorate that pathology, the communal-
contextual paradigm approach to care looks both to and beyond Joan for the both causes of and relief from her suffering. The webs are traced for connections and relationships that harm and heal. At the same time, the communal-contextual paradigm honors the particularities of Joan’s suffering while validating Joan’s experience of her illness. It looks beyond a singular cause of Joan’s malady and considers whether multiple forces could converge to create suffering, not only in Joan, but also in others. At the same time the communal-contextual paradigm recognizes that methods of healing may also be multiple, and the particular combination of activities and therapies that work for Joan may not work for another. Finally, while working to ease the specific suffering within Joan, the communal-contextual paradigm also demands we look beyond Joan herself, querying and examining the “public, structural, [and] political dimensions” (Ramsay 1349) contributing to the suffering of Joan and others. The communal-contextual paradigm articulates how bringing care to one soul translates into care for other souls, and also recognizes how none are truly free while some still suffer.

The role of the service of healing within the communal-contextual paradigm becomes almost immediately recognizable. The service provides space for Joan to celebrate her membership within the Christian community even while she is a person who suffers. It also provides a means for members of the Christian community, other than a medical or behavioral health care provider – and other than ordained – to minister to her. But if, as this thesis argues, the service of healing is a powerful form of pastoral care, we will need to explore whether the service of healing addresses the communal, the public, structural, or political dimensions that may be contributing to Joan’s suffering. If it addresses the contextual, how does it help Joan honor her own particular version of suffering in a way that moves her toward healing? And to avoid understanding the services as, in Glen’s words,
“magical prescriptions for care, hastily sketched amulets against despair or simply empty, pious platitudes with which to cloak the anguish of sickness and death,” how do we understand the healing power of the service of healing? These are the kinds of questions Susan Dunlap would answer by applying some tools of feminist discourse theory to the communal-contextual model of pastoral care.

Discourse-Informed, Communal-Contextual Care of Suffering Related to Illness

The pastoral theological shift to the communal-contextual paradigm in pastoral care, Dunlap argues, unknowingly relies upon discourse theory as “an important theoretical base” (134). In “Discourse Theory and Pastoral Theology” (1999), Dunlap describes discourse theory as more than Gerkin’s understanding that “language creates worlds,” and names three “challenges” discourse theory brings to the pastoral care encounter: 1) the consideration of subjects instead of selves; 2) an understanding of embodiment as a site of multiple, competing discourses, and 3) a recognition of (and recommendation for) pastoral theology and pastoral care as an oppositional discourse, or, in other words, an alternative discourse that competes with other harmful, dominant discourses. Through these three challenges, discourse theory broadens the understanding of the communal-contextual paradigm of pastoral care, particularly for someone experiencing the effects of illness.

Because discourse theory can be understood as the work of semioticians and linguists to examine how communication systems generate meaning and truth, discourse theory naturally proves valuable to conversation around providing care regarding issues of ultimate concern. Discourse theory builds upon the work of structuralists Ferdinand Saussure and Jacques Lacan, both of whom argued the human construction of words is also the means by
which humans also construct worlds. This idea is demonstrated in pastoral theology via Gerkin’s hermeneutical method. It is the analysis of both the function and impact of this revelation, however, that comprises the work of discourse theory. Post-structuralist and postmodern scholars examining how language creates worlds explained the arbitrary nature of the sign-signifier relationship that ultimately deconstructed the mode of binary thinking characterizing most of western philosophy, language, and communication. In binaries of good-bad, white-black, male-female, healthy-sick, no longer does the first word have to equate ‘good’ and the second ‘bad’; with either-or thinking philosophically dismantled, interpretation of signs becomes fair game. Suddenly a world exists where occupying the previously disparaged position of female (as opposed to male), gay (as opposed to straight), brown (as opposed to white), or sick (as opposed to well) can now be owned in addition to, not instead of, other language- or communication-structured subject positions. A variety of scholars since the 1960s have worked to articulate the impact of this deconstruction on understanding communication systems, and feminist discourse theory has emerged as a way of re-cognizing and re-inscribing new meanings onto old labels.

