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SPIRITUALITY AND HEALTH CARE PROVISION

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Motto: «I don't care how long I've been in pain, I can change. Maybe not many people notice my pain, but I noticed it and that's enough. I may not understand what is happening to me, but understanding will come. It's time to find the right person to listen to my words and understand my needs. I deserve to be healed.».

D. Chopra (2005, p. 46)

Abstract

The paper analyses usefulness of spiritual health care provided by health care professionals as an important part of comprehensive health care. The contribution is written mainly from the point of view of the health care management and highlights the importance education plays in this process. It is intended for experts who are interested in spirituality as part of standard health care procedures and health care management, potentially for creators and teachers of medicine study programs.

Key words: spirituality, health care, standard procedures, health care management, education

ДУХОВНОСТЬ И ОКАЗАНИЕ МЕДИЦИНСКОЙ ПОМОЩИ

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Эпиграф: «Мне все равно, как долго я испытываю боль, я могу измениться. Может быть, не многие замечают мою боль, но я ее заметил, и этого достаточно. Я могу не понимать, что со мной происходит, но понимание придет. Пришло время найти подходящего человека, который выслушает мои слова и поймет мои потребности. Я заслуживаю исцеления».

D. Chopra (2005, p. 46)

Аннотация

В статье анализируется польза заботы о духовном здоровье, проявляемой

специалистами здравоохранения, как важной части оказания комплексной медицинской помощи. Материал излагается в основном с позиции менеджмента в здравоохранении и подчеркивает важность образования в данном процессе. Статья предназначена для специалистов, интересующихся духовностью в качестве составной части стандартных процедур оздоровления и системы организации здравоохранения, а также для разработчиков медицинских образовательных программ и преподавателей.

Ключевые слова: духовность, здравоохранение, стандартные процедуры, управление здравоохранением, образование

INTRODUCTION

Spirituality, as a legitimate non-material dimension of life that permeates the physical world and whose awakening and development are desirable, implies sharing of joys, search for a personal connection with the transcendent (that which transcends us and is higher than us) as well as recognition of a certain dependence on this transcendent reality and its experience in ordinary life. This immaterial, which we refer to in various ways - sometimes as the Higher Power, the divine, God, the Creator, nature, the universe, the Higher Intelligence, etc. - is shared as both joy and sorrow, and a profound connection between humans and nature and between humans and the Higher Being [1].

Regarding the relationship between spirituality and health, authors Skoko, Topic Sipic, Tustonja and Stanic [2] have recently shown that religious people cope more easily and better with dangers that can harm their mental health, which is reflected in longer life expectancy and rare diseases.

And while spirituality is no guarantee that religious people will not suffer from mental disorders that can result in mental illness and its consequences, because being a religious person does not always mean being free from illness, on the other hand, those who are religious cope more easily with illness and more easily go through the healing process.

However, in the publication of Sawicki and Holkovic [3: 134] we can also find examples of results of older studies (Grof, 1999, 2004; Lukoff, 1998; Perry, 1999; Maslow, 1964; Allport, 1961; Banquet, 1973; Moore, 1998; Burns, 1999, etc.) that do not only tell about the experiences of individuals (which constitutes the level of scientific evidence III - Descriptive Study, Case Study), but also about the results of larger-scale psychological research conducted with larger groups of people, which has examined personality and health changes in controlled groups of

patients (Levels of Scientific Evidence IIb. to Ia.)[1], and which show that supportive psycho spiritual experiences help people in their personal development as well as in promoting their health.

For example, author Stifler [ibid] and his team of collaborators used psychological personality tests to study three groups of people: contemplative monks, psychotics, and ordinary people with no psychotic symptoms and no spiritual practice. The results showed that contemplative people showed a statistically *significant difference in personality maturity: individuals were more open, flexible, relaxed, and their personality was more integrated*.

Maslow found that mystical experiences usually marked a turning point in a person's personality and stated that «the after-effects are sometimes so intense and powerful that they resemble profound religious conversions that can change an individual forever». He also stated that such a personality transformation affects every area of the personality: *one becomes freer, more active, more creative, more responsible, more spontaneous, more honest, more capable of loving more and more deeply, and individuals are consequently less egotistical, experiencing a deeper meaningfulness in their lives and a deeper sense of happiness* [ibid: 93].

This is probably why spirituality and the need for transcendence stand at the very top of the defined pyramid in his well-known hierarchy of needs and permeate all other needs. It is now quite common in the medical literature to use terms such as spiritual needs, spiritual health and *spiritual health care.* According to these sources, spiritual health care is usually provided by nurses as part of indicated nursing care, but also by doctors and other health professionals within the scope of their medical qualifications.[2]

It is also now widely respected in medicine that spiritual health care should be a natural part of the care of persons with serious long-term chronic illnesses, as well as in the terminal stage of life, and that it should include not only the care of such patients, but also the care of their relatives and loved ones and cover the care of survivors during the period of bereavement [4].

