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Editorial

Spirituality and Health: Possible Repercussions for Theology as well as for the Sciences of Religion

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> I don't think I've ever spent a minute a day wondering why I did this job, or if it was worth it. The call to protect life – and not just life, but someone else's identity; maybe it wasn't too much to say someone else's soul – it was obvious in its sacredness. Before operating on a patient's brain, I understand that I first need to know his mind: his identity, his values, what makes his life worth living, and what kind of devastation is reasonable to let that life succumb to. (KALANITHI, 2016, p. 97-98).

The words above written by the neurosurgeon Paul Kalanithi, who died at the age of 37 due to lung cancer, point to the important dialogue that has deepened over the last few decades between health and spirituality, which can be understood as essential part of the response to the phenomenon that is conventionally called the "dehumanization of health".

While, on the one hand, we celebrate the important achievements made possible by technological-scientific advances that have positively impacted people's health and well-being, on the other hand, we regret the losses resulting from a hyper-specialized, reductionist and disease-focused model of medicine – called the biomedical model – which ended up losing sight of the patient as a human being, as Fritjof Capra well noted in his book The Turning Point.

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If we have already developed numerous resources that have made it possible to visualize the interior of the human body in rich detail, such as computed tomography, magnetic resonance imaging and ultrasound, at the same time we have given up our innate ability to know subjectivity, the inner universe and people's spirituality because of our contemptuous attitude towards our main resource for this purpose: listening.

Unlike the stethoscope that gives the health professional the conditions to hear the heartbeat, listening is the instrument that allows us to know the reasons why the heart beats, what makes life worth living, as the doctor Paul has said Kalanithi.

There are historical, philosophical, economic and educational reasons – among many others – that help us to explain the phenomenon of dehumanization of health and the prevalence of the biomedical model in the Western world. However, these reasons are not in fact the object of this brief text, whose focus is to reflect on possible repercussions in the theological environment and in the sciences of religion resulting from the rediscovery of spirituality as an essential element of health care and medicine, a discipline that was defined by Edmund Pellegrino as “the most human of the sciences, and the most scientific of the humanities” (PELLEGRINO, 2008, p. 309).

The current agents involved in the dialogue between the humanities and the sciences do not disregard the need to search for the establishment of a common lexicon, especially when they try to reflect on polysemic concepts that are subject to different interpretations. Such is the case with the word 'spirituality', which in the world of health, on a global level, has been consensually defined as being

> a dynamic and intrinsic aspect of humanity through which people seek ultimate meaning, purpose, and transcendence, and also they actually experience relationship with self, family, others, community, society, nature and what appears to us as significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices. (PUCHALSKI et al., 2014, p. 646).

Receiving a diagnosis of a serious illness that threatens the continuity of life can significantly disrupt a person's meaning of life, also impairing their ability to connect with themselves, others, the world or a higher being. When this happens, spiritual struggle or anguish is experienced.

If this dimension of suffering is not perceived and identified, this does not mean that it is not present, since most hospitalized patients, in different clinical contexts, face spiritual struggle and manifest spiritual needs (MARIN et al., 2015), which can be expressed through questions or statements such as: “Why is this happening to me?”, “I feel abandoned!”, “Is it a punishment from God?”, “Can I choose to discontinue medical treatment or only God can tell what my time is?”, “I won't see my children graduating and getting married.”, “I'm worried about how my husband will deal with my loss” or “I don't recognize myself anymore in this body".

Perceiving, identifying and taking care of spiritual pain are attributions of all health professionals, who in the case of spiritual assistance are usually identified as 'generalists' (nurses, doctors, social workers, physiotherapists, psychologists, etc.) and “specialists” (chaplains), with the latter being responsible for carrying out a more in-depth and extensive assessment of spiritual suffering, as well as drawing up an action plan with the expected results, which must be shared with the other members of the multidisciplinary team (The Impact of Professional Spiritual Care, 2018).

Unlike what has happened in Brazil, where chaplaincy is not yet a recognized profession in the health world, in the United States, specialists in spiritual assistance certified by the main associations in the country must undergo an extensive training process that includes a bachelor's degree in Theology, Masters in Divinity or any related area such as Sciences of Religion, and a minimum of 1600 hours of Clinical Pastoral Education courses offered in a hospital environment in the models of a medical residency, with supervised performance of students with patients.

One of the main pioneers of the Clinical Pastoral Education movement in the United States was Anton Boisen, a man who was raised in a very conservative

Presbyterian family who had some experiences that he called 'near psychosis', having been admitted to a psychiatric clinic for the first time with just over 40 years old. During the nearly 15 months he was hospitalized, Anton Boisen had what he considered to be his religious call to integrate health and religion. As a patient, Boisen realized that his and other inpatients' religious and spiritual needs were not properly addressed, much less taken seriously.

Influenced by the theories of William James, and his classic work on the Varieties of Religious Experience, Boisen concluded that many psychiatric disorders have religious and spiritual reasons, making it essential, therefore, to integrate spirituality and religion in the care of these patients, overcoming the distance. which separates spirituality and religion from medicine.

> For Boisen, periods of crisis in life awaken creative possibilities in human beings. He said that 'in times of crisis, when a person's fate is at stake, we are likely to feel and think intensely about the things that matter most. According to Boisen, periods of life's crisis bring with them creative possibilities, which can produce changes for better or worse. (LEAS; THOMAS, p. 1).

The reflection that emerged in the midst of Theology and the Sciences of Religion has much to offer in this regard, and the current moment is quite appropriate for that. It is exciting and promising to see that the world of health is receptive not only to researchers in these areas, but also to those who want to make their pastoral vocation with the sick also their profession. The field is in development and each of us is invited to discover how we can contribute to the changes for the better as Anton Boisen has mentioned.

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