The Effect of Serious Disease on the 'Traditional' or 'Alternative' Spirituality of Patients: Research Results in Groups of Believers with 'Traditional'/'Alternative' Beliefs[1]

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Abstract

The article presents the basic results of the qualitative research *The Effect of Serious Illness on the 'Traditional' or 'Alternative' Spirituality of Patients*. This research was conducted from March to May 2018. The research group consisted of 20 respondents (coming from different age groups and living in South Bohemia) with serious illness, half of which were 'traditional' and half 'alternative' believers. The research focused on this marginal life situation in the respondents' spirituality and its impact in the context of clinical pastoral care. Research has shown that serious illness raises questions of meaning and, in that way, opens up space for both 'traditional' and 'alternative' spirituality. At the same time, it is not a factor that would significantly influence the mutual openness of both types of spirituality. In the context of existing spirituality, it is thus consolidated, deepened, and strengthened. The 'alternative' believers become more interested in spiritual things, but not in Christianity. Clinical pastoral care therefore stands before the matter of how to approach the 'alternative' believers and how to meet their spiritual needs without losing its Christian anchorage.

Key words: clinical pastoral care, 'spiritual care', hospital chaplain, 'traditional' spirituality, 'alternative' spirituality, serious illness

The article presents basic results of qualitative research which was realised in 2018 in the region of South Bohemia. The aim of the research was to find out if and how serious disease can affect the 'traditional'[2] or 'alternative'[3] spirituality of respondents in three aspects below. The analysis

1 This article was created with the financial support of the Grant Agency of the University of South Bohemia in České Budějovice, project No. 028/2018/H 'The Effect of Serious Disease on Traditional or Alternative Spirituality of Patients'.

2 We build on the assumption that spirituality is a general characteristic of man and is present, to varying extent, in the vast majority of individuals. Cf. Pavel ŘÍČAN, Spiritualita v centru struktury osobnosti, in: *Psychologie osobnosti*, ed. Marek BLATNÝ, Praha: Grada, 2010, pp. 225–238. Here, 'traditional' spirituality refers to a spirituality raising from the Christian roots which can be defined as 'the personal experience of the relationship to the transcendental reality, in this case, to the Trinity, (...) and also as the specific conditions, circumstances, methods and stages of development of that relationship. Ivan ŠTAMPACH, Nahradila spiritualita náboženství?, in: *Spiritualita. Fenomén spirituality z pohledu filozofie, religionistiky, teologie, literatury, teorie a dějin umění, pedagogiky, sociologie, antropologie, psychologie a výtvarných umělců*, eds. Hana BABYRÁDOVÁ and Jiří HAVLÍČEK, Brno: Masarykova univerzita, 2006, pp. 99–105.

3 In this article, the term 'alternative' spirituality refers to the deinstitutionalised spirituality which covers a wide range of phenomena, such as 'reading horoscopes, belief in the ability of healers, divination or interpretation of cards, interest in parapsychology, various meditation

of this data has enabled us to gain insights that can be beneficial for clinical pastoral care, that is, for care which is provided to patients in this marginal life situation.

1. Theoretical basis

In addition to the physical care of patients, the care of the patient's spiritual needs has become an integral part of complex hospital care in Europe. In the Czech Republic, it is called clinical pastoral care.[4] This type of care is provided by hospital chaplains. While this care has been established in our western neighbours for a long time, it is not commonplace in all hospitals in the Czech Republic. Its implementation is connected, among other things, with the definition of organisational structure, objectives, the position of hospital chaplains within hospitals, their competences, etc. Thus, there is a need to clarify the role, status, and benefits of clinical pastoral care, especially in secular hospitals. Although this issue may seem to be sufficiently discussed in the Czech environment, a new definition of the role and definition of clinical pastoral care, in the context of the term 'spiritual care', is nowadays a current topic in the neighbouring German-speaking countries. This term could become a topic in the Czech Republic as well. The relationship of 'spiritual care' as a new interdisciplinary concept of care and clinical pastoral care is not discussed in neighbouring countries only. A number of 'spiritual care' concepts have been developed in the UK and the US, where the topic has sparked a debate between conservative and liberal theologians about the positives and negatives of 'spiritual care' versus traditional pastoral care (focused on denomination).[5] Indeed, this term comes from the Anglo-American environment: more than 25 years ago, it was established in the UK, the United States, and Canada as a medical reference. In Europe, this expression first spread in Holland, and gradually penetrated into Germany and other German-speaking countries,[6] where the topic is explored by theologians from the field of medicine or medical ethics.[7] In Germany, the *International Society for Health and Spirituality* (Internationale Gesellschaft für Gesundheit und Spiritualität) was established in Munich. It publishes its own professional magazine *Spiritual Care* and deals with, in addition to a number of other topics, religion, religiosity, faith, and spirituality in relation to disease and health.[8] 'Spiritual care' is based on a broadly defined notion of spirituality. The latter can be understood as an inner attitude and personal search for meaning in different life situations, especially in situations associated with existential questions. In this sense, the term does not fall within the exclusive competence of hospital chaplains but is a matter for other professional groups working with severely ill and dying patients.[9] According to Ulrich H. J. Körtner, 'spiritual care' is a reflection of the fact that medical-ethical problems are present on three levels: personal (physician-patient), institutional (hospital), and at the level of one's culture, values, world-view, and religion. At the same time, the theme of 'spirituality, religion, and culture at the patient's bedside' is present on all these levels.

techniques, yoga, new age, Eastern medicine, 'alternative' medicine such as homeopathy, etc.' Dana HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí*, Praha: Karolinum, 2013, p. 14.

4 For a definition of clinical pastoral care, see, for example, Marie OPATRNÁ, *Etické problémy v onkologii*, 2nd revised and updated edition, Praha: Mladá fronta, 2017, p. 95.

5 Cf. Ulrich H. J. KÖRTNER, *Leib und Leben. Bioethische Erkundungen zur Leiblichkeit des Menschen*, Göttingen: Vandenhoeck & Ruprecht, 2010, p. 94.