According to Cicely M. Saunders, the founder of the first modern hospice in Europe (1967) who also pioneered the *concept of «total pain»* in the terminally ill,

[1] Author's note: Level IV scientific evidence is when it is the expert recommendation, opinion, and clinical experience of a respected professional authority. Level III is a descriptive study such as a comparative or correlational case report, Level IIb. is a quasi-experimental study without randomization, IIa. Includes at least one controlled study without randomization, Ib. is at least one clinical controlled study, and Ia. a meta-analysis or systematic review of randomized controlled clinical trials.

[2] Author's note: See, for example, the many studies in the publicly available medical database PubMed, but also in many others.

this total pain has somatic, psychological, social and spiritual dimensions at the same time. The 2003 Recommendation of the Council of Ministers of the European Council, following this knowledge and experience in the context of the care of the terminally ill, therefore postulated that palliative medicine should not focus only on a specific disease [ibid].

Jasenkova [5] confirms the above with her own experience of several years as a medical doctor working in the field of palliative care in Slovakia, according to which each of the dying people she accompanied, whether they were believers in the religious sense or so-called non-believers, communicated some spiritual needs at the end of life. These showed a high degree of individual variability and the same was true for the families accompanied as well as for the survivors more broadly.

However, the above should be applied not only to palliative medicine but to medicine as a whole, because the health professional should provide health care holistically. According to the World Health Organization's International Classification of Functioning Capacity, Disability and Health (ICF) [6: 3], which extends the identification of an individual's health difficulties to include functional abilities, their limitations, risks and needs, and which also allows for the classified identification of causes, difficulties or incapacities that may inadvertently be medically ignored when using the International Classification of Diseases (ICD) due to incompleteness, and includes the area of spiritual health, we can conclude in this part of the paper that spiritual training and care are generally important in the health care provided, and this includes prevention.

PROJECTIONS OF SPIRITUALITY INTO HEALTHCARE

According to Solar [7], the essence of healthy spirituality is the personal relationship of the individual to the Creator of Life, and spirituality is part of being as such even when it is ignored. On the basis of his long professional experience and research in this field, he states that the absence of a relationship to the Creator of Life causes problems first in the psychological and then in the somatic level and can manifest itself in the form of materialized disease.

If the information obtained remains only on the rational level (in the rational consciousness) and is not transformed spiritually – means are not connecting with the spiritual consciousness – with the spiritual reality, according to this author, the spiritual transformation of the personality as a self-developing and self-healing element cannot take place and the person stagnates or regresses, and therefore, if

further therapy has to be not only symptomatic but also causal, it must necessarily deal with etiopathogenesis, and this cannot displace spiritual factors.

According to his many years of professional medical doctor experience, these are determined differently in each individual, but it is always possible to trace the so-called spiritual root represented by archetypal fears.

As the author further states, the archetype is always at work — however, in spiritually grounded people the etiopathogenesis is different than in spiritually ungrounded people, because spiritually ungrounded individuals cannot imagine that the Creator of Life really sees everything, thus nothing remains hidden, not even that which is repressed.

Solar [8: 476] further states that although it is of course beneficial for medicine to create the necessary system and teams of non-medical specialists, whether for laboratory or other diagnostic and therapeutic methods, as it is already standard in every medical field, on the other hand, it also means high demands on the educational training of medical doctors, which, in addition to medical knowledge, should also include knowledge from other related disciplines, which are not nowadays a common part of the curricula.

At the very least, such educational programs should be enriched with knowledge from physics, neurotechnologies, mathematics, psychology, pedagogy, philosophy, and, from a transcendent point of view, theology and eschatology.

Optimally, he believes that medical knowledge should also be enriched by a comprehensive multidimensional approach (i.e. not only symptomatic based on syndromology, but also a functional and causal approach).

This is not only in order for the physician to better understand the patient and his/her health problems, but also the physician´s own role in this process in the interests of better diagnosis, prevention or treatment**.**

This substantially expands the range of possibilities for solving the patient's health problems, as well as for understanding such a process in physiology, pathology, therapy and research.

Finally, he states that the therapist should him/herself be sufficiently spiritually grounded and, together with a team of other authors [ibid], whom he led in the international AKUCOM project (available at www.acuclinic.eu), he formulated recommendations for interdisciplinary education of physicians and other health professionals as well as recommendations for the content of standard diagnostic and therapeutic procedures that would address the area of comprehensive health care, which also includes the dimension of spirituality.

SOURCES OF COPING AND HEALTHY AND UNHEALTHY RELIGIOSITY

Commonly known sources of coping, including disease management, encompass physical sources such as physical strength, which can be increased by various physical training, improving muscle tone, quality of nutrition, sleep, etc., functional sources such as the systematic and conscious elimination of disease triggers, which can be worked on in collaboration with the patient, as well as the formation of habits, which in turn form or strengthen protective factors and thus ensure the creation and maintenance of health (safe home, safe car, safe work environment, etc.). Next, psychological resources such as intelligence, sense of humour, curiosity, creativity and protective mechanisms; social resources (interpersonal/social network), which include family, friends and acquaintances, etc., which allow for sharing, including sharing pain, other suffering as well as joy; and finally, spiritual resources**,** which deal with the question of meaning (being, illness, pain, disaster, etc.) and the formation of awareness that even out of suffering can come love, compassion, forgiveness, inner peace and a renewal of faith.

