iCare

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Handbook of Philosophical Self-Care

For those dedicated to hospice work and palliative care

Patrick Schuchter

For the project

iCare – an International Integrated perspective in palliative CARE for dignity and proper support in ageing and approaching end of life is an interprofessional and participatory project led by CONCORDIA Humanitarian Organization through CONCORDIA Academia (Bucharest, Romania), in cooperation with the Kardinal König Haus (Vienna, Austria) and the Polytechnic University of Leiria (Portugal). This initiative is co-funded by the European Union under the Erasmus+ programme (Grant No. 20231-RO01-KA220-VET-000166902).

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Foreword

The iCare Erasmus+ project aims to develop and implement innovative educational formats that promote the visibility of hospice and palliative care culture in various areas of society, such as the health and social care system, education, public and private institutions, communities and the general public.

Professionals and volunteers play a crucial role in spreading palliative care knowledge and hospice care culture. The project developed ideas and strategies for this – in particular, participants from the three countries of Romania, Portugal and Austria implemented them in a variety of creative ways in pilot projects. The project also developed a train-the-trainer curriculum, a manual for trainers, a practical guide for caregivers and this handbook, among other things.

Self-care is an important and essential part of palliative care and any care for others. This handbook attempts – in line with the existential depth, intensity and connectedness that we experience in palliative care, as well as the socially oriented perspective of the project and the approach of "compassionate communities" – to remove self-care from the overly narrow discussion of work-life balance and proximity-distance, and to think and practice it comprehensively from multiple perspectives. Self-care must not be individualized, nor can self-care and care for others be artificially separated from one another. Self-care is dependent on structural factors and is therefore also a task for society and the community. A culture of care concerns us all!

The content, reflections and exercises presented here are designed for self-care as a personal practice, in teams and in communities – but can easily be adapted for educational contexts (seminars, workshops, events, etc.).

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Introduction

The aim of this handbook is to empower those dedicated to hospice work and palliative care to cultivate an existentially based culture of self-care and to promote it in their environments.

The focus is not on psychological support services or further advice on work-life balance. It is about understanding that the essential source of self-care lies in the quality of the caring relationship itself. The focus is not on relieving the burden of care work, but *on enabling* good care work and sustainable caring relationships. Only in this way can care be lived in a comprehensive, holistic way: supported by an inner attitude and underpinned by an appropriate social and institutional environment.

Caring for others and self-care cannot be separated. They are interdependent in a way that can either be enriching – despite work-related and existential stresses – or exhausting. Key words here are *moral distress, compassion fatigue* and *burnout*. In all this, the spiritual meaning that lies in shared experience, caring and dialogue, especially in the most challenging phases of life, can be lost.

It is therefore crucial to understand the depth of the caring relationship. Palliative care – like any form of caregiving – is more than a sequence of medical, nursing or social services. It is always a relationship: people encounter each other as individuals, perceive each other and, in doing so, also come into contact with their own life issues. Encountering dying and seriously ill people always affects me too – emotionally, biographically, existentially. It is a mistake to reject this vulnerability from the outset under the banner of "professional distance". What is needed instead is a form of professional closeness in which one's own humanity is not a burden, but is considered part of professionalism.

Many employees in hospices, palliative care wards and voluntary work testify that encountering and being allowed to help can be existentially enriching – despite suffering and psychological stress. Hospices and palliative care facilities show how care can become meaningful.

This handbook aims to encourage readers to practice the essential dimensions of good care. At the same time, it aims to empower readers to promote a culture of care in their own contexts – in teams, families, organizations and communities.

The handbook is based on these premises. The greatest protective factors lie (1) in care that is lived holistically and from a place of inner depth, and (2) in a supportive environment – a "caring community" or compassionate community[1,2] .

The handbook aims to support committed individuals in nurturing, cultivating and promoting both dimensions to create a compassionate community. It does this by

a) encouraging personal and collective deep reflection – a reflection that we call "philosophical" here,

b) initiating processes in organizations and communities for a deeply understood form of self-care, and

c) understanding self-care not only as a matter of the private self, but also of the moral, spiritual and political self (as a citizen) and the community.

What does "philosophical" mean here?

The term "philosophical" should not be intimidating. It is not about intellectual flights of fancy, but about an attitude: perceiving experiences, taking existential questions seriously and going beyond the purely instrumental in the caring relationship. This attitude enables the self-care and culture of care discussed in this handbook.

One could perhaps also speak of "spiritual care," but this term is usually interpreted in religious or psychotherapeutic terms. The term "philosophical," on the other hand, refers to an original openness of experience that does not rush to conclusions[3,4] . This can best be understood by going back to the source of modern hospice work: Cicely Saunders, the founder of the hospice movement. Saunders was once asked what the hospice movement and palliative care should never lose. Her answer can serve as a guideline for us: "No matter what happens, it is important that we do not stop listening and asking questions"[5] . This important position of questioning alone reveals a fundamental philosophical attitude. *Listening* does not only mean conversations, but also the entire attitude in practical work. It means that institutions and employees do not "set the tone“ but rather pick it up; that they perceive people in their individuality instead of just working through programs. Many routines in healthcare still run counter to this ideal today.

For Saunders, listening and asking questions belong together internally. She says: "I believe that you truly listen when it seems completely natural to ask questions [...]".

She describes three types of questions:

a) Questions about one's own expertise: "Did I do as well as I could medically [in terms of nursing, etc.]?"

b) Questions for patients and relatives: "Addressing everything that you feel will help them – and clarifying what really concerns them."

c) Questions about one's own philosophy of life: "What philosophy is behind my actions? What beliefs am I trying to live by, develop and question? This philosophy must do justice to the individual as well as keep the community in mind."

Saunders is not talking here about an abstract, theoretical philosophy, but about a "lived" or "natural philosophy of life" (Lutz von Werder[6]). What this means is that we always live in ideas, concepts and preconceptions that shape our perceptions, judgements and actions. Philosophizing then means making these implicit assumptions visible, clarifying and expanding them – and bringing them into resonance with other ways of thinking and living.

In this sense, philosophizing means an everyday, dialogical form of thinking and reflecting. The most important resource for this is the encounter with the people we accompany. The hospice ethical motto "Learning from the dying" means that the essential questions often come to us from them – and we then ask ourselves these questions.

Conversely, however, only what I myself have thoroughly understood will ultimately benefit the other person. Gerd Achenbach, one of the founders of philosophical practice, puts it this way: "What the guest tells me gives me food for thought. As a listener, I reflect on what they think – in a sense, once again."[7]

Other people give me food for thought, and I think through what they give me food for thought. However, the result of this self-questioning is not returned to those seeking advice in the form of a lecture or a list of questions. Philosophical thinking works differently: it shapes our own attitude, from which we listen, ask questions and perceive again. Plato describes this in his Seventh Letter as an ongoing community of life and thought that develops through mutual concern for the soul and the common good.[8]

This raises key questions for hospice and palliative care, such as: How do I develop as a person in my professional role? What understanding of care, life and death do I develop from my own and our shared practice? How do I help others to develop – beyond the instrumental? How can environments be created that make this possible? How does care become a source of growth and not just a burden?

