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Interreligious Spiritual Care

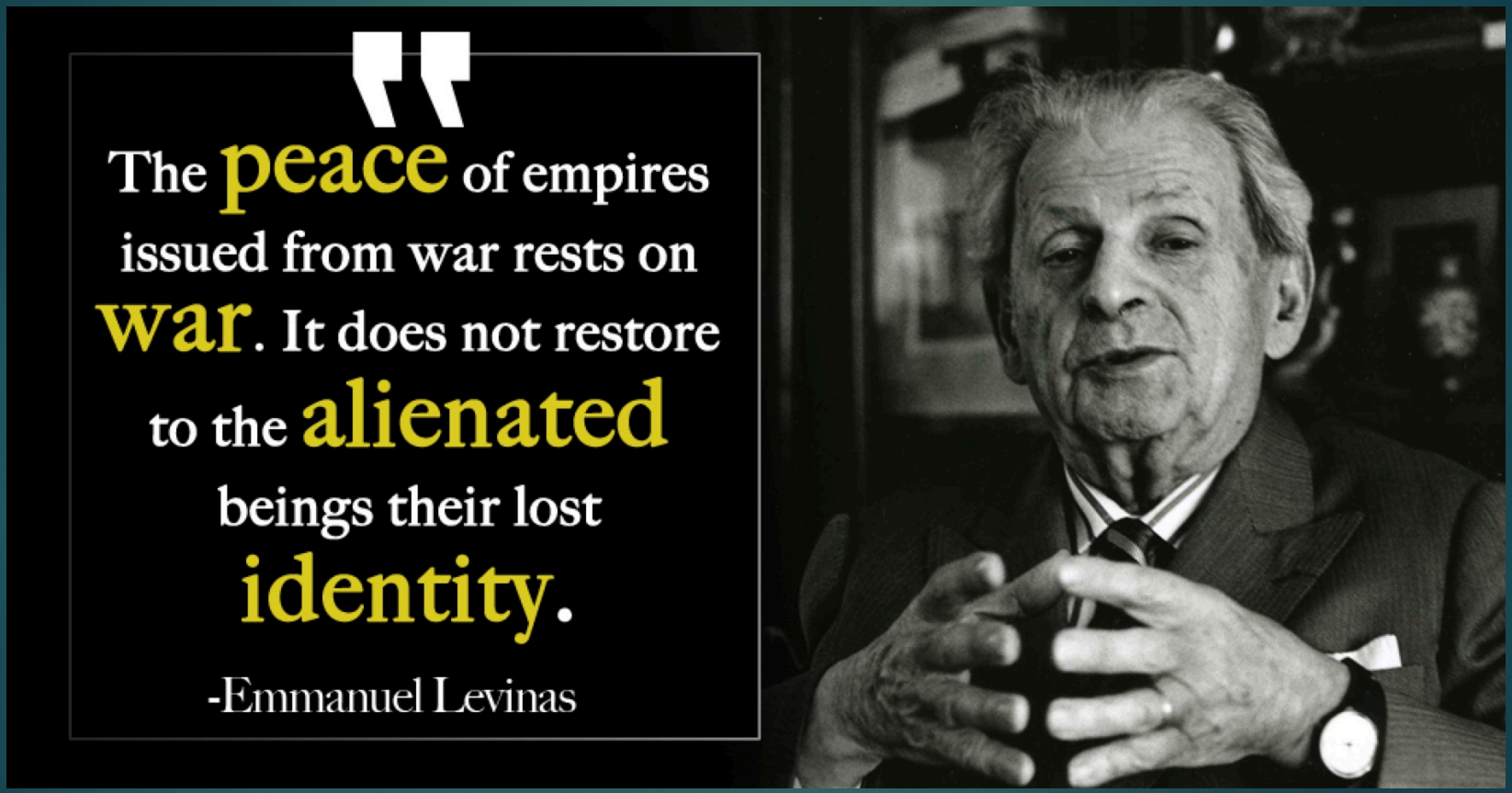
Emerging Models for Spiritual Care & Education

The Face of the Other

The dimension of the divine opens forth from the human face.

- E. Levinas

Emmanuel Levinas



Beyond Cultural Competence

Honoring the alterity of the other

Toward Cultural Humility and Hospitality

The relation with the other will always be offering and gift, never an approach with 'empty hands'.