In Kozon et al. [9: 175], the author Nová, referring to Kašparů, highlights an important fact, significant not only in the context of health care provision, that 1. There is religious and non-religious spirituality, and 2. Each of them can be both healthy and unhealthy.

According to Kasparu [ibid], who describes healthy religiosity, healthy religiosity is characterized by the following features: *it contributes to the development of personality, promotes harmonious relationships with other people, is characterized by openness to the realities of life, does not arouse fear, promotes a capacity for pluralistic tolerance, maintains an attitude of seeking, has an individually different degree of creative power, and gives room for humour*.

On the other hand, the author characterizes so-called pathological religiosity as manifested hatred against those who think differently, exaggerated fear of God's judgment, punishment and the end of the world, delusional religious ideas, spiritual coercion, religious interpretations of the future (e.g. religious delusions, inadequate fear of sinning, religious desire for power and assertion, mortification of the body by exaggerated asceticism, flight from the world, inability to love, denial of life, and occult practices. A person who lives in such religiously «defective» attitudes usually suffers from a lack of religious knowledge and fear, inner turmoil, guilt, inferiority complex, or repressed unresolved inner pain and anger [ibid].

In contrast, the characteristics of healthy spirituality in both religious and non-religious people were described by Reich, drawing on C. Beck in Strizenec [10] as follows:

1. insight and understanding,
2. a sense of context and perspective,
3. awareness of the interconnectedness of things, of unity within difference, of schemes within the whole,
4. integration of body, mind, soul and spirit as well as the different dimensions of life,
5. a sense of wonder, mystery and amazement,
6. gratitude, pleasure and humility in relation to the blessings of life,
7. hope and optimism,
8. courage, a «spirited» approach to life,
9. energy,
10. detachment,
11. acceptance of necessity,
12. love (the most apt characteristic of a spiritual person),
13. a sensitive, caring approach to other people, to yourself and to the cosmos as a whole.

Several other authors also stress that spirituality is not fundamentally about religiosity, but about maturity [9]. Smekal drawing by Stríženec [10] states that even people who are strangers to religion can cultivate and develop their own spirituality. According to this author, many people wish or try to live a spiritual life in this way, but it is not necessarily connected with organized religion.

Since the spiritual nature of life appears to be the foundation of human existence and its development, it is often latent in education, but it can play a crucial role at key moments. If a child, later a young adult, is equipped with the capacity to anticipate and reflect on the spiritual nature of life, acquired gradually through education, it can be assumed that this ingrained root of humanity will become his or her aegis for dealing with important life situations [11]. Naturally this includes life situations involving health.

RECOMMENDATIONS FOR EDUCATION

A/ Recommendations for the education of health professionals

As stated by Solar [8], the quality of health care provided in the field of spiritual care is directly related to the quality of training and education of health

professionals. As medicine has gradually atomized, each medical specialty today has its own specificities and also its irreplaceable place in comprehensive health care. Therefore, in practice, medicine as an interdisciplinary field can only be practised in the necessary interdisciplinary cooperation. However, health care should not be carried out by persons without a comprehensive medical education because, in the absence of detailed knowledge of somatology and physiology, they can never fully understand and take into account the necessary scope of interdisciplinary cooperation, even in the field of spiritual health care.

For the same reason, medics should not be without important interdisciplinary knowledge, which should include, as mentioned above, at least knowledge of physics, neurotechnologies, mathematics, psychology, pedagogy, philosophy and, from a transcendent point of view, theology and eschatology, and not only educational standards but also standards of preventive, diagnostic and therapeutic care should be adjusted in this sense**.**

Trechova [12] confirms the above when she claims that it is very difficult to imagine that spiritual services such as confession, communion, anointing of the sick, resp. talks on spiritual topics such as the consolation of the suffering performed in Slovakia mainly by Catholic priests could be classified as medical procedures. It is necessary to take into account that in health care institutions there are not only patients of Roman Catholic faith and health care services can only be performed by a health care professional with a comprehensive medical qualification.

With regard to the latest developments in Slovakia, let us mention only by way of illustration, that according to the Slovak Statistical Office from the period of the last census of houses and apartments in 2021, the largest number of people in Slovakia - 3.04 million (55.8%) - belonged to the Roman Catholic denomination, and the second largest group, whose number has recently increased, was the group with no religious affiliation — 1.3 million (23.8%). This was followed by the Evangelical denomination — 287 thousand (5.3%) and the Greek Catholic — 218 thousand (4%); while the Roman Catholic Church recorded the highest decrease - in absolute terms 308,766 (6 percentage points), and decreases were also recorded in other traditional churches in favour of an increase in the non-religious group [13, 14].

When providing health care, it must also always be taken into account that, according to Article 1(1) of Act № 308/1991 Coll. on Freedom of Religion, freedom of religion is the freedom to manifest one's religion or belief alone or in

community with others, privately or publicly, and includes the freedom to manifest one's convictions without religion. Everyone also has the right to freely manifest his or her religious faith or beliefs without religion, and no one may be compelled to profess any religious belief or be compelled to be without religion (Article 1(1) of Act № 308/1991 Coll., cited above) [15].

