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Navigating Religious Difference in Spiritual Care

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Abstract: During the last two decades there has been growing research on intercultural and, more recently, interreligious care in the face of increased, global pluralization. Representatives of various traditions are making substantial contributions beyond the pioneering work of Christian clinicians and theoreticians. This essay addresses one of the challenges and opportunities associated with multi-faith contexts: the methodological and clinical question of how spiritual caregivers can effectively engage significant difference in interreligious caregiving situations. Therefore, the twofold goal of the article is to understand and to foster competent practice by counselors, psychotherapists, chaplains, pastors and other spiritual caregivers. The body of the text describes and illustrates five strategies that caregivers can employ plus a review of seven categories of therapeutic interventions.

Keywords: code switching; consultation; counseling; psycho-spiritual care; referral; therapeutic communication; therapeutic interventions

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1. Introduction

Two major, fundamental claims permeate the content of this article: the assumption about the universal or transcultural nature of the human spirit, and the enduring significance and value of religious and non-religious wisdom traditions.[1] In a nutshell, the human spirit longs for wisdom in its search for meaning, communion, and purpose; and wisdom traditions, whether religious, philosophic, or scientific, address that search across cultures. At its best, interfaith care connects wisdom traditions with the longings of the human spirit in socio-culturally and otherwise contextually pertinent ways.

Whether expected or unexpected, caregiving encounters with significant difference can be very challenging and, especially so, in interfaith situations. Therefore, caregivers must use appropriate strategies and approaches that help make therapeutic communication possible and effective. That is the material offered in the remainder of this essay.

The first section discusses what the author calls "timely consultation" and "opportune referral" as necessary strategies to take into account under certain circumstances. The section on "bridge-building strategies" is divided into the categories "seeking common ground" and "collaborative accommodation". It is followed by a presentation of caregivers' "code switching". That discussion is furthered with a repertoire of caregiving methods and techniques typical of, but not restricted to, counseling as forms of (broadly viewed) therapeutic communication. Case studies illustrate the nature of those strategies and approaches and illumine pertinent issues of competence in spiritual care.

2. Consultation and Referral

It is commonplace to assume that caregivers of any kind must commit themselves to the basic principle "first, do no harm", a popular saying that derives from the Latin phrase, "primum non nocere or primum nil nocere". Of course, any form of clinical malpractice must be avoided always! Given the potential for misunderstanding and verbal or emotional-spiritual violence, particularly inherent in interfaith care situations, it is fitting to first discuss consultation and referral as appropriate and, indeed, indispensable

strategies. These strategies can reflect clinical competence in the face of major difference. Competencies (plural) such as cultural humility, contemplative and reverent curiosity, and emotional-interpersonal intelligence; and the ongoing practice of self-reflexivity, are key.

2.1. Consultation

Consultation is normally necessary before and, often, during interfaith caregiving. In addition to bibliographic and other resources available,[2] there is the wisdom of trusted colleagues with interfaith expertise and experience, whether or not they represent the tradition of care receivers. Thomas Plante's thorough discussion of consultation in psychotherapy applies to other forms of spiritual care as well (Plante 2009, pp. 131–45). And, of course, caregivers themselves are the primary source of guidance from the start of the caregiving process. Therefore, consultation can be viewed first of all as a strategy of primary prevention of harm, that is, before the caregiving encounter takes place and during the first steps of the caregiving relationship.

Consultation can also play a role as a strategy of secondary prevention, when assessment of forward movement in the caregiving process calls for course correction in a timely manner. In this situation, caregivers definitely need to reorient their work with the kinds of resources mentioned above and, especially, with the very life expertise of the care receivers themselves. Kathleen Greider reminds us that meeting constructively and creatively amid difference always encourages power sharing: "...it is entirely appropriate to ask clients about their religious location(s), stating explicitly our desire to know about their tradition from their point of view...this is a 'teach me' approach...a 'perspective shift' during which counselors [or chaplains, psychotherapists] make themselves students of their clients' religious knowledge and experience..." (Greider 2019, p. 37). Furthermore, the caregiver's willingness to yield power by learning from the care receiver seems to have connective and therapeutic value.

