

Spiritual Sensitivity in Caritas Services: Why and How to Work with the Spiritual Dimension of the Life Situation of Clients¹

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A remote observer might regard opening up the topic of the spiritual dimension, or spiritual needs, of the recipients of Caritas services, i.e., primarily services provided in institutional Caritas facilities,² as redundant for the reason of being absolutely self-evident. In the Catholic Church, service to the needy in the spirit of love (diakonia) is, together with liturgy and kerygma, regarded as an integral part of its mission and an intrinsic expression of its nature.³ The Code of Caritas of the Czech Republic states that spiritual aid is a path to fulfilling its mission.⁴ But numerous signals indicate that the reality of Caritas services is often far removed from this ideal.

This paper aims to present a processual model, which will enable the *personnel* of Caritas facilities to supplement the bio-psycho-social concept of their work with the service recipients with the spiritual component, if it is absent. The qualification of the personnel member (physician, nurse, social worker, therapist, worker in social services, etc.) is not strictly distinguished, although the model does not deny an inclination towards the social work sector, on which it abundantly draws, while there are also overlaps with healthcare.

In what sense do I speak of a model? The issue of spirituality, or of the spiritual needs of recipients of social or healthcare services, is not unknown in contemporary Czech professional literature.

1 This publication was supported by the project Profesionalizace a deprofesionalizace v praxi české sociální práce, reg. no. IGA_CMTEF_2017_010.

2 Assuming the same theological point of departure as the one stated below, the text could also be applied to the diaconic facilities operated by the Evangelical Church of Czech Brethren. Assuming adequate training, it would also be possible in the context of services provided by volunteers.

3 Cf. *Deus caritas est* 25a.

4 © Charita ČR, Kodex Charity Česká Republika, point 1.4 (on-line), at: <http://www.charita.cz/res/data/000077.pdf?seek=1294994736>, accessed 1st February 2017.

Nursing,⁵ social work⁶ and pastoral theology⁷ already have a greater or lesser set of publications at their disposal. But in all cases the texts are concerned with a partial aspect, for example, the content of spiritual needs, measuring the fulfilment of spiritual needs, or a typology of interventions. But no model is offered that would help the personnel of Caritas facilities to incorporate the issue of spirituality into a line of mutually linked practical steps in preparing for practice and actually beginning practice. The mutual interconnection of the individual parts of the model and the author's effort to provide incentives for *direct practice* on the one hand justifies this paper's extent, while on the other hand the paper's content in no way claims to exhaust the issue.

Why?

Reductive Caritas practice?

At the level of mediated experience, I can rely on repeated reports by students of our faculty, who in the course of their professional practice in Caritas facilities more often than not encounter a systematic concept of, for example, work with the spiritual needs of users. This experience has been fragmentarily confirmed by the investigation carried out by a Masters thesis research project under my supervision among eight clients of the field service of one Caritas in Moravia who, upon having carried out so-called spiritual assessment, expressed a certain disappointment: 'I would like the workers to help me also in this [spiritual] sphere', or, 'I am glad to be able to talk to someone about the spiritual things, in the centre there is no one to talk to about this'.⁸

At the level of personal experience, I can point out the breadth of interest with which the offer of further education in this issue is met among employees of Caritas services, who are literally starving for any practical methodological support. Unfortunately, we still do not have empirical data, making it possible to test the generalisation of these partial signals from Caritas facilities. But it is possible to point out other signals from the common milieu of social services, pointing in the same direction.

The absence of integrating the spiritual level of the life situations of social services recipients can also be inferred from the thesis of another Masters student of mine, who tested the usability of spiritual assessment in a set of eight elderly clients in a classical residential facility. She evaluated the acceptance of this kind of work with clients as follows: 'All participants expressed a more than

5 Cf. Erika HAJNOVÁ FUKASOVÁ, Radka BUŽGOVÁ and David FELTL, Hodnocení duchovních potřeb pacientů v paliativní péči, *Klinická onkologie* 1/2015, pp. 13–19; Erika HAJNOVÁ and Radka BUŽGOVÁ, Hodnocení spirituálních potřeb u pacientů s onkologickým onemocněním: Pilotní studie, *Ošetřovatelství a porodní asistence* 4/2013, pp. 708–714; Igor ONDREJKA, Katarína ŽIAKOVÁ and Ivan FARSKÝ, Diagnostika spirituálních potřeb u pacientov, in: *Ošetřovatelská diagnostika a praxe založená na důkazech II*, eds. Radka BUŽGOVÁ and Lucie SIKOROVÁ, Ostrava: Ostravská univerzita v Ostravě, Zdravotně sociální fakulta, 2008, pp. 15–20; Jitka NĚMCOVÁ, Saturace spirituálních potřeb pacientů, *Diagnóza v ošetřovatelství* 1/2010, pp. 26–29; Margaret O'CONNOR and Sanchia ARANDA (eds.), *Paliativní péče. Pro sestry všech oborů*, Praha: Grada, 2005; Radka BUŽGOVÁ and Renáta ZELENÍKOVÁ, Vytvoření měřicího nástroje pro hodnocení potřeb pacientů v paliativní péči v souvislosti s kvalitou života: Hodnocení potřeb pacientů v paliativní péči (PNAP), *Ošetřovatelství a porodní asistence* 2/2012, pp. 404–414; Marie SVATOŠOVÁ, *Víme si rady s duchovními potřebami nemocných?*, Praha: Grada, 2012.

6 Cf. Eva KRÍŽOVÁ, Specific Techniques of Exploring Spirituality as Part of Holistic Social Work, *Czech and Slovak Social Work: ERIS Journal* 4/2016, pp. 50–56; Jan KAŇÁK, Postavení diskursu spirituality v sociální práci, *Sociální práce / Sociálna práca* 4/2015, pp. 30–46; Jan KAŇÁK, Nedefinovaná profesionalita: Vztah diskursů spirituality a profesionality v sociální práci v soudobé odborné literatuře, *Sociální práce / Sociálna práca* 5/2016, pp. 72–91; Věra SUCHOMELOVÁ, Spirituální potřeby seniorů v sociální péči, *Sociální práce / Sociálna práca* 5/2016, pp. 92–108.

7 Cf. Věra SUCHOMELOVÁ, Pastorece v domově pro seniory: vybrané otázky, *Caritas et veritas* 5/2015, pp. 112–121; Věra SUCHOMELOVÁ, *Senioři a spiritualita. Duchovní potřeby v každodenním životě*, Praha: Návrat domů, 2016.

8 © Tomasz GIERCZUSZKIEWICZ, *Použití konceptu duchovního posouzení podle Davida R. Hodge v kontextu sociální práce s osobami bez domova* (on-line), Bachelors thesis, Olomouc: Univerzita Palackého v Olomouci, Cyrilometodějská teologická fakulta, 2013, p. 58, at: <http://theses.cz/id/9fi033/>, accessed 1st February 2017.

positive attitude to using spiritual assessment, noting that they would appreciate if someone asked them about their faith and their needs in this sphere more often.⁹

The results of qualitative research realised with twenty clients of two residential facilities for the elderly in South Bohemia by Věra Suchomelová are even more telling.¹⁰ The findings of her research have uncovered a situation which cannot be regarded as anything but a 'trap', the victims of which are both the social/healthcare personnel and the pastoral workers, if they take part in the provided service at all, and, of course, ultimately the elderly persons themselves. For the personnel erroneously reduce caring for spiritual needs to liturgical situations and contact with a specialised professional – an ordained minister or pastoral assistant. But the clients do not regard such specialised professionals as spiritual conversation partners, with whom they could share life difficulties and existential topics of their life situation, since the pastoral agenda consisted only of Mass, the Eucharist and the Rosary.¹¹

Theoretical prerequisites

In his paper about the discourses of professionalism and spirituality in social work, Jan Kaňák proposed to distinguish five types of their correlation,¹² whereby he recommends that authors publishing in this field always clarify:¹³

- what professional and spiritual discourse means for them;
- from which discourse they enter the topic;
- which of the types of correlation they want to develop.