In view of these developments in a society with an expanding group of non-believers and in view of the aforementioned fact that the spiritual plane as an immanent part of the bio-psycho-socio-spiritual unity of man[3] should be taken into account in the provision of health care in all contemporary medical disciplines, also in the framework of nursing, psychological and pedagogical therapeutic care in its biodimensional understanding from birth to death; it is and should be not only the role of clergy in health care, but also the role of health professionals.

On the provision of health care, Foucolt drawing by Sawicki and Holkovic [3: 106], in agreement with Solar [7, 8], states that medicine has historically been progressively unilaterally profiled as a biological science, and therefore the content of study lacks adequate psychological, psychotherapeutic, pedagogical, philosophical and spiritual education. According to Foucolt, the situation is even more pronounced in the training of psychiatrists because, although the profiling is unilaterally biological, the soul they treat is primarily psychological, philosophical, and spiritual in nature.

According to him, the only way to change this undesirable state of affairs would be to redefine and define medicine as an interdisciplinary field — medical, psychological, pedagogical, social, philosophical and spiritual, because all of these disciplines play an irreplaceable role in the formation of the human psyche, soul, personality, experience and behaviour, as well as health.

According to Trechova [16], courses or programmes of continuing or further education in the field of religious studies should be made available to health care professionals in health care education to better orient and integrate the multicultural nature of religiosity of the patients they care for in today's globalised social conditions.

[3] Author's note: The spiritual plane is sometimes subsumed under the psychological plane in the literature and is not listed separately, or it is listed as fourth in order - as the fourth dimension of the unity being referred to, depending on whether the author's intent was to highlight the individual's inner experience and behaviour (the psychological plane), or whether it was more about the development of the individual's consciousness of oneness with nature and the universe and of interconnectedness with others in the context of sharing a common existence in the here-and-now (the spiritual plane). Therefore, we highlight here the four-dimensional variant mentioned above - the human being as a bio-psycho-socio-spiritual unity.

Solar et al. [8], and Jasenkova [5] also recommend completing a shorter self-experiential communication training, which may or may not form part of the psychosocial training that students usually undergo as part of their university studies and which would help them to reflect on their own spiritual anchoring, possibly outlining the direction of their further personal-professional development in this area.

The addition of a similar self-experience and reflection on one's own spiritual anchoring as part of self-experiential curricula within the continuing education system for health professionals in the health sector can also be considered.

Example from educational practice
Reflection of spiritual anchoring

As an example, supporting the authors' recommendations for educational modification, we can cite, for instance, the results of our own participatory observation and analysis of the products of the activities of 5th year undergraduate students of therapeutic pedagogy, which we carried out in the academic years 2018/2019 to 2023/2024 (baseline set n = 32).

During the palliative care class, which was chosen as one of the electives, the students were given the opportunity for self-experience and reflection on their own spiritual anchoring through practical exercises.

In the practical part of the class, they could choose to complete assignments entitled «*Fantasy about life after death», «Why live 100 years», «What is my mission», «Exercise about death I. and II.», «Draw death», «My next 3 years of life»* [17: 189-205], «*Working with Paremias - Explore your beliefs about death»* [18: 16] and *«Meet your own miracle»* [19: 88], through which they were gradually, gently and indirectly confronted with the spiritual dimension of their own existence.

They had to describe their findings in an essay following the experiential self-experience part of the class and during the seminar they had the opportunity to share any findings with other colleagues, to compare differences and, if necessary, to continue sharing and processing the experience also during the personal consultations provided by the teacher.

When asked the question *«What did you learn through this exercise?»*, students in essays and sharing most often included statements such as *«it helped me clarify my real priorities in life/what is really important to me in my*

life», but also *«I finally touched on what makes me happy in my life», «I am ready to take an active role in my life», «I am ready to take an active role in my life, to bring joy and love into my life through myself and to others», «it was nice to realise that I am not here to do it all alone», «I had the opportunity to encounter my own inner wisdom, but I know it transcends me», «I calmed down», etc.* (32 sharings).

The isolated negative experiences that occurred (2 cases), quoting *«it was uncomfortable at first», «I was afraid of what I would learn about myself»*, were mainly related to the initial phase of contact with the exercise as a new and previously unexplored topic, which is natural and were transformed into individually meaningful and thus supportive thanks to the sharing and the subsequent professionally facilitated group processing.

Students overwhelmingly rated the exercises as enriching in a positive sense, mediating contact with uplifting feelings, feelings of calm, deeper awareness of important values, and so on. On their own initiative, they later carried out optional extra assignments on this topic, which indicates that they are interested in this area of human existence and would like to develop it further and that it should not be neglected in education.

The above example from pedagogical practice confirms the above-mentioned recommendations of the authors Solar [8], Jasenkova [5] to enrich the training of health professionals not only with informative knowledge, but also with professionally facilitated processing of their own experience(s) (or even past ones), which are important in caring for their own health and the health of others. Within this small participatory observation and analysis of the results of the activities, we could notice short-term effects especially on the area of mental health consolidation, which as Solár mentions above, has a direct impact and projections to the whole psycho-physio-spiritual-regulatory plane of the individual.