The references above to opportune consultation also apply to referral seen as an interfaith care strategy of either primary, secondary, or tertiary prevention (Caplan 1964, pp. 15–231), depending on timing as main factor. For example, referral to a caregiver of the same religious or spiritual tradition can normally be requested by patients, incarcerated people, or their families, before a caregiving relationship starts or as it develops.

2.2. Referral

Referral can also be recommended or decided by the caregiver. Therefore, it is understandable that among the list of attitudes and skills of spiritually sensitive and competent counselors and psychotherapists, we find descriptions like this: "[those clinicians] are sensitive to circumstances (e.g., personal biases, value conflicts, lack of knowledge of the clients' religious tradition) that could dictate referral of a religious client to a member of his or her religious tradition" (Richards and Bergin 2014, p. 13).[3]

On some occasions, referral does not imply the termination of a caregiving relationship, for example when care receivers are advised to consult with clergy or other authorities in their tradition as part of the caregiving process under way. In any event, as Martin Walton notes, caregivers do well in thus respecting difference provided that they do not exaggerate or absolutize it by assuming that peoples of different cultures differ from each other essentially.[4]

Having thus highlighted the strategies of consultation and referral, we can now proceed with discussing active interfaith caregiving engagement that explicitly acknowledges difference. In other words, the two sections that follow provide a response to the question of method(s): how can we actually approach and navigate the therapeutic process in interfaith situations?

3. Bridge-Building Strategies

Whether it is called the therapeutic alliance (especially in counseling and psychotherapy) or, more generally, the caregiving relationship, a collaborative connection between

care receiver and caregiver is always essential. Together they identify needs and resources, desirable outcomes, and fitting approaches or interventions. Hence, creating and maintaining such a bond can be particularly challenging in the face of perceived major difference. Our analysis of empirical evidence in multiple cultural contexts and institutional settings finds at least three kinds of bridge-building strategies at work in interfaith spiritual care. (Parenthetically, the bridge-building metaphor intentionally links the experience of difference with interpersonal and intersubjective distance as analogy; and also with finding common ground or space as necessary therapeutic context). Those sets of strategies are characterized as (1) seeking common ground;[5] (2) collaborative accommodation, and (3) caregiver's code switching.

3.1. Seeking Common Ground

Brief case studies in the following paragraphs illustrate how care seekers and caregivers found common ground in healthcare centers. The focus of the two cases selected is the question of offered or requested prayer[6] in interfaith situations involving Christian chaplains.[7]

3.1.1. A Baptist Chaplain Cares for a Jewish Family

It was Saturday evening when Chaplain Bill's pager contact informed him of a need at a palliative care unit. When Bill arrived, he found the patient's room filled with family members. The young men were wearing yarmulkes (skullcaps). A woman with grey hair who was standing by the bed looked at Bill as he entered the room; Bill realized that she was the wife of the dying man. He introduced himself and she said, "Pastor, thank you for coming. Jacob is not going to make it, and we appreciate that you are here".

Not that there was much doubt, but the chaplain confirmed with the family that they were Jewish and then asked them if it would be helpful if he contacted a Rabbi. Jacob's wife smiled and said, "No, our God is your God, and he hears our prayers". Bill affirmed her statement and, since Jacob was not responding, he asked the woman if Jacob had the assurance of God's love and care in those dying days. She smiled again and said, "Oh, yes, he knew..."

Bill was then introduced to every person in the room, and Jacob's wife directed a grandson to get him a chair so that he could sit with her by the bed. Bill sat down and invited the people in the room to tell him about Jacob. Different ones spoke up, telling him about their relationship and sharing something about how special he was to them. There was laughter as family members remembered things that had happened or lessons they had learned.

Forty minutes passed quickly, and when the time was appropriate, the chaplain stood and told them how special it was for Jacob and his wife to have such a loving family present at such time. He encouraged them to keep telling their stories and to tell Jacob how much he meant to them.

Bill usually concluded his visits with a prayer. He wanted to be sensitive to how he, a Baptist chaplain, could best minister to a Jewish family, so he asked them if he could leave them with a prayer and a blessing from the Bible. They agreed that would be good, so he read Psalm 23, offered a prayer, and then blessed them with the benediction from Deuteronomy 31:8: "It is the LORD who goes before you. He will be with you; he will not fail you or forsake you. Do not fear or be dismayed".

