CHAPTER SIX

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Interpersonal Competencies for Cultivating Spiritual Trust

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ABSTRACT *This chapter describes three interpersonal spiritual care competencies building upon each other to cultivate spiritual trust: spiritual self-differentiation, spiritual empathy, and spiritual reflexivity. In the lifelong process of learning these competencies, chaplains need to practice spiritual self-care that helps them self-differentiate by maintaining healthy boundaries within the power dynamics of caregiving. Chaplains practice spiritual differentiation by drawing upon their religious, theological, and clinical education to focus on differences between their own and another person's beliefs, values, and spiritual practices. Spiritual differentiation is at the heart of interreligious care, which makes chaplains more spiritually trustworthy. Building upon spiritual differentiation, spiritual and social empathy helps chaplains imagine how another person's suffering generates contextual values, beliefs, and coping practices that may be shaped by systemic abuses of power. People are more likely to trust chaplains who are spiritually differentiated and empathic. Such trust makes people want to search for meanings with chaplains, a process described in previous chapters. Chaplains become spiritually trustworthy when they are spiritually reflexive about how values and beliefs are contextually shaped by aspects of one's social, religious, or spiritual identities. A case study illustrates how chaplains use communication skills in practicing spiritual care that is spiritually differentiated, empathic, and reflexive.*

SPIRITUAL TRUST: THE RELATIONAL FOUNDATION FOR LEARNING AND PRACTICING SPIRITUAL CARE

In this chapter we describe three interpersonal competencies—spiritual self-differentiation, spiritual empathy, and spiritual reflexivity—that help chaplains establish spiritual trust, which is the relational foundation unique to spiritual care. Spiritual care, as we define it, is an integrative process that begins with exploring calming spiritual practices that help people to experience spiritual trust. We use the term "spiritual" as a simple way to describe complex and diverse relational experiences of transcendence. Many people experience and name transcendence through sacred texts, music, symbols, and rituals from religious or spiritual traditions. When spiritual practices help people feel held within compassionate and trustworthy relationships, they will be ready to explore what their suffering means (an essential function of spiritual care described in the chapters on meaning making).[1] When they feel overwhelmed by suffering, they can rest in practices that instill trust. In this chapter we build upon the description in chapter 3 of how chaplains listen for the ways that people may experience a sense of connectedness with the sacred/transcendent/sources of spirituality.

Chaplains become spiritually trustworthy when they convey respect for the unique ways people experience and name incarnational or transcendent aspects of their lives that mediate a deep sense of mystery, awe, beauty, goodness, holiness, or the sacred. Chaplains may be especially helpful when people experience religious and spiritual struggles that disrupt practices previously connecting them to transcendence.[2] Chaplains may invite people to collaboratively explore any sorts of calming practices that help them feel self-compassion when physiological, emotional, and moral stress overwhelms them. Calming practices help people reexperience that deep sense of connection that instills a sense of trust. In a parallel fashion, chaplains trust the process of learning spiritual care when they use spiritual practices that center and calm them when they feel overwhelmed by suffering (see chapter 3 for a description of chaplains developing specific practices to ground themselves in their bodies). We illustrate the importance of spiritual self-care in the following case study[3] used throughout our chapter.

Case Study, Part 1: Practicing Spiritual Self-Care

Our chapter's case study describes Angie, a twenty-five-year-old single African American woman with advanced Hodgkin's lymphoma, who is expected

to die during this hospitalization. She is unresponsive, and medical examinations suggest that the systems of her body are shutting down in a way that is typical at the end of life. The chaplains on the floor have been making brief daily visits. She receives no other visitors. The walls are bare of cards, and there are no flowers in the room. You know from the prior visits by chaplains on this floor and the chart notes that Angie is alienated from her family and distances herself from people she said were "bad influences" before her cancer diagnosis and earlier recovery from addiction. She credited a return to the Pentecostalism of her youth as the reason she has remained clean and sober.

Angie has been unresponsive for more than a week. You are a student chaplain new to the oncology unit today. You had spoken with other chaplains about Angie. The nurses tell you today that Angie has had moments where she is more alert. One nurse, who is very experienced with end-of-life care, tells you that it is common for patients who are dying to experience perceptions or sensations that are comforting to them. Sometimes there is no clear medical explanation for these experiences. You were anticipating that she would still be unresponsive and you would simply need to offer a silent prayer. Before going into Angie's room, you take a deep breath and realize how anxious you are. If she has a conversation with you, you will have to chart your visit and report back to your chaplaincy colleagues and summarize your visit at rounds with the medical team.

When you enter her room, you find that Angie is indeed awake and eager to tell you about an "amazing experience with God" when she was unresponsive. Her voice is low and quiet. She invites you to sit close to her so you can hear what she says. "It was just me and God dancing together up there in the corner. I had on a red dress. The prettiest red dress. I've never worn anything like it. We danced and danced. You know, people always say, 'God is this' or, 'God is that.' God isn't anything we know about, even if he is a darned good dancer. It's just, 'God is.'" She pauses. There are tears in her eyes. "Not even, 'God is.' Just, 'is.'"