This requires more than conventional models of self-management and work-life balance. These concepts often focus on control and self-optimization – Erich Fromm would say: on "having" rather than "being"[9] . They fall short of the depth and unavailability[10] of existence and the world. Nevertheless, such approaches have their place – embedded in a larger horizon.

Self-care addresses the private, moral, spiritual and political self – as well as teams, communities and societies. We act in small steps in everyday life – but it is important to think deeply and broadly about it.

For reflection - Cicely Saunders' essential questions

1. Am I working as well as I can ***professionally***?
2. Do I know ***my patients*** well enough to be able to help them appropriately – and also support them in gaining clarity about themselves?
3. What is ***the philosophy*** behind my caring work – and how can I develop it further?

Philosophical self-care is therefore not manifested in a single technique or method, but in several intertwined dimensions that support and deepen each other. This handbook follows a path that starts with the practice of care and expands step by step to other levels.

It begins with an understanding of the caring relationship itself. Those who provide care – professionally or voluntarily – always encounter themselves as well: in empathy, in listening, in responding to the life stories of others. Self-care therefore begins where we perceive this relationship in its depth and take it seriously.

Building on this, a second horizon opens up: the existential dimension of caring for oneself. Philosophical exercises – in the sense of self-questioning, clarification and inner attitude –

help us to stay in touch with our own center of life amid all the demands placed on us. This is not about abstractions but about cultivating an inner awareness that sustains us in everyday life.

Only on this basis does everyday self-management make sense. Rituals, breaks, boundaries, physical care or organizational structures only unfold their effectiveness when they are linked to a deeper attitude. Self-care here means dealing with one's own strengths and activities in a life-friendly way – not in the mode of self-optimization, but of self-respect.

However, self-care encompasses more than just the individual. Those who provide care always act as fellow citizens, as part of a community. That is why critical reflection on one's own role as *a caring citizen* is also part of it: the question of how care is shaped socially, what values it carries and what responsibility we assume in it.

This reflection leads directly to team and organizational culture. Care is never just individual – it arises between people. Teams can create safe spaces or increase stress; they can cultivate a culture of mutual care or unconsciously undermine it. Self-care therefore always means developing a sustainable philosophy of care together.

Finally, the focus is on the community as a whole. Hospice work and palliative care are part of a (more or less) "caring society". Self-care is enabled or prevented where fundamental questions – about solidarity, recognition, justice, finitude – have their place or are suppressed. Those who provide care move within these larger questions and help shape them.

This is the path that the handbook aims to accompany: from personal experience to shared practice, from one's own inner space to a shared culture of care.

1. Understanding and cultivating the caring relationship

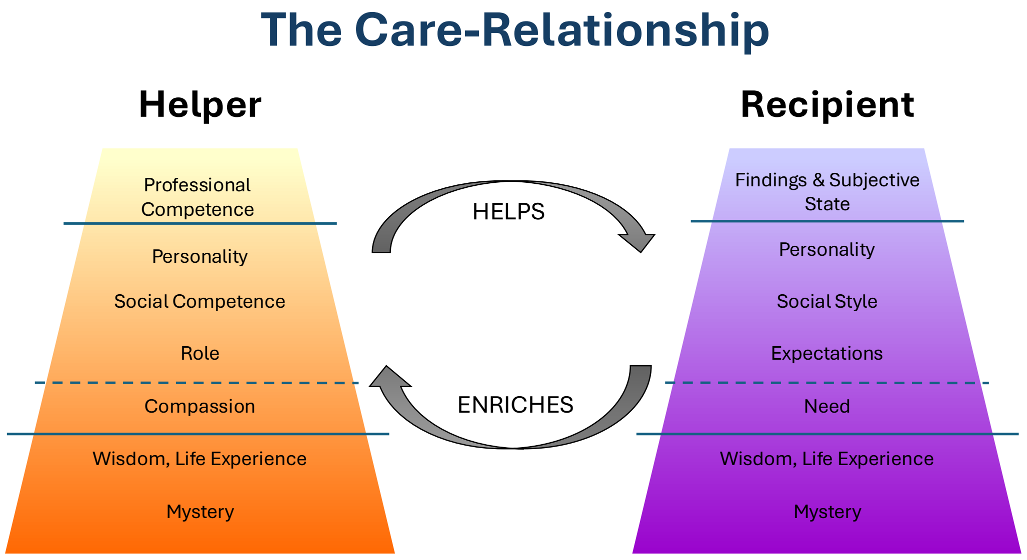
This is a fundamental insight for all areas of healthcare – and for many other fields of human care. However, in hospice work and palliative care, this insight has given rise to a culture of compassionate care in a special way: the caring relationship is not a superficial sequence of individual services, but a multi-layered encounter between people.

From the perspective of the caregiver, professional skills alone do not bear the burden of another person's suffering. Erhard Weiher describes this succinctly:

"The helper not only helps with their professional skills but is also present and effective as a human being in many ways: the helper is not filled with helpless powerlessness [...], but far beyond professional and functional thinking and acting, is filled with content that helps to bear the suffering of people ..."[11] .

Conversely, the helper encounters the affected person not only as a "case" but as a whole person. The actions of the helper therefore have an effect on several levels: **not only** through the concrete activity, but also through the inner attitude and depth from which they act.

The following illustration shows this "depth" of personal encounter in care according to Erhard Weiher[12] and makes visible how many layers resonate in a caring relationship.



Professional ("instrumental") competence forms the first layer. At this level, responses are made to diagnostic findings and, to a certain extent, to the patient's state of health. Health organisations are built around this level; it appears in planning and documentation systems and forms the visible "core business": the provision of health services in response to impairments and self-care deficits. But beneath this surface lie further, often decisive dimensions.

One layer deeper, people encounter each other with their personality traits. These are relatively everyday characteristics: is someone cheerful or rather grim? Open or closed? Some relationships are easier or more difficult as a result. Professionalism compensates for such coincidences, but they do not disappear completely.

Below this is the level of social and communication skills. This shows the extent to which a helper has learned to listen, ask questions, convey information in an understandable way and thus strengthen the autonomy of those affected. These skills respond to the different social styles of patients, to how someone understands, classifies and integrates the disease into their life.

On another level, the symbolism of the professional role comes into play - and the expectations that those affected associate with this role. Identical advice can sound different coming from a doctor than from a relative. A community nurse who visits a remote family not only provides care and advice, but often also brings a sense of basic social trust to a lonely world.

Up to this point, the relationship remains asymmetrical: one person helps, the other is helped. And all of the dimensions mentioned are still strongly linked to the professional role; they can be learned within the framework of this role.

With the next step, something fundamental changes. The relationship remains asymmetrical, but now it is no longer just the professional role that is addressed, but the person as a whole. "Compassion" refers to the attitude with which helpers feel more deeply, empathize and "see" the existential needs of others in their nursing or medical work. This refers not only to a specific problem, but also to a person's fundamental need to be recognized in their individuality – despite and through their illness.