Dunlap, in particular, has applied discourse theory to pastoral theology as a way of not only continuing the helpful work begun by Charles Gerkin and Edward Wimberly that helps provide the theoretical basis for the communal-contextual paradigm, but also bringing particularly feminist perspectives to the treatment of issues of ultimate concern (Dunlap 134, 147). Where the communal-contextual paradigm moves from living human document to larger communal web, Dunlap explains how discourse theory “casts the net wider, and views language as enmeshed with other entities, such as social structures, institutions, truth claims, ‘scientific’ knowledge, power dynamics, the body, and the psyche” (134). The concept of
discourse encompasses the messages and meanings resulting from communication systems, systems we now know to be discursive and dependent upon particular contexts and meanings participants bring to act of signing and signifying. The work of scholars Michael Foucault, Julia Kristeva, Luce Irigaray, Judith Butler, and Hélène Cixous in the second half of the twentieth century demonstrated linkage between primary communication systems – namely language – and patriarchal attitudes, challenging caregivers to grapple with the consequence: if language creates worlds, then our worlds are have been created according to patriarchal philosophies. In examining the relationship between worlds and the communication systems, scholars can articulate how communication systems – including language – work to continually create and re-create our worlds, can study the relationship between discourse and power in community, and can identify and listen for messages from competing discourses. “The sources of competing discourses are many,” Dunlap observes: “church, family, journalism, popular media, psychiatry, advertising, medicine, social welfare, and liberal feminism, for example, [are] each linked to institutions and languages and authority structures” (136).

Where the communal-contextual paradigm, then, would approach the issue of suffering related to illness by honoring the particular elements of the individual’s suffering and by examining, through interpretation of assigned meanings, how that person’s suffering is manifesting itself in her community – her family, her social relationships, and her work life, for example – the discourse-informed, communal-contextual approach would also not only examine beliefs and feelings about illness and wellness, current scientific knowledge about the etiology and treatment of that person’s dis-ease, and dominant cultural messages about personal efficacy and worth, but in doing so would also, in the tradition of Gerkin, assist the
care receiver in adopting or maintaining messages that lead to wholeness while addressing particular issues of ultimate concern. The pastoral caregiving encounter informed by a particularly feminist discourse theory, Dunlap insists, is simultaneously deepened and broadened with three particular understandings, according to Dunlap: 1) the individual is a subject position instead of a self; 2) the experience of embodiment is at the same time a social construction as well as a particular reality; and 3) the distinctively Christian nature of pastoral caregiving must function as a life-giving, hopeful alternative discourse in opposition to discourse that send messages of brokenness and despair.

Take, for example, a person suffering from measles in early the twenty-first century United States. This person may be encouraged by some caregivers to focus on the individual’s response to treatment of symptoms, hoping that resolution of those symptoms will come with time and use of appropriate medicines and treatments. A discourse approach, however, would also take into account the suffering that person also experiences from not only being unable to earn money while being dis-abled by the disease, but also the clear social difference highlighted by the onset of a disease against which a segment of society has been vaccinated and therefore will not acquire. “Discourse is never simply language,” Dunlap explains. “[I]t is always linked with concrete, social, cultural, historical realities, including psyches and bodies” (135). In other words, a discourse approach to the care of someone with measles interprets the messages about economics and class that the experience brings. It takes into account corporate medical structures that create medicines and vaccines for a segment of society, the economic structures that enable or disable such medicines to be accessed by certain people in society, and the priority of treatment given to persons suffering from diseases that may be more socially acceptable than others. A discourse approach
understands that addressing and replacing damaging messages is a critical element of providing effective pastoral care. Specifically, Dunlap argues that discourse theory improves the communal-contextual approach to pastoral care by illuminating three elements critical to understanding more about people in their living human webs: the link between discourse and subjectivity, the link between discourse and embodiment, and the understanding of pastoral care as an oppositional discourse. The final paragraphs of this chapter will explain how these three elements reveal themselves in the “healing and transforming web.”

Discourse and Subjectivity

A key understanding of discourse theory is the understanding that personal identity formation is an ongoing process resulting from interactions with other beings. This idea is summarized by the phrase “subjects instead of selves” (Dunlap 135). The immediate impact of this understanding for pastoral care is significant: the embodied soul is inextricably bound to – and cannot exist without – interactions with the world. Where the clinical-pastoral paradigm treated “a self that is a separate, autonomous, freely choosing being, disconnected from community, context, tradition, power relations, and constitution by language” (136), the discourse-informed, communal-contextual paradigm understands “the individual is more of a ‘subject position’ that is made possible by the interplay of discourses rather than a prelinguistic ‘substance’ called a ‘self’” (136). The impact for the practice of pastoral care is in how we understand “care of souls.” Rather than being understood as an entity that exists independent of the world around it, discourse theory forces pastoral caregivers to acknowledge “[t]he soul, and its desires, rages, passions, and instincts, is always a product of place and position in the world” (136). In a moment this section will discuss some of the
competing discourses Joan is facing regarding her own experience of illness and the care of her soul, but first, there is another characteristic of subjects and discourse that caregivers must understand: not only is the body – and the soul – the site of multiple discourses, but those discourses also are in constant competition with one another for dominance, power, authority, and control (Dunlap 136). The pastoral response, Dunlap suggests, is to “listen for the competing discourses in their words and in their actions” (136), noticing how these discourses are “invested with varying and changing amounts of power, each linked with habits, subcultures, authority structures, mechanisms for determining the true, offer competing subject positions” (136). The implications then, of the subjects-instead-of-selves thinking discourse theory provides is clear: if a person understands her self as a fixed entity, her choices become centered on how to live life as that fixed entity. However, if a person understands her subject position as one who experiences many emotions and experiences as a result of her interactions with other subjects around her, her choices may then include evaluating and perhaps even changing her subject positions, rather than accepting some or all of them as permanent. Dunlap insists that “[a]s caregivers, we can empower [people] to choose where they will stand” (137). This process of identifying, evaluating, and choosing resembles Gerkin’s hermeneutical narrative methodology, but adds to it a way of 1) identifying discourses that may not previously have been understood as being part of a care receiver’s narrative of suffering or healing, and 2) understanding the varying degrees of power some discourses have over others, a concept to be explored further later in this section. At the moment, the pastoral caregiver ministering to Joan from a discourse-informed, communal-contextual approach would think of Joan as an individual whose identity is
constructed of multiple, competing discourses, and who, at the very least, may seek guidance in identifying and evaluating the presence and impact of some of those discourses in her life.