6 Cf. Doris NAUER, *Spiritual Care statt Seelsorge?*, 1st ed., Stuttgart: Kohlhammer, 2015, p. 10.

7 Let us mention, for example, M. Belok, C. Kohli Reichenbach, B. and A. Heller, E. Frick, M. Klessmann, D. Nauer, U. H. J. Körtner or T. Roser.

8 Cf. Traugott ROSER, Seelsorge und Spiritual Care, in: *Handbuch der Krankenhausseelsorge*, ed. Michael KLESSMANN, 4th extended ed., Göttingen: Vandenhoeck & Ruprecht, 2013, pp. 70–71.

9 © Cf. Michael KLESSMANN, Im Strom der Zeit … Von der evangelischen über die ökumenische zur interkulturellen Seelsorge und spiritual care (on-line), available at: https://www.researchgate.net/publication/274455153_Im_Strom_der_Zeit, cited 17th March 2019.

'Spiritual care' takes into account all these levels best and it helps to integrate generally denominationally based pastoral care in different churches into a more comprehensive concept of care and support within the hospital system.[10] According to T. Roser, the term 'spiritual care' should be understood as a superior term, as a kind of 'umbrella' under which various professional groups and different concepts, including pastoral care by churches, have their place. At the same time, however, it must create its profile and define itself in relation to other 'spiritual care' professions and clearly formulate its proprium.[11] This brings questions about its new role, definition, and competency.

Therefore, in this context, thoughts about the role and place of clinical pastoral care in hospitals are also legitimate in the Czech Republic. This applies especially with regard to the persisting low interest of Czechs in churches and the related type of spirituality or religiosity on one hand,[12] and a rather high interest in 'alternative' spirituality on the other.[13] Although clinical pastoral care, as its definition implies, is aimed at a relatively wide range of clients (regardless of their religion), the question is whether and to what extent it is able to reach the 'alternatively' believing patients and whether these patients would ask for a hospital chaplain. For example, foreign research among cancer patients has shown that 40% of them consider their family members and friends to be their spiritual companions. Also, 29% of them refer, in this sense, to medical staff, and only 17% to spiritual or hospital chaplains.[14] Another question is whether even some Christians, in times of severe illness, seek help outside Christianity, and whether serious illness really opens up room for questions of meaning, for transcendence, and thus touches upon the sphere of spirituality, transcendence, and religion.[15] The presented qualitative research has sought answers to these questions by focusing on the marginal life situation and its reflection in the 'traditional' and 'alternative' spirituality of respondents in the context of clinical pastoral care. The research was also inspired by the fact that while the spiritual needs of patients (in connection with a serious illness), or the influence of spirituality/religiosity on the physical health, mental health, and well-being of the patient are a frequent subject of research interest, the opposite relationship – the effect of a serious disease on the 'traditional' or 'alternative' spirituality of patients – has not been explored and there has not been an interest. Also, there is no relevant literature on the subject.

2. Research

The actual research took place between March and May 2018 in the region of South Bohemia. The originally intended quantitative research was not used for the questionnaire. Instead, the qualitative research was used for data collection. The semi-structured interview method seemed more appropriate due to the personal nature of the questions and the possibility of an in-depth interview even though it supplied data from a smaller number of respondents.[16] The research was

10 Cf. KÖRTNER, *Leib und Leben* …, pp. 93–94.

11 Cf. ROSER, Seelsorge und Spiritual Care…, pp. 62–76; further cf. © Michael Kessmann, Im Strom der Zeit…

12 Cf., for example, Pew Research Center research, published in 2017. © Pew Research Center, Religious Belief and National Belonging in Central and Eastern Europe. National and religious identities converge in a region once dominated by atheist regimes (online), available at: http://www.pewforum.org/2017/05/10/religious-belief-and-national-belonging-in-central-and-eastern-europe /, cited 10th February 2019.

13 Cf. HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí…*, pp. 14–15 and 74.

14 Cf. ROSER, Seelsorge und Spiritual Care…, p. 74.

15 Cf. Marek VÁCHA, Radana KÖNIGOVÁ and Miloš MAUER, *Základy moderní lékařské etiky*, Praha: Portál, 2012, pp. 71–87.

16 Although the term 'communication partners' is used in qualitative research, the term 'respondent' is used in this article. We believe that this term represents the essence of this research better. It is also used, for example, by J. Hendl. Cf. Jan HENDL, *Kvalitativní výzkum: základní teorie, metody a aplikace*, 4th revised and expanded edition, Praha: Portál, 2016, pp. 168–170.

focused on two goals. The first was to find out what factors had contributed to the formation of the 'traditional' or 'alternative' spirituality of the respondents. The second goal was to answer the question of how the 'traditional' and 'alternative' spiritual attitudes are affected by a serious disease. In order to fulfil the goals, two key research questions and their sub-questions were defined:
1) **What factors contributed to the formation of 'traditional' or 'alternative' spirituality of respondents?** *How did these factors affect their spiritual attitudes before the serious illness?*

2) **How does a serious disease affect the 'traditional' or 'alternative' spirituality of respondents?** *To what extent does a serious disease open up space for the 'traditional' or 'alternative' spirituality of respondents? Does a serious illness lead to a change in the existing 'traditional'/'alternative' spirituality in terms of its consolidation, weakening or loss? Does a serious disease cause a shift from the 'traditional' spiritual attitudes to the 'alternative' ones and vice versa?*

