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Spiritual Care / Counselling / Religious Coping

1 Introduction

The content of this chapter stems from my work as a practical theologian engaged in teaching, supervision, and research and in spiritual caregiving practice. Further, that work has been enriched in diverse contexts in which I lecture and enjoy collegial collaboration in Canada, the United States, Latin America, and Europe. One common, general observation correlates the transition in nomenclature – from ‘pastoral’ to ‘spiritual’ care – increasingly explicit in health care centers and educational programs, with ongoing sociocultural developments in religion and spirituality in late modern societies as highlighted below.

Attention to the related processes of deinstitutionalization and pluralization helps us to appreciate the significance of social changes taking place in our times while also illumining the challenges and opportunities of caregiving in multifaith and multicultural contexts. ‘Deinstitutionalization’ refers to the process in which the traditional religious institutions, especially Christian, lose control over the religious and spiritual dimensions of society and culture. ‘Pluralization’ refers to the increasing diversity of religious and spiritual traditions and perspectives. ‘Multifaith’ is here used descriptively to denote the presence of a plurality of faith traditions (that is, religious and non-religious, such as Humanism) in a given social context; it should not be confused with ‘interfaith’, a term that connotes dynamic interaction between persons of different faith traditions.

Connected to deinstitutionalization and pluralization we encounter more and more frequently people self-defined as “spiritual but not religious” (Mercadante 2014) together with increased religious and spiritual fluidity and hybridity (Bidwell 2018). Further and, to some extent, in response to those trends within the overarching socio-economic and cultural globalization process underway, we also recognize the presence of religious fundamentalism (Antoun 2008; Armstrong 2001). This is the

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1 Those countries include Argentina, Brazil, Colombia, Dominican Republic, Cuba, Guatemala, Mexico, Paraguay, Puerto Rico, and Uruguay.
2 Visiting scholar and lecturer, VU University Amsterdam; active member of the Gesellschaft für interkulturelle Seelsorge und Beratung-Society for Intercultural Pastoral Care and Counseling; and the International Association for Spiritual Care.
3 Major recent books in these areas include the following: Federschmidt, Hauschildt and Schneider-Harpprech (2002); Schipani and Bueckert (2009); Weiß, Federschmidt and Temme (2010); Schipani (2013); Schipani, Walton, and Lootens (2018); Noth and Kohli Reichenbach (2019); and Snodgrass (2019).
case especially, though not exclusively, among Christians and Muslims, including specific challenges to counseling, chaplaincy, and psychotherapy as spiritual care work.  

It is with awareness of such complex and challenging realities that I invite the readers to reflect on spiritual care. I do so by employing a practical theology framework with its fourfold epistemological structure and methodological dimensions: empirical-descriptive, interpretive, normative, and pragmatic-strategic.\(^5\) That structure and those dimensions characterize the case study method as a way of doing qualitative empirical research (Schipani 2014).

The remainder of this chapter has two main sections. The first one consists of a case study from chaplaincy practice; it is the story of an atheist caregiver who discovers the value of prayer in an interfaith encounter. That chaplain’s testimony is examined as an exercise of practical theology. The second section of the chapter addresses the search for common ground in spiritual care as a discipline. It does so by highlighting unique contributions of spiritual caregivers and the necessary place and role of interdisciplinary perspectives; it also proposes a four-dimensional framework for spiritual care theory and practice.