As he rode the elevator to the lobby, Bill was aware that he had just experienced a special moment unlike any he had ever experienced. He had been able to contribute to a meaningful grieving process with people whose religious experiences were in some ways similar and yet very different from his own. At the same time, he had been blessed by the Jewish family. It was affirming to know that being sensitive to the belief system that has given people hope through the years makes it possible to connect with them deeply in a significant way.

This case study illustrates the profile of a caregiver's core competencies that meet established standards of excellence in interfaith spiritual care. It can be read as a threefold example of identifiable principles, or dependable guides, in terms of being, knowing, and doing competencies (Schipani 2012, pp. 95–97).[8]

3.1.2. A Mennonite Chaplain Encounters Two Hindu Men

Tarak was a 43-year-old Hindu man being treated on the neuro-medical surgical unit following a stroke. Originally from India, he was currently living in the States. I [chaplain Leah] had visited Tarak once before. This time another man was with him standing at the foot of the bed. During our conversation I learned that this man was Tarak's friend, Peter, also from India but having lived in the United States for a longer period of time. He was fluent in both Hindi and English.

> "How have you been since the last time we talked?" I asked. Tarak responded with a questioning look on his face. I started again, "How are you?"
>
> "Fine", he answered.
>
> "Have you been doing exercises?" I inquired, trying to open a conversation that connected with the first time I met him. Peter interpreted my question.
>
> "Yes", Tarak answered affirmatively.
>
> "In the mornings", Peter added.
>
> "What kind of exercises do you do?"
>
> Peter again interpreted my question. Tarak began to lift his left arm up and down with his right hand.
>
> "Arm exercises. And walking?"
>
> Peter answered, "He uses a walker and somebody supports his left side."
>
> "Are you here when he does his exercises?" I asked Peter.
>
> "No, I'm not here in the morning."
>
> "How did the two of you meet?" I asked.
>
> "We come from the same place in India and we have the same last name."
>
> "Oh really? But you met in this area?"
>
> "Yes". A friend of his is also my friend and so we met. I am looking for a job and I heard that he was in the hospital. So I came here to be with him—I like to be here when he needs help.
>
> Turning to Tarak I said, "Good to have friends, isn't it?" Tarak nodded. "Last time we talked you told me that you are Hindu."
>
> "Yes", Tarak replied.
>
> "As a Christian, I'd love to know more about what it is like to be Hindu." Tarak smiled and nodded. "It must be different here, where there aren't very many people who are Hindu . . ."
>
> Peter responded: "In India about 80 percent are Hindu, 13 percent are Muslim, and the rest are Christian and others."
>
> "Oh, I see", I said. "That must be a different experience."
>
> "Yes. It's different." Peter replied, "but I go into a church."
>
> "A Christian church?"
>
> "Yes. There is one God. Whether I am in a temple or in a mosque or in a church—Krishna, Rama, Jesus—it's all the same God."

"Different names for one God", I said.

"Yes—different names for one God. That's what *I* believe."

"What about you?" I asked, looking at Tarak. Peter interpreted my question. Pointing up with his finger Tarak said, "One God."

"I also believe that." I stated. "Do you also pray in the Hindu tradition?"

Peter interpreted and then said, "Yes, we pray."

"What is it like for you to pray…?" Peter chuckled and interpreted for Tarak. Tarak put his hands together and bowed his head.

"Do you know what he is saying?" Peter asked me. "He is saying when we go into the temple we stand in front of the god, we put our hands together—like you—and bow our head—the same. In a temple there is a statue, in a mosque there may be nothing, in a Christian church there is a statue of Jesus. The method doesn't matter, it's what is in the heart that's important."

"Yes, God knows the heart." I replied. Looking at Tarak I asked, "What do you pray for?" Peter interpreted and Tarak touched his arm, looking at me.

"For health, for the body to be restored." I said.

Peter added, "For strength in his leg and his arm so that he can go back to India."

