

The Clinical Mandate—Integrating Spiritual Care into the Social Determinants of Health

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III. The Mediating Role of Spiritual Care in Public Health Outcomes

The preceding conceptual framework established spiritual well-being as a direct mediator of health outcomes, a connection that requires deep scholarly engagement to inform policy. The integration of **Spiritual Care Practitioners (SCPs)** into the public health model is a clinical mandate, not a pastoral preference. The SCP's function, often viewed anecdotally as emotional support, must be rigorously defined through its measurable impact on the **Social Determinants of Health (SDOH)**, particularly the domain concerning **Social and Community Context**.

This domain encompasses the quality of social relationships, the presence of social support networks, and the overarching sense of trust and safety within a community. SCPs, through their expertise in navigating existential and relational crises, directly reinforce this domain by operationalizing two crucial, preventative health mechanisms:

A. Mitigating Existential Isolation and Fostering Cohesion

The internalization of **Hegemonic Masculinity (HM)** often culminates in profound isolation, forcing individuals to suppress vulnerability and engage in the reactive state of the "monkey-mind." This self-imposed isolation is a potent risk factor for severe adverse health outcomes, including depression, chronic stress, and diminished self-rated health.

The SCP directly counteracts this pathology. By providing a non-judgemental presence, SCPs create a **psychological bridge** for individuals to articulate their deepest fears and anxieties—the 90% **of the Iceberg** that is hidden. This act of being authentically "seen" fosters:

- **Relational Restoration:** It helps individuals navigate the complex emotional landscape of betrayal and disappointment, as documented in **GNOSIS**, allowing for the eventual acceptance of new relational norms.
- **Decentering of the Ego:** By guiding the client toward the "monk-mind," the SCP facilitates a psychological shift away from the ego-driven need for control and external validation, diminishing the social friction that fragments community bonds.

This intentional, relational work by the SCP strengthens the **Social Cohesion** of the community, turning fragmented isolation into shared resilience—a direct, measurable improvement in the SDOH framework.

B. Purpose-Driven Engagement and Resource Optimization

The SCP's therapeutic focus on **meaning and purpose**—the core teaching of the Munroe archetype—is a powerful driver of **resource optimization** within the healthcare system. When individuals are tethered to a clear sense of purpose, they exhibit improved

adherence to care plans, higher rates of **proactive self-care** (conquering their personal **BUTs**), and superior coping mechanisms during chronic illness.

Crucially, in end-of-life care, the SCP's intervention facilitates critical conversations around existential closure, leading to:

- **Reduction of Aggressive Intervention:** Patients who receive comprehensive spiritual support are statistically more likely to opt for hospice or palliative care, directly reducing the utilization of high-cost, aggressive interventions (e.g., Intensive Care Unit admissions) that are often driven by unresolved spiritual or existential angst.
- **Enhanced Family Satisfaction:** By supporting both the patient and the family unit in navigating grief and finding meaning in loss, the SCP ensures the human-centered delivery of care, enhancing the overall quality and efficiency of the health ecosystem.

IV. The Systemic Gap: The Unseen Burden and the Need for Protection

The paradox of the SCP role is that while their function directly addresses systemic public health needs, they often operate outside of adequate financial and institutional scaffolding. The **unseen burden** of financial precarity, coupled with the emotional drain of serving as a constant receptacle for human trauma, makes SCPs highly vulnerable to professional burnout, attrition, and secondary traumatic stress.

This precarity is not merely a personnel issue; it is a **systemic flaw** that directly undermines the SCP's capacity to deliver the very SDOH benefits they are designed to provide. A practitioner distracted by their own financial **WAIT**—the excess baggage of insecurity—cannot fully manifest the unwavering presence required to guide others through their deepest crises.

Therefore, the investment articulated in the Conclusion is not merely an ethical consideration; it is a **mandatory policy requirement** to protect a critical public health asset and ensure the sustainability of resilience within our communities.

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