### 2 Case Study: An Atheist Prays with Hospital Patients and Relatives

Sally Fritsche’s reflection on her personal story and her vocation as a spiritual caregiver (2018) supplies an interesting window to the promise and possibilities of a transcultural and transreligious approach to spiritual care. Following the excerpt that documents her transforming encounter with the family of a dying man will be a brief analysis of her experience:

Meeting Ernesto was the beginning of a shift in my feelings on how an atheist might pray. [...] It was one of my first shifts as a chaplain at Brigham and Women’s Hospital in Boston, and a nurse called to say that a Catholic man was nearing the end of his life, and his family wanted someone to come say some prayers. I was the only chaplain on call, so I went. The small hospital room was crowded with easily 15 people, Ernesto’s bed in the center. His wife was there, his children and cousins and brothers, his grandchildren. I was prepared to hold their sadness and anger, to offer support and affirmation of their grief. But I couldn’t imagine how I was going to pray. I didn’t want to lie to these people. They want me to talk to God for them, but won’t a prayer from me be empty? Won’t the words come out meaningless? Won’t it feel like a lie on my tongue? But a dozen pairs of teary eyes turned to me. I invited everyone to gather close and reach out for each other and, together, we prayed the Hail Mary, the Our Father, and prayed for whatever

\(^4\) For example, Muslim practical theologian Nazila Isgandarova (2019) addresses the challenge of certain implications of Islamic fundamentalism in connection with domestic violence.

\(^5\) The fourfold epistemological structure and methodological dimensions and tasks of practical theology are well described and illustrated by Richard Osmer (2008).
comes next to come with peace and overwhelming love. And those prayers, those prayers were far from empty. I came into the room wanting to help and expecting to feel helpless. I came with skepticism, ready to say the words of Catholic prayers if they wanted them, but not expecting those words to come from my heart, or to become a truly spiritual experience. But joining my voice with the sobs of those at their father’s deathbed, and saying the words, “Our Father, who art in heaven ...” I didn’t have to believe we were talking to God to see something real in that. Those prayers were deeply healing, not just for the believers in the room, but for me, too. (Fritsche 2018)

2.1 Description

Sally Fritsche is an atheist chaplain who grew up Unitarian Universalist. She had been encouraged to experiment with prayer, meditation, and different kinds of spirituality:

I went to church, to mass, to Hindu temple, to synagogue, and to my mid-Missouri town’s lone mosque. And [...] I loved it. I loved religion wherever I found it. I coughed through the incense, fumbled the right-to-left prayer books, and soaked in the powerful peace that can happen when faith communities come together. The problem was, when I looked honestly into my own heart, there just wasn’t any ‘religion’ there in the way I had been taught to think about it. When it comes down to it, I lack, quite simply and sincerely, any belief in God, an afterlife, or anything not earthly, observable. [...] I never intended to be an atheist, but here I am. My love of religion, my commitment to religious community, and my personal atheism exist side by side, deep and unforced, beliefs that I find written into my very bones. (Fritsche 2018)

Sally has always loved religion but has never prayed as a religious practice. She always viewed prayer critically and had been convinced that she could never pray. It would be expected, therefore, that prayer and praying would present a special challenge both personally and professionally. Again, in her own words:

Given my non-belief, prayer has never meant a lot to me. Can an atheist pray? Or perhaps more importantly, why would an atheist want to? [...] when I came to terms with my lack of belief in God, I never felt like I was missing out on much by missing out on prayer. Even the more thoughtful approaches to prayer haven’t gotten through to me. [...] [W]ith no God, what’s the difference between prayer and just reflecting on a concept in the privacy of your own head? And when I need help, or want to express gratitude, it would feel silly to turn to a listening ear I don’t believe actually exists. Why pray when no one’s there to hear me? So, prayer, I’ve gradually come to realize, just isn’t for atheists like me. And that’s fine. There are other ways I connect to the sublime and the sacred, but without a belief in God, prayer can’t really be one of them. (Fritsche 2018)

2.2 Interpretive Analysis

Sally recognizes that her encounter with Ernesto and his Catholic family was a turning point for her, both vocationally and professionally. She discovered that she can
actually pray meaningfully and, in her words, “from the heart” in ways that are timely and effective. Let us consider what was going on, and why, by listening to her own way of making sense of the experience:

So what, exactly, was happening when I prayed for Ernesto and his family? This isn’t a conversion story about an atheist who sees the error of her ways and the power of the Lord. I wasn’t praying to any God, but I was praying. And there was something powerful happening in that room. Something about the end of a life, the family’s intense need, the connection formed when they reached for me, the chaplain, asking me to carry their sadness and their hopes, asking me to help them put it all into words and to tell their God what they need. Ernesto and his family were the first people I prayed for in the hospital, but they were far from the last. In my work as a chaplain, I have become almost comfortable offering sincere prayers for peace, for healing, and for God’s presence in patients’ lives. I had thought that my own theology would get between us and turn those prayers into lies. But when I open my mouth, the particulars of my own beliefs become enormously unimportant. [...][W]hen I am praying for a patient in the hospital, it’s not about me. The prayer is theirs, and I am just the conduit for their deep need. [...] Their prayers flow between us in those terrible moments of loss and diagnosis and anxiety, and I speak them into the world. Not for God to hear, as far as I am concerned, but for us to hear. I never thought I could truly pray because there’s no one listening. But here, someone is listening. Those words of gratitude and love and hope are heard by those who most need to hear them. Heard by Ernesto, and his family, and by me. Those prayers are powerful, and those prayers were prayed by an atheist. (Fritsche 2018)

2.3 Evaluation

In light of Sally’s testimony, we might say that the encounter with Ernesto’s family mobilized her compassion and passion as a spiritual caregiver. She was able to engage that family spiritually and connect with them deeply and in their (not her!) terms. In her reflection of spiritual practice, Sally focused on the nature and the role of prayer. She says:

Christian prayer is different from Muslim prayer, is different from Buddhist prayer, is different from Jewish prayer. And I hadn’t thought atheist prayer was a thing that could exist. But this, speaking aloud the prayer of another and lending my voice and the strength of my heart to the belief of someone who needs to feel their God listening, this I can do. The prayer that I pray is an articulation of our connection, a deep investment in the lives and beliefs of fellow human beings. Prayer cannot bring water to parched land, nor mend a broken bridge, nor rebuild a ruined city, but prayer can water an arid soul, mend a broken heart, and rebuild a weakened will. [...] Sometimes, being in community is more important than being in agreement. [...] I no longer run from prayer. I am learning something. Can an atheist pray, and why would she want to? After today, let the answers to these questions be a little less clear, and let us remember how it can feel to pray the prayers of others with our whole hearts, to stop trying, for half a breath, to make a prayer fit neatly into our theology, and just let it come. To open ourselves up to some change, to pray heartily, and to learn something. (Fritsche 2018)

It is apparent that the caregiving situation was transformational for the spiritual caregiver. Sally became a better chaplain! Significantly, she reports having experi-
enced healing. Regarding vocational growth, Sally experienced enhanced understanding, deepening “therapeutic love”, and strengthened professional competence. In other words, the assessment of Sally’s spiritual caregiving competence may be seen in light of a normative framework of holistic competence, as follows: academic-interdisciplinary formation and growth (competencies of ‘knowing’), personal formation (competencies of ‘being’), and professional formation and growth (competencies of ‘doing’).⁶

The account of Sally’s caregiving encounter with Ernesto’s family illustrates key features of appropriate and effective spiritual care practice. Regarding the action and content of her praying, we might say that, for the care receivers, they were both “psychologically functional” and “theologically appropriate” (van Deusen Hunsinger 1995, 130–145); they were fitting as far as the family’s religious beliefs and spiritual practices were concerned. Put in terms of the psychology of religion and spirituality, the chaplain had facilitated ‘positive religious coping’.⁷ The relationship that was co-created by caregiver and care receivers made it possible for those experiencing anticipatory grief to create meaning in the face of Ernesto’s impending death, to garner emotional control, to acquire comfort by virtue of a sense of closeness to God, and to achieve closeness with each other. Actually, all of those outcomes are indicators of what we might call healthy spirituality. That claim calls for further discussion of the place and role of interdisciplinary views in psycho-spiritual assessment, as proposed below.

