The Wholeness Care Project

Project Overview

Working collaboratively with faculty from the University of Georgia (UGA), the Athens College of Ministry (ACMin) proposes a 3-year pilot study that explores the effects of intentionally incorporating biblically-based Christian faith practices with mainstream medical approaches for the purpose of building a strong understanding and practical strategies for improving whole person care. By studying the effects of fully integrated faith and health care, the project aims to develop effective pathways for improving patient health and wholeness through a comprehensive team approach, which equitably incorporates physical, mental and spiritual interventions of care.

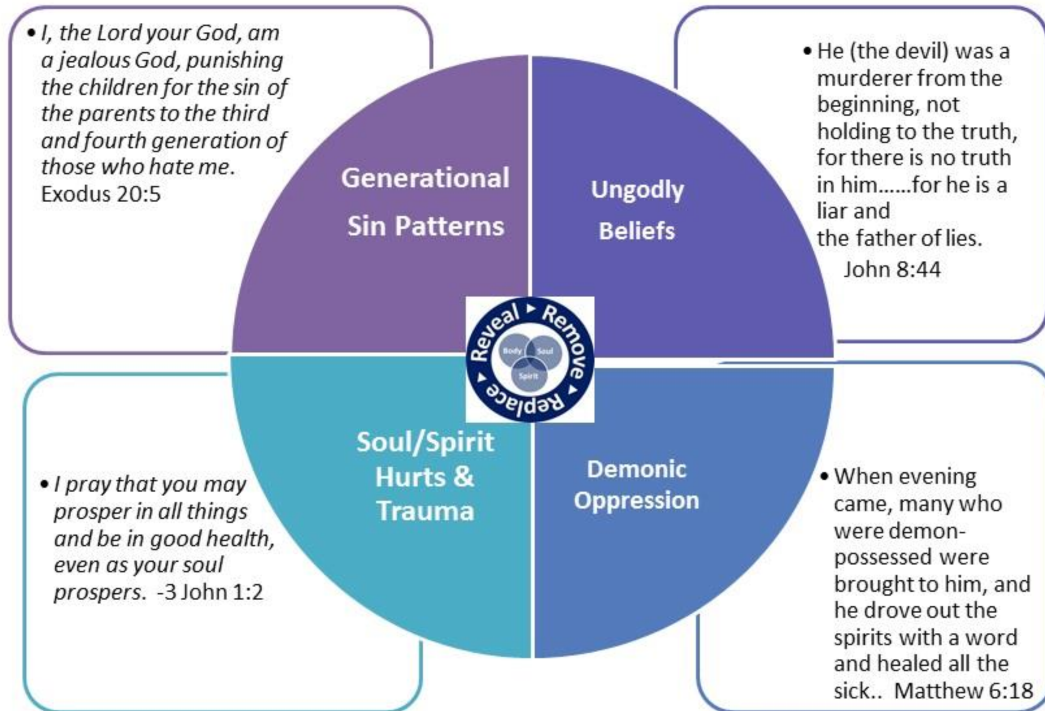
Introduction

Because ministry and healthcare professionals are in a position to impact the wellbeing of many other people through their influence and practices, this project will add knowledge that challenges and changes the status quo of their routine practices in order to bring about an increase of wholeness in every individual impacted. Overall, health care professionals are trained to diagnose physical problems and recommend optimal treatments, however, without equitable consideration of the possible spiritual roots of presenting illnesses, elimination of the underlying problem is unlikely. From the Christian church perspective, a different disconnect is noted between what the Bible says about physical and spiritual health and what believers actually do when faced with a physical or spiritual issue. Thus, the aim of this project is to heighten the awareness of wholeness care among healthcare and ministry care providers and create bridges within and between those providers that results in collaborative life-changing care.

Although members of the medical profession are knowledgeable of the leading causes of death, most are less aware that, as presented in Figure 1 below, the root causes of many illnesses may not be physical problems at all.