Discourse and Embodiment

The second challenge discourse theory brings to pastoral care regards the body, keeper of the soul during its time on earth. The communal-contextual paradigm places importance on the experience of the body; discourse theory explains in more detail why the placement of this importance is relevant. Discourse, Dunlap explains, does not only have “effects on the experience of the body . . .: ‘The body is the inscribed surface of events’” (Dunlap quoting Foucault, 139). In other words, one’s body is constructed, and continually re-constructed, out of dialogue with multiple discourses. Consequently, the work of identifying and evaluating these multiple discourses must include naming the unwritten rules or regulations of those discourses that lead to the disruption of a life lived abundantly – that lead to suffering and impede healing. When thinking about discourses that make up Joan’s experience of embodiment, we can quickly identify three: one related to the western medical model, one related to religious beliefs connecting sin to sickness, and one related to capitalistic conceptions of productivity and worth.

First, Joan undoubtedly understands the western medical model of the body as a machine. “According to this metaphor,” writes sociology and anthropology scholar Meredith McGuire, “disease is the malfunctioning of some constituent mechanism (such as a ‘breakdown’ of the lungs)” (88). McGuire explains that other cultures use different metaphors that hold different implications. The message of the machine metaphor for Joan, though, is clear: some mechanical element is broken and a specialist – someone who
understands the structure and function of the machine – must be consulted to ‘fix’ the brokenness. Critiques of the machine metaphor abound; the message of brokenness and wrongness associated with this metaphor place a suffering person in a position of vulnerability, subservient to the accessibility and willingness of the machine-experts to perform the ‘fixing’ function. This metaphor also makes strong suggestions about the body as a static, knowable entity, encouraging an approach that relies solely on etiology and treatment “located strictly within the [individual] body” (McGuire 87). As a result, “modern medicine is poorly equipped to deal with distress in the social body or with the impact of the individual’s social or emotional life upon physical health” (McGuire 87). Dunlap specifies the importance of a discourse understanding of embodiment when caring for persons experiencing illness: “[i]n our prayers at the hospital bedside we must avoid subtly referring to the body that is ill as a machine to be fixed, or something to be loathed for its weakness, or to be disciplined for being out of control” (Dunlap 140). Because Joan understands her body according to this dominant discourse, she is probably not going to seek care for it beyond therapies sanctioned by the medical model. Pastoral care may not even be considered as something that could provide real relief from her suffering; a service of healing would be considered an antiquated form of wishful magic, according to the medical model. But according to another powerful discourse in Joan’s life, it may provide the exact antidote to the origin of her suffering.

A second discourse Joan would have been exposed to (given her particular religious history) is the theological relationship between sickness and sin. This idea has its origin in the Judeo-Christian story of The Fall, and reveals itself in a question Jesus’ disciples ask him when coming upon a blind man: “Rabbi, who sinned, this man or his parents, that he was
Born blind?” (John 9:1-2). Jesus’ answer, “Neither,” hasn’t been enough to completely erase the idea of a link between sickness and sin, and historically other passages have been used to make the connection, particularly Mark 2:1-12 (Senn 670). Both western and eastern cultures have manifestations of a blame-the-victim mentality, an idea that somehow, a suffering person must deserve what she is receiving. An understanding of embodiment influenced by this discourse would utilize a service of healing, particularly the Episcopal one, which often links anointing with the Celebration of the Eucharist – a celebration of new life through Christ. This new life challenges the link between sin and physical consequences, and insists on claiming the healing and newness proclaimed by Christ and his followers throughout the New Testament scriptures.

Finally, Joan’s experience of embodiment would also be constructed of discourse about the body and productivity influenced by capitalistic values of economy and production. A capitalistic view of illness may inscribe the sufferer as a non-producer and therefore a non-contributing member of society. Consider the English word invalid: as a noun, the Oxford English Dictionary (OED) tells us the word means “a person enfeebled or disabled by illness or injury.” The word also functions as an adjective, however: “not valid, esp. having no legal force” (OED). A service of healing would combat this message strongly. The many communicative elements of the service of healing combine to both acknowledge and encourage Joan not because of her value to the secular community, but because of her identity in Christ.