"Yes of course." I said. "To recover and be well again; to go home." Peter returned to the subject of God. "Human is the same everywhere—one God. But not everyone believes that. If everyone believed that, the world would be very different, I think. Now there is always fighting."

"Yes, it seems that our differences sometimes get in the way." Looking at Tarak, I asked, "Would it be all right if I say a prayer with you?"

Peter interpreted the question and then said, "That would be all right." He interpreted to Tarak as I prayed, line by line.

"O God who loves us all, thank you for the opportunity to talk with Peter and Tarak. As Tarak spends these days in the hospital, we pray that your healing will strengthen his body and that your spirit of peace would bless him. Thank you for the friendship that Tarak and Peter share. Thank you for the care of the medical staff here. Give the staff guidance and wisdom. We pray that Tarak will regain his strength day by day. We pray that he will soon be able to return home to India. May Tarak know your love and healing through the care of those around him. Amen". After exchanging a few more words, I thanked them for the visit and we said good-bye.

4. Collaborative Accommodation

This caregiving strategy can also be viewed as a variation of seeking common ground as a broader category. In this case, care seekers and caregivers explicitly agree regarding the bridge-building activity which, like in the case that follows, may include a blessing or a ritual. This is the situation faced by a Lutheran chaplain when asked to bless a deceased newborn child. The case study was originally presented as an example of how chaplains often seek to "reconcile" their theological convictions with care receivers' different spirituality in sound ministry practice. The study of the case revealed that the situation may also be viewed as a case of reframing the chaplain's initial assumptions coupled with his disposition to provide compassionate care (which actually facilitated the reframing).

Alone in the room, sitting up in bed, was a late-30s-ish woman of oriental descent. I presumed Chinese.

C (chaplain) "Hello, I'm Jack, one of the hospital chaplains".
P (patient) "Hi Jack. I'm Jane."
C "I'm so sorry for your loss. I'm here to help you through this in any way I can."
P (Tearing up and weeping mildly) "Thanks, I appreciate that".
C "The nurse told me you want a blessing for your baby."
P (Quietly) "Yes, I do."
C "It's my privilege to help you with that. I want to accompany you as best I can."
P (Quietly) "Thanks."
C "Can you share with me what it means to you to have your baby blessed...? I mean, what do you wish for your child as I bless him. . .?"
P (A little more strongly) "It's about the gesture."
C "Does the gesture come from any particular tradition?"
P "No. I'm less religious than spiritual."
C [After a brief exploration of Jane's being spiritual but not religious] "I understand now. That's helpful. Thank you."

Our conversation turned toward her general situation until I departed the room while a nurse tended to Jane.

I faced an interesting situation. Jane did not even remotely refer to baptismal language or baptism. Could I, in good conscience, perform what she wasn't asking for? Part of my question came from the fact that I did not have "fetal demise blessing language" at my quick reference and use. Another source of my question was whether I fully understood what she meant by "gesture", and "spiritual". Did I have enough information to feel confident that I could provide something to meet her need? It was not a question of whether or not I would do this for her, especially since I had already begun a pastoral relationship with her. I cherished the opportunity to provide compassionate care in the face of Jane's pain.

It is unnecessary for Lutherans to baptize deceased babies, the common practice of doing so out of compassion for parents and respect for sacra mental mystery had become my reflexive response to fetal demise. Once I clarified my own theological convictions in my own mind, the clarity I experienced was as if the skies had cleared on a gloomy day.

What I knew and what I had experienced was, specifically, baptism. However, Jane's request for a non-specific spiritual "gesture" has expanded what I know, and now, what I have experienced: to gladly provide something outside of my theological views and ecclesial practice in good conscience. Thus, I avoided going through the motions just to fulfill Jane's request like some chaplain chore to get over with. Having internally negotiated these doctrinal and spiritual hurdles, I was ready to provide Jane with compassionate and meaningful care.

A short time later, Jane's baby boy was returned to her. She, two of her friends, another chaplain, and I shared a meaningful and moving blessed ritual that included prayer for the boy, Jane, her absent husband (who was traveling and would join her soon), family, and friends. I had "reconciled" my doctrinal views, common practice, and Jane's spirituality. I'm grateful.

