The Faith Factor in Wholistic\(^1\) Care:
A Multidisciplinary Conversation

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The postmodern era requires a new angle of vision regarding life. Human beings are no longer content to be defined within a strictly mechanistic, deterministic, materialistic, or empiricistic world. There is a plaintive cry emanating from the breast of humankind akin to that of a caged creature yearning for liberation. Human beings are no longer content to define existence in such a limited manner.

The clamor for viewing life wholistically signals that the cooperative efforts, creative genius, and special gifts of all people are required to effect healing and health. Given the magnitude of the problems we face in the arena of total health care, we cannot afford the luxury of the internecine warfare that has been waged in

\(^1\)Recent literature has attached the letter “w” to the normal word “holistic” to signal the fact that the spiritual dimension of total care is also included in this view of the issue.

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An open and honest conversation between the faith tradition and the human sciences will best serve the treatment of the whole person required to bring full health. The case is made here by a pastoral caregiver and in the following response by a teaching psychiatrist.
the past among various disciplines. The competitive swords of the past need to be beaten into the cooperative plowshares of the future.

I. FOUNDATIONAL AFFIRMATIONS

The claim of this article is not related to a particular faith posture (though I am clear in claiming my own perspective as one who embraces the Christian faith); I argue more broadly that the faith dimension has a significant contribution to make to the conversation about holistic care. Faith is a factor for many people both in the evolution as well as the resolution of health care issues. What follows are the reflections and insights that have emerged over the years as, in my own ministry, I have sought to engage in the integrative enterprise of bringing to bear the knowledge and truth that emerge from a variety of disciplines. Insights have been gained from an innovative course team-taught by William Meller, staff psychiatrist from the University of Minnesota, and me, then a professor of pastoral care at Luther Seminary. This course, “Ministry to the Mentally Ill and Their Families,” was an attempt at a truly integrative enterprise of coupling the insights of medicine and psychiatry with those of theology and ministry. In viewing this endeavor from a theological perspective, I lift up several foundational theologoumena. These theological affirmations, though neither exhaustive in scope nor sufficiently plumbed in depth, are foundational for the subject at hand.

1. The unitive nature of reality

The Judeo-Christian tradition has resolutely affirmed that reality is unitive in nature. The dichotomizing of reality into the secular and the sacred that permeates so much of our thought and language is fallacious. Reality itself is unitive and not bifurcated into that which has to do with God (the sacred) and that where God is either absent or unnamed (the secular). To suggest an adversarial relationship between theology and the social sciences predicated on sacred and secular categories is to miss the deep truth of the tradition and to perpetuate a false dichotomy. The spirituality of the Judeo-Christian tradition would make an unequivocal claim for the unity of all reality under the aegis of the God who has created and who is concerned about all that exists. A spirituality that does not embrace the totality of reality is seriously lacking in breadth and depth.

The unitive nature of reality also critiques the conventional categories of the spiritual and the material. The words spirit and spirituality frequently conjure up images of something non-material and other-worldly or some kind of disembodied mysticism divorced from the concrete reality of life. These conceptualizations arise in western philosophy primarily from the Platonic school of thought. In the Judeo-Christian tradition, spirituality is always anchored in the material, the here and now, concerned with the stuff and fabric of this life. Some of the earthy lan-

language and metaphors of the Old Testament are indicative of this resolute determination not to split reality into two separate and unrelated realms.

The scandal of the Christian tradition lies precisely in the metaphysical claim made by the writer of John’s Gospel: “In the beginning was the Word, and the Word was with God, and the Word was God....And the Word became flesh” (John 1:1, 14). The ancient Christ hymn of Phil 2:5-11 is a canticle to incarnation; God takes upon God’s own self human flesh to identify with and to become one with God’s creation. Any spirituality that separates the spiritual from the material, the spirit from the flesh, or the “this worldly” from the “other worldly” clearly is alien to the Judeo-Christian tradition.

2. The implications of vocatio

Streaming in an uninterrupted channel from the first affirmation about the unitive nature of reality is a second critical factor in fostering conversation between the disciplines of theology and the social sciences: the understanding of vocatio or vocation from the Judeo-Christian perspective. This tradition affirms that everyone is created by God and graced with certain gifts and skills for service to God and neighbor. Whether one’s vocation is that of a farmer, physician, clerical worker, clergy person, mental health worker, or mechanic one exercises legitimate gifts and talents diversely given by God for serving the neighbor. The Scriptures are replete with examples of people serving in various capacities as artisans, shepherds, physicians, fishermen, or fashioners of tents, and all play an integral part in the functioning of the whole. While human distinctions are possible, the various gifts of vocation are given by God in order that the world might continue to exist and all of creation might be more adequately served.