We know from the generally accepted knowledge of pedagogy that there is a tendency to use what is learned in life and practical activities not only what is perceived as meaningful, but also what is repeated more often, with a higher degree of intensity, etc... Therefore, the above topics and knowledge should be exposed repeatedly in the training of health professionals, not only in the undergraduate training of professionals for practice, but also during their further continuing education, so that the student has the opportunity to be involved when he or she is internally prepared for the topic. The same subtle and gradual

immersion in the subject also applies to previous general training within the family and the community outside the field of vocational training, in their synergistic effect on each other.

Mental health crisis

Spiritual health should be included in the education of health professionals not only due to the fact that health professions are among the helping professions with increased contact with taboo topics of human existence such as the integrity of the body, pain and death, and are more frequently exposed to negative emotions such as patients' irritability or anger, exhaustion and depression [20], but also due to recent developments in the mental health of the population.

According to a recent comprehensive study on the negative consequences of Covid-19 infection in the Slovak population [21], a general acute mental health crisis has developed in society as a result of society-wide measures to prevent Covid-19**,** which is closely related to the knowledge and active application of coping resources mentioned in the previous chapter.

For all the data that increase the urgency of taking the necessary measures, let us mention the 36% increase in the number of new patients in outpatient psychiatric care in the 15-19 age group in Slovakia since 2011, with a concomitant ageing of the population [22], or the most recent data from 2022 - which was one year after the end of the Covid-19 society-wide measures - that psychiatric outpatient clinics in Slovakia examined a total of 417,530 people (769.1/10,000 population), which represents a significantly important increase of 10.7% from the previous year [23].

The authors of the proposal for the first preventive action of the Ministry of Health of the Slovak Republic [16] to support the development of spiritual care as part of the health care provided by qualified health care professionals in Slovakia presented several other important epidemiological data on the health status of the population from national and transnational information sources [21, 24, etc.]. For all data, let us just mention the increasing trend of cancer incidence, which for some diagnoses in Slovakia is even among the highest in the world [25, 26, 27], most of which are now considered preventable or successfully treatable.

These should be an important reason for changing the way of providing patient care to the above-mentioned multidimensional model not only in the treatment of mental illnesses and the management of acute mental health crises, but also, as Solar [8] states, in the management of prevention, diagnosis and treatment of other illnesses. According to Solar [7], when caring for a particular patient, it is usually

always possible to trace a clear spiritual root/conflict in the spiritual dimension, regardless of whether or not the patient is religiously or non-religiously spiritual.

B/ Recommendations for public education

Health education is an important part of education. Catalan drawing by Strizenec [10] states that it should also include the development of a spiritual life, which depends on the education of the whole person towards human maturity within the community in which he or she grows up.

For example, the Recommendation of the Council of the European Union of 22 May 2018 on key competences for lifelong learning [28: 10], specifically under point *5 on personal and social competence and the development of the ability to learn*, states that in formal and non-formal education and informal learning in all forms and stages of education, building this competence should require knowledge of the components of a healthy mind, body and lifestyle, the ability to identify one's own capacities, to face complexity, to think critically and to make decisions.

In all levels and forms of education, the ability to face feelings of uncertainty and stress, to respect diversity, others and their needs while respecting one's own needs, to develop resilience and self-confidence, to cultivate a constructive attitude to problem solving, to deal with obstacles and change, to be prepared to overcome prejudice, to express oneself and understand different points of view, to show tolerance, to gain trust and to feel empathy are to be shaped (in all levels and forms of education) [ibid].

According to this document, failure prevention and resilience building should be part of not only family education, but also all other levels and forms of education (individual, group, collective) in and out of school, including teacher and adult education.

Thus, as the previous chapters have shown, not only in the education of health professionals, but also in the education of children and adults, philosophical, ecological and spiritual education (with respect for the choice of education of a non-religious spiritual character), but also education towards health and healthy lifestyle as such, with knowledge of the different developmental and social roles and roles in this area in families and society, should be promoted more significantly.

Emphasis should be placed not only on leading the individual to responsibility not only for himself, but also through himself to responsibility to others and to the world as a whole, as a universal unity. And this applies equally when he acts, but also when he does not act in terms of formulated universally accepted ethical

principles, even though he knows that he could or should act. The social aspect of spirituality is represented by the persons and relationships of which the child is a part from the beginning of life.

According to Volny [29], R. Coles' 1990 publication Spirituality of children can be considered a breakthrough event that influenced the scientific research of spirituality in children.

Coles replaced the previously used term «religious development» with «spiritual development» and with this term he wanted to describe aspects of life that are inherent in all people, regardless of the presence or absence of belief in God.

According to Coles, children are nurtured by the community in which they are immersed from the beginning of their lives. This introduces them to religious symbols, rituals, traditions, stories, systems of thought, and foundations of theology, and the same is true if a child grows up in a secular or programmatically anti-religious environment. However, said religious or non-religious influence must be distinguished from children's spiritual journey and also from their individual attempts to make sense of this world.

Coles drawing by Nova in [9: 176] points out that spiritual mission does not take place in isolation, but in the context of a network of community that helps the individual to organise reality and face life's challenges using religious ideas and understandings. According to this author, guiding children and adults in the context of a network of community that leads them to seek and find unity with the community, a higher universal meaning, and through it to organise the world and face life's challenges, appears to be an effective prevention.