In each of these discourses that contribute to Joan’s personal identity, Joan’s caregiver “must be able to hear the ‘practical rules and regulations’ that may render bodies, and thus body-selves, thwarted, damaged, stunted” Dunlap argues (140). The pastoral
caregiver must be able to, in conjunction with the care receiver, identify and interpret the
effects of existing discourses on both the construction of the body and the experience of
embodiment. The work of pastoral care, providing care for souls suffering from issues of
ultimate concern, demands that pastoral caregivers work with care receivers to understand
what discourses are functioning to sow discord and what discourses are functioning to
promote peace. It is in this judgment of discourses that Dunlap now turns for her third
challenge discourse theory offers to the communal-contextual paradigm.

Pastoral Theology as Discourse

Dunlap names “pastoral theology as discourse” as the third challenge to pastoral
theology to emphasize how, according to discourse theory, pastoral theology is simply one of
many competing discourses from which care receivers can choose. It exists as a valid
discourse as much as, in conjunction with, and sometimes even within the discourses of
medicine, capitalism, and other religious perspectives (including other pastoral care
perspectives). However, Dunlap asserts that the nature of Christian discourse requires that, of
the three functions of discourse named by feminist Nancy Fraser – oppositional,
reprivatization, and expert – the discourse of Christian pastoral care must act as an
oppositional discourse to other discourses, discourses that over time, and because of who
holds power, become dominant and threaten harm to the embodied soul (141).

For Joan, examples of orthodox discourses include the ones identified above: the
body as machine, the link between sin and sickness, and the representation of sick people as
invalid members of society. According to Fraser, a characteristic of an orthodox discourse is
its public-ness, as opposed to issues that traditionally have been economic or private.
Orthodox views therefore may not address issues of family life, sexuality, class, or health, and therefore, by definition, would not have been considered previous to the discourse-informed, communal-contextual paradigm for either their role in or impact on a care receiver’s suffering. Under a discourse-informed approach, however, orthodox discourses must be understood as not only present and powerful but also, because of their nature, probably communicators of values that may not represent previously unheard voices.

In addition to discourses being either orthodox or not, they can also function, according to Fraser, as oppositional, re-privatizing, or expert, meaning they can function to 1) oppose discourses deemed to be harmful to the sufferer, 2) encourage the sufferer to keep her suffering to herself, or 3) infantilize or objectify the sufferer in a way that keeps her from participating in her recovery respectively (Dunlap 141-3). Dunlap insists that effective pastoral care should function as oppositional discourse, acting to identify and re-inscribe perspectives, metaphors, and actions that continue to damage persons seeking care (140). For Joan, this means advocating for the same insurance coverage for her behavioral health medications and therapies as for care related to a broken arm or a cancerous tumor. It means ensuring Joan has access to the health care that she needs, regardless of the many barriers that various systems – influenced themselves by orthodox discourses about bodies, illness, and productivity – imposed on people according to their gender, race, class, and geographical location. Understanding the oppositional nature of some discourses means that pastoral theology must “self-consciously choose to function as an oppositional discourse, one that challenges narrow interpretations of the normal and the deviant, the just and the good, the healthy and the pathological,” insisting “[o]nly when we are also able to function in an oppositional mode can we promote good care for all God’s children” (Dunlap142-3). It is a
central argument of this thesis that the ritual of anointing has the power to function as such an oppositional discourse, did so in early Christian history, and may have re-emerged for the same reason in contemporary Episcopalian Christianity.

Discourse Theory, Pastoral Care, and the Service of Healing

Dunlap suggests that discourse theory offers promise to pastoral care methodology in that it understands the person as a site of multiple, competing discourses and the role of pastoral care as a process of helping care receivers identify and encourage discourses that support care of the soul. While making her arguments for these contributions (or “challenges,” as she names them) of discourse theory to pastoral care, Dunlap notes that, “[b]ecause so many of our caring practices address the body, it is critical for us to be aware of how our words, behaviors, uses and practices of Scripture and tradition, participate in constructing the body” (139). It is to the “words, behaviors, uses and practices of Scripture and tradition,” specifically regarding illness and the ritual of anointing as pastoral care, that I now turn.
CHAPTER III