At the deepest levels of encounter, the relationship ultimately loses its one-sidedness and develops genuine reciprocity. Many people working in palliative care and hospice work report that they receive a "gift" from the dying person or "get back more" than they could give[13, 14] . This experience refers to what is called "wisdom" here: both encounter each other from their entire life experience – with all the knowledge, all the ignorance and all the fragility that lies within it. The dying "go before" and teach the living. Paul Ricoeur expresses this experience as follows:

"The suffering other gives something that no longer draws on their ability to act and exist. [...] A self reminded of the vulnerability of its mortality can receive more from the weakness of its friend than it gives, drawing on its own reserves of strength."[15]

Finally, at the deepest level, two people encounter each other in the face of the "enigma and mystery" of life and the world. One could also speak of the unattainable or the transcendent. While the level of wisdom still has something that is "in human hands" – reflectable experience – the "mystery" marks a dimension that remains open: the unspeakable and unattainable, which touches on dying, suffering and accompanying.

For reflection: My caring identity in all its complexity

How do I believe that *patients,* residents, clients or guests experience me in the various dimensions of my caring identity – *in my professionalism, my personality, my social and communication skills, my role, my compassion, my "wisdom" and in my attitude towards mystery?*

The most important form and inner core of self-care for healthcare professionals is to be allowed to live care in all its depth – and at the same time to work within society to ensure that this depth is not lost. Caregivers thus keep alive the memory of the deepest humanity. And this inner treasure is something they receive from the dying and the suffering.

In a culture of philosophically inspired self-care, those who suffer give us cause to reflect on life through their experiences and their presence. Their situation touches us and stimulates reflection that goes beyond the immediate moment. By thinking through what we see in others for ourselves and relating it to other perspectives, our perception becomes more mature and sensitive. This enriched life experience flows back into our encounters with the people to whom we give care and attention. This creates a quiet, dialogical process.

But this inner enrichment does not happen automatically. We have to reflect on our experiences, pause and give them shape. And then encounter life again. We live in dialogue – with ourselves, with the world and with others. We can ignore this dialogue or consciously tune into it. However, complete and enriching care only arises when we engage in this dialogical relationship.

This "receiving" of existentially significant experiences can happen quietly, almost incidentally. But it can also fail to happen at all if those providing help concentrate exclusively on instrumental action, do not allow themselves to be touched and remain "unmusical" to the deeper dimensions of interpersonal encounter. However, it can also become the source of a conscious, shared and reflective culture of self-care.

The following exercise invites you to learn from a concrete encounter and deepen your own philosophy of care. It structures the implicit dialogical process in a reflective way. The exercise is the pulse of philosophical self-care, because it combines thinking and interpersonal relationships:

EXERCISE 1

Allow yourself to be "inspired" by the other person

Take some time to reflect on a specific encounter or episode with someone from your practice – someone who moved you emotionally or made you think.

1. Which encounter or episode with a person do I remember particularly well – which scene stays with me, interests me or continues to occupy my thoughts?
2. What feelings arise when I think about this situation? What touches me, what irritates me, what amazes me – and why?
3. What question or "theme" does this memory of this person raise for me?
4. How does this topic/question arise in my own life in concrete terms?
5. Who and what is this person from whom I received my question – and who and what am I (or would I be) in this situation or in the face of this question?
6. What is his/her – and what would be my – answer, attitude or practice in relation to this question?
7. What can change in my life and in the way I live my life as a result of this person's "claim"?
8. I owe the memory of this person ...

A culture of grateful remembrance of people who have had a significant impact on us helps us to explore and expand our own practical philosophy of life, to treasure it and, in turn, to be of multifaceted help to others.

2. Boundary competence: self-care in the face of finitude

The following philosophical exercises are part of a long tradition dedicated to self-care. At the same time, similar reflections have also been found for many years in the training of volunteers and full-time staff in hospice and palliative care. Their origins in ancient philosophical traditions have simply been forgotten.

At the center is a basic exercise in the ancient art of living and, at the same time, a core element of the palliative approach: *meditatio mortis*, the contemplation of one's own life from the perspective of finitude. It also includes reflection on the many small losses, transitions and farewells that shape our lives. In many spiritual, religious and philosophical traditions, this view is considered a privileged approach to living life more truthfully, deeply and empathetically. People who work in this field often learn a corresponding attitude to life from their daily activities and experiences. Palliative care and hospice work have taken up this ancient human knowledge and integrated it into their culture of care and training.

For most ancient philosophers – Socrates, the Stoics, Epicurus and many others – philosophy was not a theory but a way of life: the art of practicing living and dying, living well and caring for one's own soul as well as for the community.[16, 17, 18]

They were not concerned with intellectual discussions, but with lived philosophy – with those opinions, attitudes and patterns of evaluation that are deeply rooted in feelings, spontaneous reactions and routines of action. Mere arguments hardly reach this level; it requires practice and repeated reflection that incorporates emotions, everyday experiences and lifestyle. Thus, the ancient schools – especially the Stoics such as Epictetus and Seneca, but also the Epicurean tradition – developed a rich repertoire of such exercises[19] . Similar forms can be found in many spiritual traditions.

For them, the key to a deeper way of life lay in consciously confronting the limits of existence, especially their own finitude and mortality. The exercises therefore systematically focused on borderline situations. One could speak of a "borderline competence"[20], a courage to face limits that makes life clearer and more authentic. Like many religious and spiritual traditions – but without dogmatism or esotericism, based instead on rational reflection on experiences that are inevitable as a human being – the ancient thinkers also assumed that a life that faces finitude gains depth, truth and justice.

The starting point is two simple facts: first, life is limited, we are mortal (the perspective of death). Second, we exist, we live, there is existence – and not nothingness (the perspective of being born).

2.1 Meditatio mortis

The practice of thinking about death, meditatio mortis, occupies a prominent place in this tradition.

"This is not [...] a therapy against the fear of death, but rather an awakening of awareness of the value of life. Shaping one's life based on an awareness of death is a recommendation that was frequently attested to in antiquity."[21]

Meditation on death is therefore not intended to "accustom" us to the idea of our own death, nor to dampen our spirits. Instead, the Stoics saw the awareness of our own mortality as an opportunity to enhance our lives, because we perceive its preciousness more intensely.

Meditatio mortis can have two effects:

Firstly, it reveals our deeper desires – the things that are truly important to us and prevent us from bending too far out of shape.

Secondly, it sharpens our awareness of values that are significant beyond our personal survival. Allan Kellehear has shown how strongly dying people uphold values that transcend their own lives.[22]

The following two self-care exercises – which, in various forms, are also part of the training of palliative care professionals and volunteer hospice workers – represent ways of taking the "point of view of death". They are intense reflections or "meditations" – and each person should assess for themselves what is good for them at the moment and what is not. Epictetus recommends starting with simple things ("a jug," he says) and only gradually moving on to more important relationships and deeper issues. The two exercises follow this logic: the first takes the perspective of death, the second applies it to the many small and large losses and farewells in life.

EXERCISE 2
Meditatio mortis

Imagine you have **four to six months** left to live. Take time to consider the following questions:

- What would be really important to me in this remaining time? What would I do – and what would I not do?
- How do I view my life so far, the life I have lived?
- How would I like to be able to look at myself in the mirror at the end of my days?