Skublics drawing by Sawicki and Holkovic [3: 56] explains that in modern man, individual consciousness has expanded at the expense of instinctiveness, and in this way, he has gradually lost his ability to integrate into a group. It is therefore necessary to find a way to make this possible again, because, according to this author, an effective prevention is a return to practiced spiritual (not only religious) activities, strengthening the sense of unity of family, group, community and society, as well as inner integrity and the experience of union with something eternal.

Finally, he stresses that social support that helps to structure the different phases of life in a meaningful way and to assist in the search for the meaning of existence is also well realised through social support in 'non-religious' communities. As diverse as the approaches are, Sawicki [ibid, 57] notes that the gradual spiritual-psychospiritual transformation of the personality has a markedly self-developing

and self-healing effect.

SPIRITUAL HEALTH CARE AS PART OF PRIMARY, SECONDARY, TERTIARY AND QUATERNARY PREVENTION IN THE CONTEXT OF THE HEALTH CARE PROVIDED

Primary prevention and health protection and promotion, as described above, includes both natural education in the family, school, community or other natural social community and, in terms of the provision of professionally led prevention as part of health care and health protection and promotion, is defined as **general prevention** organised and usually carried out by multiprofessional teams under the leadership of a health professional.

This can be individual, group or mass (in all age groups of the population - children, adults, seniors) health counselling, health education and awareness-building, active early search of people at risk directly in the field or through the analysis of the results of population-based epidemiological studies, or the planning and organization of general population interventions, population-based prevention projects and programmes [30: 57].

Secondary prevention is purposefully selective. It is always organised and carried out by health professionals. Mostly on an individual or group basis, and less frequently on a mass basis in people identified as being at risk of disease.

Tertiary prevention, which is also selective and is carried out by health professionals, concerns people who have been identified as being at risk of relapse. It focuses on measures to mitigate the impact of a developed disease or its acute exacerbation in order to prevent recurrence or worsening of the disease.

And finally, there is quaternary prevention, which is both general and selective, focusing on identifying and eliminating the risk of overmedication of patients, omitting unnecessary invasive measures, and selecting the most ethically acceptable procedures in order to eliminate iatrogenic harm as much as possible [ibid].

In secondary prevention — i.e. as we have already mentioned above in people who have already been identified as being at risk of the disease — ***differential diagnosis*** is extremely important. For example, in the case of too rapid spiritual awakening, when the spiritual opening passes into a crisis phase with symptoms of mental disorders, Grof and Grofova drawing by Sawicki and Holkovic [3: 113] recommend implementing the following activities: Temporary suspension of active self-examination; temporary suspension of all forms of spiritual exercises; change

of diet - stop fasting and purgation if it has been held; include glucose and heavier foods such as meat, dense cereals, cheese, dairy products, sweets and coffee in the diet; engage in very simple and calming activities; undertake regular exercise, movement and physical work; move temporarily to a socially and personally calm and natural environment.

The same authors, in another work cited in the same source, state that the crisis phase sometimes occurs in the form of ordinary psychological problems and difficulties and so the crisis manifests itself mildly. Typical symptoms are despondency, depressive states, moodiness, doubts about the meaning of existence, and a reassessment of previous values and ways of life. A rapid, sudden and intense spiritual awakening brings with it dramatic and complicated states, which are called psychospiritual crisis. The individual is not sufficiently prepared for the change and therefore resists it, is unable to integrate it into his personality and his life, and therefore more serious psychically disturbed manifestations and processes occur.

The role of the professional is not to suppress this process, but to facilitate it. The professional should have experience with this condition and the necessary psychiatric training. The professional informs and educates about the spiritual journey as a process of healing and personal growth, directs the understanding of its relevance to the individual´s personal life, and encourages the individual to use this process as an important resource for personal growth and life [3: 109].

Psychiatrist Grof [ibid: 134] states that psychotic states mostly have no organic basis, they are only functional disorders and therefore differential medical diagnosis is extremely important. On the support of patients by professionals, he also states that from a therapeutic and psychological point of view, it is important not to question patients' experiences and to work with them as reality.

Then they bring the person progress in transformation, psychotherapeutic and personal development potential. The author points out that these condensed experiences and experiences can occur in various forms of biographical, perinatal and transpersonal maps of consciousness. Experiences can be put into context with what is going on in a person's present life, which often brings about an improvement in symptoms as well as a change in quality of life. While the connections may or may not be rationally explicable, the effect is the same in both cases [3: 156].

A similar stance is taken by Vancura [31], who stresses the need to create a safe positive framework for patients, i.e. a sensitive, accepting and non-invasive

approach to them. He also specifies helpful methods that are effective, such as: sensitively maintaining appropriate contact, from eye to touch; affirming to the person a personal space that will not be disturbed; allowing catharsis and explaining what is happening to them; bathing in a sea salt solution, frequent showering and rubbing with sea salt; creatively enacting/expressing the ongoing process; and the like are also recommended. It is also important to pay attention to hydration and adequate nutrition of the patients, as they tend to neglect these aspects themselves.

DISCUSSION

The results of this study are not yet comparable, as a similar study that would address the rationale for including spiritual care in the application of standard educational, diagnostic and therapeutic practices from the perspective of healthcare organisation and management has, to the best of our knowledge, been conducted for the first time - apart from studies on palliative care.