This perspective on vocation is an important consideration in the ongoing conversation between health care providers and people who represent various religious traditions. Health care is not a matter of oneupmanship, where some lay claim to superiority in terms of importance or function. Every person has been given gifts for the service of healing and wholeness. We need each other. The whole becomes more than the sum of its parts when various vocations work to the best of their ability to cooperate for the sake of the neighbor.

A personal experience might serve to illustrate. A few years ago, I fell and sustained multiple fractures in my right leg and ankle. The healing process was accomplished by the cooperative efforts of the ambulance crew, surgeon, maintenance team, nurses, aides, pastors, family members, and a host of other people of whom I have no knowledge. All of these people carried out their respective roles and vocations in varying capacities. A joint effort on the part of many people was required to enable me to walk today.

The Judeo-Christian faith affirms the vocation or calling of every person. The spiritual responsibility of each is to utilize the gifts that God has given them for the well-being of one another in the world.
3. Developed theological anthropology

The Christian tradition affirms the fact that the author of life and well-being is none other than God. The created order is evidence of the creative genius of God. Without equivocation, the creation narrative asserts that God looked at what had been made and pronounced it very good. Implicit in the Hebrew word translated as “good” (בֹּטחֶן) is the assertion that it was of inestimable worth and value, evidencing the handiwork of God. God created humankind in God’s own image, thus substantiating the immeasurable worth and value of every human being in the eyes of God.

This theological truth has two implications for our mutual work in providing care to others: (1) we respect one another with our diverse professions as mutual partners in our world, and (2) we treat those for whom we provide care as true “thous” and not “its”—to borrow a concept from Martin Buber.\(^3\) Such a developed theological anthropology might provide not only fertile soil for continuing conversations but also a common meeting place for our mutual work. The fundamental question is not whether human beings are moral or immoral. History clearly elucidates that human beings are capable of both great good and incredible atrocities. The fundamental question is whether human beings are intrinsically of worth and value, irrespective of the moral judgments we may make about their behavior.

It is not enough only to affirm the value of every human being, the question also looms large as to what has gone wrong in the human family when the intention of the Creator is frustrated by human behavior. Theologians have quickly answered the question with some form of a doctrine of sin. Whether sin is defined as rebellion, missing the mark, loss of nerve, alienation, estrangement, or some other category, the explanation is myopic and therefore limited. Little credence has been given to the social sciences and medicine, where we might learn more about genetics, biochemistry, and abnormalities of the brain that spawn some of the inexplicable behavior of some human beings. Not all unacceptable behavior can be relegated to the catchall category of sin, but neither can it be assigned exclusively to biological or sociological determinism. We have much to teach each other when it comes to developing an adequate theological anthropology. As theologians we could well learn from history: we need think only of the embarrassment of the past, where the faith community condemned to death those scientists who dared to suggest that the earth was not flat or that it was not the center of the universe.

The contribution of theology to this conversation may be in its lifting up the reality of systemic evil evidenced in oppression of various kinds, ranging from sexism to racism to ageism to classism. Reinhold Niebuhr’s work, Moral Man and Immoral Society,\(^4\) was an attempt to get at some of these issues. Greed, domination through power, intimidation, and all forms of oppression are also evidence of what

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the Scriptures metaphorically refer to as the principalities and powers of this present darkness (Eph 6:12). Rather than becoming hung up on the metaphorical language, we can better acknowledge the realities to which it points and the necessity of some kind of redemption, liberation, and transformation of those powers that oppress. The clash of the forces of good and evil in our world is a profoundly powerful spiritual issue. Hammering out a viable anthropology is no small task, yet we must do so in order to facilitate conversation as well as to strategize for a more wholistic view of healing and health.

4. Salvation as wholism

The intent of this essay is to develop language that might enable us to engage in mutual conversation and strategizing in dealing with the health of the whole person.