5. Caregivers' Code Switching

Strategies of mutually and explicitly minimizing difference and collaborative accommodation are deliberately co-created and enacted jointly by caregivers and care receivers. Code switching in interfaith spiritual care is a strategy used by caregivers at their initiative; normally, they are not discussed with care receivers as a chosen therapeutic communication technique or overarching approach. The case illustration that follows is used by permission of a prison Christian chaplain and the institutional setting is a maximum-security prison.[9]

Mr. Gates just received a call from a family member that his son 'DJ' was shot and killed during a drug deal gone wrong. He is Muslim serving a 60-year sentence. It seems that his son became victim to the father's criminal lifestyle. So, this father is in his cell overwhelmed with sadness and despair for having failed his son as well as himself. Furthermore, his biggest challenge is trying to heal the relationship with his daughter, Mia. She is currently in college, married with two kids. Mia has a lot of anger towards Mr.

Gates, primarily because of his poor example as a father to her deceased brother. Below is a slightly simplified excerpt of a visit-counseling session with Mr. Gates regarding the death of his son and the possibility of improving the relationship with his daughter.

The institution is on lockdown (temporary restriction from leaving the cell). While walking to the cell, Mr. Gates appears to be depressed. His cell is moderately in order, but he's pacing from the front of the cell to the back. His copy of the Holy Qur'an is open on his bed, his prayer rug is on the floor and his eyes are slightly red. I approach him with caution, looking for the opportune moment to offer care and to find out what my role would be to collaborate with him pastorally.

> Chaplain: Good afternoon Mr. Gates. I received a call about the tragic news you received. My deepest condolences to you.
>
> Mr. Gates: Yeah, I f***** up chap.
>
> Chaplain: You have your Qur'an open and your prayer rug on the floor. Did I interrupt you?
>
> Mr. Gates: Naw, you good chap. Just messed up how they did my son like that. 10 times?
>
> Chaplain: Oh Lord, that's tragic. I'm sorry to hear that.
>
> Mr. Gates: It's cool. Allah has forgiven them. It's just going to take me time. What's f***** up chap, all he had to do was listen to me on how to sell drugs and he'd be good. Now my daughter blames me for what happened.
>
> Chaplain: Selling drugs never has had a good ending, but I don't think you need to focus on what you could have taught him. Maybe there's something you need to give more attention to…?
>
> Mr. Gates: What's that?
>
> Chaplain: Your daughter. Right now, your daughter is angry that her brother is gone, and she could be angry with you for a different reason.
>
> Mr. Gates: What would that be?
>
> Chaplain: Perhaps your daughter misses her dad. Maybe the best thing you could do right now to please Allah is to try to heal the relationship with her.
>
> Mr. Gates: I'll try, but we never got along really.
>
> Chaplain: Somewhere I read in the Hadiths, "When the believer commits a sin, a black spot appears on his heart. If he repents and gives up that sin and seeks forgiveness, his heart will be polished. But if sin increases, the black spot increases."[10] What am I saying…? Mr. Gates, perhaps it's best to start forgiving yourself of the absence and work towards healing the relationship with your daughter.
>
> Mr. Gates: Yeah, you right. That's a good idea.
>
> Chaplain: Is there anything I can do for you?
>
> Mr. Gates: Naw, I think I'm good. But I appreciate you coming by to talk with me.
>
> Chaplain: Sounds good, just keep me posted if you need anything.

Chaplain Davis reflected that his spiritual care approach deliberately included helping Mr. Gates to access and integrate spiritual resources from his (the care receiver's) religious-spiritual tradition in the face of critical circumstances. He also engaged the care receiver with an eye to moving forward towards healing the relationship with his daughter. The chaplain's reference to Islamic resources strengthened the relationship in terms of mutual trust and respect. In turn, this encounter rekindled a vision to gather focus groups of men incarcerated that desire a better relationship with their children.