2.1 Research Procedure

The data were obtained from respondents from the South Bohemian Region. The equal presence of men and women in the sample was our aim. Other important criteria for the selection of respondents were the past experience of serious illness, or the current experience of serious illness, and the age of the respondents. The upper age limit was not limited, while the lower age limit was 20 years. The age of 20 to 25-30 is considered to be early adulthood in terms of developmental psychology. At this age, personal maturity is already achieved, identity is consolidated, and personal and professional goals are clarified.[17] These respondents should therefore be able to think more seriously and deeper about issues related to the meaning and value of life in relation to a serious illness. The last criterion was the 'faith' of respondents, that is, whether they are 'traditional' or 'alternative' believers. A total of 30 respondents were approached. Eight respondents refused to participate in the research. Two of them – a woman and a man, aged 73 and 80 – were not included in the research but they helped to make the research questions more understandable and clearer before their final formulation. The research included 20 respondents. The youngest was 28 at the time of research, the oldest was 75. Ten respondents were in the group of 'traditional' believers, and the other 10 respondents were in the 'alternative' group. While the first group consisted of a balanced representation of both men and women (5 + 5), the other group had a significantly higher share of women (8 + 2). This fact is also reflected in the findings of other research. According to them, women (more often than men) believe in amulets, horoscopes, healers, and diviners, regardless of their education, age, economic activity, size of place of residence, etc.[18] Out of 20 respondents, 11 had oncological disease, 4 respondents had a psychiatric diagnosis, two had cardiovascular disease, and the last three respondents had a gastroenterological, metabolic, and pulmonary diagnosis.

2.1.1 Realisation of Interviews and Ethical Aspects

All respondents were approached in person, the first respondents being people from the immediate social surrounding of the author who subsequently recommended other possible respondents

17 Cf. Josef LANGMEIER and Dana KREJČÍŘOVÁ, *Vývojová psychologie*, Praha: Grada, 2006, pp. 167–170.
18 Cf. HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí…*, p. 110; further cf. Olga NEŠPOROVÁ, Českolipská necírkevní spirituální scéna, in: *Náboženství v menšině: Religiozita a spiritualita v současné české společnosti*, Dušan LUŽNÝ and Zdeněk R. NEŠPOR et al., Praha: Malvern, 2008, p. 150.

and helped to mediate contacts. Then the 'snowball' method was used. Before the interview itself, it was verified (by telephone interview with the respondents) that they met the above criteria. Then information about the place and time of the meeting was specified. The interviews were conducted in different environments, according to the respondents' choice, and without the participation of third parties. It was always a safe environment. Prior to interviewing, the respondents were informed about the purpose of the interview, and that the conversation would be recorded and then rewritten. They were also assured that the data obtained – with the exception of demographic data – would remain anonymous. Based on this information, the respondents were asked whether they agreed to participate in an interview (i.e., whether they gave informed consent).[19] The average length of the main phase of the interviews was about 35 minutes, the total length with the introductory and closing phases (during which questions about demographic data were asked) was about 45-50 minutes.

In view of the relatively personal nature of some of the issues covered by the research (namely the serious disease and the respondents' beliefs), it was also necessary to take into account the ethical aspect. Throughout the research, the emphasis was on complying with the ethical principles of confidentiality and informed consent.[20] The sensitive question of the nature of the disease was asked only in general. Neither the specific diagnosis nor the prognosis of the disease has been researched, and there is also no association between a particular disease type and a particular respondent. The names of the respondents were changed for the purposes of the article. None of the first names corresponded to the real names of the respondents. Regarding the question of faith, belonging to the 'traditional' or 'alternative' group of believers was determined by the respondents' own declaration, and then by using two groups of clarifying questions that were used in the surveys by sociologist D. Hamplová. These were questions of do you believe in: God, afterlife, heaven, hell, miracles? And the further questions were of do you believe in: amulets, reincarnation, healers, diviners, astrology?[21] As expected, the level of consent in one or the other group of questions was not the same for all statements. However, the acceptance of one or the other type of questions was essential.

2.2 Method of Data Analysis and Processing

The data processing was done through thematic analysis based on a literal transcription of twenty interviews and open coding. First order reduction was not performed between transcription and text coding. This reduction is recommended, for example, by M. Miovský.[22] The texts were left in their full version, including the passages that did not respond directly to the questions (with unfinished sentences, etc.). These passages often made the respondents' opinions clearer. The analysis of the interviews was done by using open coding (that is, categorising words, phrases, paragraphs into similar content categories and their subcategories). Although open coding is linked to the grounded theory method,[23] it is, as stated by V. Suchomelová, 'used by other analytical approaches for its simplicity and efficiency in large-scale data sorting',[24] and has therefore been used in this research. In the initial reading phase, the main themes were colour-coded. A different colour

19 Cf. Roman ŠVAŘÍČEK, Klára ŠEĎOVÁ et al., *Kvalitativní výzkum v pedagogických vědách*, Praha: Portál, 2007, pp. 46–49.
20 Cf. ibid., pp. 43–49.
21 Cf. HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí…*, pp. 59–61.
22 Cf. Michal MIOVSKÝ, *Kvalitativní přístup a metody v psychologickém výzkumu*, Praha: Grada, 2006.
23 Cf. Anselm STRAUSS and Juliet CORBINOVÁ, *Základy kvalitativního výzkumu: postupy a techniky metody zakotvené teorie*, Brno: Sdružení Podané ruce; Boskovice: Albert, 1999.
24 Věra SUCHOMELOVÁ, *Senioři a spiritualita: duchovní potřeby v každodenním životě*, Praha: Návrat domů, 2016, p. 130.

was chosen for each theme making the subsequent orientation in the text easy (as suggested by M. Miovský).[25] Basic categories were then created for each thematic area – codes in the colour corresponding to the given theme. These codes were used to mark recurring, relevant research statements. The occurrence of these statements was very clear thanks to colour differentiation in the text. In the second phase of the coding, individual texts were checked again. Their parts were assigned to the base categories created in the first phase, and a new category was created when necessary. The first, rough differentiation of the text was done using the 'pencil-paper' method. Then the texts were processed using the MAXQDA 12 software program. The relations between individual categories and subcategories were also illustrated by mind-maps in the application Mindly. The thematic analysis enabled us to obtain a number of statements, attitudes, and opinions regarding the individual thematic areas from the texts examined. These were then compared with the results and findings of the other quantitative and qualitative researches.