From the point of view of the discourse of professionalism these requirements can be met only analogically, because the discourse of professionalism in Caritas services is not identical with the discourse of professionalism in social work, since it is not in fact a separate profession, but a specific and broad-spectral sphere of helping practice and helping professions. If within this professional spectrum I choose social work as the reference point, then the reasoning of this study coincides most with the model of *spiritually sensitive social work*, which strives also for a reflexive coping with life and of the clients' social functioning.¹⁴ A recurrent theme of this type of discourse of spirituality in social work is the need to recognise the client's system of orientation in life, i.e., what the client, and not primarily the worker or organisation, regards as important for functioning and coping and then to mobilise these findings and integrate them into an intervention. The way in which the discourse of spirituality is anchored in the nursing setting will be briefly discussed later. There is no doubt that Caritas facilities cannot give up the responsibility to offer a Christian, or even Catholic cultivation of the clients' spiritual dispositions and by means of, for example, sacramental tools, open up space for the Spirit of God to act in human hearts. For only where the Holy Spirit can act in a human being do natural spiritual dispositions reach their final ends. Of course, such supernatural action of the Spirit of God on a human spirit has natural prerequisites, which

9 © Marie SCHREIEROVÁ, Koncept duchovního posouzení podle Davida R. Hodge v českém prostředí při práci s klienty Domova pro seniory v Bruntále (on-line), diploma thesis, Olomouc: CARITAS – Vyšší odborná škola sociální Olomouc, 2015, p. 40, at: <http://theses.cz/id/4i9iho/>, accessed 1st February 2017.

10 See note 6 above.

11 Věra SUCHOMELOVÁ, Pastorační práce v domově pro seniory, p. 113.

12 Spiritually sensitive social worker; spiritual worker inspired by social work; spiritually sensitive social work; spiritually oriented social work; theology sensitive to social work. Cf. Jan KAŇÁK, Nedefinovaná profesionalita, pp. 72-91.

13 Cf. *ibid.*, p. 87.

14 Cf. *ibid.*, pp. 82-84.

must be respected and also cultivated in the sense of the scholastic principle *gratia supponit naturam*, i.e., grace presupposes nature. In that which follows, I want to focus precisely on this anthropological ‘first layer’ and further to outline a set of several tools which – having been mastered by some Caritas workers – could bring about a new level of their service to human beings.¹⁵ In this alignment the presented model is compatible with the holistic conception of Caritas practice.

The holistic conception of Caritas practice

Within the theoretical conceptualisation of Caritas practice, as it is developed by ‘Caritaswissenschaft’ on a scale unparalleled worldwide, in the public declarations of the profile of individual Caritas facilities, which an external observer can easily find in websites under the heading ‘Who we are’ or ‘What we offer’, or in the basic document (Leitbild, Kodex), it is regarded as standard that Caritas practice wants to, and ought to, react to *human needs at all their levels*, including the spiritual ones.

Pompey and Roß implicitly formulate this postulate when they tie together Caritas practice with a ‘multidimensional conception of the human being’,¹⁶ which, according to them, leads to a critical attitude towards various ‘reductive perspectives and models’.¹⁷ Haslinger specifies his requirement for an integral conception of the human being in Caritas practice as a response to all of his needs: bodily, psychological, social and spiritual.¹⁸ None of the authors, however, offers practical incentives, proposals or instructions for fulfilling the requirement.

The postulate of the holistic conception of Caritas practice also nonproblematically correlates with the theory applied in Catholic social ethics, or Catholic social teaching. There the theory of needs is correlated with the conception of *integral human development*, as outlined by the encyclical *Populorum progressio* and updated by the encyclical *Caritas in veritate*. According to the latter, integral human development ‘concerns the whole of the person in every single dimension’.¹⁹ The paradigm of integral human development and not merely of a holistic attitude to human needs seems to me to accord strongly with a further type of discourse correlation, as distinguished by Kaňák: *spiritually oriented social work*, which opens up space for the ‘spiritual transformation of clients’.²⁰ The reasoning and tools developed in this paper can therefore be also partially understood in light of this type of relationship between professional and spiritual discourse.

15 This maxim can be used in the sense that God’s saving action regarding the human being (grace) does not exclude and does not abolish the natural laws of human nature established by God, as we know them in light of the findings in psychology, sociology, biology, etc. The grace of a functional, successful relationship of a human being to oneself, to others, to the created world and to God wants to build on the natural foundations with which the human being is endowed and not to avoid or suppress them. In this sense, the vital religious relationship of the human being to God the Father, through Jesus Christ in Holy Spirit, as Christians formulate it, has its natural spiritual prerequisites, which this paper wants to help to clarify. Cf. Heinrich POMPEY, *Beziehungstheologie: Das Zueinander theologischer und psychologischer „Wirk“-lichkeiten und die biblisch/theologische Kontextualisierung von Lebens- und Leidenserfahrungen*, in: *Caritas – Das menschliche Gesicht des Glaubens: Ökumenische und internationale Anstöße einer Diakoniethologie*, ed. Heinrich POMPEY, Würzburg: Echter, 1997, pp. 92-106.

16 Heinrich POMPEY and Paul-Stefan ROSS, *Kirche für andere. Handbuch für eine diakonische Praxis*. Mainz: Grünewald Verlag, 1998, p. 207.

17 Ibid, p. 186.

18 Cf. Herbert HASLINGER, *Diakonie: Grundlagen für die soziale Arbeit der Kirche*, Paderborn-München-Wien-Zürich: Ferdinand Schöningh, 2009, p. 314.

19 *Caritas in veritate* 11. A related concept is *integral humanism*, as introduced by the *Compendium of the Social Doctrine of the Church* (art. 19).

20 Jan KAŇÁK, *Nedefinovaná spiritualita*, p. 84.

Findings concerning the positive effects of spirituality and religiosity on health and social functioning

In answering the question of why the sphere of the spirituality of service recipients ought to be integrated into Caritas services, one must not neglect the change in climate that has taken place in healthcare and social work in recent decades with respect to the concepts of spirituality and religiosity.