The Question of Integrity in Code Switching Strategies

By definition, code switching in spiritual care consists of adopting and adapting someone else's language and frame of reference as a therapeutic communication approach. So, the question can be raised whether this is a (justifiable) form of misleading or deceiving the care receivers. Buddhist chaplain, Monica Sanford, helpfully addresses this question of authenticity often encountered, for example, in connection to requests for a ritual, a blessing, or a prayer. How can we pray authentically to deities we do not believe in? She responds by explicating the notion of "as-if space"[11] with an illustration from the time when the wife of a beloved professor at an ICU asked her to take his hand and say a prayer:

> "The words, 'Our Father, who art in heaven, hallowed be your name,' came from a place of authenticity deep inside me. In that moment, if anything I said could be of comfort to him and his family, I would say it. And if God existed in the way Christians believe he does, I knew he would understand. I don't know if God heard me, but I know my professor did. He stilled and rested for the remainder of the Lord's prayer and for several minutes thereafter. His wife and mother thanked me. I left with a heavy heart, but knowing that if I called upon to pray with Christians or Jews or Hindus, I would do so authentically. . . When I pray for someone, 'May you have peace in Jesus Christ,' I truly hope they find that peace exactly according to their beliefs. This is not a lie and it is not wrong speech. I doubt that the historical man called Jesus Christ was the Son of God, but I nevertheless hope for the care seeker's sake, that He is listening and granting lasting peace". (Sanford 2019, pp. 196–97)

Chaplains Davis, Sanford and others can aptly employ code switching as an interfaith caregiving strategy inspired and supported not only by adequate clinical training but, especially, by the normative framework of the wisdom traditions—Buddhist, Christian, or otherwise—that they consistently represent.

So far in this chapter we have reviewed strategies and approaches specially, although not exclusively, designed for interfaith care situations. In any case, a reminder by pastoral theologian, Martin Walton, is welcome: "The discernment of difference and the appreciation of diversity are a critical test for interreligious and intercultural care. The care needs also to be 'intercontextual', or intersectional, in recognition of the palette of social dynamics that affect our identities and perspectives. . . In the contemporary fluidity of religious and secular worldviews, all pastoral, chaplaincy, and spiritual care should be considered interreligious, intercultural and intercontextual until proven otherwise" (Walton 2021, p. 63). In the next section we discuss other ways of addressing diversity and difference under the overarching category of cultivating spiritual reflection.

6. Cultivating Spiritual Reflection

All spiritual care strategies and approaches offer opportunities while also presenting potential risks of misunderstanding and unintentional aggression; and that is especially the case in interfaith situations. Normally, some combination of methods can be chosen in light of careful clinical discernment. This section discusses an overarching approach that is both, necessary clinical discernment as well as a way to "identify, access, engage, and evaluate spiritual thoughts, experiences, and resources at play in caregiving conversations" (Gabriel and Bidwell 2022, p. 93).

The following paragraphs describe seven categories of therapeutic communication forms, often called interventions or techniques. They come from the fields of counseling and psychotherapy and are especially applicable in interfaith situations in diverse institutional settings. Of course, in actual practice these communication forms are employed within the dynamic flow of psycho-spiritual caregiving processes (Clinebell 2011, pp. 65–92; Liefbroer 2020, pp. 171–92).

Probing. Caregivers pose questions in order to elicit information or encourage further discussion of a given topic. The content of probing can be factual information as well as

emotions and feelings experienced by care receivers. It should be noted that this form of communication must always reflect an optimal blend of contemplative (or "reverent") and clinical (or "scientific") curiosity. It is of course indispensable for assessment purposes but not exclusively so.

Reflecting. Responsive listening normally leads to communication of empathy and understanding. Simultaneously, and often implicitly, this intervention seeks confirmation that mutual understanding is actually happening. Reflecting can be expressed in different ways such as paraphrasing and "echoing" (repeating certain caregiver's statements). The feedback thus provided can nurture rapport and also serve as a supportive technique.

Evaluating. Sometimes caregivers need to express value judgement regarding the nature of care receivers' behaviors or feelings. Direct, negative evaluative interventions (e.g., via statements or questions) can serve the purpose of necessary confrontation (e.g., in the face of abusive behavior, or self-harm). Indirect evaluative comments can encourage an alternative course of action. Positive evaluation (e.g., by agreeing, complimenting, affirming) can serve as a supportive or even empowering[12] technique.