Angie goes on to tell you that she received a blessing and a healing and that even though she will die with the cancer, she has been made whole.

Trusting the Process of Learning Spiritual Care

What helps chaplains instill spiritual trust in those facing the void of death, like Angie in our case study? Chaplains serve as a liaison between participants in the care recipient context (for example, in healthcare, between

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patients and their medical caregivers). At the same time, chaplains enable careseekers like Angie to trust the process of spiritually integrating their suffering when chaplains are on their own journeys of spiritual integration. Spiritual integration is a collaborative and relational process of using calming spiritual practices that help people explore life-giving beliefs about suffering and hope. Spiritual integration is "the extent to which spiritual beliefs, practices, and experiences are organized into a coherent whole."[4] What helps chaplains on the parallel course of spiritual self-care/integration while caring for others?

Like the process of spiritual care, spiritual integration begins with exploring and using calming practices for coping with stress. If you were the student chaplain in our case study, you might feel overwhelmed by the challenge of offering spiritual care to this young African American woman dying of cancer who has been unresponsive for a week and is now periodically stirring and more responsive. It is easy to imagine your stress response. Your breathing becomes shallow. Your heart beats faster. Your shoulder and facial muscles tighten. You feel momentarily overwhelmed by the complexities of interdisciplinary spiritual care to dying patients who experience sensations or perceptions that are comforting. You want to empathize with this patient's emotional and spiritual experience while placing it in an interdisciplinary clinical context that honors her dying process. You want to align your body language with the compassion of your heart and your interdisciplinary understanding of her spiritual experiences of dying.

Imagine taking several slow, deep breaths while you focus for a moment on something with spiritual meanings, such as a sacred text, or a place or image with sacred meanings. Calming practices like slow, deep breathing can be incorporated into regular spiritual practices like prayer, devotional reading of sacred texts, participating in liturgies, mindfulness meditation, and yoga, as well as any sort of practice that instills a sense of beauty, awe, or goodness through the arts and nature. Calming spiritual practices ground chaplains in their own religious or spiritual heritage, identity, and communities in ways that enhance spiritual differentiation, empathy, and reflexivity—three core interpersonal competencies for socially just and interreligious spiritual care that build upon a spiritually integrative learning process. As we noted in the introduction to part 3, we use the term "socially just spiritual care" to describe the need for chaplains to understand how systems of social privilege and disadvantages interact in their own lives, in the lives of careseekers, and within the organizational contexts where they practice spiritual care. Developing interpersonal competencies is a lifelong learning

process within relationships of collaborative accountability with peers and clinical pastoral educators, as we illustrate in the following descriptions of spiritual self-differentiation, spiritual empathy, and spiritual reflexivity.

SPIRITUAL SELF-DIFFERENTIATION

Self-differentiation helps chaplains maintain healthy relational boundaries within the power dynamics of spiritual care, so that chaplains do not become emotionally/spiritually fused with careseekers and their families or with colleagues. The importance of managing relational boundaries in the emotional intensity of intimacy and family relationships was first defined and described in Murray Bowen's family theory and therapy exploring intergenerational family patterns of relational boundaries.[5] Self-differentiation in intimate/high-investment relationships is both an interpersonal process of managing relational boundaries and a psychological process of managing emotions, thoughts, and behaviors. "In Bowen's approach," David Schnarch and Susan Regas tell us, "differentiation of self is the most critical to mature development and attainment of psychological health."[6]

The emotional intensity of spiritual care can cause chaplains to lose their "emotional balance" and blur the boundaries between self and other. Emotional contagion infuses chaplains with another's emotional struggles. Chaplains may feel overwhelmed by another's overt emotional distress. They may feel swept off their feet by the hidden currents of another's sadness, anger, or shame. They may reexperience memories of life threats, magnifying their moral responsibility to protect others from harm. Chaplains may cope with fusion using emotional disengagement or cutoff, which, as Schnarch and Regas emphasize, is not the opposite of fusion but an attempt to regulate one's emotions and sense of self.[7]

Conflicts involving power dynamics and relational boundaries are an inevitable part of couples' and family relationships, or any relationship in which people have an emotional investment. Schnarch and Regas's "crucible therapy" promotes "anxiety tolerance rather than . . . reduction" during "the natural emergence of emotional gridlock as a result of healthy differentiation."[8] Their crucible approach views "gridlock as normal and inevitable, and conflict as healthy and necessary for personal growth. . . . The ability to maintain good cognitive functioning and emotional self-regulation during stressful situations develops through high-anxiety, high-meaning encounters, which emerge during the course of marriage, love relationships,

family, school, and work life." They define four points of balance necessary to navigate gridlock:

1. A solid, flexible self that is not dependent on "a positive reflected sense of self from others, allowing you to maintain your own psychological shape when other people pressure you to conform. Likewise, it reflects the ability to change and adapt, accept influence from others as good judgment dictates, and heed good advice without losing sight of your goals and values."
2. A quiet mind and calm heart, using soothing and calming practices for managing conflict without "dominating or accommodating others, or by becoming emotionally distant or intrusive."
3. Grounded responding, using "the ability to make modulated proportionate responses to provocations and difficult circumstances . . . [by] not locking into arguments or over-reacting, while also staying emotionally invested and not avoiding difficult people or situations that need to be handled."
4. Meaningful endurance, using "the ability to get out of your 'comfort zone,' tolerate discomfort for growth, and persevere through disappointment and hardship to accomplish your goals."

Those in professional helping relationships learn how to psychologically self-differentiate in order to maintain healthy boundaries. The added dimension of spiritual self-differentiation is what makes chaplains competent in interreligious spiritual care (see chapter 4 for the importance of inter-religious care—unique to spiritual care—in the search for meanings). We use the term "interreligious" to describe a specialized kind of intercultural humility that integrates

- knowledge of the socially constructed nature of religious beliefs, values, and rituals;[9]
- attitudes of intercultural humility toward cultural, religious, moral, and spiritual differences and the ineffable mystery of the other;
- capacities in spiritual differentiation, enabling chaplains to distinguish among particular religious, spiritual, and moral orientations of others; and
- skills in spiritual self-care for coping with the anxieties or losses of letting go of absolute meaning or value systems that avoid, polarize, or minimize religious and spiritual differences.[10]

Chaplains learn interreligious care through graduate studies, especially comparative studies of religion, and clinical training that enhances spiritual self-differentiation in religiously diverse contexts. We recognize the limitations of the term "interreligious" for describing spiritual care to those with humanist, agnostic, or atheist orientations, as well as those who reject the term "spiritual" in describing their traditions and communities (for example, Buddhist, Confucian, Hindu, or American Indian persons).

Spiritual care combines psychological and interpersonal growth through self-differentiation with an interreligious radical respect for differences in the narrative "truth" of one's own and another's spiritual/moral orientation to stress or suffering. How can chaplains develop a solid flexible spiritual self (using Schnarch and Regas's first point of balance for self-differentiation)—sometimes called spiritual or pastoral authority? First, chaplains need graduate education in comparative studies of religion that helps them pay attention to how Christianity is used in normative and hierarchical ways to interpret and "rank" other religious traditions through Christian categories and beliefs. In describing spiritual empathy and reflexivity, we will elaborate how a social constructionist comparative approach is combined with a de-colonialist understanding of the fusion between colonialism and Christianity. Spiritual self-differentiation within religiously diverse contexts must truly respect religious differences by not enacting a caste system of religious/spiritual traditions and practices, with some more superior or truthful than others.

This cognitive dimension of a solid flexible spiritual self is challenging to practice within religious traditions that have not developed beliefs, values, and practices supporting radical respect for religious differences. Chaplains practicing spiritual care in religiously diverse contexts often struggle with becoming spiritually differentiated when their religious "family"—the community or organization that may ordain them and endorse their vocations of spiritual care—requires them to affirm the absolute truth of that community's religious doctrines and to practice spiritual care that "saves souls" through adherence to doctrine. Chaplains often cope with these doctrinal demands by adopting an inclusive orientation to religious differences that searches for commonalities and assumes that all religions of the worlds share common beliefs.[11] While inclusivism may alleviate religious conflicts between bi-vocations as chaplains and faith community leaders, inclusivism minimizes and ignores vast differences across religions of the world, especially historical trajectories and cultural contexts. When inclusivist spiritual caregivers assume there is "one God"[12] at the heart of each person's

experience, they risk spiritual coercion by overlaying their experience of God onto another's unique experiences, values, and beliefs.

When chaplains are able to practice interreligious spiritual care using cognitive capacities for respecting a careseeker's narrative truth, they will be able to trust the cocreative process of spiritual care—the intermingling of their and a careseeker's stories, practices, values, and beliefs. Chaplains practice spiritual self-differentiation by combining a solid spiritual self that is grounded in their ongoing process of spiritual integration with a flexible spiritual self that trusts the spiritually intersubjective process of searching for contextually meaningful practices, values, and beliefs.