After meditatio mortis, which radically shifts one's perspective, the next exercise takes us a step further into the everyday experience of transience. It is less absolute than the idea of a limited lifespan, but often just as powerful: dealing with the small and large losses that constantly accompany our lives.

The following exercise has its roots in the Stoic art of living. Over many centuries, it has been incorporated into spiritual and religious traditions – such as Christian retreats – and can now also be found in modern psychology and palliative care training. It is often done in groups, but here we present it as a personal exercise[23] . As mentioned, it is important to practice mindfulness.

Ideally, one should start with the smaller losses in life: first with things – and only then turning people and to personal characteristics, relationships or images that are closer to one's own identity. The aim is to consciously assess how far one wants to go here and now.

At the beginning of Stoic concern for the soul lies the "fundamental rule of life, namely the distinction between what is within our power and what is not within our power"[24] . The main problem of human existence, in the words of Epictetus, is that we take too much for granted that "foreign" things (things that are not within our power) are our "property." Things that are not within our power include our bodies, other people, possessions, reputation, the functioning of our organs, and much more.

Epictetus suggests that we learn to view such things not as possessions but as loans by making this distinction. Hence his statement: "Never say of anything, 'I have lost it,' but rather, 'I have returned it.'"[25]

Essentially, this exercise leads to the development of an appropriate attitude towards the important things in life:

on the one hand, to recognize that we have not created many things ourselves, but have received them from "nature", and to treat what we have borrowed with gratitude, to care for it and share in it – knowing that one day it must be returned;

on the other hand, in the face of painful experiences that we can do little to change, to rediscover our own inner standpoint, the supportive attitude from which action remains possible.[26]

EXERCISE 3
On "giving back"

I. THINGS

1. Write down ten important things in your life, each on a small piece of paper.
2. Arrange the pieces of paper: the least important ones are at the top.
3. Now "give back" one piece of paper after the other – consciously put it away.
4. Reflect: How does it feel to give something away? How does it feel to be *without* ...?

II. PEOPLE

1. Write down ten people who are important in your life.
2. Arrange the pieces of paper: the "least close" ones are at the top.
3. Once again, put one piece of paper after another away.

4. Reflect: How does it feel to let go? How does it feel to be without these people – in your imagination?

III. MY PERSONAL CHARACTERISTICS

1. Write down ten important personal characteristics, roles or status elements on separate pieces of paper.
2. Arrange the pieces of paper: the least important ones go on top.
3. Again, 'give back' one piece of paper at a time.
4. Reflect: How does it feel to let go of this characteristic? How does it feel to be without ...?

The exercise of letting go is now followed by another path of self-care: the Epicurean turn towards existence and its quiet pleasures.

2.2 The pleasure of existence

Unlike the Stoics, the ancient philosopher Epicurus (341–270 BC) places pleasure, rather than death, at the centre of self-care.[27] For him, however, "pleasure" does not mean exquisite delights or spiritual ecstasy, but the absence of pain, both physical and mental. Once basic needs are satisfied – "not being hungry, not being thirsty, not being cold" – humans already live in a state that Epicurus considers happy enough to "rival even Zeus".[28]
The central idea: We do not have to create pleasure. We already live in pleasure, in the simple joy of existence. The challenge is not to accumulate pleasures, but to perceive the ever-present pleasure of being alive. The observation is that the basic acts of life (breathing, warming oneself, moving, eating, etc.) are experienced as pleasurable in themselves, but this pleasure is overlooked in everyday life. We do not live only "in order to" ...

Pierre Hadot sees a similarity to Aristotle here. What Epicurus calls "pleasure" is described by Aristotle as the seeing person being aware of seeing, the hearing person being aware of hearing, and the thinking person being aware of thinking[29] . In feeling and thinking, we simultaneously experience our being, the astonishing fact that the world *is*, that life *is* and takes place. The feeling or awareness of this could be called a "sense of existence".

According to Epicurus, two things are necessary for this sense of existence to emerge freely: firstly, the alleviation of the most severe pain and suffering, and secondly, the reduction of needs to a minimum so that the feeling of mere existence does not disappear under excessive desire, social expectations or fears about the future. "Thanks to fortunate nature, because it has made the necessary easily accessible and the difficult to access unnecessary," says Epicurus.

Epicurus' art of living is therefore not a meditation on death, but a meditation on gratitude for existence – an ethic and art of living that actually starts from the other end of life, from being born. Epicurus responds to the Stoic orientation towards the end with the reminder that we have been given life. Being reveals itself less in fear than in familiarity with existence. The basic attitude of this lust for existence is wonder: "Those who marvel are [...] moved by the fact that something exists and not nothing."[30]

The Epicurean attitude to life consists in connecting oneself again and again with the mere being of things, especially in adverse situations. As long as there is a breath of life in us, this connection exists. This is also significant for the ethics of care: especially in illness, borderline situations and dying, the sense of existence can reappear as a delight in mere being, which often remains hidden from healthy people.

This is an essential insight for people working in the care sector. Caring and nursing mean more than satisfying needs or preserving life. Behind all the tasks, they open up a space in which the elementary impulses of life become visible: breathing, perceiving, being touched, participating. The goal of care, for example in nursing, therefore has two levels: Firstly, of course, the alleviation of problems and the satisfaction of needs. Secondly, however, it also means enabling the feeling of existence and participation in the elementary impulses of life in which life "reveals" itself. Self-care therefore means becoming aware of this dimension of activity – the closeness to the mystery of life – and drawing fulfilment and meaning from it.

Thinking this through to its conclusion means that it is not the "how far" or "where to" that brings joy, but the mere act of moving. It is not the exact words of another that bring pleasure, but the fact that someone is speaking to us. It is not the specific color, but the fact that we see. The wonder at the fact of life – this inexhaustible "there is" – is a central experience of the ethics of care; it corresponds to gratitude for existence.

For reflection – The joy of mere existence

"Live in such a way that you never lose the feeling of existence itself in all your actions."

This is how the core of Epicurus' self-care can be summed up in one sentence.

Isn't it sometimes the case when we are seriously ill that, for example, being able to walk a few metres (from the bed to the toilet) without feeling short of breath finally conveys to us the fact of breathing itself in such a joyful and liberating way that we are grateful for it – whereas in healthy days we skip over the fact of breathing itself in our activities? Or, for example, after a long stay in a hospital bed, surrounded by the sterile white of the hospital, the steady ventilation of air conditioning, doesn't the first breath of fresh air, the first ray of sunshine and the first chirping of birds seem like paradise itself? After a long and serious bowel illness, or even just a bout of mild diarrhoea or food poisoning, isn't the first well-formed bowel movement and the familiar movements and sounds of the bowel something like grace itself ? Or isn't the taste of a piece of bread and butter after a long period of fasting a feast of a different order, one that no ordinary feast can match? Such experiences show that it is not the extraordinary that brings joy, but mere existence. When we forget these elementary sensations in everyday life – breathing, warmth, seeing a face – we alienate ourselves not only from the foundations of our lives, but also from the quiet gratitude that sustains self-care.

The Epicurean exercise addresses, if you will, the limits of death. For it is precisely because we find ourselves born and existing – and because this mere sense of existence is in itself pleasurable and astonishing – that death is limited. "What ultimately alleviates the fear of death is not hope or desire, but memory and gratitude," writes Elisabeth Young-Bruehl[31] , following Hannah Arendt – very much in the spirit of Epicurus.