### 3 Interdisciplinary Perspectives on Psycho-Spiritual Assessment

One way of exploring the question of ‘healthy’ and ‘toxic’ spiritualities consists in studying them with an interdisciplinary approach that includes psychological and theological norms, as suggested in the diagrams that follow. Readers should keep in mind that on this point I write explicitly as a Christian practical theologian. My practice and theory of spiritual care always reflect my theological grounding, including normative claims regarding the nature of reality and of human wholeness, health and healing, and related concerns. In reality, all spiritual caregivers must competently address and respond to those and related questions whether or not they identify with a given religious tradition, as in Sally’s case. Even though we (spiritual caregivers) will not impose our normative views and criteria on care receivers, our normative criteria will always be operative in all forms of assessment and therapeutic approach.

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⁶ For a presentation of a competency profile including formation pedagogies, see Schipani (2017b, 134–144).
⁷ The categories ‘positive religious coping’ and ‘negative religious coping’ are described and illustrated thoroughly in Kenneth I. Pargament’s work (1997; 2007).
It is precisely because of that grounding that I deem the outcome of Sally’s care for Ernesto and his family as ‘theologically adequate’ while focusing on the religious faith and the response of the care receivers. Furthermore, I can also assess Sally’s work theologically from my perspective. In light of my theological framework (especially Christological and Pneumatological theology), I view and interpret it as an event in which Sally became a partner, not only with Ernesto’s family, but also with the Spirit of God, regardless of her desire for or awareness of such partnership. It is also possible that Ernesto’s family considered Sally as an instrument of divine grace in light of their Christian faith.

Depending on the epistemological place given to theology (or another worldview and ethical framework) in connection with psychology, theological criteria and judgment may determine *a priori* that some spiritualities can never be ‘healthy’ even if they are psychologically functional (integrating), as in the case of options [2] and [6] in the diagram below. Conversely, theological norms may determine that certain spiritualities are ‘healthy’ (or faithful, from a certain theological perspective) despite their possibly being psychologically dysfunctional, as in options [3] and [7] in the diagram. It is obvious that spiritual care providers must always be able to assess spirituality and to help people access their spiritual resources in the direction of healthy integration (for instance, by moving beyond ‘negative religious coping’). (Schipani 2017a, 82, including diagram)

**Table 1:** Norms and Criteria for Interdisciplinary Assessment, © Daniel S. Schipani.

<table>
<thead>
<tr>
<th>theologically adequate</th>
<th>theologically inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>psychologically functional</strong></td>
<td><strong>psychologically dysfunctional</strong></td>
</tr>
<tr>
<td>1. life-giving, community-building spiritualities</td>
<td>2. spiritualities connected with “Prosperity Gospel,” or with fundamentalism</td>
</tr>
<tr>
<td>3. spiritualities that see the self-limiting Divine as a benevolent partner in one’s suffering and in one’s healing process; God is closely present with compassion, in solidarity. <em>Positive religious coping:</em> emotional-spiritual comfort; strength, peace</td>
<td>4. spiritualities that see a micromanaging God as one who “knows better… has a plan for my life… is testing me… I suffer here but will be compensated in heaven… I’ve been chosen for this test” <em>Positive religious coping:</em> meaning and purpose clarified; “blessing in disguise”</td>
</tr>
<tr>
<td>5. prophetic spirituality confronted as antipatriotic</td>
<td>6. spirituality of People’s Temple that led to mass suicide</td>
</tr>
<tr>
<td>7. spiritualities that see God as “just and wise, and has made us free…. We face the consequences of that freedom [accident, illness]” <em>Negative religious coping:</em> increased sense of vulnerability, weakness, diminished hope</td>
<td>8. spiritualities that see a micromanaging God as one who “is punishing me… has abandoned me… I’m not worthy of God’s love” <em>Negative religious coping:</em> increased angst, guilt, isolation, despair</td>
</tr>
</tbody>
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4 Application