In the center of Figure 1 above, we note the interconnectedness of our bodies, souls, and spirits and the resulting conditions. Root causes, as presented in Figure 2 below, may include: a) the consequences of sins from past generations; b) lies we have believed about ourselves, God, and life situations, (often rooted in fear, unforgiveness, or hopelessness); c) past traumas and/or abuse; and d) demonic oppression. Through effective ministry (education, transformational prayer, and the power of God), the root causes of presenting physical, emotional, or spiritual problems are identified and replaced with God's Truth and subsequent healing. His Truth sets us free, free indeed! (John 8:32 & 36)

Figure 2



In large part, the Wholeness Project will educate health care professionals, ministry leaders, and individuals receiving care how to reveal and eradicate the potential causes of physical and mental illness and the key to life in the Spirit of God. For example, through the study of epigenetics, science is already confirming the effects of thought patterns to alter an individual's DNA switches, changing the DNA function from one generation to the next, making a strong case for the effects of generational sins (Roach, Bronner, & Oreffo, 2011).

David Fountain reports the case of John, an 18 year old high school student admitted to the hospital in Africa with advance pulmonary tuberculosis and how his belief almost brought about his death. A student nurse caring for him made a significant discovery. John's parents had borrowed money to pay for his high school education and when they were unable to repay the money, the uncle put a curse on John saying he would become ill and die in spite of whatever treatment he might receive. This is an example of how demonic powers can hold a person in bondage. The nurse shared her faith and John entered into a personal relationship with Christ. Within a short time, he recovered completely from his illness and returned to school (Fountain, 1999).

Gregg Braden shares a story about his grandfather who had lived through the Great Depression and for the rest of his life carried with him a sense of guilt and shame for not being able to provide adequate food for his wife and extended family. Years later, when his wife of 50 years died and he was again

unable to do anything for her, the sense of helplessness brought back a flood of similar emotions from the Depression years. A short time later, the grandfather was diagnosed with Myasthenia Gravis. The chronic sense of helplessness became the literal expression of his body or as Braden stated, "His body became the helplessness of his belief." Through his mind/body relationship and the partnership with ungodly beliefs, his physical-self recognized his beliefs as an unconscious command and masterfully produced the chemistry to match them (Braden, 2008).

Man is God's creation. To be human is to be created in the image of God. That image is only realized through surrender to Christ. As a result, whole, abundant life is seen as man in proper relationship with God and fellowman. "*Be perfect, therefore, as your heavenly Father is perfect*" (Matthew 5:48). By teaching ministry and health care professionals to understand wholeness and by supporting them and those they serve with Transformational Prayer Ministry where the root causes can be revealed, removed, and replaced, the keys to wholeness care are secure.

Definition of Terms

For the purpose of this project, we are using the following terms and their commonly accepted definitions:

Wholeness – The quality or state of being whole, shalom, peace, balance, well-being, or harmony. Wholeness indicates restoration of the whole person to God's image.
Wellness—The state of being perfectly well physically and mentally.
Health—the state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (World Health Organization, 1946).
Healing – A permanent, overcoming improvement from an ailment to the body, soul, or spirit.
Body --The tangible, physical aspect of a whole person that will eventually die.
Soul – An individual's mind, will, and emotions.
Spirit—The eternal aspect of a person's identity. For Christians, the Spirit of Christ occupies the physical body (1 Corinthians 6:19).

Problem Statement

While ministry and medicine are both considered healing disciplines, there is little history of the two working together seamlessly and successfully. The appropriation of whole-person health has the potential to revolutionize the well-being of people everywhere. This project will provide Christian leaders and health care professionals a fresh, unified perspective between the scientific principles of physical health with the tenants of faith and spiritual health, breaking down our western-thinking secular-sacred compartmentalization.

We begin with the Bible, the most published book of all time. Jesus said (John 10:10) that that He came to give us life and life abundantly. Further, the Bible declares in 3 John 1:2," *I pray that you may prosper in all things and be in health, even as your soul prospers*." The integration of body, soul, and spirit is the path to the abundant life that Jesus intended. Further, Jesus made a way for us to be restored to the abundant life by His death on the cross. Jesus did all of that on the cross to restore us to our original design, and yet because we do not understand the fullness of what Jesus accomplished for us by His death, we are neither whole nor free from sickness and disease. Because a vital, interconnected

relationship exists between physical and spiritual health, there is a strong need to serve them both in an integrated way in order to achieve wholeness.