In our case study, Angie's description of her experience of God could easily overwhelm chaplains, especially within the drama of her emerging from a week of being unresponsive. They could be tempted to foreclose meanings cognitively through skepticism that questions Angie's sense of "reality"—her conviction that God was "speaking" to her. Skepticism could be a way of coping with emotional/spiritual fusion through disengagement. Such skepticism could be justified within progressive religious traditions that question "direct revelations" of God. Skeptical chaplains could easily become anxious about how those in their "religious home" would question any endorsement of such revelations. Alternately, chaplains within religious traditions that believe in direct revelations and miracles could become emotionally and spiritually fused with Angie in proclaiming this as a miracle. In either scenario, spiritual and emotional fusion will be more likely when chaplains do not understand what happens medically when people are intermittently responsive and then unresponsive due to the shutting down of their organs and body processes.[13] Collaboration with medical providers helps chaplains to be aware of medical reasons for a patient's unusual perceptions or unresponsiveness. Is the patient unresponsive due to a medical episode that can be treated and may or may not end their life? Or, as in Angie's case, are patients in their final days or weeks of life and not responsive because this is the body's way of minimizing suffering at the end of life?

By using calming spiritual practices in a spiritually integrative learning process (Schnarch and Regas's second point of balance for self-differentiation), chaplains can recognize when stress makes them cope with jarring experiences of religious differences by minimizing, polarizing, or using inclusion as a way of "recentering" themselves in familiar or habitual orientations that blur differences, which are shaped by childhood and culture. By grounding themselves using spiritual practices, such as deep, slow breathing that shifts chaplains out of a stress response into calmness, chaplains

can reconnect with a felt sense of trust in the collaborative, cocreative process of spiritual care. With trusted others, they can explore what jarred them—what emotions were part of feeling overpowered and what values and beliefs about religious differences were generated by their stress responses. Spiritual practices that ground them in self- and other-compassion can help them use critical thinking skills in theological and religious studies to search for values and beliefs complex enough to bear the weight of suffering and offer realistic hope for healing and social justice.[14]

In our case study, chaplains could use calming spiritual practices when jarred by Angie's description of her experience with God in order to become more emotionally and cognitively able to cocreate meanings with her, especially about how she has "received a blessing and a healing"—that even though she will die with the cancer, she has been made whole. Our case study illustrates how chaplains can remain spiritually balanced and self-differentiated when they have developed a *solid flexible spiritual self* and *a quiet mind and calm heart* using calming spiritual practices. These cognitive and spiritual capacities of self-differentiation could help them use *grounded responding* as they cocreate contextual meanings arising from Angie's experience. They will be able to "surf" the anxiety of hearing about and responding to Angie's amazing experience of God by being able to *get out of their cognitive/theological "comfort zone,"* tolerating discomfort for spiritual growth. In order to understand what spiritual self-differentiation looks like in practice, we need to understand differences between agential and receptive power.

The Role of Agential or Receptive Power in Spiritual Self-Differentiation

A key aspect of spiritual differentiation is paying attention to how one uses agential or receptive power from one moment to the next. Agential power "influences, guides, and shapes, while receptive power receives and takes in."[15] Agential power is grounded in chaplains' specialized knowledge of and training in spiritual care and in their organizational role, which often includes interdisciplinary teamwork within health, hospice, and long-term care as well as within educational, prison, military, and nonprofit organizations. Receptive power is grounded in spiritual self-differentiation that opens chaplains to the mystery of the other. Agential and receptive power use different styles of communication, ranging from following to guiding and directing, and different communication skills of listening, asking, and informing.[16] Agential power typically uses directing and guiding styles, along with informing and asking skills. Receptive power uses a following

style along with listening skills. How do agential and receptive power and their related communication styles and skills play out in a spiritual care conversation?

Chaplains usually begin by introducing themselves in ways that help others "locate" the chaplain's agential power within the organization's purpose/mission—in our case study, holistic healthcare with possibilities for hospice care. Chaplains often then shift from agential power to receptive power, using a following style and listening skills to receive the other's response—especially communicated through a person's body language. If the other seems hesitant to interact, chaplains might shift into agential power by using a guiding style and asking skills to gently seek permission to either say more about their role or find out more about the other's hesitation. For example, questions about the chaplain's religious affiliations may arise from another's desire to find commonalities or from religious or spiritual struggles that make that person suspicious of those with religious/spiritual authority. When chaplains use "in the moment" calming practices like slow, deep breathing, they can differentiate their own need to help from the other's hesitancy over or refusal of spiritual care. They will then be able to receive and respect the other's response.

Let's imagine how a chaplain might use agential and receptive power and related communication styles and skills in an opening conversation with Angie.

Case Study, Part 2: Practicing Spiritual Self-Differentiation

Our chapter's case study continues with Angie, who is expected to die during this hospitalization. Her chart indicates that she has no family support and that returning to her childhood Pentecostal faith has help her recover from addiction. Angie has been unresponsive for a week due to the shutting down of her bodily systems at the end of her life. The chaplain is visiting her on a day when she is having intermittent periods where she is somewhat responsive.

> Chaplain: Hello, Angie. I am [name], a chaplain in the Spiritual Care Department of this hospital. (Chaplain uses agential power, a directing style, and informing skills to clarify professional/organizational role.)