4.1 Interdisciplinary Understanding of a Spiritual Care Practice

We can apply the same kind of analysis to our spiritual care practices (Schipani 2017a, 83). Let us consider, for instance, the case of praying during a counseling session or a hospital visit and let us assume that the prayer was either requested by the patient or gladly welcomed when offered by the spiritual care provider. Of course, there are many ways of praying wisely for a care receiver whether in a counseling setting or in a health care center. We might say that, in all instances, prayers, blessings, or our words of support and guidance in the face of crisis should be sources of comfort or healing; they must communicate a deep spiritual-theological truth (e.g., the sustaining presence of Grace, however understood or defined, in all circumstances). At the same time, such prayer must be mentally and emotionally helpful (e.g., by fostering trust and hope in the face of anxiety and fear, by including the health care team and the family, etc.). Regrettfully, there are also harmful ways of offering care, as suggested below with some simple examples in the chart with psychological and theological norms and criteria (cases 2, 3, 4):

Table 2: Assessment Applied to Prayer with Care Receivers © Daniel S. Schipani.

<table>
<thead>
<tr>
<th>theologically adequate</th>
<th>theologically inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychologically functional</td>
<td>1. prayer that elicits a sense of grace and activates emotional and spiritual resources of the patient and family</td>
</tr>
<tr>
<td>psychologically dysfunctional</td>
<td>3. prayer that elicits a sense of grace and activates emotional and spiritual resources of the patient and family</td>
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</tbody>
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4.2 Common Ground and the Unique Contribution of Spiritual Caregivers

Literature on spiritual care across traditions and cultures allows us to identify common ground regarding both practice and theory. One can experience something similar in multicultural and multifaith collegial conversation and collaboration. It is not a question of finding some common (minimum) denominator shared by everybody; distinctness and difference must be duly recognized. Common ground cannot be explained only in terms of similar clinical training or formation of caregivers. Rather, common ground can be appreciated as actually reflecting the reality of the holy ground of human encounter created in spiritual caregiving situations, as illustrated in our case study. Indeed, those encounters normally deal with fundamental needs,
questions, potential, and resourcefulness that point to transcultural and transreligious issues of meaning, connectedness, vocation, and mystery; in short, the very concerns of the human spirit through the ages.\footnote{This affirmation implies several claims I make, as follows: (1.) We are human because we are spiritual beings (i.e., spirit is the essential dimension of being human). (2.) Spirituality can be understood as how our spirit manifests itself in ways of searching or longing for, experiencing (‘inner’ sense), and expressing (‘outer’ manifestations) in interrelated realms: meaning, truth seeking, wisdom; faith; relatedness and communion with others, nature, oneself, the Divine; and life orientation, purpose. The claim that those dimensions of spirituality – meaning, communion, purpose – name fundamental (or existential) experiences and expressions of our human spirit is based on consistent confirmation stemming from various sources such as these: my clinical work and supervision, analysis of sacred texts, cultural anthropology, and comparative studies including literature in the fields of pastoral and spiritual care, and spiritual direction in particular.}

Another general observation has to do with the central place and role of wisdom in diverse traditions basically understood as both a way of life and discernment of the journey forward in the face of life challenges and struggles (Boelhower 2013). That is, spiritual care tends to be shaped as a dialogical-hermeneutical process involving a normative body of existentially pertinent knowledge together with the contextually pertinent resources of the people involved in the process.\footnote{I offer a reframing of pastoral counseling along those lines in The Way of Wisdom in Pastoral Counseling (Schipani 2003). In that book I argue that the biblically grounded Jewish-Christian wisdom tradition consists in a way of doing practical theology which can help redefine the counseling process and its overarching goals. Recent texts representing different traditions can also be viewed as wisdom-focused even though they don’t share similar theological grounding, cf. Giles and Miller (2012); Rassool (2016); Friedman and Yehuda (2017).} In all cases, holistic formation of spiritual caregivers include work on several sets of competencies, as already indicated.\footnote{See annot. 6 above regarding academic-interdisciplinary, personal, and professional sets of competencies.}

