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Tradition and Transformation: Spirituality in Church-Related Caring Communities in a Pluralistic Society

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Abstract: Demographic change in aging societies makes it urgent to ask how care can be understood as a social task. This is where the concept of caring communities comes in, which understands care as a task of many, indeed, of society as a whole, and aims to offer mutual care in communities. While the concept has been described in theory many times, empirical studies are rare. In pluralistic Western societies, the church as an institution is becoming less important while spirituality and spiritual needs are increasing in prominence. These processes of secularization run parallel to a growing interest in spirituality and an individualization of religion. Nonetheless, church congregations have always offered a place of mutual care and lived religion that functions as a network and social resource. So far, the role of spirituality in church-related caring communities has not been sufficiently addressed. In an exploratory qualitative study of three church-related caring communities in Germany, we focus on the target group of caring relatives, of whom we interviewed nine. The results show that church-related caring communities provide important spiritual resources and rely on the basis of shared values that are closely connected to Christian convictions. However, the different understandings of care and spirituality point to the relevance of discussing the often preliminary motives and values of care. Especially in plural societies, the discourse on plural values for mutual care is important and can form a basis for caring practices such as spiritual and pastoral care. Opportunities and places to discuss and debate different and shared values underlining care practices are necessary. The potential of spiritual and pastoral care in church-related caring communities is important and needs to be further strengthened.

Keywords: caring community; spirituality; religion; values; psychology of religion and spirituality

1. Introduction

While the processes of secularization and pluralization of Western societies challenge the church as an organization and institution, new models of care are evolving. Demographic change raises the question of how care and related processes can be understood in the future. The currently discussed innovative social concept of the "caring community" provides a new understanding and opportunities for changed practices of care to these central societal challenges. Care is thus framed as a task of many people helping each other.

A caring community is understood as a community in a neighborhood, municipality, or region in which people care for and support each other, together taking responsibility for social tasks. The concept of care not only involves physical care but also includes forms of social awareness for each other, psychological support, or even spiritual and pastoral care. The basic idea of a caring community is to distribute care and related tasks

among many actors in the sense of a "welfare mix" (BMFSFJ 2017, p. 182) by activating necessary resources in the immediate surrounding area and providing support from the state (Klie 2013, p. 18) to relieve people, promote participation and self-determination, and enable a good life for all (Hofstetter 2016, pp. 213–30). Shared care includes several institutions, groups, and organizations that interact together, including volunteers and professionals: "A caring community is the successful interaction of citizens, the state, civil society organizations, and professional service providers in organizing care for and with people in difficult life situations and phases of care dependency" (Wegleitner and Schuchter 2020, p. 5; translated by the authors). According to Zaengl (2023, p. 8), caring communities are characterized by the following seven essential features: community, care, participation, organization, exchange, responsibility, and values. They are situated on the levels of the social, the cultural, and the technical–instrumental. The concept of "caring communities" itself originally derives from school social work and was intended to improve the school community by establishing helping and caring for others as central values and attitudes (Battistich et al. 1997). It has gained increasing attention in Western Europe, especially in Germany and Switzerland, due to demographic changes and the crisis of the welfare state associated with the shortage of nurses, increased rates of home care, and the burdens of caregiving relatives (BMFSFJ 2017; Kruse et al. 2022). Although the theories on caring communities are available and extensively discussed in a variety of ways (Coenen-Marx 2019; Kunz 2018; Sempach et al. 2023), it is yet to be explored how caring communities are organized in practice and under which conditions a well-working caring community can be established and sustainably and successfully persist.

Caring communities depend on the building of bridges between different actors, such as volunteers and professionals in the social sector, caregivers, and care receivers. Caring communities are considered an important building block to foster social integration and sustainable structures of solidarity, which is needed to realize democracy where citizens can make a contribution to the common good through their actions in increasingly individualized, pluralistic, and disintegrated societies. In Western societies, the term "caring community" was often used for the phase of old age and care as a means of caring for the elderly (BMFSFJ 2017; Klie 2014; Kruse 2017), but it can be extended to any practiced mutual caring. The concept is strongly linked to the practice of solidarity and common good orientation. These values are closely related to Christian values and supported by religious organizations. But at the same time, several religions and spiritualities, even secular worldviews, include the thought that care for others should be something to be shared and taken responsibility for by the community. Care, community, and spirituality/religion thus are closely intertwined across religions and cultures, which makes it important to include the dimension of culture to an interculturally oriented spiritual care that is open to different religions, spiritualities, and world views (Doehring 2015; Lartey 2003, 2017). However, there is some substantial empirical research on spiritual care (e.g., Nolan 2015) that may be useful to further explore the relationship between spirituality, care, and community.

Spiritual care is known as a powerful resource supporting individual resilience by not only reducing loneliness but also providing interpersonal support and acceptance, which is not limited to a certain religious or cultural group (Doehring 2015). Usually, different dimensions of religion/spirituality are distinguished as cognition, feelings, social (church, congregation, or community), and practice (behavior) (also Haussmann 2019). According to this multidimensional understanding of religion and spirituality, contradictions or ambivalences may also emerge across those dimensions. Religion and spirituality therefore may not be understood as something stable and unchangeable but rather as a dynamic and lively process that also transforms life and the perspective on life itself (Pargament 1997; Haussmann 2019). Spirituality/religion can serve as a resource for health and well-being (Koenig 2012) and can also contribute to community development (Chile and Simpson 2004). Community and spirituality/religion are thus closely intertwined.

Religious communities such as church congregations play an important, yet ambivalent, role in caring communities also aiming to include and support the spiritual dimension.

On the one hand, church congregations seem particularly capable of building caring communities due to their shared value base, such as charity and compassion, their traditional community of faith in word and practice, and their wide-ranging experience in care for one another (Klie 2013, p. 21). On the other hand, they present themselves well as a community of care due to their centralized and publicly accessible spaces as well as their professional contact persons (Coenen-Marx 2019, p. 30). Here, the willingness to care finds its space, recognition, and opportunities for implementation (Klie 2013, p. 21). Caring communities in a church context are considered to be spiritual places in which—following Mt 25:35–60—the guiding principle is "I care about you!" (translated by the authors) (Gebhard 2021, pp. 75–76). Church-related caring communities offer spaces of encounter in which people can narrate their lives and confide in other people with their concerns, always in the knowledge that they are valued and accepted by them as a person and welcome to be listened to (Coenen-Marx 2019, pp. 42–43). It is essential "to perceive and at the same time to leave behind us what makes us 'stick' to the past or the present, and thus to find inner freedom" (Coenen-Marx 2019, p. 40; translated by authors). In end-of-life care, one's own life is reflected upon and interpreted, whereby it can be comforting to know that—with a view to a Christian horizon of interpretation—one's own life does not end with death. In addition, it is also known that spiritual and religious groups can be helpful for family caregivers in dealing with difficulties in caregiving (Casaleiro et al. 2022, p. 250). Religious communities provide spiritual support—such as prayer, worship, or meeting religious leaders—that may strengthen resources in the daily lives of family caregivers (Casaleiro et al. 2022, p. 250). In addition, Schaeffer and Tamminga (2023) define four types of communities of care that are particularly found in Christian communities as follows: (1) "communities devoted to particular target groups", (2) "communities devoted to care in general", (3) "communities that highlight specific care programs among their ministries", and (4) "communities that aim for holistic care" (p. 10). The basis of caring communities is values that the community has agreed on together: "church congregations do not carry out their civic engagement purely out of particular interests, but directly trace it back to their own system of values and a specific image of humanity, the idea of a common good orientation becomes obvious as a constitutive characteristic of civic actors" (Ohlendorf and Rebenstorf 2019, p. 241, translated by the authors). It may be pointed out that religious/spiritual groups and communities can also have negative effects on well-being and health, causing spiritual struggles and worries. The positive effect therefore depends on the nature of the religious/spiritual contents (such as values, norms, and God images) and proclamations in those communities (Exline 2013).