In the sphere of *medical and nursing research*, enormous interest in spirituality/religiosity and their impact on health appeared in the 1980s and especially the 1990s. Even the World Health Organisation (further only WHO), despite the present definition of health, which mentions only its physical, mental and social components,²¹ introduced the *domain of spirituality* into the official tool of evaluating quality of life WHOQOL.²² In 1995, WHO also acknowledged *providing spiritual support* as an essential part of palliative care.²³ WHO is also hosting a debate concerning the so-called *4th dimension of health* and tools for measuring it have already been developed.²⁴

The best illustration of the medical interest in the role of spirituality/religiosity is the *Handbook of Religion and Health* by the American professor of psychiatry Harald G. Koenig and his colleagues. In the first edition, Koenig and his colleagues summarised the results of more than a thousand research studies, which have shown a greater or lesser correlation with various spheres of bodily and mental health.²⁵ In the second edition of 2012, the *Handbook* (in more than 1200 pages) identified over three thousand studies.²⁶ Religiosity and spirituality therefore correlate positively with:²⁷

- increased adaptation to the loss of a close person;
- social support;
- life satisfaction;
- the feeling of happiness, hope and optimism;
- perceiving the meaning and purpose of life ;
- a decreased feeling of anxiety;
- a decreased feeling of desolation;
- a decreased suicide rate;
- a decreased length of psychiatric hospitalisation;
- an increased probability of schizophrenia remission;
- quality of life;
- healthy lifestyle;
- emancipation from drug addiction;

21 Cf. © WORLD HEALTH ORGANIZATION, Constitution of World Health Organization, (on-line), at: http://www.who.int/governance/eb/who_constitution_en.pdf, accessed 1st February 2017.

22 Cf. Margaret HOLLOWAY, Spiritual Need and the Core Business of Social Work, *British Journal of Social Work* 2/2007, p. 266.

23 Cf. Aline NIXON and Aru NARAYANASAMY, The spiritual needs of neuro-oncology patients from patients' perspective, *Journal of Clinical Nursing* 15-16/2010, p. 2260.

24 Cf. Neera DHAR et al., Spiritual Health Scale 2011: Defining and Measuring 4th Dimension of Health, *Indian Journal of Community Medicine* 4/2011, pp. 275-282.

25 Cf. Harald G. KOENIG, Michael E. MCCULLOGH and David B. LARSON, *Handbook of Religion and Health*, New York: Oxford University Press, 2001.

26 Cf. Harald G. KOENIG, Dana E. KING and Verna Benner CARSON, *Handbook of Religion and Health*, 2nd ed., New York: Oxford University Press, 2012.

27 According to David R. HODGE, Spirituality and People With Mental Illness: Developing Spiritual Competency in Assessment and Intervention, *Families in Society* 1/2004, p. 36; Jaro KŘIVOHLAVÝ, *Psychologie zdraví*, 3rd ed., Praha: Portál, 2009, pp. 157-162; Marc GALANTER et al., Assessment of spirituality and its relevance to addiction treatment, *Journal of Substance Treatment* 3/2007, pp. 257-264.

- a lower smoking rate;
- a higher experienced control over own bodily and mental state;
- a lower depression rate;
- higher self-esteem;
- lower blood pressure;
- a lower death rate following a heart operation;
- a higher average lifespan;
- a higher ability to cope with stress.

In the sphere of *social work*, the situation is similar. Up to the 1980s, spirituality and religion were a neglected topic, which some authors ascribe to 'the deep-rooted, historical antipathy towards religion amongst social work in Western societies'.²⁸ Then literally a renaissance of interest appears in literature. The first edition of the representative work *Spirituality and Social Work: A Comprehensive Bibliography with Annotations* by Edward Canda and his colleagues of 1999²⁹ listed 550 publications, and the second edition four years later listed 770 publications, being an increase of 40%.³⁰ In 2000, Hodge compiled the following list of findings concerning the effects of religiosity and spirituality relevant for social work.³¹

A positive association with:

- successful aging;
- satisfying marriage;
- interpersonal friendliness;
- resiliency;
- coping;
- minority leadership;
- post-divorce stabilisation.

A decreased rate of:

- substance abuse;
- mortality;
- illness;
- homelessness;
- sexual assault.

But interest is not growing at the same rate everywhere. As two comparative studies of social workers (1997, 2008) in the USA, Great Britain, Norway and New Zealand have shown, the British or, for example, Norwegian community of social workers is significantly more cautious and sceptical concerning the possibilities of working with clients' spirituality/religiosity, as compared with the community in the USA.³²

28 Margaret HOLLOWAY, *Spiritual Need*, p. 268.

29 Cf. Edward R. CANDIA et al., *Spirituality and Social Work: A Comprehensive Bibliography with Annotations*, Council on Social Work Education, 1999.

30 Cf. Connie KVARFORDT and Michael SHERIDAN, Predicting the Use of Spiritually-Based Interventions with Children and Adolescents: Implication for Social Work Practice, *Currents: New Scholarship in Human Services* 1/2010, p. 2.

31 Cf. David R. HODGE, Spirituality: Toward a Theoretical Framework, *Social Thought* 4/2000, pp. 3-4.

32 Cf. Edward R. CANDIA and Leola Dyrud FURMAN, *Spiritual Diversity in Social Work Practice. The Heart of Helping*, 2nd ed., Oxford University Press, 2010, pp. 370-375.

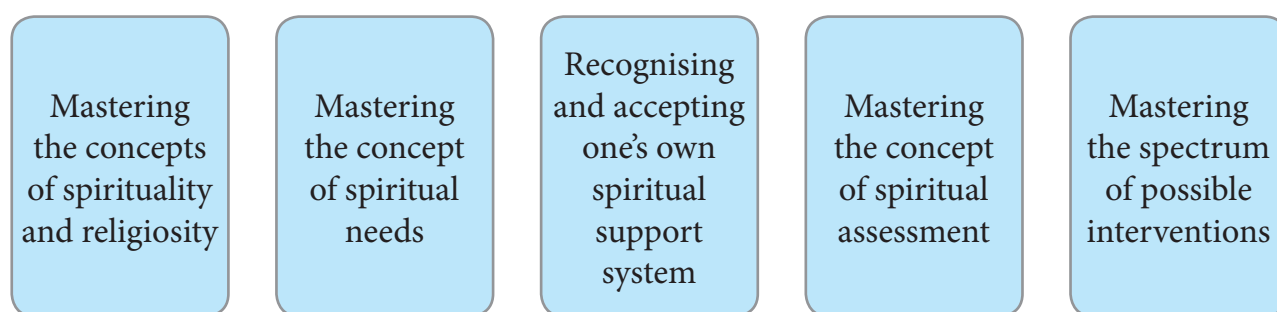
How?

Processual model of spiritual sensitivity in Caritas services

I propose to cultivate the discourse of spirituality in Caritas services so that it contains five partial concepts, which ought to be incorporated into the competency equipment of individual workers in direct practice with clients in the order indicated in Figure 1.

Authors writing in healthcare about the concept of spiritual needs focus mostly on the technical level of the competence of nurses and physicians. Only exceptionally do they reflect upon the prerequisites on the individual level of the workers,³³ and they mention the standard of culture in the organisation most in the form of complaints about the unprepared state of the hospital environment.³⁴ Authors from social work, on the other hand, place significant emphasis on the organisational factors of spiritually sensitive practice.³⁵ Within this distinction between the individual and the organisational level of spiritually sensitive Caritas practice, the model presented below takes into account only the individual level of professional competence.