Meditatio mortis and the practice of existential pleasure are therefore complementary: Alongside the reduction to the meaningful "essential" in the run-up to death, there is a return to the sensual elementary in gratitude for an original familiarity with being.

However, this sense of existence is not limited to individual moments. It thrives on pausing again and again and consciously perceiving the simple stirrings of existence. Such moments give rise to an attitude that can be transferred to our actions, our evaluations and our everyday perceptions.

In this way, the joy of mere being becomes an inner standard that clarifies our orientation: it prevents us from overlooking the elementary joy of existence – and reminds us that many fears and desires arise from forgetting these simple but fundamental experiences.

Exercise 4

Learning to feel a sense of existence

1. Practise the basic attitude of wonder

Consciously adopt the philosophical attitude of wonder again and again:

Why does anything exist at all – rather than nothing?

Interrupt your daily routine for a moment and ask yourself this question in very concrete terms: in relation to an object, a person, a feeling, a desire, a plan or an event.

Everything you encounter can be a cause for wonder.

2. Perceive the elementary execution of life

Focus your attention on the simple activities and impulses of life:

- What daily activity am I doing right now?
  (Breathing, walking, seeing, hearing, touching, speaking ...)
- What is the basic experience behind it?
- What do I really need in relation to this? What is essential? What is dispensable?
- What could I leave out so that the experience is not burdened, but emerges more

clearly?
- What pain or burden do I need to alleviate so that I can feel the fulfilment of life?
- And finally: what amazes me about it?

If we take Epicurus seriously, then the simple activities of daily life are not mere routines, but expressions of a deeper sense of existence. This is precisely where the danger lies: those who merely manage them instead of experiencing them transform the fulfilment of life into self-technologies.

That is why we need an attitude that does not leave these basic activities to pure optimization but instils care and moderation in them.

The next chapter is devoted to life-friendly self-management. However, it only makes sense if we think about and practice it from an Epicurean sense of existence – so that concern for everyday life does not become control, but rather the cultivation of a good life.

3. Life-friendly self-management for those committed to caring

The exercises mentioned so far come from an existential depth and focus on inner attitude. But people do not live permanently in this deep connection with the mysteries of existence. Everyday life challenges us – with its pragmatic demands, routines and also its small joys. The aim here is to shape one's own life in such a way that professional stresses do not spill over into private life and cause impairments there, such as disturbing sleep. Contact with existential depth remains the inner key to living a caring, humane and enriching life. Without this contact, caring people risk missing the point. However, this contact is only possible in moments – as a conscious pause, as a small interruption of everyday life. These moments have a lasting effect; they shape our attitude in the long term. At the same time, however, it is also necessary to organize everyday life pragmatically.

There is no shortage of recommendations for work-life balance. Closeness and distance are one of the most common topics in supervision, especially in nursing and palliative care teams. Professional associations for palliative care also offer numerous suggestions and formats to promote self-care at this level. The scientific literature contains a wide range of overviews of self-care techniques.[32, 33, 34, 35, 36, 37]

Essentially, the most important measures cover some fundamental areas of standard healthcare. It is crucial to take time and ask yourself questions about these areas: What is the current situation? What needs to be changed?

These questions address our everyday health skills and do not require any special knowledge – just attention. In the case of more severe impairments, such as pronounced sleep disorders, professional support is of course necessary.

Exercise 5
Life-friendly self-management

For reflection, two questions can be asked for each keyword and each dimension. In a sense, they form a simple "diagnostic" and "therapeutic" basic pattern:

1. **What is the current situation?**
2. **What can or do I (or do we as a team) want to change to improve health and well-being?**

Pause for a moment after each topic to consider the answer before moving on.

Professional dimension
Breaks | Quality of the team | Opportunities for processing within the team (discussions, exchanges, supervision) | Sense of effectiveness and pride in one's own work | Management's attention to *care for the carers* | Boundaries in the workplace

Physical dimension
Sleep | Nutrition (and sufficient time for it) | Physical exercise | Breathing exercises, relaxation, body awareness | Dealing with fatigue

Social dimension
Time for meaningful relationships | Family and friendships | Neighborhood and community | Spaces for encounters

Psychological dimension
Time for hobbies and interests | Dealing with feelings | Mental hygiene | Self-calming techniques | Dealing with stressful thoughts

Spiritual dimension
Contact with deeper sources of meaning: nature, silence, prayer, meditation, music, reading, time for your own thoughts | Spaces for gratitude, remembrance and connection

Self-organization
Awareness of stressors | Dealing with peaks of stress | Planning small, achievable self-care steps | A personal self-care log or reflective diary (e.g. on sleep, energy, mood, stress, small successes)

When it comes to self-care management, it is important to remember that the essential resource for self-care should be found in the act of caring itself – and not merely in "distancing" oneself from it. If caring is understood primarily as an instrumental activity from which one must regularly recover, then it almost inevitably appears as a burden rather than in its enriching dimensions. This is neither personally nor socially sustainable and reproduces a negative image of care work.

Recommendations for self-management are often formulated using the metaphor of "recharging your batteries". This metaphor is catchy, but ambivalent: firstly, it suggests a technical understanding of human beings – as energy generators. Secondly, it focuses on maintaining the workforce. Self-care then appears to be a measure to function more efficiently. Without critical reflection on structural conditions – many burdens are not individual, but organizational or socially generated – it may appear that there is care for the carers, when in reality structural imbalances are perpetuated.

There is also another risk: the problem is shifted onto the individual. A poster by the German "Arbeitskreis Feminismus" (Feminism Working Group) put it bluntly: "40-hour job, three children and a care case? Do yoga!"[38]. It makes it clear that some life situations do not need "practical tips", but rather a collective awareness of the problem.

Nevertheless, the „dietary“ measures are not wrong. However, they need a deeper foundation: on the one hand, in an existential attitude and practice of care, and on the other hand, in an awareness of the circumstances under which care work takes place. Self-management remains useful as long as it is applied in moderation and does not tip over into a self-technology that seeks to (subtly) control life from the perspective of efficiency rather than supporting it.

The big political and systemic issues – the organization of care work at the societal level – are mostly beyond our immediate sphere of influence. But in their everyday professional lives, healthcare professionals do have an influence on how care work is organized in teams and communities. This is where the collective dimension of self-care begins: self-care is never just individual, but always communal as well.

The following section will focus on these broader perspectives.

4. Self-care as critical reflection by caring citizens

While the considerations and exercises in the previous chapter focused on the private self – personal everyday life, physical and mental self-care – the focus now shifts to the political self. This perspective is necessary because many of the stressors and burdens to which caring people are exposed – as parents, family carers, volunteers or health care professionals – do not arise from individual incompetence or a lack of self-regulation, but from social contradictions, structural constraints and political decisions.

Self-care therefore means not only treating oneself well, but also becoming aware of the conditions under which care work takes place in the first place. Viewing one's own self not only psychologically, but also sociologically and politically, is an essential part of care identity. Those who do a lot of care work live a deeply social practice – and are at the

same time shaped and challenged by it.
In 2013, an initiative group *("Care-Macht-Mehr")* of academics and politically active individuals published the Care Manifesto[39].