> Angie: Chaplain, I am so glad to see you. I had an amazing experience with God. I tried to tell the nurse and doctor but they were

too busy assessing my health and doing tests. (Angie conveys a sense of immediate trust and desire for spiritual care.)

Chaplain: I'd like to hear about your "amazing experience with God." (Chaplain shifts into receptive power, using a following style that respects Angie's unique experiences by using her words.)

Angie: It was just me and God dancing together up there in the corner. I had on a red dress. The prettiest red dress. I've never worn anything like it. We danced and danced. You know, people always say, "God is this" or, "God is that." God isn't anything we know about, even if he is a darned good dancer. It's just, "God is." [She pauses. There are tears in her eyes.] Not even, "God is." Just, "is."

Angie goes on to tell the chaplain that she received a blessing and a healing, and that even though she will die with the cancer, she has been made whole.

Angie's chaplain draws upon receptive power, using a following style and listening skills to echo Angie's words without adding interpretations. The chaplain minimizes asking questions, which would put the chaplain in the "driver's seat" by directing the conversation. Spiritual self-differentiation supported by calming spiritual practices helps this chaplain recognize and set aside any immediate need to "fill in the puzzle" of Angie's story by asking for narrative, emotional, or spiritual details that would "make sense" of the mystery of her experience. The chaplain can make a mental note to speak with the bedside nurse or attending physician to further understand the medical and psychological aspects of Angie's experience. Spiritual trust will deepen when the chaplain follows Angie's searching for meanings, assuming the role of a respectful guest who has been invited into the mystery of Angie's "amazing experience with God." Spiritual self-differentiation helps this chaplain honor the narrative and contextual "truth" of Angie's experience of God. Her chaplain might be tempted to use agential power to negatively judge Angie's experience by using stereotypes of Pentecostalism. Conversely, her chaplain might become "stuck" in receptive power that conflates Angie's experience with the chaplain's own intense religious experiences, absolutizing both in ways that blur religious differences.

This case study raises the question, how are the chaplain's reactions to Angie shaped by his or her perception of interacting aspects of Angie's identity (such as gender identity, religious/spiritual identity, racial identity, and other salient aspects of identity)? Religious and spiritual identity is always contextually experienced as intertwined with other aspects of identity.

In this conversation, the chaplain's immediate impressions are shaped by his or her perceptions of Angie's gender, age, race, health status, and other perceptions of her identity. How do chaplains begin to imagine what it is like to be Angie? How do they build upon spiritual differentiation by using spiritual and social empathy to imagine Angie's spiritual world at this moment?

SPIRITUAL AND SOCIAL EMPATHY

Spiritual empathy helps chaplains imagine how another's stress-based emotions generate contextual spiritual/moral orientations to stress and suffering—"lived" values, beliefs, and coping practices—that "make sense" given family and cultural contexts, especially intersecting social advantages and disadvantages generated by systemic racism, sexism, heterosexism, ableism, and other forms of social oppression. Psychologists using brain imaging technology have mapped the neural circuits active during empathy,[17] demonstrating how "affective empathy describes the physiological aspects of vicariously feeling what another person is feeling; while cognitive empathy involves the mental processing of another's feelings, thoughts and intentions."[18] Affective empathy occurs in part at an unconscious, physiological level. Chaplains need self-differentiation in order to manage affective empathy so that, as we noted earlier, boundaries between self and other are not blurred. The cognitive component of empathy uses perspective-taking to imagine what it is like to stand in the other's shoes. Spiritual empathy uses spiritual perspective-taking. Chaplains imagine others' emotional responses to stress and suffering and how their emotions generate a moral/spiritual orientation to their stress or suffering.[19]

Chaplains draw upon specialized knowledge from their theological and religious studies to combine psychological perspective-taking with spiritual perspective-taking that pays attention to religious, spiritual, and moral differences and particularity. As we noted earlier, chaplains need to listen for and echo back the particular words others use to speak of themselves spiritually. Do they use words like "God"? What is particular to the way they use this term? If they describe pain and suffering, what words do they use? How do their words and bodies convey emotions that might empower or overwhelm them? How do these emotions seem to influence their relational boundaries from one moment to the next? Do their boundaries blur in their rush to disclose or in a projection that blurs the chaplain's identity with another's? Does the careseeker seem to experience an emotional and spiritual disengagement in order to protect what is vulnerable and precious?

In answering such questions, chaplains draw upon their emotional and spiritual attunement to careseekers while using spiritual perspective-taking at several levels. They are using spiritual empathy to gain a perspective on the careseeker's experience of overwhelming stress or suffering—in Angie's case, an amazing experience of God. They are also paying attention to how the careseeker understands this spiritual care conversation and are considering how to be a liaison with medical providers so that the patient can receive holistic, culturally responsive care. Medical providers are trained to assign diagnostic categories to patient experiences, and a chaplain will be in a position to also provide spiritual care to staff who may be distressed about encountering a situation that may have no clear medical explanation. Just as chaplains enact their values and beliefs about spiritual care in this conversation, as much through body language as through words, so, too, careseekers put into practice their beliefs and values about spiritual care in their body language and the ways they respond to the chaplain. When chaplains are experienced as trustworthy, they will be invited into a careseeker's spiritual home with its immediate experiences of pain and suffering, lament, mystery, and hope. Perspective-taking entails imagining that any and all aspects of this careseeker's spiritual home may be sacred or memorials of desecration.