Figure 1. Diagram of the processual model of implementing spirituality in Caritas services



In introducing the individual components of spiritually sensitive practice to the reader, authors mostly begin with a clarification of the concepts of spirituality and religion (religiosity) in the main current of discourse in the helping professions, especially in social work and nursing.³⁶ This helps to prevent confusion between the two concepts, the resulting limitation of perspective for evaluating the client's life situation, and also facilitates a better orientation in the worker's own spiritual story. Then the workers can be introduced to several models of conceptualising the spiritual and religious needs of clients from different target groups, to whom the particular Caritas facility offers services. A broader spectrum of models and their contents can decrease the risk that workers miss relevant signals and information from the client. After this step, at the latest, workers must be provided with suitable stimuli and space for self-experience focused on recognising and accepting their own spiritual system, of which they can be more or less aware. However, it

33 Daniel Sulmasy requests that a physician takes the following steps: start paying attention, first, to signals coming directly from the patient, second, to the physician-patient relationship, third, to the spiritual lesson implied by the patient's situation also for him, fourth, to his own spirituality and the way how it affects his care of patients, and fifth, to start finding out the patient's spiritual story, cf. Daniel P. SULMASY, Addressing the Religious and Spiritual Needs of Dying Patients, *Western Journal of Medicine* 4/2001, p. 253.

34 'In the anonymous hospital milieu, the spiritual need of the ill is often suppressed [...] Accepting the spiritual dimension of care is still absent in hospitals today', Erika HAJNOVÁ FUKASOVÁ, Radka BUŽGOVÁ and David FELTL, *Hodnocení duchovních potřeb*, p. 18.

35 James R. DUDLEY, *Spirituality Matters in Social Work: Connecting Spirituality, Religion, and Practice*. New York: Routledge, 2016, pp. 105-107, 167-168, 242-247. Canda and Furman summarise their reflection on this organisational setting in the chapter 'Creating a Spiritually Sensitive Context for Practice', cf. Edward R. CANDIA and Leola Dyrud FURMAN, *Spiritual Diversity*, pp. 213-242.

36 'Spiritually sensitive practice naturally begins with understanding the concepts of spirituality and religion', James R. DUDLEY, *Spirituality Matters*, xvi.

would be just as possible to associate this phase with the first step.³⁷ In any case, self-orientation in this dimension of their own life not only increases the workers' empathic sensitivity to the clients, but also helps to prevent situations of counter-transfer, or even manipulation with the client. Only after this preparatory phase is it possible to theoretically and practically master the skill of spiritually evaluating the client's situation, which – according to the chosen perspective – leads to the detection of unfulfilled needs, or of resources on which the client can rely again. Based on such assessment, it is possible to propose, carry out and evaluate suitable interventions. The Caritas worker will be better able to consider and select these based on an overview of the spectrum of interventions reported on by professional literature.

Mastering the concepts of spirituality and religiosity

To consider the possibilities of working with the spiritual dimension of the client's situation, it is necessary to understand the basic notions and concepts. In the discourse of the helping professions, such as nursing and social work, the last two decades have brought the conviction that it is *useful to distinguish* between the notions of spirituality and religiosity.³⁸ Although authors do not agree on a unified definition, the differences in defining the two concepts are not dramatic. Kaňák serves to introduce the reader to the issue.³⁹ An example of distinguishing between the two concepts can be the renowned publication on social work *Spiritual Diversity in Social Work Practice*:

Spirituality refers to a universal and fundamental human quality involving the search for a sense of meaning, purpose, morality, well-being, and profundity in relationships with ourselves, others, and ultimate reality, however understood.⁴⁰

Religion is an institutionalized (i.e. systematic) pattern of values, beliefs, symbols, behaviours, and experiences that are oriented toward spiritual concerns, shared by a community, and transmitted over time in traditions.⁴¹

A similar definition is found in other authors in social work⁴² or medicine.⁴³ The authors mostly agree in conceiving religiosity as a part of spirituality, which is mostly manifested in a religious way, albeit many prefer to express it by their relationship to nature, music, art, sport, to a certain philosophical current, or to friends and family, i.e., in a non-religious and secular way.⁴⁴

The phase of distinguishing between the concepts of spirituality and religiosity can help to pre-

37 As did Edward R. CANDA and Leola Dyrud FURMAN, *Spiritual Diversity*, pp. 59-97.

38 The reference point of this text is not spirituality from the point of view of the Christian tradition and spiritual theology. The Christian and Catholic cultivation of the spirituality of the helper or the helped represents a 'second step', which is not the subject of this paper.

39 Jan KAŇÁK, Postavení diskurzu spirituality, pp. 32-34.

40 Edward R. CANDA and Leola Dyrud FURMAN, *Spiritual Diversity*, p. 59.

41 Ibid.

42 *Religiosity*: '...shared set of beliefs and practices that have been developed and institutionalized in a community context', David R. HODGE and Violet E. HORVATH, Spiritual Needs In Health Care Settings: A Qualitative Meta-Synthesis of Clients' Perspectives, *Social Work* 4/2011, p. 308. *Spirituality*: 'A search for purpose and meaning in life, a sense of being connected with self, others, and the universe, and an ability to transcend our immediate experience to something larger known by many to be a Higher Power beyond human power', James R. DUDLEY, *Spirituality Matters*, p. 4.

43 'Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community', Harald G. KOENIG, Michael E. MCCULLOUGH and David B. LARSON, *Handbook*, p. 18. 'Religion is an organized system of beliefs practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one's relationship and responsibility to others in living together in a community', *ibid*.

44 Cf. Daniel P. SULMASY, A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life, *The Gerontologist* 3/2002, p. 25.

vent situations of *conceptual confusion* of the two concepts, when the client's religious/church membership, if it is actively ascertained at all, is used to infer information about the client's spiritual preferences, wishes, needs and resources.

Mastering the concept of spiritual needs

Caritas workers must be introduced to models of spiritual needs, as they have been distinguished, based on empirical investigations among different target groups of the helping professions. Examples are listed in Tables 1–4. Their common feature is that they effectively illustrate the breadth of what patients and clients themselves regard as spiritual needs compared to the traditional indicators, such as receiving Sacraments or a visit by the hospital chaplain. Of course, it is not merely a matter of memorising the published schemata. The worker will gain a higher competence by becoming familiar with the characteristics of the individual partial needs, illustrations of situations, and the statements, based on which they were recorded, and interrelating these with his own experience of contact with clients.

An important principle of the pedagogy of spiritual needs is the awareness that in a particular patient one must expect an *individual constellation* of needs. Consequently, not every patient experiences all needs. Familiarity with a broader spectrum of published models thus serves especially to stimulate *imagination and sensitivity* to the client's individual situation.⁴⁵

Table 1. *Spiritual needs of South Bohemian elderly*⁴⁶

| |
|--|
| Awareness of one's own dignity and value |
| Of meaning and continuity of life story |
| Of faith and trust |
| Of hope and goal |
| Of love |

Table 2. *Spiritual needs of psychiatric patients*⁴⁷

| | |
|------|------------------------------|
| 90 % | Care and support from others |
| 84 % | Knowing about God's presence |
| 80 % | Prayer |
| 75 % | Purpose and meaning in life |
| 65 % | Chaplain visit and pray |
| 59 % | Visit from clergy |
| 51 % | Relief from fear of death |
| 39 % | Sacraments |

45 Cf. David R. HODGE and Violet E. HORVATH, *Spiritual Needs*, p. 312.

46 According to Věra SUCHOMELOVÁ, *Senioři a spiritualita*, p. 217.

47 Georg FITCHETT et al., *The Religious Needs and Resources of Psychiatric Inpatients*, *The Journal of Nervous and Mental Disease* 5/1997, pp. 320-326.