In the faith tradition, the word salvation may come as close as any to describing the reality of full health. Unfortunately, the term has often been singularly associated with the activity of God in redeeming humankind from sin and damnation. Or, salvation is appropriated only in its eschatological sense as being associated with the promise of God in granting eternal life. While these considerations certainly are a significant part of the story and message of the faith tradition, the word is not used exclusively in these ways. To use the word salvation only in this narrow sense can contribute to misconstruing faith. This perspective leads to the conclusion that faith has to do only with that which is other worldly and is not concerned about what happens to people in this world where we live and move and have our being.

The faith perspective asserts that salvation also has to do with healing, health, and wholeness in the here and now. The well-being of all that God has created constitutes an integral part of the message that is espoused by the faith community.

Perhaps a more suitable word comes from the Hebrew language of the Old Testament. The word is shalom (שלום), which is rich in its multiple meanings. It connotes an internal and external sense of peace and harmony for both individuals and groups of peoples and nations. Shalom denotes well-being, harmony, congruence, and the integration of all that is into a unified whole. This all-encompassing term provides a provocative image of life lived in communion with God and others.

This idea is capitalized upon in the New Testament, especially in the ministry of Jesus, whose concern was always for the total person. Jesus’ ministry involved healing the sick, restoring sight to the blind, exorcising demons, and enabling the lame to walk (Luke 4:16-44). He spoke words of forgiveness, love, reconciliation, and grace to those who were wounded in their relationships with God, others, nature, or themselves. But there were also words and actions of judgment when human well-being and community were disrupted. The ministry of Jesus was to the whole person. The haunting parable of Matt 25 states in unequivocal fashion that God visits humankind in the form of sisters and brothers who are hungry, naked, imprisoned, and lonely. Forasmuch as you have done it unto the least of these my
sisters and brothers, you have done it unto me. The faith community is not about “saving souls,” whatever that may be, it is about the salvation of the total person.

Once again this wholistic view of human beings and their salvation precludes splitting the human person into body, mind, emotions, soul, or spirit, for we are all of this and more as created children of God. Irrespective of where the point of attack might be for any given disease, it is an assault on the whole person, and the whole person must be treated accordingly.

Thus, the richness of the word salvation in the faith tradition needs to be emphasized. It is a comprehensive term that encompasses the totality of that which makes us human. A concern for “salvation” will require us to deal wholistically with individuals and groups rather than dealing with them atomistically, predicated on an inadequate understanding of what it means to be fully human.

As asserted at the outset, this list of theologoumena is not exhaustive, for many more theological assertions could be made. Even in articulating the aforementioned tenets, only a superficial exposition of each was possible. Still, those delineated can form the foundation upon which a framework of mutual respect, cooperation, and work can be erected.

In the second part of this essay, I will lift up attitudinal dispositions that we in the communities of faith might exhibit if we are to work towards an integrative and cooperative venture.

II. CONSIDERATIONS FOR THE FAITH COMMUNITY IN THIS DIALOGUE

We do not live in a perfect world or society. Because we are the inheritors of the legacy of prejudices and presuppositions concerning the various disciplines we represent, it seems judicious to think more specifically about the role that the faith community plays in promoting and insuring an integrative approach to our common work for the welfare of all human beings. I certainly do not pretend to speak for all faith traditions, but will proffer my own thoughts and ideas about the way in which faith can participate and contribute to the dialogue that occasioned this reflective essay.

1. Commitment to openness

I once had a cartoon posted on the door of my office depicting a church structure, and the sign erected on the church lawn had the following warning: Beware of Dogma! One of the many sins committed by those of us who represent various faith traditions is the sin of being closed to perspectives, worldviews, ideas, and even new data that do not fit within a particular dogmatic structure. While those who represent the faith tradition likely do not have a corner on the phenomenon of a closed mind, we do often have to own the fact that, seeing the sciences as the enemy, our minds become as closed as a steel trap. In my judgment, the essence of prejudice is the closed mind; it is epitomized by the old maxim that says, Please don’t confuse me with the truth!
The sine qua non for true dialogue is an open mind on the part of all participants. This does not preclude differences of opinion or conflict, nor does it imply relinquishing one’s convictions or capitulating to others by repressing one’s own concerns. Rather, it involves the attitude that we bring to the table of conversation. Attitudinal dispositions that involve exclusivistic claims to superiority or total truth subvert the integrative process. It is my philosophical and theological conviction that truth emerges from a respectful dialogical process.