Social empathy builds upon spiritual empathy by considering the macro systems of intersecting social privileges or disadvantages within a careseeker's current contexts. Perspective-taking of another's intersecting social systems of privilege and disadvantage is enhanced by knowledge about social oppressions, especially oppression justified through religious dogma. Intersectionality is a theory and strategic practice of identifying which systems of social oppression interact contextually to benefit or harm persons in distress. Black feminist scholars[20] and womanist pastoral theologians[21] help chaplains develop spiritual social empathy that pays attention to how religious and spiritual identities intersect in helpful and harmful ways in careseekers' struggles. For example, womanist perspectives could be used to explore how racism might interact with sexism in our chapter's case study.[22] Social and spiritual empathy fosters an appreciation for the alterity or mystery of another whose spiritual orientation or social location is radically different from one's own.

In order to understand the interrelationships among systems of oppression such as racism, classism, heterosexism, and sexism, chaplains need an overarching orientation of "post/decolonialism"[23] to name the ways that

colonialism exercises power over all aspects of ecological, transnational, political, and economic life. As practical theologian Kristina Lizardy-Hajbi argues, "These collective systems and dynamics are part of the larger construction of the U.S. as a modern colonial empire; therefore, post/decolonial leadership frameworks that seek justice, transformation, and the re-existence of marginalized peoples and ways of being-thinking-acting are necessary for the collective liberation of all people of faith."[24] Colonial systems of power can be likened to gravity. They are an interconnected and ever-present force, irreversibly harming this earth's ecology, decimating Indigenous peoples and their lands and cultures, perpetuating poverty, and locking in economic disparities. All of us who benefit from colonialist power systems traverse our daily lives with the power/gravity of colonialism holding our privileges together in invisible ways. These privileges are often misnamed as accomplishments that open doors and keep us safe from harm.

Bringing post- and de-colonial orientations to understanding spiritual care interactions makes chaplains realize the impossibility of "doing no harm" in a world organized by colonialism. For example, the places where we live and work are built on Indigenous lands stolen in settler colonialism and on the genocide of Indigenous peoples.[25] Lizardy-Hajbi states, "The actions of resistance, subversion, and reclamation by those harmed and abused by colonialism constitute the beginnings of postcolonial and decolonial practice."[26]

Socially just spiritual care that does no harm is enormously challenging and always unfinished. When chaplains use calming spiritual practices, they may be able to feel in their bodies and their very bones their interconnectedness with a suffering humanity and creation. Social empathy often evokes lament, especially for racial violence, which may be shared within spiritual and religious rituals of repentance and social rituals of protest (see chapter 5 for descriptions of rituals that mourn and lament systemic abuses of power). Pastoral theologian Larry Graham describes how lament may be a process of "sharing anguish, interrogating causes, and reinvesting hope" with God as "our co-creative partner in healing, sustaining, and guiding the shaken, shattered, exploded, bombed, bulleted, and drowning human community."[27] Spiritual and social empathy develops in a collaborative learning process grounded in spiritual and communal accountability.[28] The profound shame, guilt, grief, fear, and moral distress of such learning can be supported only through personal and communal practices of lament.[29]

The next morning, you report your conversation with Angie at interdisciplinary rounds just before the treatment team enters Angie's room. You preface your report by asking the medical providers for a summary of her medical condition. You use her words to describe her experience of God when she was unresponsive and relate how she feels as though she has received "a blessing and a healing"—that even though she will die of cancer, she has been "made whole." The chief oncologist, a white male agnostic, turns to the students and says, "And here we have a prime example of drug-induced delirium. People experience all sorts of things because of the medications we give them for pain management."

SPIRITUAL SELF-REFLEXIVITY

Once chaplains have begun to develop spiritual differentiation and empathy, they will be ready to learn spiritual self-reflexivity. Self-reflexivity has been described by pastoral theologian Kathleen Greider as "disciplined, accountable practices to decrease our unconsciousness and increase in depth our understanding of our life narrative, sense of self, participation in relationships, and social-historical location."[30] (Chapters 4 and 5 describe the role of meaning-making in spiritual care). Spiritual reflexivity goes beyond theological reflection to understand how a chaplain's and a careseeker's social and religious/spiritual identities interact in the process of exploring contextual values and beliefs about suffering. Reflexivity begins with identifying one's own stress-generated beliefs and values (for example, about Angie's suffering and her experience of God) and then intentional values and beliefs that emerge from using calming spiritual practices. Spiritual self-reflexivity is then used to identify how one's stress-oriented and intentional beliefs and values are shaped by one's own intersecting social privileges and disadvantages.

