

Cure or Healing?: Teaching the Healing Miracle Stories through the Lenses of Exegesis and Pastoral Care during the AIDS Pandemic

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ABSTRACT

“Healing Miracles” is an interdisciplinary MDiv course that seeks to start a conversation across the disciplines of biblical studies and the theology and ethics of pastoral care. The course examines the Healing Miracle stories in the gospels and considers the theological, ethical, and pastoral implications of the exegesis and interpretation of these passages. A primary focus of the course is the distinction between healing and curing and how these concepts both were understood in their biblical context and are used in contemporary culture. Taught by an interdisciplinary team, the course uses HIV/AIDS as an exemplar of a health condition that challenges both the biblical texts and pastoral caregivers today. In this paper, the course instructors reflect on the need for this course for seminary students, the structure and implementation of the course, and its impact on the students who took it. The reflection is offered as a dialogue between the instructors.

Note: The syllabus for the course “Healing Miracles: Biblical Exegesis and Pastoral Theology in the Context of HIV/AIDS,” taught by G. Guy Pujol, Jr., DMin and Margaret P. Aymer, PhD

at the Interdenominational Theological Center (ITC) can be downloaded from Practical Matters Journal: <http://practicalmattersjournal.org/issue/4/teaching-matters/cure-or-healing>.

Guy Pujol: How do you preach the healing of the ten lepers when people sitting in your pew are infected with and affected by HIV disease? How do you teach the story of the healing of the blind man when a woman sitting in your Sunday school class is losing her sight to CMV retinitis? These questions were never asked when I was a student (in college or seminary); nor were they asked when I began teaching. These questions were never asked when I was growing up in the church; nor were they asked when I served as a pastor.

But as my vocational calling keeps me in the trenches of the AIDS pandemic and my academic interests draws me toward pastoral care and pastoral theology, these questions remain at the forefront of my mind. How does one understand these biblical texts we call the Healing Miracles? How does one interpret these first century miracle stories in a Western, twenty-first century context; and, more importantly, how does one *use* them today? How does one *critically* exegete the exorcism of the demoniac in the synagogue? What are the *ethical* implications of how one frames the healing of the paralytic? What are the *theological* implications of Jesus healing the centurion's *pais*? What are the *pastoral* implications of the interwoven stories of the faith healing of the woman with the hemorrhage and the raising of Jairus's dead daughter?

It was over good food and happy taste buds that I first articulated these questions to my colleague and ongoing conversation partner, Margaret. What grew out of that meal was the creation of a course that seeks to start a conversation across the disciplines of (1) the theology and ethics of pastoral care and (2) biblical studies through an examination of the Healing Miracles and the theo-ethical barriers and facilitators to pastoral care and healing.

Why the Healing Miracles of the Gospels?

Margaret Aymer: Like Guy, I did not have any seminary classes that looked at the first century healing narratives of the gospels through the eyes of exegesis, theology, ethics, and pastoral care. But my study with Vincent L. Wimbush led me to think about the documents of the biblical canon not simply as ancient texts to be understood within their own cultural context but also as modern texts used as scriptures to form community.

Any "scriptures" can be formative. For Christians, and particularly for our students—the bulk of whom come from African American southern Christian communities—this formation is pointedly evident. For our students, what "the Bible says" influences how they conceptualize all aspects of life: in the case of these miracle stories, how they think about matters of sickness. John Pilch has argued, I believe very effectively, that first century people understood sickness through the lens of illness and healing, which he contrasts with twenty-first century cultural constructs of "disease and cure."¹ I would argue that our students view sickness in a more amalgamated manner: both as a dis-

ease that may or may not have a cure *and* as an illness for which there may or may not be a source of, often supernatural, healing. This is particularly true for the numbers of our students that have been raised with Pentecostalism; for them, if Jesus could perform miracle healings (and cures, they would argue) then they who are to do “greater things than these” should be able to expect and to perform similar things. Joel Shuman and Keith Meador have referred to this as a therapeutic understanding of God, a God whose duty is to cure if Christians pray in just exactly the correct way.²

Guy has pointed out that this formation can prove to be a barrier for the prevention and treatment of HIV disease and other forms of sickness, since Jesus is not walking about today, touching and curing people. The expectation of supernatural cure, rather than social healing, could make people unwilling to seek medical treatment, for to do so would be to demonstrate faithlessness. Still, dismissing these texts is not an option. They are still powerfully formative and thus will be read and interpreted by our students; and our students’ interpretations will inform not only their own interactions with health and healing but also their eventual parishioners’ understandings of health and healing. So my interest becomes not to silence these texts but to encourage our students to read these texts carefully.