Once established, volunteers play a crucial role in caring communities. Volunteering in formal and informal settings is considered a major way to foster social integration within a society (Putnam 2001). Motives that drive individuals to engage in volunteering are a key condition to build and sustain social solidarity (Haussmann 2021). According to Clary et al. (1998), the six potential motives for volunteering are protection, values, career, social, understanding, and enhancement. In addition, religion can be a motivational basis for volunteering (Wilson 2012). Meanwhile, less is known about the motives of volunteering in specific areas, such as social volunteering, as well as whether and how this importance has changed over time. Little attention has been paid to the interplay of individual motives and organizational contexts in volunteering (Wilson 2012). Yet, the organizational structure of caring communities might be crucial for volunteers to engage on a long-term basis.

These results indicate that it is difficult to raise and implement caring communities from scratch. It therefore makes sense to build on grown structures of solidarity within a pluralistic society. In Western pluralistic societies, the idea of a caring community can be related to a Christian-influenced understanding of a community that supports the health and well-being of its members in a subsidiary way based on tradition and values. Care is understood in the sense of holistic, mental, and physical health support that concerns intergenerational cooperation and mutual social responsibility (Jakob and Weyel 2020). Volunteers in the church context can therefore be understood as actors in civil society (Schleifenbaum 2021). Religious networks offer social support and provide care

from an existential, psychosocial, and spiritual perspective by sharing mutual values and supporting with pastoral/spiritual care (Haussmann et al. 2020; Haussmann 2021; Kunz 2018). This support is especially crucial for caregiving relatives, although caregivers only use the support system offered by church congregations or other caring communities to a limited extent (Haussmann 2019). On the other hand, their social integration is declining especially in long-term caring conditions (Haussmann 2021). It seems that their needs of perceived reciprocity (also being seen as someone who cares, rather than only needing to be taken care of) and previous experiences with the church or one's own religious or secular values and attitudes are important to consider as conditions of caring communities (Haussmann 2021).

We intended to examine the discussed aspects empirically by studying a model project of church-related caring communities. The project "Becoming a caring congregation" ("Sorgende Gemeinde werden" in German) is rooted in the regional Protestant church in Baden, which is located in the south of Germany, and aims to unite church-based diaconal services with other actors, taking into account the social space and a specific focus on older people to improve the expansion of the social infrastructure (Schendel and Laemmlin 2022). Thus, church-related caring communities are directly supported by the church but, at the same time, reach out to the social space in cooperation with other institutions and organizations. Based on the model project, initial contacts to church-based initiatives made it easier to find church-related caring communities for participation in this research project (see Section 2).

1.1. Research Questions

This article investigates the functioning of caring structures characterized by social cohesion and reciprocity and aims to answer the following research questions:

-    What is the role of spirituality in church-related caring communities?
-    How do the actors in a church-related caring community describe the distinctiveness of a caring community with respect to spirituality and the realm of a church?
-    What values are described as the basis of the caring community?
-    What spiritual needs and spiritual practices emerge in church-related caring communities?

We aimed to distinguish the following three perspectives to examine the role of spirituality: (1) institutional professional actors (e.g., church institutions, care and citizen services, and other clubs and associations), (2) volunteers, and (3) family caregivers.

1.2. Overview and Terminology

Based on the current research findings described in this Introduction Section (1), the subsequent part will describe the empirical methodology of this study (2), before exemplary results for the role of spirituality in church caring communities will be presented (3). These will then be reflected upon in the Discussion Section and linked to the existing literature and research (4).

Concerning the terminology used in this article, we will largely discuss spirituality and religion, referring to a strong consensus in theological, psychological, and spiritual care discourse that aims to provide a broad view of the individual phenomena (Pargament 2013; Puchalski et al. 2014). Furthermore, we will also sometimes mention spiritual and pastoral care as complementary and sometimes in distinction: spiritual care is defined as providing care for the spiritual and religious needs of an individual or group, while pastoral care is defined as a Christian form of care for another person that is directed towards individual or collective needs in life and the spiritual realm.

2. Methods

2.1. Study Design

This is a comprehensive exploratory study in a cross-sectional design. The objects of investigation are three caring communities in the context of the Protestant church,

which were examined in further detail. The data presented here derive from the project "Experiencing solidarity: Values, motives and practices in caring communities and social volunteering", which is an interdisciplinary research project including gerontology, political science, and Protestant theology. The focus is concentrated on family caregivers, as they are characterized by particular physical, psychological, and socio-emotional burdens, as well as immense (usable) potentials and resources (Wiloth et al. 2022a, 2022b). Specifically, the project aimed to analyze (1) the prerequisites and framework conditions of a caring community that can contribute to supporting family caregivers, (2) specific motives and conditions of social (voluntary) engagement, (3) the effects of caring communities on—for example—resilience and regulation processes of family caregivers, and ultimately, and (4) the opportunities and added value of caring communities.

2.2. Recruitment of Caring Communities

The caring communities were recruited by contacting existing regional church projects dedicated to the aim of becoming a caring community of the Protestant church of Baden as a regional church in Germany. Included were projects that considered themselves as caring for others in the sense of a "caring community". For the purpose of this study, we predefined inclusion criteria as the following: (1) an explicit self-image as a "caring community" (identified in their guidelines or through participation in the regional church project of caring communities); (2) orientation towards caregiving relatives; and (3) opening up to the neighborhood and district (social space orientation).

The aim was to select caring communities for qualitative exploration that are particularly relevant for answering the specific research questions.

2.3. Participant Recruiting

The participants provided written consent for the qualitative interviews after verbal or written notification. In all three parishes, a preliminary discussion took place with full-time actors who simultaneously functioned as multipliers for the project and were able to recruit team members. The aim of the preliminary meeting was to inform the potential participants about the project, answer their questions, obtain initial relevant information about the congregations (e.g., soft inclusion criteria), and—if necessary—plan the next steps together. This was followed by the recruitment of caregivers and volunteers with the help of the multipliers.

In selecting the participants, the focus was on group heterogeneity and the relationship with family caregivers in their own full-time or volunteer work. Thus, we aimed not only to include church employees and volunteers such as pastors, project leaders, or employees in the visiting service, but also other actors from the social realm, such as employees of the local social services, neighborhood assistance, or care facilities. The participation in an offer for caring relatives of the caring community and thus the experienced support represented a decisive criterion for the selection of caregiving relatives. Sometimes, former caregiving relatives who participate in discussion groups were also interviewed despite no longer being caregivers to pass on their experiences to other—possibly still inexperienced—caregiving relatives. One focus group (FG2) was conducted with coordinators of caring communities who had experience in cooperation and support for different caring communities that they could share in a focus group. In contrast to the other three group interviews, the participants of this focus group were characterized by the coordination and accompaniment of emerging, local projects. This approach was chosen to capture the diversity and generate different mechanisms and framework conditions for their emergence (Przyborski and Wohlrab-Sahr 2022, p. 134). The aim was to ascertain the extent to which the experiences with caring communities of people who are involved in a concrete, local caring community differ from the perceptions of coordinators at a supraregional level. The focus group conducted with coordinators equally contrasted with the other focus groups (Przyborski and Wohlrab-Sahr 2022, p. 134).

2.4. Enrollment

Individual church congregations were contacted by mail, informed about the project, and asked to participate. Three out of six contacted parishes agreed to participate, the other three declined due to lack of time and capacity. Overall, twenty full-time employees and nine volunteers participated in the four focus group interviews. Five of the ten volunteers were also family caregivers. In the course of the interview, this dual role was sometimes evident in the participants' remarks.

In addition to one to four project managers and coordinators per interview, three pastors, one dean, three church education officers, one mayor, and three employees of local institutions that support caregiving relatives such as neighborhood assistance, social services, or the diaconal station participated in the interviews as full-time employees. The volunteers included three employees of the (birthday) visiting service for members of the church community, two members of the project advisory board of the respective project, one intern, two everyday helpers with care activities, one person from the neighborhood assistance, and one person who was involved in a discussion group for caring relatives This composition of participants resulted from the inquiries of the multipliers and the inquiries to potential caregivers on the part of the employees of this research project.

2.5. Procedure

Four focus groups and nine individual interviews with family caregivers were conducted using guided interviews (see Tables 1 and A1). Respondents also provided information about themselves and the caregiving community through a questionnaire.

Table 1. Overview of the interview guidelines.