THE SERVICE OF HEALING AS PASTORAL CARE

Introduction

In her introduction to *The Sacrament of Anointing of the Sick*, Lizette Larson-Miller notices an interesting distinction in nomenclature regarding this ritual, one that distinguishes the service of healing as a form of pastoral care. “It is striking,” she begins, “that the Pastoral Care of the Sick (hereafter PCS), inclusive of all its ritual dimensions, is the only sacramental rite with the word ‘pastoral’ in the title” (xii). But after explaining different ways pastoral care can be manifest, she makes a critical point about the communal-contextual nature of the service of healing. “[W]hereas pastoral care focused on attentiveness to the needs of the individual person is sometimes cast as opposed to ritual, the PCS makes explicit the recognition that they are not opposed but woven together, each functioning as a vehicle of expression for the other in an efficacious synergy” (xii). For Joan, every element of the service of healing, occurring within the service of worship, is an opportunity for her to commune with others in the room, the community of saints, and the Divine. During these moments of relationship, messaging is constant. The experience combines relating and signaling that bring hope, acts that aptly can be characterized as pastoral care.

The service of healing, at it simplest, occurs when people who have become brothers and sisters in Christ recognize the reality of another’s suffering and choose to touch and pray over that person for restoration of health in the name of Jesus Christ. This section will consider how three elements of the service of healing, as practiced in at least one
contemporary Episcopal community, function as effective pastoral care when examined through a discourse-informed, communal-contextual paradigm: the inclusion of the sick in the Christian service of worship; the connection of the service of healing to a larger service of worship that revolves around not only the physical bodies of worshippers but also invokes the actual body of Christ; and the assertion of hope for someone suffering the effects of illness. When viewed through a discourse-informed, communal-contextual lens, the Episcopalian service of healing acts as part of the “healing and transforming web” available to all who seek care.

Inclusion as Oppositional Discourse

As early as the second century after Christ – and well before pastoral theologians emerged to put labels on practices of care – we see people performing acts to include the sick who couldn’t gather with the rest of the Christian community. Hippolytus’s *Apostolic Tradition* names the official offices responsible for delivering bread to those who couldn’t come to church and share in the goods that had been brought for the needy:

> 26. In time of need the deacon shall be diligent in giving the blessed bread to the sick. If there is no presbyter to give out what is to be distributed, the deacon shall pronounce the thanksgiving and shall supervise those who carry it away, to make sure that they attend to their duty and [properly] distribute the blessed food; the distributors must give it to the widows and the sick. (Later additions, ETH, 26)

The inclusion of the infirm was not, however, limited to delivery of their share of food. Justin Martyr’s *First Apology*, according to Senn, proves “[t]he idea of reserving the consecrated Eucharist for the communion of the sick or dying goes back at least to the second and third centuries. … [T]he deacons took the consecrated elements to the absent after the celebration” (223). Senn also writes that materials from the Reformation Era provide evidence that this
tradition continued through the Middle Ages: “Mark Brandenburg 1540 provided an extended distribution of communion to the sick. At the conclusion of the Service of Holy Communion the minister […] took the sacrament from the altar to the sick person’s home and communed him or her there, after hearing his or her confession” (353). The point here is that, despite a clear and persistent connection in Judaism and Christianity between illness and sin, the Christian community throughout its history has considered ill persons to be part of the Christian community, as is evidenced by the pains taken to ensure that community members not present at a service of worship, where the Lord’s Supper would certainly be celebrated, would still be allowed opportunity to confess their sins and take of the consecrated bread and wine. It consequently is no surprise that this inclusion should continue in contemporary Christian communities. We can argue immediately, then, that this act of care is already functioning in opposition to any discourse that would argue, on any ground, that someone who is sick should be excluded from the larger religious community.

In her reading of the service of healing as part of “the evangel, the good news of the in-breaking of the kingdom of God” (159-60), theological-anthropologist M. Therese Lysaught argues that the very act of providing a service of healing is “an action that embodies the communities’ claims about its identity as the Body of Christ; it is an action that seeks to reinscribe what it knows as truths on the bodies of the sick” (174). She grounds her reading in the James example of anointing the sick, and argues that “the ‘ekklesia’ is to anoint the sick precisely to counter the social distinctions and alienation introduced into the community by the advent of illness” (173). Lysaught argues that by providing a space for a service of healing within the community, James’s community is making a statement about their deliberate choice: they choose God’s version of human life – it is to be cared for and
embraced – over the world’s version – sick people are to be shunned or even exiled, a choice similar to the choice people today must make about competing discourses in their own lives (172-3).

For Joan, then, the placement of the service of healing within the larger service of worship sends at least two messages: her suffering is of legitimate concern to her religious community, and in fact is so understandable that her religious community has created (or maintains) a place to address her suffering within the context of the regular worship experience. These messages directly oppose discourses about suffering and illness from more orthodox models: rather than isolating herself and relying upon a medical expert to ease her suffering, and rather than withdrawing from her normal activities of worship in community, Joan is invited to explore the ancient Christian response of anointing and prayer within a service of healing.