While the first Century church regularly exercised the gift of healing, by the middle ages, healing of the soul became the Church's primary mission, declaring that disease was God's judgement for man's sinfulness and ~~began~~ using disease or illness as an indicator of an individual's state of sin.
Today, health care professionals are educated in the principles of anatomy and physiology and understand the etiology of physical diseases and mental and emotional disorders. Ministry professionals are educated in theology, anthropology, and pastoral care. Ministry professionalsunderstand how to support people spiritually through life's circumstances. However, education in the health care disciplines does not typically incorporate the Hebrew concept of unity with regard to the body, soul, and spirit in its teachings of anatomy and physiology. Depending on the emphasis of the seminary or Bible college, ministry professionals may also be unaware of the body, soul, and spirit connections. Health care tends towards the dualism of Greek philosophy, which separates the body and spirit by focusing primarily on the physical with a perfunctory acknowledgement of a person's spirit. Ministry professionals tend towards Greek dualism as well, focused primarily on individuals' spiritual health with a disinclination to consider the physical catalysts in a person's wellbeing.

Health care professionals understand that behaviors contribute to chronic health issues. Lack of physical activity, poor nutrition, tobacco use and excessive alcohol consumption are responsible for much of the illness, suffering, and early death related to chronic diseases. However, little to no ~~care~~ attention is given anywhere in health care to the spiritual and emotional roots of sickness and disease due to lack of time and/or understanding.

Christian churches typically pray for the sick. Overall, there is a widespread lack of understanding of the spiritual roots of sickness and disease among believers simply because it is not taught (Hosea 4:6). Further, there is hesitancy among churches to engage in healing prayer due to real or perceived excesses demonstrated by 'faith healers.' The result is that churches focus primarily on care of the spiritual self with much less attention to physical health—and yet both are needed to achieve full health and wholeness.

Beyond the physical and spiritual aspects of our beings, humans also have souls—the seat of our mind, will, and emotions. Our mental and emotional hurts are much like physical wounds that scar over in time. However, under the emotional scar tissue, there is frequently shame, anger, rejection, unforgiveness and guilt (see Figure 1). These invisible wounds are not as easily healed because we make less effort to care for them as we do the physical ones. Over time, neuro-chemical responses released in our bodies due to the pain and stress of emotional wounds lead to sickness and disease (Wright, 2009). Essentially, whatever affects the mind influences the body, and whatever affects the body influences the mind.

Further, while wellness programs can only focus on improvement of overall physical health and saving lives, eventually, every human being will experience the end of his or her physical life. We were all born to die. Through the wholeness project, we expect to see tremendous healing—body, soul, spirit – and

ultimately, greater spiritual life in Christ, given that a healthy spirit in Christ will never see eternal death. Wholeness will lead to *eternal* life as people come to understand the power of Christ to save them from sickness today and from permanent death forever.

Literature Review

Based on existing research, we believe that better understanding of the unity of the body, soul, and spirit and how to effectively provide care for a person as a whole being will augment the quality of life of each person served. The following are examples of studies that have addressed the intersection of faith and health.

Dr. Harold Koenig, the Director of Duke University's Center for Spirituality, Theology & Faith, whose thirty years of research concludes that people who actively maintain the spiritual practices of prayer, worship, service and fellowship enjoy increased physical health over their non-spiritual counterparts. (Koenig, 2001). Looking at sickness through the lens of the soul, Dr. Caroline Leaf states that "seventy-five to ninety percent of illnesses are a direct result of our thought life." (Leaf, 2014)

In *The Biology of Belief,* Dr. Bruce Lipton writes, "We are made in the image of God and we need to put Spirit back into the equation when we want to improve our physical and mental health. Our beliefs control our bodies, our minds, and thus, our lives." (Lipton, 2008)

The positive effects of spiritual healing are the found in a study by Barlow, Walker and Lewith of women undergoing long-term hormone therapy for breast cancer. The study explored the potential therapeutic use of Spiritual Healing towards successful completion of the drug therapy. Results after ten weeks of sessions included relief or respite from physical pain, relaxation, emotional release, stress reduction, and increased hope. The study concluded that Spiritual Healing has the potential to support patients with breast cancer in the maintenance of their long term therapy (Barlow, Walker, & Lewith, 2013). Similarly, Kubzansky (2007) demonstrated that negative emotions clearly play the role in the development of heart disease. Further, a metareview of 25 clinical studies found a significant association between anger and hostitily and coronary heart disease development and death (Chida & Steptoe, 2009).