For reflection: Key statements from the Care Manifesto

1. Foundation
Care – caring for one another, for the common good and for ourselves – is a fundamental pillar of every society. Where care is overburdened, ignored or poorly organized, this pillar begins to falter.
2. Invisibility
Care has historically been made invisible in many ways: attributed to women, devalued as "natural", relegated to the private sphere and underfunded in the professional sphere. These patterns continue to have an impact today – and shape how care work is perceived, distributed and remunerated.
3. Reality
Many burdens do not arise from individual incompetence, but from social conditions that overlook or underestimate care needs. People then try to solve structural problems on their own – often at great personal cost.
4. Recognition
A sustainable care culture requires a reassessment of care: as a qualified, relationship-oriented activity ( ) that requires time, good conditions, recognition and fair distribution. Caring is not a marginal issue, but a benchmark of social justice.
5. Community
Care creates identity and cohesion. It can only succeed if it is shared – between people, generations, organizations and political levels. A just society is one that supports, enables and respects care work.

The above key statements show that care is never just a private matter, but always a political one too – embedded in social expectations, values and structures. Those who provide care therefore have not only a personal responsibility, but also a wider social context.
The *"Denk- und Handlungswerkstatt Wirtschaft ist Care" (Think Tank and Action Workshop 'Economy is Care')*[40] has developed a particularly helpful tool for this purpose: the "Care Biography"[41] . It reveals how much care shapes our lives – as carers, as recipients, as people in social roles and political contexts. The full versions (German/English) can be found online; below, we use a carefully adapted short form as a self-care exercise.
It invites you to explore your own history of care and thus strengthen the political self that not only performs care, but also understands, classifies – and defends it.

Exercise 6
My care biography

This exercise invites you to explore your own history of care in the context of family, society and politics. To do this, go through the generations of your "care line" step by step.

Generations

Think about the following generations one after the other:

1. The generation of my grandparents and other ancestors
2. My parents' generation
3. My own generation
4. The next generation

Key questions

For each of these generations, you can use the following questions as a guide:

1. How is care work organized?
2. What socio-economic conditions (money, occupation, gender and family images, images of age, war and peace, etc.) shape care work?
3. Which particular scene – recounted, handed down or experienced first-hand – succinctly expresses the care relationships of this generation?
4. What ideas and values about care work and housework are being passed on to the next generation?

Summary and outlook

Finally, you can take a look at the big picture:

1. What has changed over time – and what will or must change in the future?
2. What insights do I now take with me – about myself, my family, my role as a caregiver and as a citizen?

By looking at our own care biography, it becomes clear that care is never just a private matter: it arises from historical lines, is practiced in families, framed by society and enabled or hindered by politics. This insight opens our eyes to the collective dimensions of self-care. What applies to individuals also applies to teams and organizations: they too are shaped by cultures of care, work structures and shared attitudes.

In the next step, we therefore turn to the question of how self-care can be lived, protected and shaped in a team – as a shared practice, as an organizational culture and as a shared responsibility. Only where teams care for each other can individual self-care take root in the long term.

5. Self-care as a team task: developing a shared culture of care

It is particularly instructive for organizations and teams when new members join. At such moments, it becomes clear what culture is actually practiced in the team – and where personal ideals and practical reality diverge. At the beginning of their careers, nursing staff often experience a "practice shock". Training focuses on ideal images of good care. The operational reality of healthcare organisations sometimes has little to do with this. Carers then know what good care *could* look like but are hardly able to implement it in their daily practice. The reasons are well known: time pressure, staff shortages, complex processes, administrative tasks, interface problems, fragile communication within the team or a generally reduced, instrumental understanding of care. Adapting to these realities can lead to creeping frustration. At some point, the memory of how care was originally intended fades. The question arises: how can care be designed without chronically losing its "humanity"?

This exaggerated portrayal points to something fundamental: the collective care provided by a team does not arise from the sum of individual efforts, but from its culture and interaction.

An example may illustrate this. Caregiver A has a holistic understanding of suffering and is familiar with the concept of "total pain". She would be professionally and personally capable of responding to physical, psychological, social and spiritual needs. However, these dimensions are hardly present in the team and in the structures of the organization. Handovers focus primarily on organizational and physical matters. The documentation systems hardly ask about spirituality or mental health, and colleagues show little interest when A addresses such aspects. Her personal competence remains ineffective because structures and culture do not support it – and her ideal of good care falls by the wayside.

In general, a simple but often underestimated rule applies: individual measures (training, self-care) are overestimated – work on the common culture is underestimated.

That is why comprehensive self-care that goes beyond individual emergency assistance begins with an awareness of team and organizational culture. Culture can be analyzed on many levels[42] . One dimension is particularly relevant for self-care: the way teams communicate – especially in their meetings.

For reflection

What meeting structures do we have – handovers, team meetings, case discussions?

What is discussed there – and what is not?

Who speaks? Who remains silent?

Which dimensions of care – such as "total pain" – receive attention, and which remain invisible?

What forms of discussion do we need? What needs to change in the existing ones?

Let us think back to nurse A. When people repeatedly find that they have to act in a way that is contrary to their moral convictions, moral distress arises[43,44,45,46] . This can occur acutely, but also chronically, quietly and almost unnoticed. Moral distress is stressful, can lead to a crisis in professional practice – and cannot be resolved individually. It is structurally conditioned and must be addressed collectively.

Self-care therefore has a collective and organizational dimension. Problems that arise structurally must not be shifted onto the individual.

To prevent moral distress, there needs to be space for ethical discussions and a culture in which irritations are taken seriously. The starting point is the feeling that "something is wrong here."[47,48] Dealing with this feeling is a crucial turning point for a holistic culture of care and organizational ethics in healthcare. If the irritation is ignored – due to time pressure, perceived callousness or fear of showing feelings – it leads to distance, numbness or escape from the profession. However, if it is shared and discussed, space can be created for job satisfaction, relief and a deeper sense of humanity within the team.

A basic rule of organizational ethics is that every person – including cleaners, relatives or the caretaker – should be allowed to say, "Something is wrong here!" And structures are needed in which this can be heard.

For reflection

How is it for us—in our team or in our organization:

Can anyone say, "Something's not right here"?
Can feelings be addressed?
Are there spaces where we can share moral concerns and make them fruitful for our work?

Since misunderstandings repeatedly arise in practice and "professionalism" is sometimes associated with the callous suppression of feelings, the following point should be emphasized: Addressing one's own feelings is not about psychological navel-gazing or mixing with one's private life, but about *insight*. Of course, feelings and *intuitions* must be interpreted in joint rational discourse and "examined" from different perspectives, but they are the starting point and basis for relevant insight – they are often professional and life experience that has accumulated over years and decades. In the interpersonal and existential sphere, professionalism includes the ability to resonate with one's own feelings and in communication, as well as a reflective approach to intuition[49] .

Ethics thus also takes on a dimension of self-care that should not be underestimated. In addition to the familiar ethical case discussions (for dilemmas in therapy decisions), the prevention of *moral distress* requires formats of a culture-building, encouraging ethics – an ethics that supports everyday life. The following approaches can help to develop a shared culture of care and strengthen self-care within the team, not only individually but also structurally.