By “carefully” I mean first to read them exegetically. One cannot, without careful exegesis, understand the satire involved in the Johannine narrative of the man born blind, nor can one begin to understand who is actually being healed in the narrative of the widow of Nain (Lk 7). But the challenge from pastoral care is also to read them with an eye to pastoral care. Why does Jesus give the blind man in John’s gospel sight? If no one sinned, why not just leave him blind and question the oppressive system that sees blindness as a sin? Do we want to mimic every pastoral method of Jesus, and if not, what do we do with these texts?

GP: When ABC News Primetime aired “Out of Control: AIDS in Black America,” the special opened with footage from a T. D. Jakes revival. Jakes, one of the most prominent black church figures today, was criticized for not addressing AIDS despite the disproportionate number of African Americans infected with HIV. When asked why he did not speak out about HIV, Jakes responded that he did not *preach* about AIDS because AIDS was not mentioned in the Bible. This pathetic deflection of pastoral responsibility and accountability to one’s own community was an attempt to justify his silence by doing what Margaret described earlier: invoking “scripture.” Instead of silencing one’s opponent by declaring “the Bible says,” Jakes effectively does the same thing, making AIDS a non-issue because it is not an issue in the infallible Word of God. Thus he attempts to silence his critics—because who can argue with the Bible?—and perpetuates the praxis (the *intentional* practice) of silence in the church regarding AIDS. But Jakes’ argument is easy to refute; the Bible speaks volumes about the socio-moral issues related to sickness and health, the communal aspects of stigma and shame, and the interstructured oppression of racism, classism, sexism, and homophobia—all intensified in the context of AIDS. And what better passages to examine these issues in the face of the AIDS pandemic than the Healing Miracles?

Why Focus on HIV/AIDS?

MA: Despite the fact that Guy's lifetime of ministry and justice work has focused on the treatment and prevention of HIV infection and AIDS, it was my idea to focus this semester's work around HIV, for a number of reasons.

My reasons were pragmatic. There is no other single disease that is so impacting the African American community in which I teach, and infection levels in the zip code in which ITC finds itself are the fourth highest in the state of Georgia.³ Thus, there is no African American church in the USA that is not affected by HIV, and most ministers will have to face one or more parishioners that are infected with HIV or living with or dying from AIDS. Our first days of class bore this out. In an assignment that Guy developed, students were asked to write—and to read aloud—a reflection paper about a person they knew who was infected with HIV or who was living with or had died from AIDS. If they couldn't identify such a person, they were asked to write a paper about someone who was affected by HIV or AIDS. And if they couldn't manage to do this, they were to write a paper telling the class what they knew about HIV and considering the question of why they didn't know someone who was HIV-positive. Of the twenty-one students who presented reflection papers, three knew no one, one presented on someone who was affected by HIV-AIDS, and seventeen students—of a range of ages and experiences—presented papers about someone they knew personally who was HIV-positive. Of these seventeen papers, four were about one of the students sitting in the room.

HIV/AIDS is thus a deeply relevant subject. Moreover, HIV/AIDS touches all of the issues attendant to other kinds of sickness. It can affect one's sight, hearing, mental health, and physical ability. Side effects of HIV medications and/or of the infection include wasting and lipodystrophy, issues connected with body image. And HIV/AIDS, more than any other bio-medically-defined disease, is also socially constructed within the church as an illness, often an illness based on "sin," as the church still defines the majority of the ways in which one contracts such an infection as "sin": sex (particularly same-gendered sex and sex outside of legal marriage) and intravenous drug use. HIV/AIDS, thus, is both the most relevant, and at times the most difficult, example. It is easy for our students to dismiss blindness as caused by sin; blindness is not, fundamentally, constructed as an illness in their minds but rather as a disease and/or a disability. It is not as easy for our students to dismiss the question of who sinned when the question is focused on a person who is HIV-positive or living with AIDS.