This presupposes openness, willingness, and ability to enter into the reality of the other in order to appreciate the insights that come from disparate perspectives. A critical factor in openness is that we also listen carefully to the voices that previously have been muted in a society dominated by white patriarchy. The choir is not complete without the voices of women, people of color, those who are not heterosexual, the poor, and those who are disabled. The monotone of exclusively white male voices does not constitute the intended rich tones of the whole choir. My hope and prayer is that more and more people who represent the faith tradition will acknowledge that all knowledge is important and every human perspective is legitimate. Thus, a fundamental ground rule for dialogical truth seeking is a firm commitment to openness to the other, seeking to benefit from the contributions of those whose worldview, perspective, and orientation may be different from our own. Truth seeking needs to be a mutual quest of aspiring seekers from various disciplines, backgrounds, and orientations, whose commitment to openness surpasses their propensity to cling to pet prejudices or stagnating dogmas that preclude mutual respect and sharing.

2. The interdisciplinary team approach

The care and healing of the total person requires the “networking” of an interdisciplinary team. Our inability to network may be a result of vocational prejudice or bad experiences, or it may be simple ignorance of what others do professionally with people. A paradigm of wholistic care was developed decades ago by Vernelle Fox, a research physician and clinical director for the treatment of addiction. In an essay entitled, “The Best Prime Therapist for an Alcoholic is an Interdisciplinary Team,” she argued that no singular staff person in the recovery process of the alcoholic is more critically important than another staff member. The contributions of the physician, psychologist, social worker, clergyperson, occupational therapist, and recreational therapist all have an equally important role to play in the healing process. While one person serves as a case manager to facilitate the coordination of the treatment, the strength of the treatment process lies in the multidisciplinary approach. From her many years of work both as a physician and administrator, Fox was cognizant of the turf battles waged among helping profes-

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5This unpublished essay became available to some of us who did Clinical Pastoral Education in an institution where Fox was the medical director: Vernelle Fox, “The Best Prime Therapist for an Alcoholic is an Interdisciplinary Team” (paper delivered at the Second World Congress of the International Rehabilitation Medicine Association, 1974).
sionals that ended up in competitive struggles. Her point was that the patient was often more victimized than helped by the process. As she cultivated a staff mentality that ascribed to each person an important role in the process, the team concept took on a life of its own. It made professional relationships more harmonious, because integrity, respect, and credence were given to each professional on the team; at the same time, Fox discovered that the patients became well and healed more rapidly. This was not only an abstract idea, it was a model that was implemented in practice. I was privileged to participate in this model of learning in my own clinical pastoral education training and experienced first-hand its results.

Fox acknowledged the resistance that many professionals had to this model. The conclusion of her paper states,

The struggle and effort [to establish such a team] is worth it just to experience the strength and creativity of being a part of a shared responsibility interdisciplinary team. The range of effective service and the innovative means of meeting patient needs that can be developed from the pooled resources of people trained in varied disciplines is amazing. The impact of such pooled resources on the growth and development of people trapped by alcohol and/or drug dependency is even more amazing.6

This model of networking and cooperation works if one is committed to the concept and open to working through all of the issues created by an interdisciplinary approach. It has as salutary an effect on caregivers as on those being cared for in the process.

3. Centrality of caring for persons

A critical attitudinal disposition and a core value of the faith tradition is the centrality of caring for persons. The professional temptation that can lure us off course is to think of success, statistics, or stewardship in our dealing with people. Those whom we are asked to help often lose in our need to be winners. Professional and personal ambitions must be subservient to caring for the total person.

A critical factor in dealing with emotional illnesses is what I call the shame factor. For many, the very mention of mental illness constitutes a taboo. The social stigma or shame factor creates a conspiracy of silence, and the consequences of this secrecy can be fatal.7 A billboard in the Minneapolis-St. Paul area reads, “Untreated depression—the leading cause of suicide.” If caring for the total person is a core value, then concerted efforts need to be launched to bring issues of emotional illness out of the darkness of secrecy into the light of caring concern.

The faith community has sometimes exacerbated the problem of mental illness by interpreting it as demonic possession or by claiming that if the person had sufficient faith she or he would not be suffering from mental illness. Even though the climate has improved in recent years, a major educational task still lies ahead of

6Ibid., 11.
us so that those both inside and outside of the faith community can look to the community of faith as a source of strength and support. Until we deal effectively with the shame issue and become reoriented in terms of our attitudes, both the afflicted and those affected will retreat into seclusion and languish in silence for fear of being rejected, ostracized, or shunned.