Worship as Oppositional Discourse

It could be argued that the myriad activities taking place within and throughout a service of worship not only all act as imprinting discourses but also all serve to engage the full range of human senses. The chapel often holds the lingering scent of burnt incense and candles, and the service of healing, in particular, holds a scent of its own in the use of oil for anointing (discussed further down). Historically incense served as a symbol, representing “the prayers of the faithful which drift upward like incense and present a pleasing aroma to God” (Klein 24). By only taking a step into a chapel, then, a person is immediately connected to a message of the Christian faith simply through the sense of smell: God hears your prayer.
As the service progresses, worshippers are given opportunities to join in songs that orient their minds by use of the bodily functions connected to speech and song: the vocal chords, the tongue, teeth, and lips, muscles of the throat, and the pallet of the mouth. Speech and song are evocative, deliberate acts, and in the service of worship, they serve as opportunity to reinforce messages of linkage to both the historical and contemporary religious community as well as to the Divine. Songs and psalms, sung and spoken in unison, join participants in the retelling of ancient stories of suffering, hope, and transformation. Our ears hear these messages even as we participate in creating/re-creating them, and prepare to hear other audible sounds of worship – instrumental music and homily – that will follow.

The service also offers opportunities for physical movement. Moments and elements of the service evoke bowing and kneeling, changes in physical positions that, whether we realize it or not, have an impact on the way we respond to and interact with the world around us. We bow and feel respect and humility; we kneel and feel humility and vulnerability. We even respond to the priest’s invocation to “Lift up your hearts” with the phrase, “We lift them up unto the Lord,” producing through our physical words the very desires we have for our spiritual selves.

All of these physical senses are stirred in addition to sight. In addition to the colors and textures present in the chapel, the service of worship produces sights unique to that setting and time: the powerful community leader in position of supplication before communion; the juxtaposition of the wealthy with the poor at the altar rail; the presence of one who seems physically fit in a chapel reserved for those seeking prayers for healing. All these elements – smell, sound, voice, movement, and sight – combine with taste – the taking of bread and wine of the Eucharist – to reinforce and re-inscribe a message of Christian
discourse about the body: you are created by God. You belong to Christ. You are sustained by the Spirit.

The culmination of worship, according to many, is the Celebration of Eucharist, an act with discourse implications worthy of its own dedicated thesis. It is worth exploring some of the historical understandings of the purpose and meaning of the eucharistic meal from several sources, to reveal the particular discourse this act reinforces for members of the Christian Community.

Senn describes the Lord’s Supper in the New Testament and the Didache as a ritual of “eschatological fulfillment”: “Paul has interpreted this as a reminding of God of the unfulfilled climax of the work of salvation whenever the bread and cup are taken in remembrance of Jesus. They become a visible proclamation of the Lord’s death until the parousia” (59). Senn further explains that “the eucharistic meal was the eschatological feast at which the sanctified ones gathered in fellowship” (66). Key words here are “sanctified ones” and “fellowship.” This fellowshipping element points to the community aspect of the eucharistic meal. Referencing 1 Corinthians 10 and 11, Senn argues that Christ’s “presence in the eucharistic meal includes his presence as judge,” so “those who participate in the Lord’s Supper should be those who are able to withstand the eschatological judgment” (98). Senn explains, “The unity of an otherwise fractured humanity at the Lord’s Table is a powerful sign of the new creation in Christ. The more diverse the eucharistic assembly, the more powerful a sign it is of the new creation” (98). This interpretation, that the theology of the Eucharist mandates inclusion of the diverse and that the Christian community must accept one another who have become initiated members of the Christian community regardless of differences, is comforting for those to whom the stigma of illness has been
connected. An inclusive meal that celebrates the future coming and fulfillment of God’s Kingdom is indeed a celebration of gratitude for those who are participating.

The Didache also provides evidence of the Eucharistic meal as a ritual of gratitude to God and as spiritual sustenance for God’s people. Consider this excerpt from a prayer following the first community meal taken by new members of the Christian community, which demonstrates an early understanding of the Lord’s Supper as a gift of sustenance for the community of God: “Almighty Master, 'you have created everything' for the sake of your name, and have given men food and drink to enjoy that they may thank you. But to us you have given spiritual food and drink and eternal life through Jesus, your child” (10:2, emphasis added). Similarly, Thomas Aquinas articulates his opinion in the thirteenth century with his questions and answers on the Eucharist, clearly classifying the Eucharist as spiritual food:

I answer that, The Church's sacraments are ordained for helping man in the spiritual life. [...] Consequently, just as for the spiritual life there had to be Baptism, which is spiritual generation; and Confirmation, which is spiritual growth: so there needed to be the sacrament of the Eucharist, which is spiritual food. (Summa theologica part 3, Q. 73, art. 1, resp.)