My most pointed reason for focusing on HIV/AIDS is a young man named "Carl." In the very first class that Guy ever taught about HIV on our campus, "HIV/AIDS, Sexuality, and the Church," "Carl"—born and raised in rural Alabama—came to me to tell me that he, a devout Christian and an ordained Baptist preacher, was positive. When he disclosed this to me, this young man of less than thirty years had buried over ten of his friends and was not treating his infection medically because of a combination of the barriers that Guy has posited: most notably, supernatural cure, doc-

trine of sin, alienation of the body, and the praxis of silence. “Carl” has fundamentally changed our campus, in large part because, as an alumnus, he has revealed much of his life as an HIV-positive, silent student, including how close he came to dying on our campus.

“Carl’s” story is not a story from the 1980s; his story happened during this century, despite the availability of antiretroviral chemotherapeutic treatment. For “Carl”—and for the many “Carls” that my students will encounter in their years of ministry—it was not, primarily, the disease that needed to be treated but rather the illness that needed to be healed;⁴ only when the former took place could “Carl” reach out for the latter.

Why Teach Exegesis and Pastoral Care Jointly?

GP: “Carl” disclosed his status to Margaret before he disclosed it to me . . . to Margaret, the New Testament professor who was sitting in on *my* class. And she employed her best pastoral skills to respond to “Carl’s” unexpected and bold revelation. I say “bold” because it was a risky move for a student to come out as both gay and HIV-positive at a historically black seminary in the South. His act—and Margaret’s, for that matter—paved the way for other students subsequently to do the same. But I mention “Carl’s” disclosure because it illustrates, I believe, the main reason why we chose to make this an interdisciplinary dialogue between biblical exegesis and pastoral care. “Carl” expected Margaret, a New Testament professor, to be pastoral.

The students we teach are expected by their congregations to be able to do it all. They are expected to be dynamic preachers, astute biblical scholars, and sensitive pastoral caregivers. Ideally, the first two roles—preacher and biblical scholar—would be a natural fit, but pastoral caregiver is seldom associated with either of those roles. Simply put, they will be expected by their congregations to be generalists. Yet, the various disciplines taught in most seminaries are rarely integrated within the curriculum. This class, therefore, seeks to create a space for such integration to occur—specifically an integration of biblical exegesis and pastoral care. This means we seek to give the students the skills necessary to exegete the texts so that they become *usable* in their pastoral arts of healing, guiding, sustaining, and reconciling. Such skills allow the students to reflect critically, theologically, ethically, and pastorally on the Bible—sometimes to critique the biblical story and sometimes even to critique Jesus’s healing ministry rather than simply to use the Bible to proof-text platitudes in times of physical, emotional, or spiritual pain. An interdisciplinary approach seeks to elucidate the richness and complexity of these stories in order for them to inform and enhance the pastoral functions.

We seek to do this in four ways. First, the content of the course is designed around a model that first names and critiques the theological and religious barriers to HIV prevention and care and then proposes theological facilitators for overcoming those barriers. The use of the Healing Miracle stories shows not only how these formative stories can be used to reinforce those barriers but also how they can be used to overcome them. Second, the content of the course is conveyed

through complementary methods from our respective fields: Margaret approaches exegesis by teaching a combination of historical, literary, social-scientific, and personally located methods, and I approach pastoral care from a post-structural practice that I describe as “narrative pastoral theological reflection.” Third, the structure of the classroom presentations for each session begins with an exploration and interpretation of the pericope and then moves to consider the theological, ethical, and pastoral implications of our exegesis. Students’ assignments follow a similar structure: students write short exegetical papers that another student then reads and critiques from the pastoral care perspective. Fourth, Margaret and I are intentional in modeling an interdisciplinary method. Within the class structure, Margaret typically teaches exegesis and explores the Healing Miracle texts during the first half of the class, and I teach pastoral care and consider the implications of our earlier exegetical work during the second half. But several times during the semester we switch roles; I lead the exegetical discussion and Margaret facilitates the pastoral care conversation. I attempt to show proficiency as an exegete using narrative criticism, and Margaret sparks the students’ pastoral imagination using one’s social location as a lens for pastoral care. We do not announce the change in the lineup; we simply switch roles and model the kind of holistic approach we envision our students adopting in their respective ministries.

“My Foundation Was Rocked Completely”

This semester, on the first day of class as Margaret and I walked through the syllabus, describing the interdisciplinary nature of the course and the learning objectives for the class, one student, “Mark,” asked, “Are you expecting us to change the way we preach?” There was an audible silence from the two of us as we tried to conjure a more thoughtful response than “Well, yeah!” So, he took the silence as an opportunity to comment further, saying, “It sounds like you’re saying that we should be *responsible* for what we preach.”