In her dissertation study, Dr. Deborah Huckaby's data revealed that attending a seminar on the integration of faith and health played a statistically significant role in helping attendees gain a more wholistic understanding and helped them adopt behaviors conducive to whole person health of mind, body and spirit. The study addressed the problem of compartmentalization of the human being with respect to faith and health and demonstrated how providing healthcare and ministry professionals with an increased awareness of the biblical and theological foundations of faith and health: a) resulted in significant changes in their beliefs and behavior; b) facilitated advances towards their personal wholeness; and c) motivated them to share this insight with others (Huckaby, 2016).

There is a wealth of data to support the importance of spirituality in the matter of physical health (Koenig, 1999; Koenig & Cohen, 2002; Koenig & King, 2001; Koenig, 2008; Lipton, 2008; etc.). However, there has not yet emerged a contemporary model *in practice* for the true integration of spirit, soul, and body care leading to wholeness.

For example, studies on approximately 500 patients who were members of the Methodist LeBonheur Congregational Health Network revealed a fifty percent decreased mortality, decreased readmission rates, decreased length of hospital stay, decreased costs and increased patient satisfaction (Cutts & Baker, 2012). Through the LeBonheur system, 'navigators' (chaplains, clergy, social workers etc.) work with church liaisons and the extended church family support system so that there is a continuum of care during the acute stage of an illness or injury and after the patient's discharge. However, the spiritual etiology of the patient's condition is not included equally in the plan of care. Rather, it is more of an adjunct to care and/or considered as a form of personal 'comfort.

As another example, data from the Transformational Prayer Ministry Center, in operation at the Athens College of Ministry since 2013, show that 85% of prayer ministry recipients found Transformational Prayer Ministry (TPM) to be "highly effective" in helping resolve their spiritual and emotional issues. Another 10% considered their TPM experiences to be "effective," for a combined total of 95% effectiveness. This Center deals most directly with spiritual and emotional healing and at times ministers to individuals with physical concerns. However, the Center is not yet integrated with a whole-person care team.

Although health care and ministry professionals attest to a foundational understanding of the essential unity of mind, body and spirit, their practices are lacking. In health care, the physical and mental aspects are considered equally valid in the assessment and treatment of illness or disease, but the spiritual aspect is not. In existing models, spirituality is documented but not incorporated equally into the individuals' assessment or plan of care. In ministry, the potential impact of a person's physical condition upon their mental and spiritual condition is not incorporated either. Further, ministry professionals are often not trained to address the root causes of sickness and disease. Wholeness Care considers each aspect of a person equally in the assessment and treatment of their condition(s).

Project Goals

The goal of this project is to study the effects of a health and wholeness approach to individuals' care through the creation of a networked health and wholeness care team approach. To accomplish the Project Goals, the Project Advisory Board will:

+Create and administer wholeness training materials and experiences to project;
+Train a cross-section of 30 health care professionals, 12 clergy members, and 30 prayer ministers who will serve as an interconnected Wholeness Care Network (WCN);
+Foster deep cooperation between faith and health care communities through the development of a local wholeness care network;
+Collect data on the impact of the model to inform the long-range vision; and
+Develop tools for large-scale replication of the WCN in other communities (to be revised as a result of project data collection).

Hypothesis

By raising their ~~a~~ general understanding of wholeness care, and how it can be integrated into the medical field and Christian churches, the health care professionals, prayer ministers, and church leaders

involved will demonstrate: a) a deeper understanding of the connections between body, soul, and spirit; b) a new conviction in their attitudes about wholeness care, and c) sustained changes in their practices resulting in increased cooperation with the Wholeness Care Network.