Topics of the Focus Group Interview Guidelines	Topics of the Individual Interview Guidelines
- Working with family caregivers: assessment of needs, integration, and participation. - Existing offers of the caring community. - Role understanding and function within the caring community. - Challenges in collaboration and project design. - Satisfaction with team collaboration. - Motives, values, religious beliefs: the basis of caring communities. - Personal resources. - Understanding of "caring communities" and "care". - Specifics of religious caring communities in contexts of the protestant church.	- Everyday care. - Resilience and support factors (resources). - Understanding of "caring community" and "care". - Personal assessment and perception of support services (including empowerment, spirituality, and appreciation). - Motives for participation in the caring community.

2.5.1. Focus Group Interviews

Based on semi-structured guiding questions, between four and twelve full-time and voluntary employees of a caring community were interviewed in four focus groups. The focus groups were intended to provide information on cooperation and networking and which further processes are necessary for its continuation. In addition, it depicted discursive processes. Due to the pandemic, the focus group interviews were conducted from May to September 2022 in person, online, or on a hybrid basis. A member of the research project moderated the interview and—supported by a co-moderator—asked open-ended questions that the participants answered one after the other, in no particular order.

2.5.2. Individual Interviews

Nine individual interviews were conducted in each of the three selected caring communities, with three caregiving relatives in each community, from June to September 2022. Participants provided information about their caregiving situation, resources, and sup-

port needs, as well as the extent to which the caring community provides actual support for them.

2.6. Measurements and Interview Guidelines

2.6.1. Interview Guidelines

Semi-standardized guided interviews were conducted with a set of question content and question order. The questions were developed based on literature reviews and identified research gaps. "How"- and "what"-questions were preferred to stimulate narrative and focus on specific topic areas. After the initial interviews, the guiding questions were re-analyzed, modified, and reordered to ensure comprehensibility and fit with practice.

2.6.2. Focus Groups

After personal introductions, the focus was shifted to the work with family caregivers, in particular, their integration into the caring community and the focus on their needs. The extent to which the needs of family caregivers are known and how these are reflected in the project offers were explored. A central question focused on the integration and participation of family caregivers as active co-creators of the caring community. It was asked to what extent existing offers for family caregivers are sufficient and what wishes exist beyond that. The results of the focus group survey were used for further analysis. The own understanding of the role and the specific function within the caring community as well as group dynamic processes were intensively examined. The participants were asked about the challenges that they face in their daily work, the extent to which collaboration and networking are successful, and whether their own work is fulfilling and satisfying. Subsequently, motives, values, religious convictions, and personal resources were examined. Finally, the participants were asked to describe what they understand by a "caring community" and explain the extent to which mutual concern and solidarity are implemented at a practical level.

2.6.3. Individual Interviews

The individual interviews included open questions about everyday caregiving, resilience, and the framework conditions of the caring community. In order to facilitate the introduction to the sensitive topic, the caregiver was first asked to report on his or her everyday caregiving. In addition to questions about the extent and type of care, the participant was sensitized to the topic of the project and asked about his/her own definition of a "caring community." Subsequently, the personal assessment and perception of the support services were discussed. The evaluation of contents, processes, and effects of caregiving offers such as discussion groups by the caregiving relatives were central. Regarding the perception of offers, it was asked to what extent caregiving relatives experience appreciation for their work through the caring community, what feelings subsequently arise—for example, in the exchange with like-minded people—and to what extent participation in a caring community is perceived as strengthening for their own caregiving. Resources in everyday care were also analyzed.

In addition to social and psychological factors, spiritual aspects were also surveyed. Questions were asked about the importance of faith and spirituality in everyday care and the specifics of dealing with people in an ecclesiastical context. Finally, motives for participating in care services and the personal benefits of a caring community were identified.

2.7. Analysis of Empirical Material

After the data collection phase (May to September 2022), the interviews were transcribed by a transcription service and anonymized. The evaluation regarding the research questions (e.g., challenges, necessary preconditions, and regulation processes as well as connections between spirituality and understanding of care) was carried out methodically using qualitative content analysis according to Kuckartz and Raediker (2022) and with technical support by the evaluation software MaxQDA 2022®. In the first evaluation phase,

case summaries of focus groups and individual interviews were written and important text passages were marked (Kuckartz and Raediker 2020).

Category terms were then deductively created from the research and guiding questions and provided with anchor examples (e.g., the main category "motivation to help shape the caring community"). Subsequently, the main categories were inductively differentiated by sub-categories based on common theorizing (e.g., the main category "spirituality", taking into account the multidimensionality of the construct; Pargament 2013), with the formation of the sub-categories "church", "community", "religious beliefs", "religious values", and "religious practice" (Kuckartz and Raediker 2020, p. 32). Overall, the deductive category system comprised fifteen main categories with twenty sub-categories in total, although not every main category was divided into sub-categories. The coding itself was based on established coding rules, which were developed by the research team and constantly tested on the material.

The interview material was first analyzed using macro-coding. The questions posed by the moderator served as the first division into coherent sections of meaning. The respective answers of the participants were then examined individually line by line in the sense of micro-coding and assigned to appropriate codes, whereby multiple coding was desired to reflect the polyvalence and ambiguity of the statements. All interviews were initially coded by one person at a time.

In order to achieve a comprehensive understanding of coding through as many perspectives as possible, the coding process was regularly discussed within the team in the sense of peer debriefing as part of a joint dialogue, and independently conducted assignments were compared. The coding process thus follows a consensual validation of the material (Flick 2019). In particular, this involves the validity of interpretations and accordingly, assignments, whereby consensus is established between the coders.

After the initial coding phase, coders shared their observations, and a comprehensive summary was prepared for each major category. This procedure was used to ensure reliability and validity. In the fourth phase, the category designations were differentiated by taking into account the coded text passages, further sub-categories were inductively formed on the material, and definitions were refined (Kuckartz and Raediker 2020, p. 138). Subsequently, the data were coded and structured again with the new sub-categories (Kuckartz and Raediker 2020, p. 142). Again, summaries were written, and findings were presented and discussed with the research team. Central key passages of the interview material were analyzed and discussed together as a team in a topic-based research workshop.

2.8. Sample Characteristics: Participants of This Study

The sociodemographic data are displayed for the focus groups and individual interviews (see Tables 2 and 3).

Table 2. Sociodemographic data for the four focus groups (FGs).

Demographic Variable	Focus Group ($n = 29$)
focus group	FG 1 $n = 9$ (5 f, 4 m); FG 2 $n = 4$ (3 f, 1 m); FG 3 $n = 8$ (7 f, 1 m); FG 4 $n = 8$ (6 f, 2 m)
gender ($n = 29$)	female: 21 (72.4%); male: 8 (27.6%)

Table 2. *Cont.*

Demographic Variable	Focus Group (*n* = 29)
age (*n* = 27)	30–40 years: 4 (14.8%); 50–60 years: 8 (25.9%); 60–70 years: 9 (33.3%); 70–80 years: 4 (14.8%); older than 80 years: (11.1%)
professional qualification (*n* = 27)	apprenticeship diploma: 5 (18.5%); technical college degree: 2 (7.4%); university degree: 19 (70.4%); other educational degree: 1 (3.7%)
martial status (*n* = 27)	married: 18 (66.7%); divorced: 3 (11.1%); single: 6 (22.2%)
length of volunteering time (*n* = 25)	<1 year: 4 (16%) >1 year: 2 (8%) <5 years: 5 (20%) >5 years: 14 (56%)
monthly working hours (*n* = 25)	<5 h: 4 (16%); >10 h: 7 (28%); >20 h: 2 (8%); >40 h: 4 (16%); >60 h: 8 (32%)
full-time or voluntary (*n* = 26)	full-time: 17 (65.4%); voluntary: 9 (34.6%)
additional volunteering in other contexts (*n* = 23)	yes: 14 (60.9%); no: 9 (39.1%)
team size (*n* = 20)	>5: 7 (35%) >10: 2 (10%) >30: 3 (15%) >40: 8 (40%)

The focus groups are largely homogeneous in their mix of participants. Of the 29 participants, the majority are female (21), over 50 years old, and have a university degree. The majority of the participants are married and work full-time in one of the projects studied. Although they already invest a considerable amount of their monthly working time in the respective projects of a caring community, more than 60% are also involved in tasks of their church communities.