In the Christian tradition, Jesus of Nazareth is lifted up as a model of sensitivity and compassion. He is portrayed as one who was particularly sensitive to and concerned about the disenfranchised, those labeled as unclean, the marginalized, and the outcasts of society. His ministry was always person-centered and wholistically oriented in ministering to the total needs of the total person. His modus operandi was always to see the person rather than the problem.

The haunting parable of the last judgment in Matt 25 is ample evidence that the person in her or his total needs is paramount. The essence of the parable is that whoever ministers to those who are hungry, naked, imprisoned, or sick actually ministers to the Christ who comes incognito in the person of those who are in need. This service of the neighbor in need, irrespective of what the need might be, is indicative of the kind of spirituality that was modeled by Jesus in his ministry of mercy.

4. Communal dimensions of the enterprise

Finally, we who are members of the faith community need to take seriously the communal dimensions of the healing process. Spirituality in the Judeo-Christian tradition is centered in relationships. Since God has taken the initiative in establishing a covenantal relationship of love, all spirituality is anchored and has its origin in God and not in human innovations. However, the expression and experience of spiritual life is found in community.

While individuals may and certainly do practice a particular piety or meaningful spiritual exercises, the witness of the tradition is that spiritual living is found in community.

It is God who called Israel into community as a people. It is God in Christ who called the Christian community into existence. The early Christian community was constituted by the faithful devoting themselves to the teaching of the apostles, fellowship, and prayer (Acts 2:42). According to the New Testament, the developed and mature community of the body of Christ provides the locus and matrix for the healing of the whole person. The apostle Paul reminds the community that when one rejoices, all rejoice; when one suffers, all suffer (1 Cor 12:26). In Galatians Paul states that “mutual burden bearing” is the distinctive mark of true community (Gal 6:2).

Some years ago I had an extended conversation with a chaplain in a depression unit. His observation was that while the patients were in the unit, carefully monitored and attended by a supportive staff and caring environment, healing began to take place and health emerged out of illness. His concern was what happened to these people when they were discharged from the unit. What kind of communities would they face upon discharge? What kinds of challenges would
confront them as they now bore the label of people who had been hospitalized for depression? Would the congregations to which they might return be supportive communities for them? In other words, would the communities live out their own spiritual nature as caring groups of people, or would they ignore, avoid, or otherwise ostracize these people? Without a caring community the depression could easily be triggered again.

In this regard, I have learned much from my years in working in chemical dependency, observing and experiencing the power of community provided by Alcoholics Anonymous and other such twelve-step groups. In my opinion, labeling these “self-help” groups is an unfortunate misnomer. The sobriety of the recovering people is attributed exclusively to a power greater than themselves that is able to restore them to sanity. The supportive and sustaining power in maintaining sobriety with serenity is dependent upon the group or the spirituality of the recovering community. Embodied in healthy chapters of Alcoholics Anonymous is this commitment to participate in a caring community of honesty, love, acceptance, and non-judgmentalism. A powerful communal spirituality has been developed that could well be emulated by the faith community. These groups embody the finest integrative tradition of spirituality, medicine, and the sound principles of mental health. We have had a model in our midst that has worked for decades, and we would all do well in our respective professions to learn and benefit from it.

You may recall the title of an old romantic song, “We’ve Only Just Begun.” That title characterizes the conversation that has been suggested by this essay. We certainly have not arrived, we are only in process. Someone once said that old prejudices die hard, probably about an hour after we do! If from our vocational perspectives we can make a common commitment to conversation that is open and respectful and that centers on the health and well-being of others—whether we call them patients, clients, neighbors, relatives, parishioners, friends, or members of particular communions and communities—we will at least begin to make a commitment to the literally thousands and millions of people who have been afflicted and affected with debilitating conditions.

The task is formidable, but not impossible. The work required to achieve an integrated approach is arduous, but not infeasible. The effort will require openness, respect, and honesty to supplant the prejudices and suspicions that have abounded in the past. Perhaps the foremost requirement is the capability of truly listening to one another as professionals as well as to the people whom we seek to serve.

Inhabitants of the so-called postmodern era will not be impressed by our turf wars, our disciplinary hubris, or our solitary claims to have all the answers. They seek, demand, and rightly expect an integrative approach that takes into account the totality of their being and the reality of what makes them truly human. With this credo and this commitment, we can be led into a more effective and efficient service in the future.