Ethics of success

"Highly reliable organisations"[50] – as described by organizational theorist Karl E. Weick – are institutions that are particularly good at dealing with mistakes. These are organizations in which a mistake could quickly lead to great harm: aircraft carriers, intensive care units, nuclear power plants, fire departments. In such contexts, control is not enough. It requires a collectively practiced mindfulness to respond to the unexpected and to the smallest details. "Near misses", i.e. situations that just turned out well, are considered special learning opportunities in such contexts.

Something very similar applies to ethics in care organizations. The damage that can be caused often does not affect the body, but rather dignity, autonomy, care – those subtle levels of humanity that are particularly vulnerable. Care teams should therefore be especially "reliable" and sensitive. Here, too, there is a great learning opportunity in ethical near misses: in situations that were difficult or delicate, but in which the team managed to provide good care and uphold core values.

Such situations are commonplace. Precisely for this reason, they often go unnoticed. This is where the dialogical-philosophical approach comes into play: much of what is successful in care rests as intuitive, silent experiential knowledge in the team members – and only becomes conscious through joint reflection. Caregivers and other professional groups often "know" more in practice than they can say or reflect on at the moment. This implicit knowledge deserves recognition[51] .

This is because people who are ill, frail or otherwise vulnerable experience situations every day in which their autonomy is threatened, or they may feel ashamed. In good everyday care, teams transform such potentially degrading moments: they not only prevent the bad, but – paradoxically – often enable something good: a restoration of dignity, a small piece of self-determination, a moment of connection.

Dealing with these "ethical near misses" is therefore not only a learning opportunity for the organization, but also an act of self-care. It makes carers aware of what they are doing well. It strengthens their confidence in their own professionalism, brings the invisible to light and restores resources. This is precisely what can help prevent moral distress and maintain the quality of care.

The following exercise is a simple way to make such moments of success visible within the team – and to learn, appreciate and strengthen each other in the process.

Exercise 7
Ethics of success

Setting: Team meeting or a sub-team (approx. 20-45 minutes)

1. Individual recollection

Each person thinks back – as specifically as possible – to a situation in which the team or individual team members performed particularly well despite an unusually difficult starting position.
"This story comes to mind..."

2. Joint reflection within the team
The stories are worked through one after the other, following a fixed, simple procedure:

1. **Narration**
   The person describes the situation as vividly as possible.
2. **Questions/clarification**
   The team asks questions to clarify their understanding: *What do we need to know in order to really understand this situation?*
3. **Resonance**
   Brief discussion about how what was heard affected others:
   What touched, surprised, irritated or impressed me?
4. **Joint interpretation**
   - What was the "secret to success"?
     (Focus on specific, small details or behavioral characteristics that made the difference.)
   - Which values were protected or strengthened by our actions?
     (Dignity, autonomy, care, justice, etc.)

Some tips for implementation

a) In addition to the more analytical aspects of joint reflection, resonance in the form of emotional engagement with the stories of others is also important for strengthening relationships and cohesion within the team.
b) When discussing the secrets of success, pay attention to the *specific (!)* details, because generalities ("good communication" – which will almost always be a factor) are not insightful and offer little inspiration.
c) Variation: Of course, it is also possible to play this through with negative examples: We were particularly – and unnecessarily – bad at this. What were the secrets of failure? What do we want to do differently? But for the self-care of the team, the positive variant is recommended. Problem orientation dominates ethics anyway, and the negative version is also more prone to conflict. The ethics of encouragement aims to recognise the often invisible ethical "high achievements" (also for the carers themselves)!

While joint reflection, the structure of communication and practiced attentiveness form the core of a caring culture within the team and the organization, self-care does not end

there. Care is always *socially* and *societally* embedded. The conditions under which people care – and under which they themselves experience care – are significantly influenced by the environment beyond the organization: by neighborhoods, local networks, civil society initiatives and the political framework.
That is why the focus is now on the **community and society**: on those larger contexts in which care is shared, enabled or hindered – and in which caring people can also experience themselves as active, co-creative citizens.

6. Strengthening self-care in communities

We are now expanding the radius of self-care: from personal reflection on the direct care relationship and team culture to the larger social contexts – to the *community* and society. This also changes the perspective: whereas the focus *was* previously on the self-care of *palliative care practitioners, they now become advocates for* a care-for-the-carers perspective within their community and society.
Three aspects are central to this:
Firstly, it is about bringing the philosophical attitude and practice of care, as lived in daily palliative care, into the public eye and making it visible.
Secondly, the situation of caring relatives is too important in social and socio-philosophical terms to be ignored in a comprehensive self-care perspective. Current developments – for example in *public health palliative care*[52] , *compassionate communities*[53,54] and approaches that view *death and dying as a matter of social justice*[55] – demonstrate this impressively.
Thirdly, expanding the role beyond direct care – towards *shaping* and empowering communities – can be a source of professional satisfaction and deeper meaning.
Fourthly, professional and voluntary carers are also citizens or even affected themselves: they live in neighborhoods, have families and care for relatives themselves. No one is exclusively a "professional".
And fifthly, in the long term, successful self-care depends largely on whether a society is capable of shaping care processes in a fair and supportive manner – materially, politically and culturally.
There are therefore many reasons to broaden our perspective: from a professional point of view to a general human attitude and the question of a *caring society*.[56]

Care for the carers - a test question for our society

The philosopher Avishai Margalit[57] describes a criterion for a "decent society": no one should be humiliated. Even if "dignity" is difficult to define positively, we recognize *indignity* immediately. Applied to our topic, this raises a simple but profound question: Does our society treat family carers decently?
Reality often paints a different picture: helplessness due to caregiving, social isolation,

damage to self-esteem and existential overload are widespread. Many family carers report

- of losing social relationships,
- a feeling of merely functioning,
- of being overwhelmed by conflicting role demands,
- feelings of guilt and uncertainty.

At the same time, reports show how meaningful care can be – how deep, connecting and humanly precious. This gives rise to social responsibility: care must not become a source of humiliation, but should be experienced as a source of meaning and connection.[58,59,60]

Caring for the carers – a central question of social organisation

Approaches from care ethics— particularly those of Eva Feder Kittay[61,62] —shed light on how strongly our societies are still oriented toward the ideal of the autonomous, rational, adult—and historically male-conceived—individual. Phases of life and situations of vulnerability and dependence lie outside the self-image of the autonomous individual; as a result of historical conditioning, they are scarcely thinkable or feelable in any other way than as an affront, humiliation, or shaming of the "healthy" and "successful" life. She emphasizes: employers, local communities, and the state share responsibility for supporting caregivers ("dependency workers")—that is, taking care of those who care. How can we shape our communities and our society so that the beautiful, enriching, and gift-like aspects of caring for others can become the norm—and not overload, disadvantage, or even humiliation? How must we practice, as communities and as societies, so that different experiences and images of care become possible? This brings fundamental fields of tension in social organization into view, such as:

1. **The gender order of care** – between traditional role models and modern lifestyles.
2. **The image of humanity** – between autonomous decision-makers and relationally embedded beings.
3. **Forms of social cooperation** – between the liberal contract paradigm and the care-ethical relationship economy.
4. **The status of care work** – between economic invisibility, limited recognition and global asymmetries.