Supporting. Caregivers often seek to reassure, reduce intense emotions and feelings, and to deescalate tension and anxiety. They thus remind care receivers that there are internal and external resources available to them, especially in situations of serious crisis, loss, and trauma. The very caregiving relationship thus becomes a primary source of support.

Clarifying, interpreting. There is often a fine line separating and connecting these two types of therapeutic communication. Strictly speaking, interpretation (e.g., unveiling subconscious motives, meanings) happens more readily in psycho-dynamically oriented counseling and psychotherapy. More often than not, reframing seekers' messages blurs the distinction between clarifying and interpreting techniques.

Performing. All kinds of spiritual care, without exception, can include particularly directive approaches and interventions under appropriate circumstances. Diverse activities, either by care seekers' request or by caregivers' initiative may define the latter's engagement as guides of the therapeutic process, such as opportune self-disclosure (e.g., sharing a personal experience, or a held value or opinion) and leading spiritual practices (e.g., prayers, blessings, rituals).

Advising, assigning. The repertoire of directive approaches and interventions also include a variety of possibilities, such as providing useful information and making recommendations during a session or a visit. They may also give assignments (e.g., performing certain exercises, reading from a sacred text) between sessions or visits.

The chart below comes from my work on counseling as psycho-spiritual care and can be applied to other caregiving specialties as well (see Table 1). It shows the connection between four main situations that commonly make caregiving necessary—disorientation, conflict, crisis, and loss—and the seven categories of caregiving interventions or techniques described above.

Table 1. Caregiving interventions for spiritual reflection.

	Disorientation	**Conflict/Struggle**	**Crisis/Trauma**	**Loss/Death**
Probing	What are you looking for? How can I be helpful?	Are there spiritual resources to help you face this dilemma?	What do you need to feel safe right now?	How does your spiritual tradition respond to suffering?
Reflecting	I hear you say that you feel stuck.	So, sometimes you feel helpless and even hopeless.	You're feeling overwhelmed and very anxious.	As you said, some tragedies are very hard to face.
Supporting	We are here because we believe we can process this. . . You are working at it.	Your anger is going to help make a way forward for you.	I am here with you. God is here with you.	I will be available whenever you wish to call.
Evaluating	You are understandably feeling bad and guilty because. . .	It's a good thing that you are working on this.	Life seems to be very unfair sometimes.	It's helpful to cry and lament at a time like this.
Clarifying, Interpreting	I wonder if there is a deep fear you're not acknowledging.	I feel there is a part of you that doesn't want to move forward. . .	I get the impression that you are blaming yourself for what happened.	I wonder whether sometimes you feel your faith is too weak.
Assigning, Advising	What would you like to do next? This is something that has helped a number of people. . .	Think of those times when you could count on strength and support.	I recommend that you consult a doctor in order to make sure that. . .	It will be helpful to reorder your daily routine during this journey of grief.
Performing,	You seem to have options. Let's write the pros and cons on a piece of paper.	Let's pretend that I'm God. What will you tell me?	Offering water. Breathing exercises.	Special blessing. Ritual of lament.

7. Conclusions

Ten years ago, a group of colleagues representing six religious traditions and a humanist perspective, articulated their views on how their traditions inform, inspire and guide their work in spiritual care. They reflected on the place and function of foundational sources and normative frameworks in interfaith situations, and identified core competencies of professional excellence (Schipani 2013). However, the question of clinical approaches and therapeutic communication was not a major focus in that project. Interestingly, the very same year a major article was published that began to address systematically the issue of how to negotiate religious difference (Cadge and Sigalow 2013). The present article represents the fruits of further reflection on that challenge in therapeutic communication during the last decade. It is offered as a contribution to the growing field of interfaith spiritual care across diverse cultural contexts.

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Notes

[1] These claims are based on converging data stemming from various sources such as these: 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.

[2] For valuable information about beliefs and practices pertaining to diverse cultural and religious traditions see, for example, in the case of counseling, Sue et al. (2022), *Counseling the Culturally Diverse*, pp. 33–35; for psychotherapists, Richards and Bergin (2014), *Handbook of Psychotherapy and Religious Diversity*; for chaplains, Wintz and Handzo (2014), "Patient's Spiritual and Cultural Values for Health Care Professionals".