4.3 Core Competencies Identified

Two special core competencies – ‘bilingual proficiency’ and a four-dimensional view – must be highlighted. The unique contribution of spiritual caregivers within any health care team is that they need to view and work with the care receivers holistically while primarily engaging them psychologically as well as spiritually. Therefore, spiritual caregivers must develop the core competency of ‘bilingual proficiency’ in terms of understanding the languages and resources of psychology and spirituality / theology (or non-theological worldviews, as in the case of Humanism and Buddhism) and employing such understandings and resources in spiritual assessment and all other verbal and nonverbal (e.g., rituals) caregiving practices. The spiritual caregiver’s main function is to connect persons in crisis to their (the care receivers’) spiritual resources and community. Given the plurality of sociocultur-
al and religious variables at work, caregivers will normally be faced with situations that present either commonality, complementarity, or contrast and even conflict. This issue can be helpfully considered with the aid of three concentric circles of interreligious spiritual care representing three categories of situations that can be addressed: (1.) ‘common (universal) human experience’, in which the caregiver functions primarily as companion; (2.) ‘interconnected spiritual practice’, in which the caregiver functions as representative of the sacred; and (3.) ‘particular religious spiritual practice’, in which the caregiver functions primarily as resource agent who relates (and often refers) care receivers and their families to their spiritual communities and resources (Grefe 2011, 49–53).¹¹ The diagram that follows represents the opportunities and challenges of intercultural and interfaith care we face in our time (Schipani 2017a, 81). Specific illustrations may include situations like these: a Protestant caregiver cares for a grieving Jewish family in the hospital; a Humanist female chaplain blesses the stillborn baby of a Catholic couple; a Buddhist caregiver helps a young man in despair and unable to pray; a Muslim therapist counsels another Muslim woman suffering depression (somehow connected with spousal abuse and religious instruction); a Jewish chaplain offers a Jewish ritual (washing hands) to a non-Jewish grieving husband and son; etc. Therefore, spiritual caregivers must be able to work with hermeneutical, communicative, and tradition-specific competencies.

In all cases, competent spiritual caregivers seek to engage in holistic care. Further, spiritual care that is intentionally and consistently offered and reflected upon as a spiritual health discipline also calls for a four-dimensional view of reality, as explained below. In other words, this discipline must function as a special form of intercultural care and counseling (Sue et al. 2019) with explicit consideration to normative frameworks regarding the nature of reality and of human wholeness (Schipani 2013, 149–166).

### 4.4 A Four-Dimensional Framework

Psychotherapeutic and psychiatric approaches normally assume a two-dimensional view involving the self (or selves, in the case of couples, family, or group therapy) and the lived world. The recent and ongoing ‘recovery’ of spirituality in health care and, especially, counseling, and psychotherapy includes emphasis on spiritual assessment (Richards and Bergin[1997] 2005, 219–249), engaging clients’ spirituality (e.g., beliefs, sources of meaning, and hope, etc.) during therapy (Miller 2000; Pargament 2013), and integration of spirituality into the therapeutic process (Alten and Leach 2009) including issues and practices (e.g. meditation, prayer, sacred readings,