3. Results

The following part presents the results of the research in the basic form with respect to the scope of the article.

3.1 The Shaping and Transformation of Spirituality throughout Life

The first part of the data analysis was a search for key factors that influenced the formation of the 'traditional' or 'alternative' spirituality during the respondents' lives and before the serious illness. The answers of the respondents showed that it is possible to distinguish roughly three basic factors: the roots of faith received in the family environment and the formation of ideas about God in childhood (that is, what we could, in sum, describe as a form of *early religious socialisation*), *significant breaking points in life*, and finally a *serious illness* (which will be discussed in detail below). An important factor shaping the basic orientation towards the 'traditional' or 'alternative' spirituality of respondents was their *religious socialisation in childhood*. Its influence on the later spirituality of the 'traditionally' believing respondents was manifested in two respects. The first was its distinctive social dimension. Religious activities took place within the family or the church, and as the research showed, if the respondents perceived their visit to worship and other religious practices as an obligation, habit, or even an enforced activity, they replaced it (in the period of *significant breaking points in life*) with other activities for longer or shorter periods after the disappearance of this duty. These *breaking points* included the beginning of university studies (which attracted some respondents to various 'alternative' phenomena), marriage (believers stopped practising for a while due to the influence of their spouses), and, in particular, the change of political circumstances in 1989. Due to this political change, many respondents became interested in 'alternative' spirituality (e.g., Alena, 40; Květa, 53; Marek, 47; or Zdena, 75). Secondly, data analysis showed that some respondents (whose families were less 'orthodox' and whose attendance at religious services, religious life, and religious practices were irregular and less intensive) decreased their interest in Christianity or even temporarily (in the period of *breaking points in life*) increased their interest in 'alternative' spirituality. This finding corresponds to the results of the quantitative research *DIN 2006*. According to this research, in the Czech environment, the probability that the respondent will believe the elements of Christian beliefs

25 Cf. Michal MIOVSKÝ, *Kvalitativní přístup a metody v psychologickém výzkumu*, Praha: Grada, 2006.

(but also the probability that he will believe 'alternative' phenomena) is significantly influenced by the attendance of worship services in childhood. The frequency of these visits plays an important role. The strongest belief in amulets, horoscopes, diviners, etc., was among those who worshiped in their childhood only from time to time (i.e., less than once a month). In addition, religious socialisation in the family also played an important role.[26] A fundamental change for the respondents was the moment of 'internalising' their faith and creating a personal relationship with God that brought them back to Christianity.

Also, in the group of 'alternative' believers, the form of early religious socialisation influenced their later spirituality, but differently (in comparison to the previous group). Although eight respondents in this group were baptised, nine respondents said that at least one of the parents or grandparents was a believer, and five respondents had some experience of visiting church, reading the scriptures, or praying in childhood, the families (in which the respondents grew up) were not associated with the life of ecclesiastical institutions and did not pass on 'traditional' faith to the next generation. The occasional visit to church, especially during important holidays, could not form a sufficient basis for the later Christian orientation of the respondents. According to D. Hamplová, 'occasional contact with the Church and religion in childhood increases the interest in the supernatural, but it is not sufficient enough to create one's awareness of specific religious facts'.[27] The absence of religious socialisation in churches and families thus created space for a different type of spirituality than the 'traditional' one. We can trace the roots of 'alternative' spirituality in the family in the case of two respondents (Gabriela, 43; Daniel, 60). Their families have even sparked their long-term interest in astrology and healing. In the period of *significant breaking points* in life and especially in the *period of serious illness*, the respondents did not seek answers to their questions and problems in Christianity but in various 'alternative' phenomena. In this group of respondents who (through their classmates, acquaintances, friends, or the esoteric literature boom in the 1990s) contributed to arousing interest in 'alternative' spirituality, the *breaking points in life* were mainly the beginning of later high school studies, political changes after 1989, and the need for a major life change in adulthood. These *breaking points* in life significantly influenced the spirituality of 'alternatively' believing respondents, including the induction of interest, or the expansion and deepening of such matter.

3.2 'Traditional' and 'Alternative' Spirituality in the Context of Serious Illness

In the next part of the data analysis, the aim was to find out how a serious disease is reflected in the respondents' 'traditional' or 'alternative' spirituality. It was examined whether and to what extent serious illness opens up a space for 'traditional' or 'alternative' spirituality, whether a serious illness leads to a change in existing 'traditional'/'alternative' spirituality (in terms of its consolidation, weakening, or loss), and whether (as a result of a serious illness) 'traditional' spiritual attitudes change towards the 'alternative' or vice versa.

3.2.1 Illness as Open Space

In the group of 'traditional' believers, all respondents stated that their disease meant a change in the ranking of values. These changes included a deeper view of one's own life, an awareness

26 Cf. Dana HAMPLOVÁ, Čemu Češi věří: dimenze soudobé české religiozity, *Sociologický časopis / Czech Sociological Review* 4/2008, pp. 714–715.