Clearly, then, the patristic understanding of the Lord’s Supper includes beliefs about 1) fellowship with other members of the Christian community, 2) gratitude for the ritual of remembrance that also points toward a future of Christian hope, and 3) spiritual nourishment for the path one is currently traveling toward eternity with Christ. What a powerful form of oppositional discourse this act offers to a person suffering from illness: not only is Joan invited to share with her brothers and sisters the most sacred meal of the Christian community, but she is also promised the benefits of that meal – spiritual feeding and support for her in her journey – are available to her despite any challenges her journey brings. This is
a powerful oppositional discourse to messages that would link Joan’s experience of illness to despair.

Anointing as Oppositional Discourse

The Episcopal service of healing utilizes anointing with oil and laying on of hands while prayers are being said for healing. The primary scriptural impetus for Christian anointing for healing is found in Mark 6:13 and James 5:14, and we can imagine these early followers’ appropriating the Hebrew use of oil, touch, and prayer from other rituals, including anointing for kingship. In Hippolytus’s *Apostolic Tradition* we see a prayer for blessing oil that bishops will be using on those who come to them (no. 5), and in Cyril’s Catechetical Lectures we see a connection between receiving of anointing and receiving of the bread:

> But beware of supposing this to be plain ointment. For as the Bread of the Eucharist, after the invocation of the Holy Ghost, is mere bread no longer, but the Body of Christ, so also this holy ointment is no more simple ointment, nor (so to say) common, after invocation, but it is Christ’s gift of grace, and, by the advent of the Holy Ghost, is made fit to impart His Divine Nature. Which ointment is symbolically applied to thy forehead and thy other senses; and while thy body is anointed with the visible ointment, thy soul is sanctified by the Holy and life-giving Spirit. (Cat. Lec 21.3.3)

While Cyril here is referring to the anointing that takes place when a person becomes a member of the Christian community, this understanding of oil as “Christ’s gift of grace” also applies to its use in the service of healing. Liturgical scholar John Halliburton argues that “We know very little about the use to which this blessed oil was put” (85) in some of his summary comments on the origins of the Christian ministry of healing, but he does tell us “[t]he Fathers believe profoundly in the power of prayer, repentance, exorcism and baptism (with its anointings) to heal the misdirected life and sickness of soul. They believe equally
profoundly in the power of prayer, holiness and anointing with oil to heal the sick in both body and soul” (89). As inheritors of these early acts, contemporary ministers and lay persons have the opportunity to also use oil and prayer to articulate our beliefs about healing for our suffering brothers and sisters. Just as Cyril’s community shared bread and oil to celebrate someone’s new membership in the cult of Christianity, so does the Christian community today share bread and oil to celebrate the belief that ease of suffering can and will come to each member of the Christian family.

Similar to the power of touch with oil is the act of laying on of hands, accompanied by the act of speaking to God on someone’s behalf. The laying on of hands symbolizes “God’s power to bless,” and is seen in the New Testament texts in reference to “blessings and in baptism, the healing of sickness, and the reconciliation of sinners (I Tim. 5:22)” (Senn 103). When considered from a discourse-informed point of view, this act of touch communicates powerful messages about inclusion and acceptance. In choosing to touch someone, the minister actively opposes cultural messages about unworthiness or uncleanness related to illness. Further, as Senn notes, the Judeo-Christian tradition connects the deliberate act of touch to blessing. The message of such touch, then, is twofold: you are not only accepted; you are also a recipient of the power of God.

The reclamation of the simplicity of anointing, touching, and praying is a powerfully embodied practice to counteract the abstraction too often experienced in a culture fraught with competing messages about what bodies are acceptable to touch and what bodies are not. Too many times the vulnerable in our society – including the old and the poor as well as the sick – are only touched when others are being paid to touch them, either through providing services like bathing or performing ‘civic duties’ like putting someone under arrest or
performing bodily searches. Lysaught captures the impact of the act of touch – particularly
healing touch – as an oppositional discourse:

It challenges cultural aversiveness [sic] to sick bodies, as well as unattainable
cultural norms of bodily perfection, by practicing a witness of touch and
blessing. It counters the tendency in the practice of medicine to reduce the
patient’s voice to a mere matter of consent by both encouraging the patient to
summon the church and acting as a surrogate voice of prayer before God
(rather than a surrogate voice of choice before the law. And it will counter the
construction within medicine of sick persons as, contradictorily, both
autonomous individuals and passive recipients of medical ministrations”
(Lysaught 175).

Within the service of healing, touch occurs at two places considered to be particularly
powerful for spiritual connection: the forehead, known to some as the third eye – an invisible
area connected to inner or consciousness – and the crown of the head, known to some as an
area for receiving energy. When considered from this perspective, the particular placement of
touch in the service of healing becomes not only a way of re-awakening the physical body to
the memory of sensory touch, but also a way of re-connecting the body to the unseen,
spiritual energies available for healing.