A total of nine family caregivers were interviewed individually (see Table 3), the majority of whom were female and over 60 years old. More than 50% of the respondents take care of their husbands in need of care and spend more than 20 h a week on this. Almost all respondents are primarily responsible for the care of a relative, although the degrees of care significantly differ: three relatives in need of care are under care degree 5 and four are under care degrees 2 and 3. On average, the relatives have been active in home care for three years.

Table 3. Sociodemographic data of individual interviews.

Variable	Individual Interviews (*n* = 9)
gender (*n* = 9)	female: 7 (77.8%); male: 2 (22.2%)
age (*n* = 9)	50–60 years: 1(11.1%); 60–70 years: 5 (55.6%); 70–80 years: 2 (22.2%); older than 80 years: 1 (11.1%)
professional qualification (*n* = 9)	no professional qualification: 1 (11.1%) apprenticeship diploma: 2 (22.2%); technical college degree: 4 (44.4%); university degree: 2 (22.2%);
martial status (*n* = 9)	married: 6 (66.7%); widowed: 3 (33.3%);
responsible for care (*n* = 9)	yes: 8 (88.9%); no: 1 (11.1%)
caregiving time (*n* = 9)	<5 h: 1 (11.1%); >5 h: 1 (11.1%); <10 h: 1 (11.1%); >20 h: 6 (66.7%);
person in need of care (*n* = 9)	husband: 5 (55.6%) wife: 1 (11.1%) own mother: 1 (11.1%); own father: 1 (11.1%); own daughter: 1 (11.1%);
care level (*n* = 9)	care level 1: 1 (11.1%); care level 2: 2 (22.2%); care level 3: 2 (22.2%); care level 4: 1 (11.1%); care level 5: 3 (33.3%);
duration of care (in years) (*n* = 9)	M = 3.11 SD = 1.85 Min = ½ year; Max = 6 years

3. Results

First, the main findings of the analyses of the focus group will be presented. A link between spirituality and care could be identified, as well as findings on relational and social aspects, including spiritual–religious values, spiritual practices, and dealing with other spiritual and religious backgrounds and worldviews.

This part is divided into five parts. First, we will introduce a short sequence of a focus group interview that contains different aspects of the relationship between spirituality and a caring community (Section 3.1). Results are then presented on four dimensions of spirituality including cognitive (Section 3.2), social (Section 3.3), emotional (Section 3.4), and practical aspects (Section 3.5).

3.1. "It Is in Your DNA:" The Link between Spirituality and Care in a Nutshell

For a starting point, we introduce a section of the interview discussion of focus group 1, which refers to the complexity and richness of the discussion when considering the relationship between spirituality and care. Many of the topics and themes explored and analyzed in the whole project are presented here in a nutshell and will later be explored in more detail. In focus group 1, nine individuals are discussed together and offered a reconstruction of a religious–spiritual meaning of caring.

Interviewer: "To what extent does it perhaps make a difference from your point of view that care, caring for, self-care, is offered by the church congregation or community, or in connection with faith, and not exclusively in the local district/commune?"

FG01_HAPA04 (mayor): "It is in your DNA."

FG01_HA02 (pastor): "By profession, it's perfectly clear that it's simply –"

[FG01_HAPA03 (project coordinator): "In the ten commandments." (interrupts HA02)

FG01_HA02 (pastor): "-yes, part of it. Charity is simply one of the core things. So that we as a church community take care of others, approach others, that's actually completely clear. And it's wise to do things and network where people are doing similar things. That's good. Then everyone benefits when we join forces, as if everyone cooks their own soup or no one manages it at all. That's the stupidest thing you can do if you want to move forward."

01_HAPA04 (mayor): "That was said a little flippant now, yes, but, but if I then, as I said, take the gospel of the Samaritan, no matter how now: Caritas, which is also over here, then it is much closer as with us. Only with us, of course, the topic comes up now. I experience this quite often, and this is the total demarcation from the topic, that we then say that we are taking care of something that is perhaps not in our local, factual competence. Some colleagues have an automatic reflex: 'So I am locally responsible. Okay, yes that's not with me, not factually at all.' So. And that's how you can distinguish yourself above all. So from that I think already clearly a very different connection than also the task, a task or a mission."

FG01_HAPA03 (project coordinator): "For me, the question would be whether the caring community doesn't already have this blessing anyway and whether the church has to stand above it? So the caring as community. I think for me that would be church, I think." (FG01: 284–290)

According to the question on the relationship between spirituality and the church congregation, the interviewer offers more than one association, and the mayor first answers spontaneously, pointing to care as a core principle of the church by using a rather secular, scientific, and biological metaphor of "DNA" as an essence of being. Thus, care is not something added or peripheral, or something "nice to have", but lays in the center of what is meant to be. But whose DNA is he talking about? The mayor suggests an external interpretation, implying that he does not identify with the relation between care and spirituality, but he rather delegates this topic to the others. With "your DNA", he seems to address the other members of the group, especially the pastor. This seems interesting because one could have expected the pastor to answer first. Clearly, the mayor would also be used to reacting firsthand because he is responsible in most contexts and thus would be used to taking on a leading role. Nevertheless, he directly links care and the church resp. the Christian community, with care being one core principle or the essence of faith. Perhaps he also sees the church as more responsible for care than the secular local commune. Therefore, it seems that he animates the others—possibly also the pastor—to take a stand and explicate on the matter.

Next, the pastor reacts—as one could have expected—and brings in his own professional context. He states that care and faith belong together "by profession", which seems to be natural and self-evident for him, as he highlights several times ("perfectly clear", "simply [. . .] part of it;" "completely clear").

While making his statement, he is interrupted by the project coordinator, who refers to the Ten Commandments. This rather traditional Christian reference initially seems to be slightly "out of the blue" but becomes more transparent against the background of the entire interview and her personal background. It directly reacts to the mayor's statement of "in your DNA" and qualifies care as being stated in the Ten Commandments. However, this is only partly true, since the Ten Commandments do not mention care for others explicitly. The caring communities in question see themselves as having a significant

responsibility for family caregivers, and this was discussed earlier in the interview. The coordinator is a caregiver herself, and from this perspective, the fifth commandment of the Decalogue (Ex 20:12 or Deut 5:16), the commandment to honor parents, comes to mind. A perceived imperative of caring behavior in intergenerational respect seems to be the background to this objection. Also, when thinking about the Ten Commandments and the New Testament, an interesting link emerges: Jesus himself reinterprets the commandments in two condensed rules, also known as the "golden rule:" the love of God and the love of the neighbor. Nevertheless, an important point is made, and the project coordinator, therefore, introduces the topic of charity and loving their neighbor (German: Naechstenliebe), and the pastor immediately names it "charity."

Only a little later, he explains this with a central value of charity and refers to the biological metaphor of "DNA" (mayor) being "one of the core things" with a more religious interpretation. Care is understood as "taking care of others" and "approaching others", thus as a self-motivated behavior without the other first asking for help. The immediate recourse to religious self-evidence of care is then relativized by mentioning that ultimately it comes down to working together, despite one's religious or spiritual background and convictions. Therefore, he marks the importance of results rather than convictions or beliefs (working together, networking), and thus places practical results before believed religious differences.

The mayor then picks up on those thoughts in a twofold way. He also brings in religious traditional language and heritage by referencing the scripture as "the Gospel of the Samaritan", which is in fact not a "Gospel" as such, but within the Gospel of Luke, and cites the parable of the Good Samaritan (Lk 10, 25–37). The Samaritan is the one who provides first care for the wounded victim with severe injuries and then also cares for further institutional caregiving. Given this example of care where it is not to be expected (Samaritans were a group despised by the Jewish people), the mayor even seems to identify himself with this example: whereas the others walk away from care and the injured man, respectively (the priest, the levit resp. the other mayors or responsible in the commune), the Good Samaritan, and likewise, the mayor, takes care, feels responsible for caring and makes the caring community his own project, rather than simply leaving it to the church or the diaconal actors ("Caritas" is the name of the diaconal institution of the Catholic Church). Therefore, the conclusion from the first statement that he considers the church as responsible for caregiving ("your DNA") has to be complemented by the conviction in the eyes of the mayor that the commune is also responsible (task, assignment) for taking care by implementing and supporting a caring community.