- E. Levinas

Engaging the Other Within

To be undone by another is a primary necessity, an anguish, to be sure, but also a chance – to be addressed, claimed, bound to what is not me, but also to be moved, to be prompted to act, to address myself elsewhere and so to vacate the self-sufficient "I" as a kind of possession.

– Judith Butler (2005, p. 136)

The Interruptive Moment of Care

Beyond empathy…

toward creative interruption.

From togetherness and sameness…

toward interruption and alterity.

The Divine as Creativity

- Creativity is mysterious.
- Creativity requires that we not reify "God", thus creating idolatry.
- Creativity connects the divine with the coming in to being – in time – of the new.
- Creativity is interruptive and dislocating, moving toward an ever-increasing diversity rather than a unified, constant and monadic reality.

A Case Study in Creative Interruption

Ms. J is a 65 year old intensive care patient who was hospitalized after being hit by a car while on her bicycle. Ms. J was badly injured with many broken bones. She endured a traumatic brain injury with swelling and some damage to her brain. Ms. J has been on life support for several weeks and is minimally responsive according to the daily assessments recorded by the neurologists who are caring for her. Ms. J is originally from Bangladesh and has lived in the US for 20 years. Ms. J has two sons who speak English fluently though they prefer to speak in their native language of Bengali. Ms. J and her family identify themselves as Hindu.

Mr. L is a chaplaincy student in his first unit of Clinical Pastoral Education. Mr. L is a white, 36 year old seminary student, studying for ordination in the Presbyterian church. Mr. L is assigned to the ICU for his CPE internship. In supervision, Mr. L comes to me to share that he is upset with Ms. J's family because they "cannot accept that Ms. J is suffering and should be allowed to be withdrawn from the ventilator" and "allowed to die peacefully" rather than linger indefinitely in a marginally conscious state. The medical team wants Mr. L to convince Ms. J's family to recognize the futility of care for Ms. J. The physicians hope that the chaplain can help mediate the situation to come to a more "realistic" plan for Ms. J's treatment. Mr. L has come to supervision to ask for my help and insight. Mr. L has never met a Hindu practitioner. He wants to know how to convince Ms. J's family to withdraw support.

I suggest that we go to visit Ms. J's room together to talk with the team, meet her family and assess the situation. Mr. L agrees to co-collaborate on this case for the benefit of his learning. We enter the room and discover Ms. J's two sons, beside her bed. After introductions, I begin to engage Ms. J's sons to discover their perspective on their mother's treatment. Although Ms. J's sons are not themselves religious, they describe their mother as a devout follower of a Hindu yogi. They share that their mother is the most peaceful and gentle person they know. Her sons are amazed at the sense of peace she has been able to maintain during this hospital stay considering the profound injuries she has suffered. They tell us that Ms. J would see her suffering as an opportunity to be purified of negativity. Her calmness is a reflection of her deep spiritual practice gained after years of practicing yoga.

I share that some members of the team are wondering if it is beneficial to continue the life support treatment with the injury to their mother's brain. The sons have heard this perspective from their mother's doctors. They do not understand why the doctors think she is unresponsive. One of the sons leans down to his mother's ear and speaks gently, loudly, and with great tenderness, in Bengali. Though Mr. L and I do not understand the content of his words, Ms. J's son's affect is deeply loving and intimate. Ms. J begins to smile and laugh. She opens one of her eyes and looks directly at Mr. L who is standing beside her and she smiles. We let Ms. J's sons know we will help mediate the conversation between them and the medical team. We offer words of support to Ms. J and her sons and encourage them to bring images of Ms. J's spiritual teacher into the hospital room for support if she would like to set up an altar in the hospital room.

Later in supervision, Mr. L feels a sense of shame and anger for assuming that the medical team was accurately assessing Ms. J's responsiveness. He is frustrated and feels embarrassed for being part of the white, male dominated "system" that "undervalues cultural minorities". We process his experience and emotional reaction together and Mr. L writes a theological paper on the moment that Ms. J "looked right at me with a depth of compassion" as a sacred and theologically significant sign of the presence of Christ for Mr. L. He writes of this moment as a turning point in his learning to become a caregiver able to rely on his own authority in his role of chaplain. We let the team know that Ms. J was responsive in her conversation with us and recommend that she only be assessed in her own language with her sons present. We document her sons' perspective on their mother's "non-responsiveness." After several months of rehabilitation, Ms. J is able to return home to live independently with some help from her sons.

Discussion

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