The Service of Healing as Oppositional Discourse

The acts of anointing and healing touch occurring within a larger service of worship
act as oppositional discourse that challenge discourses about illness, embodiment, and
healing that keep people in despair. In each element named above – inclusion, worship, and
anointing – participation of the soul and the body is not the exception, but the invitation.
These elements are both designed and expected to be acts simultaneously creating,
celebrating, and re-creating bodies and The Body. Literally, individual bodies, carrying their
individual physical selves and their individual emotional mindsets, gather together in the
same corporeal space. They use stories, sounds, smells, and tastes to connect them emotionally and spiritually to the others in the room, the ancestry of Christian saints who have come before them, and the eternal, ephemeral realm of God. In this place, the Celebration of the Eucharist becomes an almost indescribably powerful discourse of embodiment when the individual bodies, acting as a Body, pray for Christ to become known in the breaking of the bread, put the bread and wine into their own bodies, and then thank Almighty God for feeding them with spiritual food, the very body and blood of the Lord Jesus Christ. The act that Body then chooses to perform through anointing, touch, and prayer for healing sings a discourse of love, oneness, and hope more powerful in that moment than any other discourse imaginable.
CHAPTER IV

CONCLUSION: THE SERVICE OF HEALING AS PASTORAL CARE

The acts commonly referred to as the Service of Healing have been and remain a powerful means of ministering to a person suffering the effects of illness, because they challenge ideas about illness and recovery that lead to despair with a discourse of hope. The service of healing originated, survived and re-emerged as a discourse of hope because of its ability to speak to critical elements of a person’s identity: who created me? Who am I in relation to others? How does my body relate to my soul? Which path do I choose to ease my suffering?

For leaders and lay ministers making liturgical decisions for their parishes, what does this understanding mean for the role of the service of healing? At least two implications arise. First, Christian communities should consider offering this service to persons suffering the effects of illness. This means at least two things. One: persons who are considered both ‘members’ and ‘nonmembers’ should have the ability to participate. The Service of Healing provides a message about creation by God, identity in Christ, and strength through the Holy Spirit that is distinct and uniquely Christian message that people need to hear. The elements of worship that normally surround the service of healing, particularly in the Episcopal setting, reinforce the idea of inclusion in the community of saints and challenge the isolation and despair that normally accompany experiences of illness. Two: the Service of Healing should be made available to all persons affected by illness. This means that not only should Joan be able to pray for her own healing from chronic depression, but Joan’s family members
and friends should also be able to pray for their own suffering related to the effects of Joan’s illness. The communal-contextual paradigm, particularly when informed by discourse theory, confirms that when one suffers we all suffer. Further, services should not be limited to illnesses that appear “physical” in nature, as opposed to suffering related to mental health or addiction disorders. The history of medicine clearly teaches us much about the relationship between the seen and unseen – we are only a few hundred years removed from the ‘new’ concept of bacterium, for example – and a consistent truth of pastoral care is that suffering is suffering, no matter what its etiology. The service of healing provides perspectives and messages that transcend earthly knowledge of the suffering body, and therein lies part of its hope.

Second, leaders should continue to incorporate the service of healing into the larger service of worship. While this is the format of the service as written in the *Book of Common Prayer*, many congregations still find a way to isolate the service of healing from larger gatherings of the community. (One example I have seen schedules the service of healing during the day on a weekday instead of part of the larger worship services on Sunday; another has the act of anointing, healing touch, and prayer take place in a different location from the Celebration of the Eucharist, requiring people who select the service of healing to physically move to a smaller chapel, participate in the acts, and then rejoin the larger worshipping community, usually as people are finishing the final song of the service.) The feminist, discourse-informed, community-contextual paradigm would critique such displacement of the suffering from the larger community of worshippers. Leaders could more fully examine their intentions for making the service of healing available at all, and the impact of including as many community members as possible. Lysaught, in particular, would
argue that the power of the service of healing is not solely for the one suffering the effects of illness, but instead holds redemptive power for all who participate.

Ultimately, though, the ability of the service of healing to act as pastoral care to those suffering the effects of illness is only one reason pastoral caregivers should inform themselves about the discourse-informed, communal-contextual paradigm. Pastoral caregivers see a variety of issues of ultimate concern; not all of them are related to illness, and the potential contributions of (or, as Dunlap would write, “challenges” to) discourse theory to understanding other issues of ultimate concern are many. A discourse approach to care allows us to start seeing and hearing our constructed worlds in new ways. We begin seeing communication systems and their consequential structures; we begin understanding how some constructions must be re-constructed, and how some visions must be ‘re-vised.’ We literally ‘re-cognize’ our understandings of power and impact. We equip ourselves with one more tool to fight oppression and bring the freedom of life abundant through actions, like the service of healing, that meet the needs of suffering individuals by literally re-inscribing their experiences in ways that embody Christianity’s eschatological narrative of hope.
WORKS CITED


WORKS CONSULTED