The project coordinator makes a further addition: although for her, the church is associated with a caring community, it does not have to be visibly labeled as such. Rather, the church realizes itself by creating a caring community and, in this respect, it would be part of the invisible church.

Interestingly, the first reactions to the question do not come from the volunteers of the project, but rather the professionals who seem to take the lead not only regarding this question but indeed throughout the interview. According to their statements, they also focus on a more political perspective, concentrating on the output of the project. The group constructively develops a sense of understanding the relationship between spirituality and care by adding topics that are important to themselves and the group. This kind of group interpretation can be understood as a way of "lived theology" (Doehring 2015). Of course, the statements are always colored by self-staging practices and the presentation of one's own role. They might differ from each other in certain aspects of interpretation and their importance, but they listen and refer to each other, supplement the statements of the other, and develop a kind of shared understanding of a spiritual/religious caring community that becomes a Christian understanding of the care and caring community, despite their individual interpretation. In a sense, they relate to what the other person is saying, but clues of validating or signs of a real discussion are missing, which may also point to a rather pragmatic identity of the group that does not rely on the others' personal views but

rather is built upon professional cooperation. Nevertheless, the conversation may reveal a certain process of seeking to understand each other that is built on appreciation and openness: the mayor names a biblical figure and uses biblical language and metaphors, while the pastor refers to "charity", but rather than that, he reduces traditional Christian or religious language and heritage and opens up to the greater good, namely, the practical aim of a caring community as teamwork for the sake of others. Therefore, the pastor himself speaks in a more political yet pragmatic language that is largely free from explicit religious language.

Thus, several topics are already mentioned in this short sequence of FG 3 concerning the relation between spirituality and care as follows: values (religious and spiritual and secular, e.g., charity), networking between secular and religious actors, the interpretation of "community", and tradition and the transformation of religion.

3.2. Shared Values as a Basis for Caring Communities

The example above already points to the importance of shared values. In this case, spirituality is at stake and, therefore, we explored the spiritual and religious values that emerged in the analysis. As described in the theory section, values can be examined explicitly but also emerge implicitly; therefore, the results presented contain both. When we asked about values and the basis for caring communities, the question did not seem to be answered easily by the participants. They stated that values may underlie their caring behavior but also remain largely unnoticed or unconscious: *"Implementing Christian values—I think a lot of things happen unconsciously. Well, I can't say that I have anything special"* *(EI04_PA04: 115).*

The most commonly named value with a spiritual/religious meaning was "charity". It was mentioned seven times overall in focus groups and individual interviews and is directly linked to caring behavior and care as a central value itself for the caring community. The following examples give a glimpse of its importance: *"That simply is also a mission of charity and to really help when someone is in need" (EI01_PA07: 146); "Charity is simply one of the core things" (FG01_HA02: 288).*

Interestingly, "charity" in the meaning of "neighborly love" is not necessarily interpreted as Christian or spiritual but also with respect to secular values. FG 3 discussed how charity might be fundamentally Christian and also a value of other or non-religious persons:

> FG03_HA09: *"So with me it's charity honestly, when I think of it like, I don't know, is that a value, what values—"*
>
> FG03_EAPA04: *"The definition: what is God? Oh, God is love. Yes, in that charity is a way of being Christian or Christianity."*
>
> FG03_HA09: *"Or of being a believer."*
>
> FG03_EAPA04: *"Or of the believing man, always, however you define it."*
>
> FG03_EAPA05: *"I think there are also atheists who have a lot of charity. That's not mutually exclusive."*
>
> FG03_EAPA04: *"That's not mutually exclusive. That's right."*
>
> FG03_HA09: *"Or also compassionate like that. So compassion is the wrong thing. But this empathy is also a concern for me, because then I put myself in this person's place."*
> FG03_EAPA04: *"That's right. But—"*
>
> FG03_HA09: *"But?"*
>
> FG03_EAPA04: *"Does that have anything to do with religion, just religion?"*
>
> FG03_HA09: *"No, no, with me, it's what drives me—"*
>
> FG03_EAPA04: *"Charity, yes, not either." (FG03: 174–185)*

The group discusses what they understand by charity and neighborly love. Whereas a caregiving relative (PA04) initially talks about her Christian understanding of charity as

an explicit Christian value (PA04: "charity is a way of being Christian"), that definition is called into question because it can also be said for atheists (PA05: "there are also atheists who have a lot of charity"), and the group seems to agree on charity as a moment that drives one to care for others but not necessarily in a religious understanding.

This interpretation is supported by one of the individual interviews, where the caregiver agrees that charity is an important value in caring but rejects its spiritual interpretation:

"No. So the topic of love, charity, appreciation, that's something that's inherent to me anyway, yes. Thinking positively of others, supporting others, yes, that has also been a part of my professional life, yes. So I don't experience any additional thrust in care now, yes. Being there, being there for others, caring, yes, of course, yes, but that I am now somehow more spiritual again. No. No." (EI04_PA01: 62)

It seems that for the participant, spirituality seems to be something to be added to love, charity, and appreciation, although it may also seem that those values are spiritual in nature at their core. This again points to the possibility that values—even in church and explicitly religious contexts—can also be interpreted from a secular perspective.

The value of charity—being present for others—is an ideal that cannot be realized in every encounter. One participant was aware of his own limitations in terms of following this value:

"And therefore it remains, so to speak, also a task to embed brother- and sisterhood and a spirit for the common good with the own attitude. We also fail sometimes at it, I fail sometimes at it. But nevertheless to go on here. And not to lose sight of these broad things. Really out of a deep Christian imprint." (FG04_HA15: 181)

This attitude of humbleness and pursuit of the greater good of the community and the common good at the same time is interpreted as a "deep Christian imprint", being a theological cornerstone of this participant's convictions and values.

The act of caring itself is rooted in Christian values, which reflect the motives of action in the community and is interpreted as an individual task or even a sense of life and purpose:

"It is actually my task, even as a Christian, to do what is within my competence. And I already see a piece of faith and religion behind it. Where I simply say, yes, perhaps I was born to this." (EI07_PA07: 113)

Although some participants have difficulties in defining specifically Christian values, it is evident that central biblical stories and Christian convictions are nevertheless used as a basis for acts of care and that central ethical aspects of one's own or church actions are derived from them:

"That is also, so to speak, an ethical, an ethical principle that runs through the biblical writings, that here those who, yes, do not have the power, that they also have a significance for God. And I think that is already very fundamental for this, for this kind of commitment." (FG04_HA15: 158)

"I try to convey that for me, in Jesus, in what he exemplified in the Sermon on the Mount and in the parable, there is an expansiveness and a fullness of life in everything, in flourishing and even when it becomes less, in success, in breaking and beyond. And I try to convey this and enter into dialogue." (FG01_HA02: 116)

"For me, however, it is important that faith or the gospel transcends the quantitatively mechanical world view in which we are very much on the move, and that therefore other perspectives on life arise that cannot be adequately described with efficiency and profitability alone. And this point of view, if I receive it for myself, then I must also, or I want to let it also apply to others, that also has a liberating effect." (FG04_HA15: 158)

"If I go all the way back to the Acts of the Apostles, where it's about the first deacons, where the early church appointed them because widows and orphans had to be cared for. So this is also a very original concern of the church, that is, in addition to the proclamation of the

word, this care for people who need help, and this runs like a thread through the whole story." (FG03_HA08: 139)

It is remarkable that in all four statements, it is the professional actors in caring communities who point to their theological understanding of a caring community and link it closely with biblical and Christian traditions. At the same time, these statements appear to be not only stated norms but internal convictions and appropriations (e.g., "for me/myself"; "I think") of traditions passed down through generations.

3.3. Relational and Social Aspects: The Church as a Community of Care

The church as a caring community becomes concrete for the participants where people meet, get in touch with each other, and communicate. On the one hand, the social sphere of the church is associated with concrete, tradition-bound characteristics and rituals. On the other hand, the church as a caring community is also perceived dynamically. Thus, spiritual practice, as experienced in church caring communities, is shaped situationally in interpersonal encounters, based on people's needs: *"That is also the mission of the church, to go out to the people and that yes, and if these are the needy, then we do that. And that brings joy"* (FG04_EA03: 142). Therefore, the spiritual practice of a caring community is to be found in personal encounters: *"What is church? Church is you or-, and me. Church is not the bishop or the bishopess, but we are"* (FG02_HA04: 49).