Our findings support the implementation of the above innovation into application practice. They correspond not only to the demonstrated theoretical knowledge and experience of experts who have been dealing with the issue for a long time, but also to the general knowledge of pedagogy, according to which successful implementation of innovations should be accompanied by the necessary education. Those who are to implement the change should have the opportunity to understand it better, be able to identify with it naturally, acquire the necessary skills and habits to make it happen, as well as the opportunity to contribute to its further improvement themselves, including by ensuring access to the necessary information resources and relevant training programmes.

The fact that accompanying education on the implementation of standards, guidelines, standard operating procedures or recommended practices in health care should be part of formal training systems is confirmed by the provision of the introductory Article 15 of Directive 2013/55/EC of the European Parliament and of the Council of the European Commission of 20 November 2013 [32: 134] on the continuing professional development of healthcare professionals.

According to this article of the Directive, continuous professional development (CPD), which forms part of continuing medical education (CME) for health professionals should *include*, in addition to technical, scientific and ethical growth, *regulatory growth, which* includes knowledge and acquisition of knowledge and skills for the implementation of legislation, standard and recommended practices,

etc. «for the safe and effective practice» of the relevant health profession [33].

According to the Decree of the Ministry of Health of the Slovak Republic No. 74/2019 Coll. on the criteria and method of evaluation of continuing education of health professionals as amended by later regulations [34], which implemented the European concept of CPD from the cited Directive of the EP and the Council of the EC into the Slovak health legal environment, the continuing professional development of health professionals in Slovakia should also be focused on *innovations that contribute to the quality, safety and efficiency of the exercise of the health profession* (§ 2 (10)).

According to the statutes of the relevant commissions of the Ministry of Health of the Slovak Republic, such innovations include recommended diagnostic, therapeutic and preventive procedures of the Ministry of Health of the Slovak Republic [35, 36].

The first attempt to incorporate spiritual health care provided by health care professionals into standard preventive, diagnostic and therapeutic clinical procedures for health care provision and to modify the relevant education was recorded in Slovakia in 2023.

At the 14th ordinary meeting of the Commission of the Ministry of Health for the development and implementation of standard preventive procedures on 24 October 2023 [16], the draft recommended practice of the Ministry of Health on spiritual care as part of prevention was discussed with reference to:

1. Erik Hofburg Erikson's theory of the eight stages of human psychosocial development [37: 242] on the process of lifelong human socialization, according to which when a person passes through different developmental periods and naturally enters into life crises in which he or she has to fulfil a developmental role. Depending on how he/she copes with the developmental task, it will affect his/her personality, survival and behaviour in the future;

2. Abraham Harold Maslow's needs theory, in which the first four stages are defined as the deficiency needs of a person and the other two as the needs of being or growth (self-actualization and self-transcendence), graphically depicted in the commonly known so-called Maslow's pyramid of needs;

3. John Bowlby's (1968) relational attachment theory of biologically based attachment, which accounts for emotional relationships to self and others [38];

4. Robert Assagioli's (1974) concept of spiritual psycho synthesis, whereby the individual, in the second stage of psychological personality growth [39], begins to find his or her super conscious/transcendental self/spiritual centre, which is the

sense of contact with humanity and nature and felt as a unity;[4]

5. Aaron Antonovsky's (1979) salutogenesis concept of individual sources of health, based on a holistic bio-psycho-socio-spiritual understanding of being human in the world [40]; and

6. the concepts of resilience of several other authors such as Viktor Emanuel Frankl, Daniel Goleman, Martin Seligman, Al Siebert, Howard Friedman, and others.

According to the above-mentioned document [16], with which the Commission of the Ministry of Health of the Slovak Republic has familiarized it, spiritual care as part of the activities in health care carried out in an interdisciplinary team of health professionals is not and cannot be entrusted only to the clergy. And although the whole document was not endorsed by the commission, it provided important background information for the development and updating of other standard practices in both inpatient and outpatient health care in the near future and provides a good basis for the intended development of comprehensive multidimensional health care in Slovakia with the support of collaborative interdisciplinary education[5] , which gives hope for improvements in the near future. It was noted that the issue of spiritual health care provided by health professionals (doctors, nurses, psychologists, etc.) should be cross-cuttingly incorporated into all recommended standard practices, such as standards for cancer care, management of patients with cardiac disease, psychological management of patients with obesity and overweight, prevention of anxiety disorders and depression, etc.[6] And also that, after successful completion of the relevant training for health professionals[7], the standards can then be successfully implemented directly in

[4] Author's note: In the first phase, it is the individual psychosynthesis and synthesis of subpersonalities (Assagioli 1974 after Sørensen 2017).

[5] Author's note: For a more detailed discussion of multidimensional health care, see, for example, in Solár et al. 2022 in the list of references used.