Training health care professionals and faith communities to understand-and-incorporate the spiritual roots will help those they serve obtain a more complete and sustainable healing. Individuals served will demonstrate: a) an increased incidence of permanent physical healing; b) an increased freedom from spiritual and emotional wounds; c) a stronger faith in Christ the Healer; and d) increased wholeness as evidenced by an abundant life.

Data Collection & Analysis

Project members will collect data as follows:
+Health care professionals and clergy will collect a Spiritual History interview checklist from network participants.
+Health care professionals and clergy will report changes in presenting symptoms among both compliant patients (those who seek Transformational Prayer Ministry) and non-compliant patients.
+The Transformational Prayer Ministers will report progress observed in TPM recipients.
+TPM recipients will complete a post-session questionnaire.
+Network participants (health care professionals, clergy, and Transformational Prayer Ministers) will complete pre-and post-participation surveys to note changes in their beliefs, attitudes, and practices.
+Network patients will be invited to complete a post-treatment survey to measure any changes in beliefs, attitudes, and symptoms.
The PI/Co-PI team will analyze and triangulate the above-mentioned data in order to determine the scope of impact of the Wholeness Care Network on both compliant and non-compliant individuals.

Expected Project Outcomes
The following work products useable for replication and/or adaptation that will result from this project are:

a) A one-page spiritual history interview for physician's and counselors' offices as they see patients. The form identifies the specific Protected Health Information (PHI) being collected and provides signed consent for that data to be shared with ACMin for the purposes of referral to the Transformational Prayer Ministry Center (TPMC) for spiritual care.
b) A tri-fold patient education brochure that introduces the concepts of spiritual causes of sickness and disease to be distributed to patients in the physician's office. The purpose of the brochure is to encourage compliance when a referral is made to TPMC.
c) An accredited course/curriculum for health care professionals about the wholeness aspects of sickness and disease that will become part of professional education with approved CEUs.
d) A model for establishing Transformational Prayer Ministry Centers as part of a Wholeness Care Network in other Christian Faith Communities with a curriculum that will include:
    i. Our identity in Christ (power, authority, greater things)
    ii. Training in how to hear God's voice
    iii. Inner healing training
    iv. Biblically sound training in the gift of healing

            v. How to introduce Christ and His healing to non-believers
            vi. How to operate a center as part of a wholeness care team
e) Lifelong learning courses to supplement the spiritual care received in the TPMC such as:
    a. Filling the Empty Places
    b. Alive in Christ
    c. Healing Shame & Trauma
    d. Walking in Sonship
f) A functional model for creating a local Wholeness Care Network.

Study Participants

The 'Network Participants" will include:

- 30 licensed, practicing health care professionals whose practices are primarily focused on in-office and/or hospital-based patient care and consulting (i.e. MDs, Dentists, PAs, NPs, RNs, counselors, etc.) Participants must be practicing Christians and regular attendees at a local church. Participants selected will represent a range of experience and type of medical specialization. Included in the participant cohort will be at least 3 interning physicians.
- 12 practicing church and/or Christian ministry leaders (i.e. senior pastors, discipleship pastors, ministry directors).
- 30 Prayer Ministers trained to minister inner healing to others.

The Project Leadership believes the number of Network Participants should be no smaller than 30/12/30 as described above for many reasons. We need to ensure that there is a good range of the types of health care professionals involved by specialization as well as strong denominational diversity among the clergy. Given the typical patient load for any given physician, the Prayer Ministry team needs to be equally proportionate in order to accommodate the flow of prayer recipients coming to receive spiritual care. Further, as we develop the functionality of the network, we believe the network size has to be a good "representative sample" in order for the model to be replicated in other communities. In other words, a smaller sample size would not allow us to beta test the functionality of a feasible network. Finally, we believe that the 30/12/30 sample size will yield enough diversity for the data to be a strong representative sample of what is possible.

Participant Selection

The Principal Investigator and the Co-Principal Investigators will invite by letter a broad range of individuals per the above criteria to apply to participate in the program. Applicants need to be located in the greater Athens, Georgia and nearby communities for ease of networking. From the pool of applicants, candidates will be selected for interview. Based on interview outcomes, the study participants will be chosen. Health care professionals should have representation from among specialists as well as generalists. Clergy should represent diverse denominations and church sizes. Preference will be given to Transformational Prayer Ministers with previous successful ministry experience. Among all participants, racial, age, gender, and socioeconomic diversity is important for selection.