With respect to spirituality, the caring community would not necessarily be interpreted as spiritual but interpreted as a contrast to "the world", which itself is identified with capitalism and personal hedonism.

> *"So we have to move closer together again, despite all the distance. And it's not about efficiency and it's not always first and foremost about what it costs and what it brings in financially, i.e., in the capitalist sense about increasing profits, but it's about moving together on another level, about a profit on another level and not, (FG04_EA04: Human.) because we all love each other or because we are so very human, not even that. But because it is original Christian. So who, yeah, so there's already getting very big, but it's just a very important value why I do this". (FG04: 139)*

For this participant, the congregational community therefore serves as an example of lived Christian ideals and norms ("originally Christian"), whereby being close to one another gives the members of the group a benefit of "another level" (FG04: 139). The community is characterized by fraternity and community spirit at its core, but the members realize that this ideal is not always met in everyday living. Nevertheless, it serves as a guideline and principle in orienting and shaping care and living together.

Caregiving relatives describe the church as an organization that provides help for them. They can trust that people in their caring community of the church will help them with their needs. Knowing that they will receive help here seems more important to them than the "what" and the "how" of the help, i.e., the type of support offered.

> *"I mean for me, I find my, I think once, for me the church is important as help, for me. Not who helps whom or whether that's the church with it now, I was thinking about me". (FG03_EAPA05: 152)*

The multiple emphases on the personal reference ("me") are striking, which could indicate that this person has had particularly intensive experiences in the church.

At the same time, there is a constitutive openness for others and their views and beliefs:

> *"We say we are church by what we do in the church community, because the whole [name of organization] we are church, but we don't expect you now, I don't expect the staff now, to join in with this spirituality". (FG01_HA01: 115)*

> *"Therefore, you also have to be open-minded and tolerant, that has to do with it, but also say at the end: "Okay. I, I have my own personal belief". (FG01_HAOA04: 125)*

Caring communities in church per se are oriented towards all who want to participate, regardless of their personal characteristics or religious beliefs. This programmatic openness is also justified theologically in reference to Dietrich Bonhoeffer:

"This issue of creating community is also important to us. That is one of the tasks that the church has. And to really open up these spaces, the church for others, says Bonhoeffer. That's a motif that we realize is of course precisely relevant at this time, when there is so much differentiation. Where so many topics are also being discussed controversially, where it is simply very difficult to attract people back into this togetherness, into these neighborhoods, to create spaces there". (FG02_HA07: 63)

Thus, it is obvious that values and theological interpretation are strongly linked to the understanding of a caring community. A caring community in the realm of the church never simply serves its own purpose, but rather it is directed to the world and others:

"And a very central mission of our church is also, so I see it at least, to go to church on Sunday and to do church there, but to go out into society and to become active there, yes, for what, where it is necessary, yes". (FG04_EA03: 86)

Then again, this would entail that some participants of this study would also mention that they love the offers and events of this particular church caring community, although this does not necessarily mean sharing their core beliefs and faith:

"I mean, the woman [name of group leader] always has some kind of Christian text when she speaks to you. And that's fine. I don't have a problem with that either. But for me that doesn't mean that I'm going back to my Catholic or Christian faith, yes."

I_03: "So that means if this offer is made by someone else in [city] or in the neighborhood."

EI03_PA05: "Yes, then I would have accepted it in the same way." (EI05: 67–69)

For some, therefore, the priority would be the possibility to meet others and share their life stories and socialize, although forms of lived spirituality or a shared belief would be secondary or rather not important.

3.4. Emotional Aspects: Mutual Care as "Education of the Heart"

Whereas values are usually understood as an expression of cognition, some participants also stated that care more strongly relates to their emotions. Caregivers describe their feelings towards others as being rooted in their spirituality, and the symbol and metaphor of the heart were mentioned twice:

"So I want to say it very simply, faith is also heart formation and that is simply obvious." FG04_HA10: "I also believe that you can't separate the two. As you say, heart and faith somehow belong to each other". (FG04_EA04: 150–151)

"So there it is again and again about the topic of the people, as said, to understand from the innermost heart". (FG01_HAPA04: 137)

Although it is not described further here, the heart functions as an organ of resonance to the other's needs. How the caring community interacts is closely related to feelings of mutuality and caring: it is implicitly described through the participant's experiences with the community or feelings that arise when participating in offerings of the church community. The community is perceived as considerate and benevolent towards each other: *"They're all very gentle with each other. But really in a very positive sense, yes. [. . .] I'll describe it gently now, and on the other hand also very committed" (EI01: 63–64).* The church is seen as a community if the individual can experience the community as active in the very direct interaction with others. If there is a "positive" interaction, it is perceived as "gentle" and "committed" (EI01). It is thus crucial to get in touch with the "church" concretely on site as the church in its overall meaning is too far away and abstract: *"I feel very comfortable in our church here. And I just see that, I don't see the big church, I see my congregation" (EI01_PA07: 122).*

There is a clear identification with the local congregation that is perceived as "my congregation", and thus the identity of this caregiving is strongly tied to the community itself.

A caring community in the realm of church is also understood as a safe space where everyone has their place and can receive help or support if needed. Thus, the idea of care is embedded in the very core of a church community, as stated at the beginning (the "DNA" of the church).

One caregiver describes her own feelings of being touched by the caring relationship built by the pastor. It is striking that no explicit care practices are mentioned, but rather the influence of the *"friendly, loving relationship"* (EI04_PA02, 61) on the person being cared for is focused on. It is not the form of care or the explicit religious or spiritual practices that matters to this participant but rather the impact of pastoral care in an emotional way. Caring can sometimes take place non-verbally through simple, everyday gestures: *"And there was just a very, let me just say, comforting relationship. That was good"* (EI02, 58–61). This citation points to the importance of relationships regarding spiritual and pastoral care. The encounter is emotionally filled with acceptance and comfort for the counterpart and therefore is experienced as "good." Others also refer to the interpersonal exchange in a spirit of mutual attention and caring and link it to a spiritual interpretation:

> *"And this interpersonal thing, you can just feel it here in [name of institution]. And I also believe that this Christian, yes, this Christian spirit or whatever you call it, that it simply prevails there".* (EI01_PA06: 69–70)

The emotional atmosphere of a caring community is also described as a feeling of warmth in the experience of God's presence:

> *"It's a feeling, because I have the feeling of being so close to God. That's such a, that fills you with warmth. I don't know why, but I just feel like that, there's a warmth flowing. And that just feels good".* (EI04_PA04: 126)

It is visible in the transcript that the participants' possibilities of describing their spiritual experiences in words are limited. However, the caring community and its spirituality are realized in the spiritual feeling.

The notion that times are also changing for the church in a pluralized world and with proceeding secularity is also mentioned in the interviews. Only a little later, the caregiver highlights that he would like the feeling of warmth to stay available for him and others:

> *"And I think it would be good if it [the warmth] stayed there in the parish. I just think that in this day and age, where the members, like me, are not churchgoers. And it's difficult to initiate a larger circle".* (EI04_PA04: 126)

According to this, caring communities in the realm of the church cannot be taken for granted. It needs interacting people and a pre-existing atmosphere of welcome and connection that is also rooted in actual meetings with others and initiated by those who are already there. This is how one participant describes caring communities as *"grown relationships"* (EI04_PA02, 37), and another states: *"A caring community also has a history with each other."* (EI04_PA02: 37).

3.5. Spiritual Practice: Forms of Lived Spirituality

In general, it is noticeable that mainly family caregivers report spiritual practices. On the other hand, full-time professionals report few to no spiritual practices, which could be due to the fact that they were not explicitly asked about spiritual / religious practices. Rather, the focus groups focused on the connection between their own faith and their work. Professionals name motivational reasons for their own work and describe their own spiritual attitudes in this context.

> *"So I believe in life that you're not always in each other's ring, you're in the big ring, and then we can just make that a little bit more livable, more lovable. That's a personal motivation".* (FG01_HAPA03: 199)

The professionals also report on their observations of the spiritual experiences of caregivers. Spirituality can also mean reflecting on and interpreting one's own life story or

suffering, e.g., when hope arises in all the heaviness. A professional sees herself as a "giver of hope" and is happy to take on this role in contact with family caregivers.