27 Ibid., p. 715.

of the value of health (e.g., Pavel, 50; Věra, 28), and a re-evaluation of life priorities. Suddenly, work was not in the first place (Adam, 58), and for some respondents (such as Alice) the disease meant a return to God: *'Many things were not important, in fact, it was mainly about my return to faith in God.'* (Alena, 40). This was closely connected with the respondents' questions related to the disease. Most respondents started thinking more about the meaning of life and of death. They worried about the future of their family, and asked the question 'why?' '*The disease will swallow you, and you start asking why it happened to me?'* (David, 41). Although two respondents said they had not asked such questions at all, they stated (in the course of another narration): *'(…) even though I was asking myself why I was sick given the fact that I had eaten healthily'* (Zdena, 75); *'(…) of course, I was dealing with matters of the future'* (Květa, 53). Only one respondent did not realise that she would have dealt with such questions: *'No, I don't realise it. I dealt with it well. And because I took it this way, so did the people around me.'* (Irma, 42). An important role could be played by the fact that this respondent (who had not felt the necessary support and acceptance during her childhood) had the strong support of the Church community during her illness. They prayed for her, helped her. They also let her know that she was surrounded by close people and that she was not alone when dealing with the illness. The importance of family and friends in coping with a serious illness is confirmed by the clinical psychologist Laura Janáčková: '*The worst thing is when a person has to deal with the illness and he is alone. (…) And it is also quite clear that emotional support during the illness has a proven positive effect on the process of dealing with this illness.*'[28] *Unconditional acceptance and support of the community could play a positive role in dealing with the disease in the case of this respondent. The source of hope and support in coping with the disease was (in addition to family and close friends) faith and trust in God as the 'guarantor of the meaning'* (David, 41; Alena, 40). God is seen as the *'One who will not leave the person'* (Irma, 42), who *'carries him in His arms'* (Peter, 65). One can also *'present his situation to God and let Him decide about future events'* (Adam, 58; Věra, 28) or *'one can also return to God in times of illness'* (Marek, 47). The statements of 'traditionally' believing respondents have shown that serious illness is an opportunity to stop in the everyday hustle and bustle, to look deeper in life, to rethink life priorities. Most of the respondents refer to existential questions in relation to a serious illness. At the same time, the illness meant a moment of realising the importance of their own faith in God while coping with the disease, and the importance of coming closer to God as a source of hope and meaning.

The respondents in the 'alternative' group of believers also reported a change in the ranking of values in relation to a serious illness. Their illness (like in the group of 'traditionally' believing people) brought a deeper consideration of their own lives and health (Ivana, 47; Karolína, 67), a reassessment of priorities especially in relation to work (Milada, 66; Jindřiška, 68; Vendula, 48), and a focus on essentials (Gabriela, 43; Daniel, 60). Like the respondents in the first group, the 'alternative' believers also considered the future, the fear of death, and the search for the cause or meaning of the disease. Jarmila, 45, for example, said: *'So I asked myself what my future would be. I also asked myself sometimes: Why has this happened to me? What is the point of this?'* The sources of hope were different for respondents in the 'alternative' group of believers in comparison with the 'traditional' group of believers. In the first place, there were family and friends. Karolína, 67, Jakub, 37, and Ivana, 47, perceived the disease as *'their fate'*, respectively their karma, and this attitude helps them to cope with the disease (in addition to family support). For Milada, 66, Vendula, 48, and Dana, 43, the illness was an opportunity and motivation for a major change in life.

28 Laura JANÁČKOVÁ, *Život je boj. Praktický průvodce rakovinou pro nemocné a jejich blízké*, Brno: Grifart, 2014, p. 53.

As Milada said aptly: *'The disease is a letter from above. It is here to teach one something. But also, one has to change something.'* For the latter mentioned respondents, faith in oneself *('I will make it through'*) was the greatest strength. They also believed that working on oneself and making changes in different areas of life (most often in the area of eating and relationships) would lead to recovery. The answers of 'alternatively' believing respondents show that, here too, their disease is an open space both for the reflection of life and for worries about one's future and about the future of their closest ones. It also raises questions about the cause or meaning of the disease. While in the group of 'traditional' believers these questions were (from the beginning) connected with the Christian belief in God as a source of hope and a guarantor of meaning, in the second group of respondents the question 'why' concerned the cause of the disease and finding its explanation. It was less about the sense of the disease. In this group of respondents, the disease was understood, among other things, as 'fate' (which explains the cause of the disease), or as an opportunity to change (in the sense of different body treatment, or personality development while using various alternative methods).

3.2.2 Changes in 'Traditional'/'Alternative' Spirituality at the Time of Illness

The next phase of data analysis was focused on examining whether a serious illness leads to a change in existing 'traditional'/'alternative' spirituality. These changes include consolidation, weakening, or loss of the spirituality. It is necessary to say that both groups of respondents have had experience with 'traditional'/'alternative' spirituality before the disease.

In the group of 'traditionally' believing respondents, our research showed that most of the respondents changed their belief in God in the time of serious illness in the sense of deepening, consolidation, internalisation, or restoration, even among respondents who (at the time of their significant breaking points in life) did not practice their faith or were interested in different alternative directions. Only one respondent said that the disease has had no effect on her existing faith in God. On the contrary, for Marek, 47 (who stopped believing in God at a young age when his parents died) his own illness meant a gradual return to God. Although it was difficult for him to talk about the matter, he said, *'I'm thinking about God a lot now. Somewhere inside I feel that God loves me and that I can turn to Him with all the questions and requests. But it's very personal.'* In this context, let us mention the results of the *International Social Survey Program 2008*. This survey suggested that 'belief in God is largely dynamic, (...) every sixth respondent said he had changed his faith during his life. More frequent was the loss of faith (I do not believe in God, but I previously believed – 11%) than conversion (I believe in God, but I did not believe before – 5%).'[29] A marginal situation (such as a serious illness) could therefore lead to an extreme attitude – a loss of faith in God. However, in the group of 'traditionally' believing respondents, such an attitude has not been confirmed in relation to their own serious illness. Four respondents said the disease was a test of faith for them, though. The disease has also changed other areas of respondents' spiritual life. For some, their earlier image of God has changed. David, 41, said: *'My idea of God has transformed. One realises his addiction to God during the disease. He is the guarantor (of meaning) and we are just creatures (…)'* Other respondents also spoke in the same way: they not only have their beliefs in God changed during the period of illness, but also the image of God and the relationship to God has changed. He has become more kind and closer to them. The disease has often transformed immature or vague images of God into the perception of God as

29 HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí…*, pp. 58–59.

almighty, good, as the guarantor of meaning, the giver of peace (e.g., Zdena, 75; David, 41; Alena, 40; Věra, 28; Petr, 65; and others). According to the respondents, the illness has also influenced another important part of their spiritual life, namely, prayer. It became more intensive, truthful, fervent, but it also taught the respondents the ability to remain in God's silence at the time of illness (e.g., Petr, 65; Věra, 28). On the other hand, among the things which have not changed for the respondents was their regular attendance at worship, sacraments, and community meetings, as long as their health allowed them.