Table 3. *Spiritual needs in the health care setting*⁴⁸

| |
|---------------------------------|
| Meaning, purpose and hope |
| Relationship with God |
| Spiritual practice |
| Religious obligations |
| Interpersonal connection |
| Professional staff interactions |

Table 4. *Spiritual needs of neurooncological patients*⁴⁹

| |
|---|
| Family support |
| Emotional support |
| Need for connection / loneliness |
| Religious needs |
| The need to talk |
| Reassurance |
| Solitude |
| Plans for the future / a sense of normality |
| Thoughts about the meaning of life |

Caritas workers with a nursing education and in the medical setting of Caritas services can find much support in the concept of *spiritual anxiety/distress*, based on its professional legitimacy. It was first listed in the classification of nursing diagnoses NANDA (North American Nursing Diagnosis Association) in 1980⁵⁰, or in 1978⁵¹. In the newest edition, spiritual distress is defined as ‘a state of distress caused by an impaired ability to live a meaningful life by means of connection with oneself, others, the world or a superordinate being’.⁵² Another definition mentions ‘a state, in which the patient’s system of belief or values, which provides him with energy, hope and meaning of life, is threatened by a disorder’.⁵³ The NANDA manual adds a characteristic of the diagnosis’ key features and a list of related factors. It must further be noted that NANDA provides nursing personnel with an even broader framework for grasping the spiritual dimension of the patient’s situation. The tenth domain, called ‘life principles’, where authors classify spiritual distress, contains characteristics of eleven other relevant diagnoses.⁵⁴

48 David R. HODGE and Violet E. HORVATH, *Spiritual Needs*, pp. 306-316.

49 According to Aline NIXON and Aru NARAYANASAMY, *The spiritual needs*, pp. 2259-2270.

50 Cf. Erika de CASSIA LOPES CHACES et al., *Efficacy of different instruments for the identification of the nursing diagnosis spiritual distress*, *Revista Latino-Americana Enfermagem* 4/2011, p. 903.

51 Cf. Heather HERDMANN and Shigemi KAMITSURU (eds.), *NANDA International: Ošetrovatelské diagnózy. Definice & klasifikace 2015–2017*, 10th ed., Praha: Grada, 2015, p. 340.

52 Heather HERDMANN and Shigemi KAMITSURU (eds.), *NANDA International*, *ibid.*

53 Cf. Stefanie MONOD et al., *The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalised elderly persons*, *BMC Geriatrics* 10:88/2010, p. 1.

54 The effort to increase spiritual well-being; the effort to improve decision-making; conflict in decision-making; impaired free decision-making; the effort to improve free decision-making; moral distress; impaired religiosity; effort to improve religiosity; risk of impaired religiosity; risk of spiritual distress, cf. Heather HERDMANN and Shigemi KAMITSURU (eds.), *NANDA International*, pp. 329-342.

Recognising and accepting one's own spiritual support system

Authors in nursing and social work point out that before a worker starts attending to the spiritual needs or assessment of others, he must become sensitive to his own spiritual system and find his way around it,⁵⁵ since 'understanding and claiming our own spirituality can prepare us to help our clients discover, understand, and affirm their own spirituality'.⁵⁶ It also makes it possible to avoid risks that would disrupt the relationship of trust with the client: superficiality, the appearance of merely fulfilling an obligation, spiritual counter-transfer, proselytising, condemnation, and bias.⁵⁷ Similarly, Svatošová warns that a person 'who is not aware of his own spiritual needs, does not want to be concerned with them, and pays no attention to them' will not be able to recognise this attitude in clients. As soon as the client notices that, he 'withdraws and keeps a distance. He changes the conversation topic, is silent or otherwise manifests a lack of interest in continuing the conversation'.⁵⁸ On the way to this competency, sometimes called 'spiritual competency' by authors in social work⁵⁹, one can use a number of practical instruments of *spiritual self-assessment*. A number of more or less formal instruments to this purpose are available in the literature. To illustrate I will present the set of questions according to Govier:⁶⁰

- *What do I believe in?*
- *What gives my life meaning?*
- *What do I hope for?*
- *Who do I love and who loves me?*
- *What do I understand by the term spirituality?*
- *How am I with others?*
- *What would I change about my relationships?*
- *Am I willing to heal the relationships that trouble me?*

Other questions suitable for the worker's self-reflection are proposed by Anemone Eglin from the Swiss Institut Neumünster; the reader can find them in the summer issue of the journal *Sociální služby* of 2016.⁶¹ Another aid for spiritual self-assessment can be the items of the 'Spirituality Self-Rating Scale' by Galanter et al.; although it was designed primarily for addiction treatment, six of the listed statements do not explicitly mention the addiction situation. In clinical use, the client expresses the level of agreement on a scale of 1 (absolutely agree) to 5 (absolutely disagree):⁶²

1. *It is important for me to spend time in private spiritual thought and meditation.*
2. *I try hard to live my life according to my religious beliefs.*
3. *The prayers or spiritual thoughts that I say when I am alone are as important for me as those said by me during services or spiritual gatherings.*
4. *I enjoy reading about my spirituality and/or my religion.*

55 Cf. James R. DUDLEY, *Spirituality Matters*, pp. 25-49; Miriam GEORGE and Vanessa ELLISON, Incorporating Spirituality into Social Work with Migrants, *British Journal of Social Work* 6/2015, pp. 1721-1722; Ian GOVIER, Spiritual care in nursing: a systematic approach, *Nursing Standard* 17/2000, p. 35.

56 James R. DUDLEY, *Spirituality Matters*, p. 26.

57 Cf. David R. HODGE, Robin P. BONIFACE and Rita Jing-Ann CHOU, Spirituality and Older Adults: Ethical Guidelines to Enhance Service Provision, *Advances in Social Work* 1/2010, pp. 5-6.

58 Both in Marie SVATOŠOVÁ, *Víme si rady*, p. 40.

59 David R. HODGE, Spirituality and People With Mental Illness: Developing Spiritual Competency in Assessment and Intervention. *Families in Society* 1/2004, pp. 39-40.

60 Ian GOVIER, Spiritual care, p. 35.

61 Cf. Anemone EGLIN, Spiritualita v institucích dlouhodobé péče, *Sociální služby* 6-7/2016, p. 38.

62 Marc GALANTER et al., Assessment of Spirituality, p. 263.

5. *Spirituality helps to keep my life balanced and steady in the same way as citizenship, or other memberships do.*

6. *My whole approach to life is based on my spirituality.*

M. Svatošová formulates the instructions for self-assessment not in the form of questions, but of four tasks:⁶³

- acknowledge my desire for love – the desire to love and be loved;
- attempt to make my own life review through the lens of the Parable of Last Judgment;
- accept my life including the givens, the limitations, and my own finitude;
- accept my life including the ‘garbage dump of life’.