> *"And then I also get this from the relatives, who have really experienced the darkest moments, that there was this light for some of them. And that is like a reflection. And there I am glad that I can reflect that back personally and with a certain fullness, which, where there is always a lot of room for improvement, of course". (FG04_HA11: 154)*

Different forms of lived spirituality and spiritual needs are evident among family caregivers. While for some, concrete rituals and practices such as personal prayers are relevant for transcendent experiences, for others, symbols of protection are significant for their own spirituality and are also considered a source of strength.

> *"Well, once with me personally that I always pray in the evening and look for the conversation with God and also draw strength from that. And because you then have the feeling, when you pray or so, that you-, yes, there is a hand that is over you, such a protective hand and yes. And then that always gives a lot of strength". (EI04_PA04: 108)*

It became clear in the interviews that spiritual needs are experienced and also addressed in the caring community. Personal prayer or blessing is requested by care recipients, making it clear that faith is an important resource to them.

> *"You notice that sometimes when you're with people who say, 'Can you pray with us? And where's the blessing?' That's important to some people, too, but they'll let you know if they'd like that or if they wouldn't like that". (FG03_EA01: 138)*

There seems to be a distinction of spiritual practice regarding the church. While the "church outward" becomes relevant in contact with other people, the "church inward" is interpreted as a place of rest, personal perception, and spirituality.

> *"Church does not mean the building church. [...] Some people find it good to be in church, just the peace and quiet and the opportunity to just sit there and listen inside themselves. Others can't do anything with it, but they live the church outwardly". (FG04_HA10: 87)*

Some participants were hesitant to report their spiritual experiences but nevertheless talked about spiritual *"glimpses of light"* or gestures of holding hands again, which would also be interpreted as spiritual experiences (protecting angel, become one as experience of connectedness). Spirituality is thus identified with the idea of mutual connection:

> *"I gave my mother a little angel to protect her and she had to go to rehab and was desperate and or she-, also just touch their hands, if she has allowed it. For a while she didn't allow it at all, now again. And yes, that just so the physical contact with her was given, so that was, yes, [...] always so to become one again". (EI04: 119–120)*

It is remarkable that most of the spiritual statements describe individual practices and experiences in everyday caregiving that are not explicitly located in caring communities. A connection with the church is sometimes affirmed by caring relatives, although religious services represent offers from which carers either distance themselves ("*I'm already connected to the church, but I'm not the one who goes to church every Sunday.*" EI01_PA07: 114) or which are considered in theory as an option to live faith, for which one could opt for but does not manage in practice (EI01_PA06: 69–70) due to a lack of time and opportunity owing to the caregiving itself.

Spirituality in the caring community is described as a *"Christian spirit"* (EI01_PA06: 70), as a spirit embodied by all in the community and expressed in looking out for each other. Consequently, spirituality in the caring community can be described more as an attitude and is less linked to concrete, religious practices.

4. Discussion

4.1. Summary of the Results and Limitations of This Study

As caring communities, church congregations become places of shared faith and lived spirituality. But also being a part of pluralistic caring communities in the social space, they open up to the needs and perspectives of others and develop a sense of community

and care. This can be experienced by the interviewees given the fact that not only regular, traditional church–spiritual practices take place, but that a sense of togetherness is lived in mutual attention and concern for the needs of others. There is also a place here for difficult issues and challenges in life and existential questions, being dependent and in need of care. This also points to the potential of lived spirituality: togetherness, in particular, is often described as an atmosphere and feeling that can be experienced in social interactions that qualify as spiritual or pastoral care but cannot necessarily be put into words very well. Where the community comes alive, the principle of a "church for others" (Bonhoeffer 2016) becomes a tangible reality that has a pastoral care quality. Spirituality is evident in the way in which relationships are lived out in congregations.

In church caring communities, the spiritual needs of those involved are partially met. Like-minded people meet here—on the other hand, the actual spiritual practice of the Christian faith is still underexposed from the perspective of those who came together in the focus groups. Spirituality and spiritual practice are also a private matter—but it may be easier to talk about helping and supporting others and their Christian/religious foundation, and less so about one's own personal spirituality practice. Nevertheless, it became clear that there is a relevant spiritual component in the individual interpretation and justification of care and the community or church.

In the context of pluralistic societies, the following facet of spirituality is particularly emphasized: being there for everyone and being aware of their individual needs, regardless of their beliefs and convictions, which manifests itself in pastoral care for others and also in diaconal individual support. This is where openness as a religious value interpreted in Christian terms comes into play, as well as care understood as an offer directed at all people, regardless of what they believe.

The study presented here has clear limitations. First, it is designed as an exploratory project with no claim to the representativeness of the results, which clearly limits the generalizability of the results presented here. In addition, all interviewees come from the southern region of Germany, and the caring communities analyzed are generally rather homogeneous in terms of culture (predominantly German) and religiosity (predominantly Christian), although there are some differences in the offerings made by the communities.

Three prominent aspects will now be considered in more detail, namely, the field of tension of spirituality between tradition and transformation (Section 4.2), values as the basis of church-based caring communities (Section 4.3), and, finally, the role of pastoral care and spiritual care (Section 4.4).

4.2. Tradition and Transformation

Participants associate care in church congregations with central theological and biblical principles. It seems that for them, these principles are irrevocable and the basis of all church care. How are these principles to be understood? Some scholars emphasize that care in church congregations is the result of either an "ingrained habit" or the "expression of personal faith" (Schaeffer and Tamminga 2023, p. 9). Both are identified in our study, whereas the habits are much more complex to identify but partially visible in the interview citations. The interviewees use biblical images and references to underline their understanding of care and its spiritual component. Since articulations of Christian faith as a "religion of the book" often include biblical references or at least mention this cultural heritage in some way (Lartey 2017, p. 131), it is remarkable that these references were explained to others in our interviews. This could be interpreted as a consequence of the Christian context of the focus groups and the specific caring communities that extend into the secular space of the commune. In the larger picture, it is a consequence of a transformation towards a post-secular and pluralistic society. Christianity and Christian belief are no longer self-evident. In the religious community resp. a Christian congregation, such references to Christianity and Christian culture serve as a means of recognition, relationship-building, and developing a mutual understanding, increasing social cohesion as a common ground and being attributed to these Christian communities. Similar to the originally described

caring communities, in our empirical observations, there is a clear focus on the Christian perspective (Klie 2013, 2014).

On the other hand, transformative processes can also be observed that indicate that such Christian coding and value attributions are no longer self-evident but require explanation. Particularly in intercultural, interprofessional relationships between congregations, the commune, and other care professionals, the images and foundations of one's own religious tradition must be explained or embedded in other narratives. These processes are described in the results. In addition, Christian values are also used in a secular way, as is the case with charity, for example. This secularization of once-Christian narratives—as we have seen in the results of the example of "charity"—is clearly noticeable in the interviews and becomes a point of discussion in the caring communities. In a professional context, one might also think about the method of "code-switching" with respect to interfaith spiritual care, which has been used to describe how professional spiritual caregivers adopt and adapt to someone else's language and frame of reference to improve communication (Cadge and Sigalow 2013). Thus, despite being rooted in one's own faith traditions, it is helpful to have knowledge about other religious or spiritual traditions and cultivate a certain openness and respect towards others and their inner orienting system.

Spirituality and religion are largely a private matter in secularized contexts of Europe, as shown in the interviews in an ambivalent way. On the one hand, individual spiritual beliefs and practices are rarely mentioned and—if so—in individual interviews. On the other hand, it is surprising that the interviews entail some discussion about Christian perspectives with references to the bible and the basis of a caring community. This may point to an openness and competence of discourse of church-related caring communities whose members are willing to share their individual lived theology: "Lived theology refers to the individually constructed, personally verified and rhythmized theology of the individualized person that is integrated into everyday life" (Mueller 2023, p. 211f.). The difference to lived religion would be that lived theology is not only based on religious–spiritual experience but transcends it by being open to discourse and critical reflection (Mueller 2023, p. 212). This ability to talk about the spiritual basis of the community and its members is crucial to establishing a caring community that is indeed open to everyone (Sempach and Zaengl 2021).