¹¹ The diagram of three concentric circles comes from the work of the Sri Lankan theologian Wesley Ariarajah (1999) in connection with interfaith worship. He visualizes the possibility of interfaith worship as a public form of interreligious prayer with the use of analogous concentric circles. Dagmar Grefe was first inspired by Ariarajah’s model as documented in her book.
Plante 2009). This is a welcome development. However, much is still missing in terms of clinical research and theoretical reflection, to say nothing of the arena of caregiving practice as such. A large majority of clinicians and theorists simply collapse the spiritual into the psychological and do not recognize the distinct place and function of the spiritual self and its inseparable connection to the psychological self. In any event, the relationship between the psychological and the spiritual self can be further understood in light of the contribution of the late practical theologian James E. Loder. In his words: “Being human entails environment, selfhood, the possibility of nonbeing, and the possibility of new being. All four dimensions are essential, and none of them can be ignored without decisive loss to our understanding of what is essentially human” (Loder 1989, 69). For Loder, the four dimensions of human existence are the self, the lived world, the Void, and the Holy. The ‘Void’ is the third of the fundamental four dimensions of human existence: human existence is destined to annihilation and the ultimate absence of being. The many faces of the Void include existential loneliness, despair, and death. The ‘Holy’ constitutes the fourth dimension of human existence which has, by the power of the Spirit of God, the capacity to transform the other three dimensions (Loder 1989, 80–91). My adaptation of the model follows below as four-dimensional framework for spiritual care (Schipani 2013, 165; 2017b 132).

Figure 4: Three Circles of Spiritual Care, © Daniel S. Schipani.
Applied to Sally’s caregiving encounter with Ernesto and his Hispanic Catholic family, the model can help us to identify several spiritual and theological issues in addition to those normally accounted for with an exclusive psychological/social science framework. By focusing on that family’s religious spirituality with theological lenses, a number of issues may be explored, such as: a sense of mystery connected with images of God and divine will; the face of evil in ultimate separation and suffering; experience of divine presence and grace in the face of death; need for forgiveness and reconciliation related to unfinished business with the dying person; a deep bond between biological and spiritual family (the faith community); and grieving well while mobilizing internal and external spiritual resources.

5 Conclusion: The Way Forward

In the face of rapid social change, there is a felt need for designing new programs aimed at the formation of competent professional spiritual caregivers working in (late) modern and increasingly secular and multifaith contexts. At the same time, it is another priority to care well for those persons who represent particular religious traditions, including ‘hybrid’ and ‘fluid’ spirituality, and those who identify themselves as non-religious spiritual people. Indeed, there is an evolving twofold movement in that direction, particularly in Europe, Canada, and the United States. On the
one hand, in addition to programs associated with the Christian faith, we now find others connected with different religious traditions, such as Jewish, Islamic, and Buddhist. They can prepare caregivers primarily, although not exclusively, for *intra-faith* spiritual care.¹² In many instances, those programs also seek to equip students for *interfaith* work carried out from the perspective of their tradition. On the other hand, new initiatives are also emerging that focus primarily on interfaith care, especially in university settings and medical centers; they can also offer the option for students to further their training within their own faith tradition, if any, including Humanism.

In addition to curriculum development and the strengthening of clinical practice as such, another priority is to focus on the specific dynamics of intercultural and interfaith clinical supervision. This agenda includes both the variables involved in the supervisory relationship itself as well as the consideration of group dynamics that foster intercultural and interfaith competency.

Finally, all those and related challenges call for additional work in quantitative empirical research as a necessary complement and, in some cases, corrective to the results of the prevailing qualitative research especially in North America (Liefbroer 2020). It is therefore to be expected that spiritual care as a discipline will be significantly enhanced as well in the days ahead.

## Bibliography


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¹² For example, several important texts have been published recently by Muslim caregivers addressing Muslim populations primarily (Ahmed and Amer 2012; Rassool 2016; Isgandarova 2019). Similarly in the case of intra-faith Jewish spiritual care (Levits and Twerski 2012; Friedman 2015).


Schipani, Daniel S., Martin Walton, and Dominiek Lootens, eds. 2018. Where are We? Pastoral Environments and Care for Migrants: Intercultural and Interreligious Perspectives. Düsseldorf: Gesellschaft für interkulturelle Seelsorge und Beratung / Society for Intercultural Pastoral Care and Counseling.