The next step is to use spiritual and social empathy to imagine the other's stress-generated values and beliefs and how these are shaped by that individual's social location. We have described how a chaplain would begin that process in a spiritual care conversation with Angie that searches for and cocreates meanings about how she experiences God as blessing and healing her and making her whole as she faces death.

The case study now presents chaplains with the opportunity and challenge of using spiritual differentiation and empathy to imagine this

oncologist's beliefs and values about Angie's experience and how these might be shaped by his social identity and medical training. Spiritual reflexivity includes understanding possible interactions among the chaplain's beliefs and values about Angie's experience, role as her chaplain, and social location; Angie's beliefs and values about her experience, her role as a patient, and her social location and medical condition; and the oncologist's beliefs and values about Angie's experience, his role as her doctor, and his social location. This multilayered process of searching for meanings is explored more fully in part 2. In this chapter on interpersonal competencies, we describe how spiritual self-reflexivity is an interpersonal competency that makes chaplains accountable for tracking how their own beliefs and values influence the search for meanings in spiritual care encounters and for understanding how another's social location shapes that person's values and beliefs. Chaplains become relationally self-reflexive[31] by using educational and supervisory relationships to understand the complex interactions among their and another's beliefs and values. A collaborative search for meanings in spiritual care is like a jazz improvisation. Chaplains are playing in the ensemble while using spiritual reflexivity to listen for and understand each player's unique contribution.

How might chaplains respond to the oncologist? Chaplains using calming spiritual practices during grand rounds will be more able to draw upon their competencies in spiritual self-differentiation, empathy, and reflexivity. They will likely realize that an immediate response is called for, given the ways that this oncologist's beliefs about Angie's religious experience could cause medical harm if he is not familiar with research on experiences of "God's benevolence" that have positive outcomes.[32] This oncologist's judgment could make Angie question her spiritual experience and her need for a process of integrating this experience of cancer as she faces death. If she does not trust her medical team, she may hold back important subjective medical details that could be red flags about suffering or could improve her quality of life. She may well experience internalized racist and sexist shame associated with sacred aspects of who she is. How might you as chaplain advocate for Angie who, like many persons of color, might have experienced health disparities and have justified mistrust of medical providers?

Spiritual self-differentiation helps chaplains rely upon a solid flexible spiritual self and a quiet mind and calm heart using spiritual self-care practices. These cognitive and spiritual capacities of self-differentiation could help the chaplain in the case study to use grounded responding with the oncologist, as the chaplain "surfs" the anxiety of responding to the doctor's

interpretation of Angie's experience. Here is an example of how a chaplain might reply: "Doctor, as you may know, research demonstrates that experiences of God's benevolence have many benefits for patients. Knowing about the variety of experiences patients have at the end of life, can we, as a team, embrace Angie's experiences and support her in her search for wholeness as she faces death?" After using his or her agential power to guide and inform this oncologist and the team, the chaplain could use receptive power to listen for this oncologist's beliefs and values about holistic healthcare and for his possible distress about facing a situation that does not have a clear medical explanation. The chaplain could follow up in a later conversation, inviting the oncologist to say more about his beliefs and values.

This extended case study illustrates the complexities, challenges, and benefits of socially just, interreligious, evidence-based spiritual care that draws upon competencies in spiritual differentiation, empathy, and reflexivity. Chaplains learn these competencies and practice them within clinical learning communities. They are not solo virtuosos. For example, the chaplain in our case study's grand rounds conversation may or may not be able to practice interpersonal competencies to the best of his or her abilities. The chaplain can take this experience back to his or her learning community so that they can all learn together and strategize next steps in advocating for Angie and engaging her treatment team in further conversations.

LEARNING TO USE INTERPERSONAL COMPETENCIES IN ASSESSMENT

Interpersonal competencies in spiritual differentiation, empathy, and reflexivity are practiced in spiritual assessments that go beyond simple assessments (like questions about religious identity or how important religion or spirituality is) often asked during initial conversations (see chapter 3 for a description of spiritual assessment as an interpretive process in meaning making in chaplaincy practice). Being research-literate is yet another learning outcome, beyond the scope of this chapter, that integrates knowledge (in this instance, psychological research on when aspects of religion and spirituality help or harm) seamlessly with spiritual and social empathy and reflexivity in person-centered spiritual care. In other words, knowledge is always integrated into the flow of a spiritual care interaction that gives primary attention to the needs of those seeking care.