Project Timeline

Year 1

+Assemble the Project Advisory Board (PAB) for 2-day kick-off meeting with the goal of developing the training and networking aspects of the project and the research protocols. The PAB meets virtually every other month for 2 hours after kick-off.
+Develop wholeness training materials.
+Invite study participants.
+Hold 2-day kick-off and training for network participants.
+Establish local Wholeness Care Network logistical protocols.

Year 2

+Host 1-day Network kick-off training for network participants
+Implement local Wholeness Care Network.
+Collect and monitor patient care data.
+PAB meets for one 2-day meeting to review Year 1 progress and to cast vision for implementation beyond the pilot. PAB meets every virtually every other month for 2 hours.
+Patients receive physical (medical) and spiritual (prayer ministry, inner healing seminars and workshops) per intervention protocol

Year 3

+Continue implementation of Wholeness Care Network.
+Assemble and analyze project data.
+PAB meets in person for one 2-day meeting to review pilot study data and to make recommendations for program adjustments as well as for larger-scale implementation. PAB meets virtually every other month.
+Project celebration at 1-day colloquium with Network Participants (held in conjunction with Day 1 of PAB meeting)

Training Protocol

Year 1

+2-day seminar for all participants to include biblical basis for sickness, disease, and healing to include:
- -Spiritual roots of sickness (generational, sin-based, demonic)
- -Understanding the effects of trauma, emotional and spiritual wounds on the body
- -Spiritual discernment (i.e. Words of Knowledge) and prayer
- -Biblical truths about God's power to heal and the gift of healing
- -Biblically appropriate cooperation with the power of God for healing and wholeness
- -Wholeness Care Assessment

+Health care professionals participate in monthly 2-hour virtual discussions about additional readings
+Clergy meet quarterly to discuss additional readings
+Prayer Ministers meet quarterly for additional training in physical healing, evangelism, spiritual gifts, etc.

Year 2

+1-day logistics and protocol training for network kick-off
+Health care professionals participate in monthly 2-hour virtual discussions about additional readings
+Clergy meet quarterly to discuss additional readings.

+Prayer Ministers meet quarterly for additional training in physical healing, evangelism, spiritual gifts, etc.

Year 3

+Health care professionals participate in monthly 2-hour virtual discussions about additional readings
+Clergy meet quarterly to discuss additional readings
+Prayer Ministers meet quarterly for additional training in physical healing, evangelism, spiritual gifts, etc.
+1-day colloquium near project end to share experiences, victories and challenges with the PAB
(CEUs for all years TBD.)

Project Personnel

Principal Investigator, Rev. Dr. Deborah Huckaby, The Athens College of Ministry
D.Min., Asbury Theological Seminary
M.B.A., Brenau University
Associate's Degree in Nursing, South Georgia College
http://www.acmin.org/ACMin-Leadership-Staff
Responsibilities: Oversee the project logistically, oversee network development, represent the project to the greater public, ensure fidelity of all data collection efforts.

Co-Principal Investigator, Dr. Ronald Blount, Professor, Clinical Psychology, The University of Georgia
Ph.D., West Virginia University
http://psychology.uga.edu/directory/ronald-blount
Responsibilities: Direct, inform, and interpret the project's data collection and analysis.

Co-Principal Investigator, Dr. Juliet Nabbuye Sekandi, Assistant Professor, Center for Global Health, The University of Georgia
Ph.D., The University of Georgia, Epidemiology
M.D., Mbarara University of Science and Technology, Uganda
https://www.publichealth.uga.edu/cgh/about/directory/faculty/sekandi
Responsibilities: Liaise project with network physicians, oversee health care-related project training, participate in the development of data collection protocols and data analysis.

Full-time Project Coordinator, *to be identified*
Credentials: Bachelor's Degree
Responsibilities: Oversee the project budget, budget reporting, contracts and honoraria payments for project personnel, PAB travel coordination, meeting planning, and data collection/ storage.

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