[3] For the art of referral in all forms of pastoral caregiving, see Clinebell (2011, pp. 392–412).

[4] Walton's whole essay is recommended.

[5] Notice that I choose the phrase "seeking common ground" instead of the term "neutralizing"; the latter is commonly used by sociologists in reference to minimalizing the significance of cultural differences or accentuating common perspectives in meaning making.

[6] Chaplains and other pastoral and spiritual caregivers possess a unique repertoire of interventions, prayer being chief among them. Indeed, prayer is an indispensable intervention in the caregiver's portfolio By now it is obvious that quality pastoral and spiritual care requires the capacity to make available both formal and informal prayers for persons of all faiths. Further, it is evident that they should exercise strong social-emotional intelligence to interpret cautiously the care receivers' cues, and to assess their comfort level. Therefore, interfaith care givers should equip themselves with a variety of resources and skills to facilitate the delicate connection between care receivers and what is sacred or holy for them.

[7] The following case illustrations are composites of actual case studies collected during the last several years. The choice of samples with chaplains representing different Christian traditions was deliberate. Earlier versions of the challenges faced by Mennonite, Baptist, and Lutheran chaplains in those caregiving situations, can be found in Bueckert and Schipani (2010, pp. 25–45, 81–98).

[8] Bill's ministry illustrates core competencies of *being* indispensable to full *presence* with the family:

- A clear sense of personal and vocational identity
- Optimal self-awareness, including a realistic view of strengths and limitations
- A plurality of character strengths such as acceptance, respect and sensitivity; humility and compassion; freedom to be vulnerable and openness to new experiences; etc.
- A spirituality that embraces complexity and paradox (e.g., regarding the normativeness of Jesus Christ and the truthfulness of the care receivers' Jewish faith)

1. As a spiritual caregiver, Bill demonstrates the value of several core competencies of *knowing* essential for *understanding* and *discernment*:

- A philosophy of caregiving primarily grounded in his Christian faith tradition and shaped by professional training and experience
- Knowledge of the complexities, dynamics, richness and challenges of interfaith situations
- Understanding of at least one other faith tradition different than his own
- Clinical and theological knowing and assessment

2. Bill's work also illustrates core competencies of *doing* required for the fine art of *companioning* in spiritual care:

- He relates to the Jewish family in ways that engage their emotions and spirituality
- He encourages and guides the family members in a time of story-telling
- He is a participant-observer who internally monitors ongoing caregiving activity thus maximizing effectiveness while avoiding invasive or intrusive interventions
- He provides a number of responses in several caregiving modes (e.g., gently probing, supporting, praying, reading, blessing)

[9] Rev. Damien W.D. Davis presented this case study in a D. Min course—M609: Culturally Attentive Pastoral Leadership – Interfaith Pastoral Care & Counseling—at McCormick Theological Seminary, in October, 2021. He went on to work on a thesis project, "Prison Life and the Aftermath of Thug Living: Chaplaincy Training Approaches for the Long-Term Incarcerated" (D. Min. Thesis, McCormick Theological Seminary, 2023).

[10] Vol. 5, Book 37, Hadith 4244. This is a reference to the collection of traditions with sayings of the Prophet Muhammad which, with accounts of his daily practice (the Sunna), is the major source of guidance for Muslims apart from the Qur'an.

[11] "As if space" here means the momentary setting aside, "bracketing" or, better yet, holding one's belief system side by side with that of the caregiver's while assuming the plausible nature of the latter. For example, in a given interfaith caregiving situation, a caregiver with a non-theocentric worldview, may communicate with a believing care seeker in her or his terms, "as if" God really existed.

[12] Within this repertoire of therapeutic communication form, empowering care receivers can be included as a combination of evaluative, advising/assigning, and performing categories, or as a separate category. In any case, the purpose of empowering interventions is to enable care receivers to build a stronger sense of psycho-spiritual worth, strength, and agency, and to encourage appropriate action in search for justice for themselves and their communities.

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