Mastering the concept of spiritual assessment: how to detect spiritual needs and resources

Probably the first tools for detecting spiritual needs were designed in connection with the nursing concept of *spiritual distress*. In 1982, O’Brien presented a scheme of the seven components of spiritual distress,⁶⁴ its manifestations, and questions eliciting its detection posed to the patient.⁶⁵ One of the newest tools of this kind was published by a team of Swiss physicians and elaborates on a set of spiritual needs identified in geriatric patients.⁶⁶ Czech and foreign literature offers a number of quantitative structured tools for detecting the spiritual needs of patients; of the foreign ones, let me cite, for example, the 29-item ‘Spiritual Needs Survey’,⁶⁷ the 17-item ‘Spiritual Needs Inventory’ for patients in palliative care,⁶⁸ the 20-item ‘Spiritual Self-Assessment Index for Older Adults’⁶⁹ or the 19-item ‘Spiritual needs questionnaire’ – SpNQ.⁷⁰ The setting of oncological patients gave rise to the Czech tool ‘Patient Needs Assessment in Palliative Care’ – PNAP, which also contains six items from the domain of spiritual needs.⁷¹

But the healthcare community evidently perceives the *limits* of using such questionnaire tools, which consist in their tendency to objectivise that which is essentially relational, in the capacity of grasping only abstract characteristics of persons, and at the risk of insensitivity to the patient’s personal sphere of life.⁷² That is why the authors also recommend using suitable open questions. In Czech literature, a set of questions by authors from the palliative setting has been available for a long time:⁷³

- *Has this disease changed your priorities in any way – for example the places, things and life questions that are important to you?*
- *Has the disease affected your family and other relationships?*

63 Cf. Marie SVATOŠOVÁ, *Víme si rady*, pp. 40-48.

64 Spiritual pain, alienation, anxiety, guilt, loss, anger and despair. Cf. Mary Elisabeth O’BRIEN, *The Need for Spiritual Integrity*, in: *Human Needs 2 and the Nursing Process*, eds. Helen YURA and Mary B. WALSH, Norwalk, CT: AppletonCentury7C-rofts, 1982, pp. 106-107.

65 For example, in case of spiritual pain: ‘Do you sometimes feel pain with respect to your spirituality or faith? Do you feel the pain of insecurity or weak faith?’, *ibid.*

66 Cf. Stéfanie MONOD et al., *The spiritual distress*, pp. 1-9.

67 Cf. Kathleen GALEK et al., *Assessing a Patient’s Spiritual Needs*, *Holistic Nursing Practice* March/April 2005, pp. 62-69.

68 Cf. Carla HERMANN, *Development and Testing of the Spiritual Needs Inventory for Patients Near the End of Life*, *Oncology Nursing Forum* 4/2006, pp. 737-744.

69 Cf. Suzanne STRANAHAN, *Spiritual self-assessment index for older adults*, *Journal of Religion & Health* 47/2008, pp. 491-503.

70 Cf. Arndt BÜSSING et al., *Spiritual needs of patients with chronic pain diseases and cancer – validation of the Spiritual Needs Questionnaire*, *European Journal of Medical Research* 6/2010, pp. 266-273.

71 Cf. Radka BUŽGOVÁ and Renáta ZELENÍKOVÁ, *Vytvoření měřicího nástroje*, pp. 404-414.

72 Cf. Margaret O’CONNOR and Sanchia ARANDA (eds.), *Paliativní péče*, p. 70.

73 *Ibid.*, p. 71.

- *Has the disease changed your view of yourself?*
- *Has the disease changed your view of life?*
- *If so, which priorities are most important for you?*
- *What is your greatest wish or desire in this phase of life?*

The distrust towards the overly normative character of questionnaire tools in the sphere of healthcare is shared by the sphere of social work, where the issue of detecting spiritual needs is standardly treated as *spiritual assessment* and where the aspect of working with the resources and capacities of clients has been asserted since the 1990s. This new perspective also ideally resonates with the discourse of Caritas practice, where authors defend the principal orientation towards the resources and competences of clients:

Since diakonia sees every human being as equipped with positive life resources, it assumes that all who are afflicted with problems possess, at least in principle, a competence of their own to overcome them. At the same time, it does not overlook the fact that these resources and the resulting competence can be strongly limited for various reasons.⁷⁴

The theory, on which the concept of spiritual assessment in social work relies, states that the social worker's task is to identify the client's system of orientation in life, i.e., what the client uses to understand life and find his way around it. Each kind of spirituality and religiosity represents such an *orientation system*.⁷⁵ In situations of stress and difficult life problems the client's orientation system gains importance.⁷⁶ Spirituality (if it is sound) can therefore become an important part of the resources on which the client can, or even must (in the sense of subsidiarity) rely. But often problems overwhelm the client so much that he overlooks his resources and does not appreciate them.⁷⁷ It is therefore important that the social worker gains access to the client's orientation system and helps him to rely on it again. To do that the social worker must carry out a spiritual assessment with the client.

Authors distinguish between several *types of spiritual assessment*, albeit they do not agree on the labels they give to them. Commonly mentioned are two pairs: introductory (short)–detailed and implicit–explicit. The goal of introductory assessment is to find out to what extent the client's spiritual system supports him. Based on information gained from such assessment the worker can estimate what effect the client's spirituality could have on providing the service, i.e., whether the spiritual convictions he holds can work as a barrier or as an advantage,⁷⁸ and whether it would be suitable to follow up with a more detailed conversation, because the client signals that spirituality plays an important part for him, or whether it will be better not to burden the client with any more, because it is not of much relevance to him.⁷⁹

The situation of first contact with the client, when his spiritual interests are expressed, whether verbally or non-verbally, and it is already appropriate to react adequately, can be regarded as a certain kind of preliminary assessment. Dudley mentions two scenarios to illustrate. In the first one

74 Heinrich POMPEY and Paul-Stefan ROSS, *Kirche für andere*, p. 188.

75 Cf. David R. HODGE, *Spiritual Life Maps: A Client-Centered Pictorial Instrument for Spiritual Assessment, Planning, and Intervention*, *Social Work* 1/2005, pp. 77–87.

76 Cf. Kenneth I. PARGAMENT, *The Psychology of Religion and Coping*, NY: Guilford Press, 1997.

77 Cf. Denis SALEEBEY, *The Strengths Perspective in Social Work Practice*, 6th ed., Boston: Pearson, 2012.

78 For example, clients with a particular spiritual conviction may prefer not to take part in certain types of group therapy, Moslems may reject being examined by a physician of the opposite sex, while clients with schizophrenia can be helped along the path of healing by active participation in the life of an ecclesial community, cf. David R. HODGE, *A Template for Spiritual Assessment: A Review of the JCAHO Requirements and Guidelines for Implementation*, *Social Work* 4/2006, pp. 319–320.

79 Cf. Edward R. CANDIA and Leola Dyrud FURMAN, *Spiritual Diversity*, p. 263; David R. HODGE, *A Template*, p. 319.

he challenges the reader to reflect:⁸⁰

Client: 'Prayers are so important to me in getting through my day. Are you allowed to pray with me in this session?'

Question: How would you feel about this question? What could you say that would be engaging the client to share the meaning and importance of prayer to her?

In the second illustration, he also mentions a possible suitable reaction by the worker:⁸¹

A homeless man openly carries his Bible into the interview with the intake worker. He refers to his Bible as his only important possession.

Worker: I see that the Bible seems to be really important to you.

Client: Yes, I use it all the time.

Worker: Would you like to share how it helps you? I am interested in hearing about it.

Client: I read special verses in it when I am having problems.

Worker: Feel free to bring your Bible into our discussions whenever you think it can help us in our efforts to find you housing.