We now describe how to integrate spiritual assessment into the early phases of getting to know those seeking spiritual care. The **Spiritual**

Assessment and Intervention Model (Spiritual AIM) provides a conceptual framework for the chaplain to

1. focus on an individual's primary unmet spiritual need—through observing the patient's words and behavior in relationship with the chaplain, as well as through the chaplain's self-awareness of the interpersonal dynamic with careseekers;
2. devise and implement strategies for addressing this need through embodiment/relationship; and
3. articulate and evaluate the desired and actual outcomes of a focused conversation.[33]

Spiritual AIM is best understood through illustrating how it is used in spiritual care. Along with generalized forms of assessment, assessments of specific stressors have been developed, such as the PC-7, which measures unmet spiritual concerns of palliative care patients near the end of life.[34] While we illustrate AIM by continuing our case study, this assessment approach can be used in any kind of spiritual care setting (like a faith community, an educational context, the military, or a correctional/prison context) or in disaster relief.

Case Study, Part 4: Assessing Spiritual Needs

Spiritual assessments explore how people's beliefs, values, and spiritual/coping practices function for them. In this case, Angie feels that her faith has been a crucial force in helping her to stay sober and is a great source of support. In the course of the chaplain's pastoral conversation with Angie, Spiritual AIM serves as a road map for utilizing the relationship to facilitate spiritual healing. The chaplain sets out to make an assessment and diagnosis about the prominent spiritual dimension where Angie is most in need of healing. AIM helps the chaplain and Angie identify one primary spiritual need. Having this focus will help to avoid a meandering encounter, which is of the utmost importance, especially given the tension with the medical team and the fact that her life is coming to an end. The chaplain observes Angie's actions and reflects on what he or she knows about Angie's history. The chaplain listens to her lovingly recount her spiritual experience of dancing with God and uses this information to make an assessment and craft spiritual interventions, which will inform how the chaplain interacts with the patient but also how he or she advocates for her with the medical team. The chaplain will know that the assessment is "correct" if Angie

demonstrates some of the Spiritual AIM outcomes. If she does not, the chaplain can assess a different spiritual need and try those corresponding interventions.

Angie's history of broken relationships and addiction indicate a spiritual need of reconciliation/to love and be loved. Angie tells the chaplain that she does not trust her medical providers and can sense their judgments and dismissive attitudes, especially about her spiritual experience. The chaplain's interventions focus on empowerment. He or she identifies the ways in which Angie is feeling powerless and reminds her what is still in her power. This includes allowing her strong and loving relationship to wash over her whenever she is feeling alienated from others, articulating her needs and wishes, and choosing which medical providers she feels she can trust. The chaplain act as her partner in prayer, a practice that connects her with God.

Spiritual AIM emphasizes the importance of the relationship, prompting the chaplain to look inward and recognize his or her reactions to Angie. Part of the reason why using any spiritual assessment model is helpful is because it balances emotions that arise in the caregiver, activating the analysis required of making an assessment. This process results in a relationally based yet somewhat more objective assessment. In embodying a truth-teller and prophetic voice to Angie, the chaplain acknowledges the systemic and explicit prejudice she is facing. But the chaplain also offers compassion for her feelings of powerlessness while reminding her of the influence that is impossible to be taken from her. Angie is able to state her truth and her wishes to her medical team and to continue to trust God.

CONCLUSION

This chapter describes and illustrates the lifelong learning process of integrating specialized knowledge with interpersonal competencies that fine-tune communication skills for particular spiritual care encounters. Developing interpersonal competencies in spiritual care is a deeply relational process grounded in a felt sense of spiritual trust experienced in one's body through calming spiritual practices. This grounding in a relational web that includes transcendent dimensions enables chaplains to trust the process of spiritual care, especially when care of self or others elicits religious and spiritual struggles and interpersonal challenges.

1. Describe a spiritual care encounter with someone whose spiritual orientation or social location is radically different from your own. How might you combine a solid spiritual self that is grounded in your ongoing process of spiritual integration with a flexible spiritual self that trusts the spiritually intersubjective process of searching for contextually meaningful practices, values, and beliefs?

2. Reflecting on the same spiritual care encounter, how might you draw upon spiritual self-differentiation to make a grounded response to a "jarring" difference between their practices, beliefs, and values and yours?

3. In spiritual care with those whose suffering is compounded by intersecting social oppressions that are religiously justified (for example, a gay or lesbian person whose community or family justified prejudice with religious beliefs), how would you respond to their suspicions about your religious/spiritual beliefs that make them hesitant to trust you?

4. What aspects of education, spiritual formation, clinical training, or religious/spiritual tradition/community help or hinder you from demonstrating radical respect for differences? Which of these aspects help or hinder you from counteracting cultural and religious abuses of power that judge others' beliefs, values, and practices as less true or meaningful than your own?

5. Socially just spiritual care is enormously challenging and always unfinished. The profound shame, guilt, grief, fear, and moral distress of such learning can be supported only through personal and communal practices of lament. What helps you remain committed to a collaborative learning process grounded in spiritual and communal accountability?

RECOMMENDED READINGS

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