However, it can be concluded that the spiritual–religious plurality in the focus groups and the examined church-related caring communities was comparatively low because spiritual beliefs or practices other than Christian were practically not mentioned. Here, church-related caring communities may still have a long way to go if they actually want to be attractive to non-religious people and people of other faiths (Watson 2016).

4.3. (Christian) Values as a Basis for Caring Communities

Caring communities are not foremost a group of people caring for each other. They can also be interpreted with respect to values: "First and foremost, caring community should be seen as a set of values. With this attitude, actors implement various concrete forms (projects) of coexistence and cooperation. With this dynamic character, caring community is also a process of continuous negotiation" (Spiess et al. 2023, p. 245; translated by the authors). One of the first publications on caring communities in the context of schools points to their ambivalence and the crucial role of values, whereby the "content of the community values is of critical importance" (Battistich et al. 1997).

The values underlie the understanding and the common discussion about what is important to the caring community and, therefore, is the basis of a caring community. The question itself (what are the central values of the caring community?) is difficult to answer and might even remain sub- or unconscious. However, the responses being provided reveal some interesting details regarding value orientation in caring communities. For all the participants, it seems that caring itself holds central value, and to many, charity is important. However, this value of charity—even being understood as rooted in Christianity or the religious tradition of the world religions—is also interpreted as a non-religious or even

non-Christian value that can also be shared by non-believers or non-religious persons. This corresponds to the secularization and individualization theory that stated long ago that originally Christian values are dissolved from their Christian interpretation (Pollack and Pickel 1999).

However, the values themselves form a strong normative basis that gives an ideal way of living together and therefore orients the individual and the community as a whole in their decisions and actions. This basic principle is thus a norm that orients towards the well-being of all members of the community and proclaims an attitude towards the common good (Sempach and Zaengl 2021, pp. 10, 33). However, what a common good would be in detail in this very community must be discussed and negotiated between their members.

Referring to the analyses in this article, it also becomes clear that it is a process to develop and share values as a community and that it is not self-evident that all members of the community share those particular values. Moreover, the values were discussed in the groups when we asked about their reflection as a fruitful process of trying to understand each other and think about the consequences of care. Thus, it becomes clear that a process-oriented perspective on values as a basis for caring communities describes the reality much more precisely, and it could even be recommended that caring communities explicitly develop spaces where those values are communicated, discussed, and shared (Bellous 2023). One possibility to share and discuss the values and directions of caring communities is through town hall meetings that invite members of the community to discuss caregiving. They aim to improve participation and center around the needs of others, e.g., give caregivers an opportunity to articulate their perspective and open up possibilities to discuss how the community might improve caring (Wiloth et al. 2022b).

Concerning the importance of Christian and—broader—religious values, it has also become obvious that for the realm of church-related caring communities, those Christian values form a central basis for their self-understanding. Participants used a wide range of biblical texts, images, and symbols from the Christian tradition that serve as a common ground for their communities. Moreover, when opening up to others, especially non-Christian persons in an inter-religious, secular, or intercultural perspective, the actors also highlight their belief in openness towards other worldviews and religions (also sometimes derived from their Christian belief) without relativizing their Christian belief for themselves. This twofold perspective on identity and openness constitutes a caring community that is directed toward the world and not only perceived as an inner Christian circle. Religious and spiritual diversity could thus be an additional value of importance and embracing plurality as a fact from a caring perspective (Lartey 2017) would be beneficial and encouraging for the community: "In communicative communities, listening to concepts people have for God is a central aspect of congregational care as someone hears how these concepts function in someone else's faith" (Bellous 2023, p. 6). It becomes clear that in order for care to be fruitful, values and attitudes such as mindfulness and responsibility need to be strengthened, whereby these do not exist on a theoretical level but rather become apparent in practical application (Schaeffer and Tamminga 2023, p. 9).

4.4. The Potential of Spiritual and Pastoral Care in Church-Related Caring Communities

The results of our study display spirituality as a powerful resource for Christian caring communities. Thus, such caring communities are places where spiritual care actually happens. However, it is spiritual and pastoral care that is rooted in sharing values, everyday life, and life events. From the analysis of the interviews, it can be stated that a caring community is not only based on values but is also, first of all, built upon relationships. These social and relational aspects were often experienced as good for emotional well-being, serving as a safe space to talk about spiritual needs and experiences as caregiving relatives. Attitudes of welcoming and warmth give comfort on an emotional level. Communication and mutual appreciation are key attitudes of community-oriented spiritual and pastoral care. However, there is also potential to address spiritual needs in more depth, since

spirituality is a rather private issue for some of the participants. Learning more about their spirituality with respect to struggles and resources could also lead to better spiritual care.

In pastoral and spiritual care theory, the complex interaction between the identity of professional and volunteer caregivers and their openness to intercultural contexts and other religions has been widely discussed and described (Visser et al. 2023). Professional spiritual and pastoral caregivers need to develop their own faith-based standpoint that then serves as a foundation for acting in care settings with openness to other traditions and backgrounds (Lartey 2003; Doehring 2015). However, critical self-reflection on those values is crucial for a professional attitude in pastoral and spiritual care.

Nonetheless, from our project perspective, it can be concluded that this professional attitude is not restricted to professional caregivers, but in the realm of caring communities, volunteer caregivers also mention such professional behavior and reflect their own background to a strong degree. Nevertheless, explicit individual theologies are more often reported by professionals than by volunteers in spiritual care. The reason might be that some of the professionals have a degree in theology or another church-related or Christian education and thus are more capable or comfortable to share theological thoughts.

Thus, with respect to spiritual and pastoral care, it is evident that basic human needs for care can be addressed, and, at the same time, a specific religious or church-related caring community is a place to offer spiritual resources that cannot easily be fulfilled elsewhere, thus playing a significant role in civil society.

4.5. Outlook

It has been shown that caring communities are particularly valuable for caregiving relatives and that the exchange in discussion groups is perceived as strengthening for coping with everyday caregiving. Many of the participants experience that the church-related caring community is a space in which they can live their spirituality and fulfill their spiritual needs. The feeling of mutual caring is crucial for not only sharing values but also experiencing them. For church communities, caring communities are an opportunity to open up to the social space and promote cooperation with community actors. Strengthening the spiritual dimension of church-related caring communities and, at the same time, their intercultural openness is a desideratum for further development and research. One profitable option could be to promote open dialogue about the values and spiritual foundations of the community. To do so, we need new models and possibilities that also need to be explored in research and practice.

Appendix A. Complete Interview Guidelines for Focus Groups and Individual Interviews

Table A1. Interview guidelines for focus groups and individual interviews.

Questions for Focus Groups	Questions for Individual Interviews
Round of introductions Concrete processes and motives • What needs do you think family caregivers have? • To what extent do the integration and participation of family caregivers as active co-creators play a role in their future work? Role understanding and communication • How do you understand your role within the caring community? Challenges and cooperation • To what extent do you succeed in working together in your caring community? What is going particularly well, what could be improved? • What special challenges do you see in caring communities? Motivation and values • Why do you do the work you do? • Are there other "sources of strength"? Understanding caring community • How do you define caring community and how does that become concrete for you? • What role does the spiritual/religious/faith-based dimension? • What role does mutual solidarity play in your project? • In conclusion: If you had one wish—what would you wish for your community in the future?	Entry • Why don't you tell us about your everyday caregiving (type, duration, extent of care)? • What is a caring community to you? Resilience • What do you like most about doing something related to the caring community? • What support do you receive from the caring community? • What topics come up in your discussion groups? • What topics would you like to see come up beyond that? • How do you think you are perceived by others? • To what extent do you get involved in the project (name offer: . . .)? What would need to be done to get you more involved? Psychological dimension • In which way can you tell that your work is appreciated/valued by the caring community? • How do you feel when you have participated in an offer in the caring community? • What moments are there in the support and care from which you can draw strength? • In what way does participation in (name offer) strengthen your work for the (affected) family member? Spiritual dimension • Does your faith/spirituality/religiosity play a role in your (care) everyday life? If yes, how? • What do you like about the way people interact with each other in the church community? General conditions • Why do you participate in the offerings in your caring community? • What do you gain from the caring community?

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