For the purposes of a brief/introductory assessment it is possible to mention the four-question scheme designed according to the strict requirement of JCAHO⁸², the largest and most influential accreditation agency for healthcare facilities in the USA, which in 2001 laid down the carrying out of spiritual assessments of patients as a condition of facility (hospital) accreditation:⁸³

1. *I was wondering if spirituality or religion is important to you?*
2. *Are there certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?*
3. *I was also wondering if you attend a church or some other type of spiritual community?*
4. *Are there any spiritual needs or concerns I can help you with?*

Also classified under the type of short, yet explicit assessment is a set of questions labelled MIM-BRA⁸⁴ by its authors. As in the case of the preceding model, its advantage is that it does not create pressure, is intended for time-limited situations of working with the client when it is necessary to find out quickly whether spirituality is important and relevant for his situation, and then to decide whether the worker will address this resource with the client directly, or whether he will pass it over to another worker:⁸⁵

I am interested to know what is most meaningful and important in your life which might be relevant to our work together. Please feel free to respond or not respond to the following questions in any way that makes sense to you.

1. *What helps you to experience a deep sense of meaning, purpose, morality, hope, connection, joy, or peace in your life?*
2. *Are spirituality, religion or faith important to you? Please explain why or why not.*
3. *Are you a member of any groups or communities (such as a religious group, support group,*

⁸⁰ James R. DUDLEY, *Spirituality Matters*, p. 155.

⁸¹ Ibid, p. 157.

⁸² Joint Commission on Accreditation of Healthcare Organizations.

⁸³ David R. HODGE, *A Template*, p. 319.

⁸⁴ This stands for: Meaning, Importance, Membership, Beliefs, Relevance, Action.

⁸⁵ Edward R. CANDA and Leola Dyrud FURMAN, *Spiritual Diversity*, p. 267.

or cultural group) that give you a sense of belonging and help you find meaning and support in life? Please explain.

- 4. Please describe any important beliefs, practices (such as prayer, meditation, rituals or holistic therapies), or values that shape your understanding and response to your current situation.*
- 5. From what we have discussed so far, what, if anything, is relevant to your current situation and your goals for our work together?*
- 6. Is there anything we have discussed that you would like us to act upon in our work together? For example, is there anything that has been helpful that we could apply, or unhelpful, which we should avoid or deal with? Are there close friends, relatives, mentors, clergy, or spiritual teachers whom I should be aware of or contact? Thank you.*

If the client's reactions to these questions indicate the presence of a spiritual perspective in his situation, the worker can proceed to a detailed assessment, which can use either spiritually implicit or spiritually explicit language. Especially in a strongly secularised environment it may be appropriate to use implicit spiritual assessment, which is the least invasive and uses open questions on spiritual issues, employing mundane, non-religious language. The questions may be arbitrarily adjusted to the client's vocabulary and their number and order is not important. As an inspiration for social workers, Canda and Furman have formulated twenty-two such questions, for example:⁸⁶

- What currently brings a sense of meaning and purpose to your life?*
- What helps you feel more awake and focussed?*
- Where do you go to find a sense of deep inspiration or peace?*
- When do you feel times of great peace, joy, and satisfaction with life?*
- What are the most important sources of strength and help for you in getting through times of difficulty or crisis?*
- Please describe some recent experience when you felt a sense of important new insight, such as an 'aha' moment?*
- Who are your most important mentors, and why?*
- For what are you most grateful?*
- What are your most cherished ideals?*
- Who is most important in your life?*

D. Hodge organised questions for implicit assessment according to the client's timeline: past, present and future spirituality. Of the set of forty questions I have selected examples, due to the limited space of this paper:⁸⁷

Spiritual past

- As you consider your life, what accomplishments are you particularly proud of?*
- When were you happiest (or most joyful)?*
- How did you cope with challenging situations in the past?*

Present spirituality

- When do you feel most fully alive?*
- What causes you the greatest despair/suffering?*
- What things are you most passionate about in life?*

⁸⁶ Ibid., p. 266.

⁸⁷ David R. HODGE, Implicit Spiritual Assessment: An Alternative Approach for Assessing Client Spirituality, *Social Work* 3/2013, p. 227

- Who/what do you place your hope in?
- For what are you most deeply grateful?
- What are your deepest regrets?
- Where do you find a sense of peace (or inspiration)?
- What sources of strength do you draw on to keep pressing forward?
- To whom/what are you most devoted?
- Who best understands your situation?

Future spirituality

- What are you striving for in life?
- Why is it important that you are here in this world?
- How would you like people to remember you after you are gone?

For the purposes of detailed and explicit assessment, the authors offer a broad range of tools, which help to structure the conversation,⁸⁸ or make use of elements of visualisation. Hodge has developed and published five such tools in all:⁸⁹

- spiritual history – a verbal description of the client's spiritual story;
- spiritual life map – comprises the same but makes use of a pictorial format and is therefore suitable for artistically skilled and reserved clients;
- spiritual genogram – maps the development of spirituality across at least three generations and is appropriate where the wider family plays an important role in the client's situation;
- spiritual ecomap – represents the client's present, his existential bonds to key spiritual variables in his milieu and is therefore more suitable for clients who find little interest in looking back at the past;
- spiritual ecogram – combines the advantages of the traditional genogram and an ecomap and allows the social worker to inquire into the relationships between past and present influences.

Rules and prerequisites of spiritual assessment

The authors formulate a whole number of conditions and recommendations that must be met in order to detect spiritual needs and realise spiritual assessment.⁹⁰ Due to the format of this paper I will only provide very brief information.

- The client's *autonomy* must be cherished. In the professional mandate it is impossible, even in Caritas services, to impose the spiritual notions of someone else on the client. However, the mandate may include the offer to reflect with the client on the risks of his spiritual system.
- One must remain within the limits of one's *own competence*. Spiritual assessment aims to identify the needs and resources that can potentially prevent or help the client to cope with his life situation. The goal is not to provide the client with spiritual guidance, which is the domain of ordained clergy and pastoral workers.

88 Cf. Edward R. CANDA and Leola Dyrud FURMAN, *Spiritual Diversity*, pp. 379-383.

89 Cf. David R. HODGE, *Spiritual Life Maps*, pp. 77-87. David R. HODGE, *Spiritual Ecograms: A New Assessment Instrument for Identifying Clients' Spiritual Strengths in Space and Across Time*, *Families in Society* 2/2005, pp. 287-296; David R. HODGE, *Spiritual Assessment in Marital and Family Therapy: A Methodological Framework for Selecting from among Six Qualitative Assessment Tools*, *Journal of Marital and Family Therapy* 4/2005, pp. 341-356; David R. HODGE, *Developing a Spiritual Assessment Toolbox: A Discussion of the Strengths and Limitations of Five Different Assessment Methods*, *Health & Social Work* 4/2005, pp. 314-323.

90 Cf. Vincent STARNINO, Sachiko GOMI and Edward CANDA, *Spiritual Strengths Assessment in Mental Health Practice*, *British Journal of Social Work* 4/2012, pp. 858-861; David R. HODGE, *A Template*, pp. 320-323; David R. HODGE, Robin P. BONIFACE and Rita Jing-Ann CHOU, *Spirituality and Older Adults*, pp. 3-10; Edward R. CANDA and Leola Dyrud FURMAN, *Spiritual Diversity*, pp. 213-222.