[6] Author's note: In the Slovak Republic, for example, the Recommended Standard Preventive Procedure of the Ministry of Health of the Slovak Republic for Psychological and Psycho physiological Procedures for the Prevention of Anxiety Disorders written by Slepecky, M., Tonhajzerova, I., Kotianova, A., Kotrbova, K., Jandova, K., Majercak, I. and Zatkova, M. [43], Standard Preventive Procedure of the Ministry of Health of the Slovak Republic for Psychological and Behavioural Procedures for the Prevention of Cardiovascular Diseases by Slepecky, M., Majercak, I., Kotianova, A., Tonhajzerova, I., Zatkova, M., Kotian, M., Kotian Chupacova, M., and Gyorgiova, E. [44]; Standard Diagnostic and Therapeutic Procedure of the Ministry of Health of the Slovak Republic for Psychological Management of Overweight and Obese Adults by Malkova, I., Sucharda, P., Malkova, H., Ukropcova, B., Ukropec, J. and Slepecky, M. [45], and many others available at www.standardnepostupy.sk.

[7] Author's note: In Slovakia, the only study programme for physicians and other health professionals accredited by the Ministry of Health of the Slovak Republic, which includes a separate internationally composed module dealing with the issue of spiritual care for other than incurable diseases, is the study programme of the First Clinic of Acupuncture and Naturopathic Medicine of G. Solár. During the course, trainees can, among other things, learn to administer and evaluate the Korngold-Beinfield Questionnaire (MKBD-S) modified by Solarova, which includes the

health care practice.

It was also stated that structural measures should be taken throughout the territory, such as the establishment and operation of evenly distributed community mental health centres and health clinics in the territory as soon as possible, providing general and specialised interdisciplinary community outpatient health care as multiprofessional teams of specialists [41, 42], which would also be dedicated to the field of spiritual health.

In order to be able to exercise the competences of health professionals also in the field of spiritual needs and spiritual care of patients, it is necessary, first of all, to adapt the content and structure of the education provided in universities and in the continuing education programmes of professions involved in health protection and promotion and health care provision and to prepare new curricula taking into account the required contents. Furthermore, to encourage centres of clinical training, research, prevention and treatment to accept the spiritual dimensions of human existence [7].

RESULTS

We have found that the results of the knowledge of professionals who have long been involved in theoretical and applied spirituality as part of the health care they provide confirm a positive impact on the individual's healing process, which provides a good basis for standardization. Experts unanimously state that spirituality influences not only mental and physical health, but also the overall quality of being.

It has been found to be good when the physical and spiritual aspects as part of the bio-psycho-socio-spiritual unity of the patient are tended to by a spiritually anchored health professional. This naturally leads to recommendations for changes in care and relevant legislative, policy and other similar documents at national or international level, including recommended standard medical practices and standards of education. As a result, the health professional should be able to notice what the patient needs and work with the spiritual level of the patient's health in a relevant way.

CONCLUSION

This qualitative study mapped and made visible the arguments for the

possibility of assessing the prevalence of a patient's share of difficulties in the context of a comprehensive diagnosis from either the somatic or psycho regulatory plane.

appropriateness of implementing spiritual health care into the educational and application process standards of health care addressed for health care professionals.

The survey showed that health professionals in practice, as well as medical and other students of helping professions study programs, patients and the general population need to learn more about the spiritual dimension of health and its importance. The education provided should therefore not only include information about different kinds of religiosity as well as spirituality of a non-religious nature, but also a professionally guided experience of reflection on one's own personal relationship to the transcendent, as well as knowledge of related disciplines, in particular physics, mathematics, neurotechnology, philosophy, and, from a transcendent point of view, teleology and eschatology.

Adaptation of educational, preventive, diagnostic and therapeutic standard practices could both enrich the application practice with wider possibilities of applying the healing influence of healthy spirituality on physical, psychological, social and environmental health, as well as facilitate the formulation of new working and research hypotheses to map appropriate and inappropriate ways of working with the spiritual dimension of health in the general population.

Adequate theoretical and empirical training of professionals should gradually increase sensitivity to the individual differential-diagnostic criteria, which, as further stated by Solár [8], are important when it comes to true comprehensive therapy. According to these recommendations, the team of health professionals caring for a person from a spiritual point of view should include health professionals who provide health care to the person, or to his/her family and loved ones, together in mutual daily cooperation, or individually depending on the needs of the patient, who, in addition to medical, should have adequate psychological, psychotherapeutic, pedagogical, philosophical and spiritual education in the content of their studies, and not only on an informative level.

To this end, the creation, existence or supplementation of existing relevant continuing education programmes for health professionals focusing on religiosity should be promoted in the near future as regards the continuing education of health professionals, also on self-awareness and reflection on their own spiritual anchoring, for example, in the framework of already existing communication or psychosocial trainings (see, for instance, the example provided from pedagogical practice), the implementation of recommended international and national preventive practices in the field of spiritual care, recommended practices in ethical therapy, and other spiritual and universal natural principles in ensuring respectful

prevention, diagnosis and therapy.

It is also recommended that the relevant knowledge and competences needed for the provision of spiritual care by health professionals can be acquired not only as part of the continuing education of health professionals, but also within the curricula designed for the training of health professionals in universities and secondary schools of health care.

The modification of educational, preventive, diagnostic and therapeutic standard procedures could enrich the application practice with the proven possibilities of the application of the healing influence of healthy spirituality on the overall health of the individual, as well as help to formulate new working and research hypotheses for the development of recommended ways of working of health professionals with the spiritual dimension of health.

ADDITIONAL

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