MA: Well yeah! But would the students’ work reflect this responsibility during and following the class? In a follow-up email to “Mark” and other students from the class, Guy and I posed the following questions: 1) What do you recall your reaction was during the class to the subject matter presented? 2) Today, two years later, what is your reaction to the class? 3) What, if anything, have you done since the class to implement or integrate the work of the class in your life and/or ministry?

In their recollections, the students reflected upon their relative levels of discomfort in the class. Some, like “Amy,” were “excited for the synthesis of pastoral care and theology” and the way in which the class put “rubber to the road.” However “Mark’s” reaction was more typical, feeling “as though someone threw [him] into a swimming pool.” Chris’s (real name used with permission) reflections were more theological than his peers, noting that the course dismantled his embedded beliefs in a Jesus who could and would produce a supernatural cure for all illness. As he put it, “My foundation was rocked completely concerning the healing acts of Jesus. I came to embrace

that, instead of a physical change in one's body, people possibly walked away with . . . a different perspective concerning their condition."

Given their different starting points, students were grateful for the class, as it gave them a method for "rigorously reading a biblical text and bringing out what it means ethically, theologically, and in terms of pastoral care." For Chris, the class enabled him to cope with his own HIV-positive diagnosis, a status he discovered after taking the class. As he put it, "I can honestly say that the course prepped my change of mind."

Two years later, what the students are doing with the course varies as much as their initial responses to it. Some, like "Amy," are in contexts where they do not confront HIV/AIDS frequently. Others, like "Mark," have moved from their positions of discomfort to positions of advocacy not only on behalf of those who are HIV-positive but also on behalf of all those who are marginalized by the church. And Chris, who is doing a CPE residency, credits this class with developing his ability "to be present with others who may not believe in the miraculous or don't possess hope of change because of the severity of their own or a loved-one's illness or condition."

GP: Throughout our semester of teaching, I argued that systematic, doctrinally-structured Christian theology—the mainstream, orthodox theology, the "dominant story" to use the language of Michel Foucault—often poses theological barriers to HIV prevention and care and that scripture is formative in that theology.⁵ Consequently, the church has silenced itself in response to the AIDS pandemic, losing both its prophetic and pastoral voices; and, as a result, the church has been reticent or slow, at best, to respond to the crisis. But pastoral theology, girded by sound biblical scholarship, can reclaim its voice and provide a compassionate, faithful response to the AIDS pandemic. And the Healing Miracle stories offer rich and multiple points of entry into addressing HIV disease. For while the acronym for the Acquired Immunodeficiency Syndrome may not be in the text itself, the Bible clearly speaks pastorally to AIDS.

Endnotes

1 John J. Pilch, *Healing in the New Testament: Insights from Medical and Mediterranean Anthropology* (Minneapolis: Fortress Press, 2000). This is a required text for the course.

2 Joel James Shuman and Keith G. Meador, *Heal Thyself: Spirituality, Medicine, and the Distortion of Christianity* (New York: Oxford University Press, 2003). This is a required text for the course.

3 GA Department of Human Resources, *Georgia HIV/AIDS Surveillance Summary*, Sept. 19, 2007. In ITC's zip code (30314), a predominately African American community, 95.7 out of every 100,000 people are living with HIV/AIDS. Three out of every 1,000 Georgians are infected with HIV, which is double the national average; among African Americans in Georgia, that ratio increases to eight out of every 1,000 black Georgians, which is more than five times higher than the national average.

4 Medical anthropology distinguishes between disease and illness. Both are explanatory concepts of the reality, sickness (the misfortune or irregularity in well-being that people recognize [Pilch, *Healing in the*

New Testament, 159]). Disease is an impairment of a normal state of functioning; thus, it can be “treated” or possibly “cured.” Illness is a social perception or personal experience of a health misfortune; thus, it can be “healed” (that is, restored of meaning). This paradigm, from medical anthropology as set forth by Pilch, proved helpful as students’ modern cultural constructs of disease were the lenses through which they read biblical cultural constructs of illness.

5 The course is structured according to a framework developed by Guy (G. Guy Pujol, Jr., “HIV Disease: Diagnosing the Theological and Religious Barriers to HIV Prevention and Care,” DMin project, Columbia Theological Seminary, 2004). The theological barriers are (1) theologies of divine healing, (2) theodicy, (3) doctrines of sin, (4) alienation or denigration of the body, and (5) the praxis of silence in the church. The DMin project is a required text for the course.