- Spiritual needs are always fulfilled in the context of a relationship. Therefore, the starting point and prerequisite is the forming of a *helping relationship* with its classical parameters (so-called common factors), such as empathy, genuineness, unconditional acceptance, warmth, etc.⁹¹ A helping relationship with such parameters already is implicitly spiritual.⁹²

Mastering a spectrum of possible interventions

The foreign literature on social work presents a rich resource of information on what procedures and interventions are used by social workers, both at the level of direct work with the client (micro) and at the level of working with organisations and communities (macro).⁹³ Thanks to the careful analysis of Jan Kaňák, several dozen of these are available to Czech readers and Caritas workers⁹⁴ so I will not elaborate on them here. Introducing the options aims to weaken possible prejudices concerning the incompatibility of spiritually based and spiritually oriented procedures with the professional mandate, and further to stimulate creativity and reflection on which of the procedures would be applicable in the individual situation of the worker's mandate and the client's life situation.

For healthcare-based Caritas workers, it will, without doubt, be more useful to point out the possibilities of procedures corresponding to their competences. In this respect, one must not omit the study realised by Roberta Cavendish and colleagues.⁹⁵ Of a total of 404 nurses, 18% (97) reported using 34 types of 'spiritual care activities' with the patients and themselves. The investigators then matched the reported activities with the categories (labels) and activities described in the 'Nursing Interventions Classification' – NIC.⁹⁶ Of the ten detected categories⁹⁷ I will cite activities of the first two for illustration:⁹⁸

Facilitating spiritual growth

- *Encourage conversation that assists the patient in sorting out spiritual concerns;*
- *Offer individual and group prayer support, as appropriate;*
- *Encourage participation in devotional services, retreats, and special prayer/study programmes;*
- *Promote relationships with others for fellowship and service;*
- *Encourage use of spiritual celebration and ritual;*

91 John C. Norcross, a respected investigator in the field, cites the following set of parameters of a therapeutic relationship: empathy, alliance/cohesion, agreement in cooperation goals, positive interest (unconditional acceptance), congruence, feedback, restitution of alliance breakdowns, self-disclosure of the therapist, management of counter-transfer and quality of relationship interpretations, cf. John NORCROSS, *Therapeutic Relationship*, in: Barry L. DUNCAN et al. (eds.), *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd ed., Washington DC: APA, 2010, pp. 113-141.

92 It must be noted that according to survey results, the effect of psychotherapy depends by 7-30% on the quality of the helping relationship, cf. Edward R. CANDIA and Leola Dyrud FURMAN, *Spiritual Diversity*, p. 214.

93 Edward R. CANDIA and Leola Dyrud FURMAN, *Spiritual Diversity*, pp. 314-361; James R. DUDLEY, *Spirituality Matters*, pp. 205-268; David R. HODGE, *Spiritual Life Maps*, pp. 77-87; Michael J. SHERIDAN, Predicting the Use of Spiritually-Derived Interventions in Social Work Practice: A Survey of Practitioners, *Journal of Religion & Spirituality in Social Work* 4/2004, pp. 5-25; Connie KVARFORDT and Michael SHERIDAN, Predicting the Use of Spiritually-Based Interventions with Children and Adolescents: Implication for Social Work Practice, *Currents: New Scholarship in Human Services* 1/2010, pp. 13-17; David R. HODGE and Robin P. BONIFAS, Using Spiritually Modified Cognitive Behavioral Therapy to Help Clients Wrestling with Depression: A Promising Intervention for Some Older Adults, *Journal of Religion & Spirituality in Social Work: Social Thought* 3/2010, pp. 185-206; David R. HODGE, *Spirituality and People With Mental Illness*, pp. 41-42.

94 Jan KAŇÁK, *Nedefinovaná profesionalita*, pp. 81-85.

95 Roberta CAVENDISH et al., *Spiritual Care Activities of Nurses Using Nursing Interventions Classification (NIC) Labels*, *International Journal of Nursing Terminologies and Classifications* 4/2003, pp. 113-124.

96 Cf. the newest edition Gloria M. BULECHEK et al. (eds.), *Nursing Interventions Classification (NIC)*, 6th ed., St. Louis: Elsevier-Mosby, 2013.

97 Facilitating spiritual growth, spiritual support, presence, active listening, humour, touch, therapeutic touch, self-awareness enhancement, referral, music therapy.

98 Roberta CAVENDISH et al., *Spiritual Care Activities*, pp. 119-120.

- *Provide an environment that fosters a meditative/contemplative attitude for self-reflection*
- *Refer to support groups, mutual self-help or spiritual based programs, as appropriate;*
- *Refer to pastoral care or the primary spiritual caregiver as issues warrant.*

Spiritual support

- *Encourage chapel service attendance, if desired;*
- *Encourage the use of spiritual resources, if desired;*
- *Provide desired spiritual articles, according to patient preferences;*
- *Facilitate the patient's use of meditation, prayer, and other religious traditions and rituals;*
- *Listen carefully to the patient's communication, and develop a sense of timing for prayer or spiritual rituals;*
- *Assure the patient that the nurse will be available to support the patient in times of suffering;*
- *Be open to the patient's feelings about illness and death.*

Conclusion

A brief look into the discourses of social work and healthcare, i.e., the two reference fields on which the contemporary practice of Caritas services relies, has shown enormous interest in investigating and integrating the concept of spiritual needs and associated concepts, such as spiritual distress, spiritual resources, spiritual (self-)assessment, etc. In the sense of the theological premise '*gratia supponit naturam*', a healthy Caritas practice can, and in fact to some extent and form must, rely on these findings and competences, must employ them, begin to critically reflect upon them, and further publish the results of the experience. Only then can it hold of Caritas services, in an analogy to medicine, that they are provided '*lege artis*'. With respect to the spiritual needs and resources of service recipients in Caritas facilities it is not legitimate to choose the strategy of creating taboos or of passing the buck and hastily delegating to clergy, chaplains, pastoral workers and other subjects of exclusive competences. So far, practical theology has not provided Caritas workers with incentives for realising services in such a quality that would also integrate the spiritual dimension of the life situation of the recipients. The presented model of subsequent steps in the preparation and practice of Caritas personnel wants to pay off that debt in part. Many aspects standardly associated with elements of the presented model have not been treated at all, or only marginally (ethical rules for assessment and interventions, evaluation of interventions, etc.), and require further reflection, as well as the organisational setting, which can effectively stunt, or facilitate, the application of spiritually sensitive Caritas practice.

Spiritual Sensitivity in Caritas Services: Why and How to Work with the Spiritual Dimension of the Life Situation of Clients

Abstract

In a society where traditional churches have lost their monopoly on defining the conditions of human spiritual life, Caritas facility workers, as well as workers in other church-operated helping organisations, can feel baffled as to how they are to fulfil the postulate of a holistic approach to the life situation of their clients and patients, not confound the concepts of spirituality and religion, and make use of their professional competences framework also with respect to the spiritual dimension of the life of the service recipients. This paper presents practical incentives to this end. First it legitimates the effort of Caritas workers to incorporate work with the spiritual dimension of their clients by means of reference to discourses conducted in practical theology, healthcare and social work. Then it presents a processual model of the preparation and practice of Caritas workers, comprising five phases: (1.) mastering the concepts of spirituality and religion, (2.) mastering the concept of spiritual needs, (3.) acknowledging and accepting own spiritual support system, (4.) mastering the concept of spiritual assessment, and (5.) mastering a spectrum of possible spiritually sensitive interventions. The individual phases of the model are interpreted and illustrated by means of reference to the sphere of healthcare and social work.

Keywords: spirituality, Caritas, social work, spiritual needs, spiritual assessment, practical theology

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