Also, in the group of 'alternative' believers, attitudes towards alternative methods has changed under the influence of serious disease, in a positive sense. This has led to a deepening of interest in these methods (usually the interpretation of different types of cards and astrology), but also to the widening of interest in other types of alternative methods, especially in 'alternative medicine',[30] but also in chakras, tantra, or in family constellations. The disease has positively influenced the respondents' opinion especially on 'alternative' medicine. The respondents have been convinced that '*it works*', as (for example) Ivana, 47 said. Positive experiences with alternative methods have led to an increase of interest in literature on this subject, to attendance at lectures, courses, and workshops. Some respondents have also begun to devote themselves to card interpretation or astrology.[31] As far as healers are concerned, respondents consistently distinguished between healers and charlatans, and they warned against the latter. In particular, they appreciated the holistic approach of healers – linking the physical, mental, and spiritual aspects. According to respondents, healers give (during the illness) positive energy, mental well-being, calmness, assurance that everything will turn out well (e.g., Ivana, 47; Dana, 43), and send healing energy. An interesting question (in this context) was asked by E. Křížová in her research, 'whether one finds alternative care after changes in the value framework and due to changed preferences and wishes (…) or whether these value transitions follow after the positive experience with an alternative treatment, and thus represent a consolidation of this view'.[32] The research data (and its analysis) suggests that both of these variants have taken place. Respondents in the group of 'alternative' believers turned to alternative methods mainly because of the need for a holistic perception of body and soul. After a positive experience with these methods, the respondents consolidated and extended them. The disease, which primarily required a health solution, also made the respondents think about things *'between heaven and earth'* and spiritual essence. These considerations did not lead to an interest in Christianity, as will be discussed below.

3.2.3 Mutual Openness of 'Traditional' and 'Alternative' Spirituality

The last part of the research dealt with the question of whether (and to what extent) 'traditionally' believing respondents are open to alternative procedures and, vice versa, whether 'alternative' believers are open to some elements of Christianity. The question of the blending of the different types of spirituality was also addressed by the quantitative research of the International Social

30 The authors Z. Vojtíšek, P. Dušek and J. Motl state that 'usually all methods of alternative medicine work with some of the levels of spirituality. They mostly provide some spiritual anthropology (e.g. teaching about chakras or acupuncture meridians), come with the presumption of positive spiritual energy, uncover the hidden meaning of the patient's troubles and make a meaningful story of one's life, (…) these methods let the patient participate in healing through rituals which are performed by healer himself or herself (…) etc.' Cf. Zdeněk VOJTÍŠEK, Pavel DUŠEK and Jiří MOTL, *Spiritualita v pomáhajících profesích*, Praha: Portál, 2012, p. 23.

31 According to the respondents, it was not about entertainment, but about 'faith' in horoscopes and cards revealing the future, fate, indicating the path (which should be taken by the respondent), etc.

32 Eva KŘÍŽOVÁ, Jak užívají čeští pacienti alternativní léčebné postupy a jak hodnotí jejich efekty? (Sociologický průzkum zkušeností s alternativní medicínou a postojů k ní), *Praktický lékař* 1/2001, p. 36.

Survey Program 2008. Unlike in other countries, the results for the Czech Republic showed that interest in one type of spirituality ('alternative' spirituality) does not increase the interest in another type of religious phenomena.[33] Given the fact that a serious disease is a specific situation, it was interesting to find out whether the results of the above investigation apply in our case as well. According to our research, five respondents in the group of 'traditional' believers have had experience with alternative methods in connection with their illness. For two of them, this experience was mediated. Věra, 28, and David, 41, became sick during adolescence and through their parents were treated by various healers. Both of them assessed this experience negatively. David said: *'Even today, Mum says how it helped me, and how I improved after that, and I say: Mom, you took me to a witch.'* Despite the persistent disease, both respondents are practising Christians and neither of them seeks alternative methods. Marek, 47, at the time of his illness visited a Chinese healer. He was undergoing acupuncture. Nevertheless, he did not consider it as an alternative treatment because it was not done by a healer but by a Chinese doctor. Květa, 53, sees acupuncture in the same way. She underwent it even before her illness. As with the others, she does not see it as 'alternative' because it was not done by a healer but by a doctor. Acupuncture, like homeopathy, is, as shown in this research, considered by some Christians to be quite compatible with their Christian orientation. The last of the five respondents, Zdena, 75, has been intensively engaged in homeopathy. Her interest in this alternative method was initially driven by health problems. She recalls this period herself as follows: *'I was looking for spirituality, but this was related to my treatment. The interest and the spirituality were added later.'* Zdena confirmed (by her words) the results of O. Nešporová's research. According to this research, people are attracted by the interconnection of spirituality with everyday life and body. 'That's how it works for healing. A patient comes with his health problem, and it is primarily at the physical level. Then he finds out that there are procedures how to get rid of this health problem. But what is important, these procedures are strongly connected with one's spiritual side, or they require a personality change.'[34] Data analysis in this group of respondents indicated that a serious disease is a factor that can lead 'traditional' believers to openness to the other type of spirituality, but the degree of openness is not very large and is primarily connected to the longing for physical recovery. If 'traditional' believers were already interested in alternative methods, it was mainly acupuncture and homeopathy. These were not perceived as alternative. None of this group of believers visited a fortune teller, did not receive purposefully healing energy, did not wear an amulet for happiness, etc., at the time of their illness. In the group of 'alternative' believers, the degree of openness to the other type of spirituality is even lower than in the previous group of respondents. While some respondents admitted that they were thinking of God at the time of illness, their perception of God was very different from the Christian concept. For Karolína, 67, God is not a personal God, it is an energy. For Jakub, 37, God is a thought construct. The others were not able to imagine anything or they talked about the universe, positive energy, and higher intelligence. Visiting churches was perceived quite positively by the respondents (seven out of ten respondents said that they had visited a church not only during the time of illness). However, it is not an expression of Christian practice. For some of them, churches represent their memories of Christmas and Easter. Most respondents said that they had visited a church because of the atmosphere, silence, calmness, the possibility of being in it alone, or the possibility of lighting a candle regularly. These statements partly correspond

