Essay

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Spiritual Care – How does it work?

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1. Spiritual Care requires clear definitions: Spiritual Care is a shared responsibility of physicians, nurses, psychotherapists, chaplains, and other health professionals.
   - Spiritual Care takes patients' needs, options, resources, civil rights, and limits in the field of religiosity / spirituality into account.
   - Spiritual Care consists of (i) a basic competency of *all* health professionals, e. g. in screening and taking the patient's spiritual history; (ii) specialised competencies, e. g. psychotherapeutic interventions, non-verbal presence of music therapists, nurses' contact with the fragile body, chaplains' theological and ritual wisdom.
   - Spiritual Care is *not* a (burdensome) add-on to "normal" care. On the contrary, it encompasses everything that makes a therapeutic relationship "spiritual", especially the helpers' first-person-perspective (my spiritual journey, my mindfulness, my difficulties with religion and spirituality).
   - Spiritual Care is *not* a synonym for chaplaincy, pastoral care etc. Neither can it be delegated as such to chaplains.
2. This core competency in Spiritual Care ("spiritual aerial") is the sensitivity for the 'dimension of ***mystery***' within the daily routine in a clinic, medical ward, etc. that lies beyond medical ***mastery***. This dimension of mystery is a release from the expectation of omnipotence – from the duty to explain, manipulate or control each and every thing. This competence supports the ability to perceive a sick person as a mystery who deserves respect – despite the urgency of diagnostic procedures and therapeutic attempts.
3. Spiritual Care works by authenticity, in the broad field of *spirituality* (Peng-Keller 2014), which encompasses different religious belongings and even existential, humanistic, and atheistic convictions. This is in tension with clear definition-making (item 1) and provokes ongoing thorny discussions and consensus processes. Conceptual vagueness is, however, not merely a problem but also an advantage: The vagueness of definitions of spirituality is not resolved by theoretical or dogmatic concepts or by empirical "objectivity." In fact, the principal validating criterion of spiritual care is authenticity in a patient-centred dialogue.
4. Spiritual Care works in a symphony of different spiritualities: spiritual quests in the framework of institutionalised religions and "unchurched" spiritual searching. In this pluralistic symphony, the patient's or the carer's spirituality may be more or less specific, e. g. a Carmelite, Ignatian, Zen, or Sufi spirituality.
5. Spirituality works in conflict, discernment, and discourse, not in easily acquired harmony. If there is a too easy or shallow "harmony", this may in fact be a consequence of:
   - hidden normativity: one religious tendency tries to impose its spiritual position and God-image, e. g. a non-conflictual acceptance of God's will
   - lack of rationality in a field which is often considered as purely subjective and arbitrary.
6. Spiritual Care works independently of religion-health research. Certainly, there is growing evidence about associations between religiosity / spirituality and health outcomes, such as quantity and quality of life, coping, and mental health. These associations have to be interpreted in suitable causal networks, taking into account the cultural specificities, e. g. between the US and Europe. However: "Even if religious involvement were completely unrelated to physical health and medical outcomes, however, integrating spirituality into patient care should still be a priority. Because so many medical patients have spiritual needs, spiritual conflicts, or derive comfort from religious beliefs and traditions, this makes a strong argument for training health professionals to assess, respect, and make accommodations for patients' spiritual beliefs and practices. It also emphasizes the importance of having strong Pastoral Care Departments in hospitals to ensure that someone meets the spiritual needs of patients in a way that is sensitive and culturally appropriate" (Koenig 2008: 172–173).

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7. Spiritual Care works beyond clinical goals. As a matter of course, patients as well as health professionals want to attain certain curative or palliative goals, e. g., "improving" a given religious coping, clarifying a relationship towards God or another religious figure. However, Spiritual Care is not about instrumentalizing spirituality for achieving health goals. For example: A plethora of studies shows that churchgoing is associated with better health outcomes. If a doctor "prescribes" churchgoing or other religious activities (Sloan et al. 2000) or if patients "use" churchgoing as they use an anti-hypertension drug or for obtaining more self-control, they might stop going altogether when they notice that churchgoing does not "work" in their case, or less than in other churchgoers'. "If people use religion for the primary purpose of achieving certain health goals, then this is a misuse of religion for non-religious goals and could ultimately lead to disillusionment and the abandonment of religion" (Koenig 2012:466). In the same direction, Spiritual Care "works" in an abusive sense when the reality of human fragility and suffering is denied by esoteric theories and interventions (karmic destiny, certain forms of "faith healing," or intercessory prayer).
8. Spiritual Care works in a network of competencies: The care-providers are chosen by professional role and training, by patients' preferences, and by team-consensus. Spiritual care works by patient-centred role-taking.

Literatur

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Biographische Angaben

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