33 Cf. HAMPLOVÁ, *Náboženství v české společnosti na prahu 3. tisíciletí…*, pp. 77–81.

34 Olga NEŠPOROVÁ, Českolipská necírkevní spirituální scéna, in: Dušan LUŽNÝ and Zdeněk R. NEŠPOR et al., *Náboženství v menšině: religiozita a spiritualita v současné české společnosti*, Praha: Malvern, 2008, p. 155.

to STEM agency research results from December 2017. According to these results, only 8% of Czechs go to church at least once a month. At Christmas, though, it is 38%. Czechs, even if they do not believe in God, rank a church visit among Christmas habits.[35] The respondents also positively commented on prayer at the time of illness. Six respondents said they had been praying. It was a prayer as a request for help especially – *'to make things go well'*, *'to make the test results good'*. R. Tichý commented on the results in his research: 'Surprisingly, prayer does not depend on religion or belief in God. (…) However, the form of prayer depends heavily on faith in God: prayer as a plea for help requires a burst of faith (…).'[36] However, prayer (in the concept of 'alternative' believers) is not a realisation of a relationship with a personal God. It is rather a formula that is supposed to function in the same way as an amulet for happiness. If the respondents commented on the churches, as in ecclesial institutions, their comments were generally negative. Mainly the Roman Catholic Church was perceived through the prisms of wars, indulgences, the presentation of power, sectarianism, and witch trials. Especially, the Church was not trusted as an institution (e.g. Jarmila, 45; Milada, 66; Vendula, 48; Dana, 43). Overall, respondents from this group did not show any deeper interest in the elements of Christianity at the time of serious illness. Even in this group of respondents, an interest in 'alternative' spirituality does not increase the interest in another type of religious phenomenon.

4. Summary and Conclusions for Clinical Pastoral Care

First of all, the data analysis confirmed that a serious illness is a marginal life situation. In such a situation, the vast majority of respondents (from both groups) want to know the sense of it, express their fears (this includes their future and also death), re-evaluate life priorities, and look for sources of hope, reinforcement, and support. These sources can be within the family and closest friends. In accordance with one's spiritual focus, 'traditional' believers look for these sources in faith in God, who is the guarantor of meaning. 'Alternative' respondents look for the sources in themselves, in understanding (they understand the illness as fate or karma), and in vital changes in life associated with different alternative practices. Thus, a serious disease opens up a space for spirituality, but not necessarily a 'traditional' spirituality.

In the next part of the data analysis, the research showed that (at the time of serious illness) the existing spirituality changes within both groups of 'traditionally' and 'alternatively' believing respondents. These changes are consolidation, deepening, strengthening, and, in the case of 'alternative' believers, an extending of interests to other alternative practices and to spiritual things, but not to Christianity. Respondents from the group of 'traditional' believers, including those who (for some time) devoted themselves to 'alternative' spirituality at the time before the illness, made a space for the seeking and acceptance of the meaning of the illness, for the internal processing of the illness, and for the spiritual anchoring at the time of the illness. That situation has led to the purification, internalisation, and deepening of their faith in God and to the intensification of Christian practices. None of the respondents lost their 'faith' at the time of the severe illness, abandoned existing spiritual attitudes, or changed one type of spirituality for another. As the results of the research have shown, it was possible to observe some openness to 'alternative' spirituality, namely 'alternative' medicine (acupuncture and homeopathy) in the group of 'traditional'

35 Cf. © STEM, Téměř dvě pětiny občanů řadí mezi vánoční zvyky návštěvu kostela (on-line), available at: https://www.stem.cz/temer-dve-petiny-obcanu-radi-mezi-vanocni-zvyky-navstevu-kostela-2/, cited 26th January 2019.

36 Cf. Radek TICHÝ, Náboženské/spirituální představy, zkušenosti a zájmy českolipských občanů, in: Dušan LUŽNÝ and Zdeněk R. NEŠPOR et al., *Náboženství v menšině: religiozita a spiritualita v současné české společnosti*, Praha: Malvern, 2008, p. 178.

believers, but the degree of openness was not very great and was primarily due to the need for physical healing. Moreover, the two methods were not perceived by the respondents as alternative. Also, respondents from the 'alternative' group of believers did not show a deeper interest in elements of Christianity at the time of serious illness. This fact can be interpreted by the fact that 'alternative' spirituality meets the needs and demands of respondents in the field of physical health, well-being, personal development, and provides a value framework. Thus, there is no need to engage in other religious phenomena such as Christianity.

As research results have shown, the openness of 'alternative' spirituality towards Christianity is very low. This fact can affect the clinical pastoral care. In the group of 'traditionally' believing respondents, clinical pastoral care in marginal life situations can offer a wide range of help in the form of prayer, worship services, sacraments, rituals, and spiritual accompaniment. While the range is quite wide for the 'traditional' group, for 'alternative' believers these possibilities are limited. Respondents from the 'alternative' group tend to look down on the churches, they do not feel the need to meet the clergy, and they fully satisfy their needs by various alternative practices. Christianity, as one of the respondents said, 'is not their way'. It might therefore seem that for the 'alternative' clients the abovementioned non-confessional 'spiritual care' would be better. It is based on a broadly defined spirituality, which is a matter of not only hospital chaplains but also of other professions which deal with the spiritual needs of people in hospital. However, pastoral care is not focused only on a narrow group of 'traditionally' believing people. It is ecumenical, religiously plural, and should be able to meet the spiritual needs of all the relevant groups of people. Of course, hospital chaplains must respect those who do not seek answers to their existential questions in Christianity and do not want spiritual accompaniment. As pointed out in the Ad Gentes decree, 'the Church strictly forbids anyone to be forced or brought in or lured by inappropriate means to receive faith (…)'.[37] Although the attempt to make contact with the 'alternative' believer may be difficult due to his lack of interest, these patients can be addressed within the area of topics connected with their serious health situation. Data analysis has shown that these topics include primarily family (especially children), as well as work and lifestyle changes related to illness or personal development. These topics can help to reach out to the patient. There can also be some potential for more in-depth interviews (such as concerns about the family's future). The hospital chaplain (through these topics) can help the patient to internally accept his illness, to overcome fear and anxiety, to activate internal sources of strength, and to find sources of hope even outside Christianity.

Another 'point of contact' for clinical pastoral care may be the need for a holistic link between the physical and spiritual element that was stated by 'alternative' believers in the research. Christianity also defends the holistic view of a person. He is viewed as a unity of body, soul and spirit. Christianity shares the definition of health as physical, mental, social and spiritual good. 'This view is (in Christianity) further deepened through the moral life of a person, his lifestyle, his relationship with other people, his serious life values and, finally, through his relationship with God as the first and last source of life.'[38] Here again, clinical pastoral care could find a common theme with 'alternative' believers.

Christianity as a childhood experience may also be a possible topic for an interview with the respondents. As research has shown, most of the respondents in the group of 'alternative' believers were baptised and half of them experienced some Christian practice during their childhood

37 *Ad gentes, art. 13.*

38 Tomáš HALÍK, *Sedm úvah o službě nemocným a trpícím*, Brno: Cesta, 1991, p. 9.

– church visiting, prayer, or Scripture reading. Although these are rather memories that belong to the past, they can be the starting point for hospital chaplains at an appropriate time.

The above research has shown another important aspect for clinical pastoral care. 'Alternative' respondents in the interviews warned against charlatans and criticised their practices (health as a business). Various alternative methods and procedures can undoubtedly harm patients in the physical, mental, and spiritual areas, as pointed out by J. Heřt. According to him, (in addition to the risk of direct damage of the patient) there is a risk of false diagnosis, financial loss, neglect of proper treatment, inappropriate healers' advice, negative influence on the doctor, and others.[39] Hospital chaplains must naturally respect the patient's decision-making freedom. However, they may also talk to an 'alternatively' believing patient (who they are in contact with) about important decisions. They can recommend him to speak with his physician before making any serious decision (for example, giving up traditional treatment in favour of an 'alternative' one).

Clinical pastoral care is still a Christian ministry even when meeting 'alternatively' believing patients. This premise is based on the fact that a person has God's law written in his heart, and that he can listen to God's voice in his conscience – 'the most secret core and sanctuary'.[40] What is more, every person is connected with the Easter mystery[41] in a way that only God knows. Both of these facts mean that every person is also able to experience himself as somewhere where God's work takes place. Therefore, even in a situation when one has difficulty in communicating, it is possible to implicitly mediate God's closeness, compassion, love, and hope. This can be done by mere co-existence (participation, empathic listening, but also by silence) with the 'alternative' believer (patient) in a difficult life situation.

As stated above, clinical pastoral care can also help patients who believe in some 'alternative' way at the time of their severe illness, if the chaplain and the patient find common discussion topics. Such topics, as the above research has shown, may not be obvious but are implicitly present in patients' expressions and talks. Obviously, it would be easier to reach out and accompany these patients within 'spiritual care' differently (that is, through someone else than hospital chaplains). However, clinical pastoral care has a specific role within hospitals coming from its Christian anchoring: it contributes, among other things, to the humanisation of medicine and is thus deeply evangelistic.[42]

Conclusion

The research that is the subject of this article deals with the issue of the effect of severe disease on the patients' 'traditional' or 'alternative' spirituality. At the same time, analysis of the data enables us to acquire knowledge that can be beneficial for clinical pastoral care.

As data analysis has shown, serious illness opens up not only space for 'traditional' but also 'alternative' spirituality. However, their mutual openness is very low. While there was some interest in alternative methods (motivated by healing efforts) in the 'traditional' group of believers, there was no inclination to Christianity in the second ('alternative') group. None of the respondents in the second group showed interest in 'traditional' spirituality in connection with serious illness, and (as the research results showed) alternative methods fully satisfied the needs of these respondents. There is an issue in clinical pastoral care of how to approach patients from the 'alternative' group

39 Jiří HEŘT, *Alternativní medicína a léčitelství*, Praha: Nosková Věra, 2011, pp. 214–215.

40 Cf. *Gaudium et spes*, art. 16.

41 Further cf. art. 22.

42 This statement does not contradict the Ethical Code of the hospital chaplain. The term 'non-evangelistic' is used as 'non-missionary' there.

of believers and how to accompany them. Moreover, in a secular Czech environment, there is a low interest in churches and the associated type of spirituality or religiosity and, on the contrary, a relatively high interest in 'alternative' spirituality. It raises the question of the role and place of clinical pastoral care, especially in the context of 'spiritual care' (which is now being discussed in neighbouring German-speaking countries). In order to fulfil its goal and 'help suffering patients regardless of their beliefs',[43] clinical pastoral care must find topics which can be relevant for 'alternative' believers as well. It has to find ways how to fulfil their spiritual needs. At the same time, clinical pastoral care has to bear in mind its Christian anchoring. The research has shown that such topics can be found.

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43 © Katolická asociace nemocničních kaplanů, Dohoda o duchovní péči ve zdravotnictví mezi Českou biskupskou konferencí a Ekumenickou radou církví v České republice (on-line), dostupné na: http://kaplan-nemocnice.cz/wp-content/uploads/2014/03/Dohoda-o-duchovn%C3%AD-p%C3%A9%C4%8Di-ve-zdravotnictv%C3%AD-mezi-%C4%8Ceskou-biskupskou-konferenc%C3%AD-a-Ekumenickou-radou-c%C3%ADrkv%C3%AD-v-%C4%8Cesk%C3%A9-republice-kesta%C5%BEen%C3%AD.pdf, cited 26th February 2019.