To address these issues concretely in communities rather than leaving them abstract, we present two instruments that can complement each other in community development processes:

1. **Care conversations** – spaces in which existential experiences, burdens and resources are shared, and care becomes visible as a fundamental human condition.
2. **Citizen forums** – participatory formats in which structural changes can be developed based on what has been discussed in care conversations.

This creates a process: the **existential** becomes audible – the **structural** becomes malleable.

6.1 Care dialogues: Engaging in conversation about the culture of care and questions of life

Care dialogues[63] create a culture of conversation in which people have the opportunity to exchange views on profound existential questions and at the same time initiate a social learning process. A care dialogue is neither a self-help group nor a therapy session. Its goal is not to solve individual problems, but to reflect together on fundamental questions of life, care and coexistence. Nevertheless, participants often find these conversations personally enriching and supportive.

The dialogues enable participants to open up from an existential depth, while at the same time keeping their focus on the general and public significance of the topics addressed. The aim is to share experiences of care and to highlight their relevance for a good life and a successful community.

The goals of the care dialogues are manifold: they promote social participation by providing a space for sharing experiences of care, and they strengthen the self-efficacy of caring relatives as well as other people in care and support roles. At the same time, they highlight the ethical and political challenges associated with care. They honor the life experience and often invisible wisdom of the participants by making it audible. They create spaces for storytelling, give people a voice and promote the art of active listening. In addition, they encourage elementary, pre-philosophical reflection on the good life, link existential questions with political perspectives and provide a trusting, safe framework for open exchange.

Exercise 8
Initiating and shaping care dialogues in the community

A. Guidelines for the care dialogue

1. Existential level - personal experience
Step 1 – Narrating
Tell a story about a concern that has had a lasting impact or remained in your memory.
Step 2 – Listening with wonder
The others listen without discussing or evaluating.
Question: *What feelings does this story trigger in me?*
Step 3 – Recognizing existential themes
What fundamental questions, needs or values are revealed by the story?

2. Political level - The structural dimension
Step 1 – Identifying areas of tension

What social, economic, cultural or historical conditions shape the experience described? (Working hours, care time, role models, neighborhood, lack of support, etc.)

Step 2 – Develop perspectives

What can we do as a community, neighborhood or parish to make such experiences less stressful and more supportive?

What small or larger changes would be conceivable?

B. Culture of conversation in the care dialogue

1. **Speak from the heart - and keep it brief.**
   Concrete, personal examples instead of abstract opinions.
2. **Listen with amazement.**
   No hasty solutions. Ask questions to understand better.
3. **Let statements stand.**
   No debate. It's about understanding, not convincing.
4. **"That gives me food for thought."**
   Take your own response seriously: *What does this story tell me about my life, my values, my community?*

C. Procedure for a concern dialogue

1. Brief introduction to the purpose and goal of the dialogues.
2. Each person notes down a concern they have experienced (optionally in writing).
3. Formation of small discussion groups (3-6 people).
4. Reminder of the discussion culture.
5. Conduct the dialogue according to the guidelines (15–30 minutes per story).
6. Documentation of key findings, if useful for further work later on
   (e.g. integration into a community project or citizens' forum).

D. Philosophy of dialogue – The basic attitude

Care dialogues are based on a simple but demanding attitude:

- **Listen fully:** attentively, slowly, with interest.
- **Name** one **feeling -** precisely and honestly.
- **Do not slip into discussions:** seek common ground
- **Allow yourself to be amazed:** let yourself be moved by what people have said.
- **Move from the personal to the general:** which question affects us all?
  What significance does it have for a good life in our community?

The question of how to organize and embed care conversations in a social learning process deserves special attention that goes beyond the immediate method of conversation. In order for care conversations to be fully effective, it is crucial to consciously design the entire process – from preparation to implementation to follow-up. This is because care conversations not only open up individual insights, but also reveal experiences that can be learned from and shaped for life in the community.

Before implementation, it is important to bring people together in all their diversity. The aim is to facilitate encounters across social differences and roles and to include a broad spectrum of perspectives and experiences – precisely because experiences of care are strongly anchored in biography, generation, position in life and social situation. While working on the care biography primarily reveals individual embeddedness, care conversations open up these insights to the community.

After the care dialogues, the knowledge gained should not remain unused. It is important to pass on the questions raised, the existential issues identified (such as powerlessness, connectedness, overload, dignity) and the measures proposed in such a way that they become insights relevant to the community. In this way, care conversations can contribute to the visibility of care issues, greater solidarity and a deeper awareness of the good life in the community. A central aspect of this is clarifying the next steps or possible follow-up activities in order to anchor the process that has been started in a sustainable manner. A suitable venue for this is, for example, a citizens' forum.

6.2 Establishing and organizing a citizens' forum on care issues

A citizens' forum on care issues – in particular on "care for the carers" and support for family carers – is a key opportunity to highlight the needs and challenges of this often overlooked group. Family carers make an enormous contribution to society by caring for sick, elderly or vulnerable family members. However, this task is often associated with emotional, physical and financial burdens.

A *citizens' forum provides a platform where this invisible care work can be made visible, where solutions can be developed together, and where local politicians and the community can be made aware of the realities of life for carers. It promotes dialogue between* citizens, *experts and* decision-makers and contributes in the long term to building sustainable support systems for family care (and other forms of care). At the same time, it asks the fundamental question: how do we want to live together?

A citizens' forum is a participatory format and typically proceeds in several phases. In the preparatory phase, the topic is defined and the question of who should be specifically invited – in addition to an open invitation – is clarified. To achieve a certain degree of representativeness, it may be useful to issue additional invitations by lottery. Ideally, the invitation should be issued by local politicians and include people in decision-making positions. Organizational framework conditions such as space, catering, materials and financing must also be clarified.

In our hypothetical case, preliminary discussions are organized in the community. These not only serve to raise awareness but also provide the existential and structural topics that are to be discussed and further developed in the citizens' forum.

During the forum, participants discuss their perspectives, challenges and ideas in moderated groups – for example, in formats such as World Cafés. The aim is to develop concrete proposals and measures that improve the situation of family carers and make care processes fairer.

After the forum, the results should be documented and forwarded to the relevant authorities. Transparent communication about progress and implementation is crucial to strengthening the trust and commitment of the participants. The process model outlined here assumes that the results of the care discussions will serve as a starting point for the citizens' forum and will be structurally incorporated into the subsequent process.

Exercise 9

Organizing a citizens' forum (core process)

1. **Welcome**
   by representatives of local politics and key officials.
2. **Clarify the objectives of the event**
   a. *"Your perspective as* citizens is the focus."*
   b. Discussing visions of a "caring community" together.
   c. The proposals developed will be taken up and further processed by local politicians.
3. **Make visible who is present**
   Raise awareness of social differences, different roles, backgrounds and perspectives.
4. **Presentation of the topics from the care dialogues**
   a. Introduction via a particularly striking quote or a typical statement.
   b. Briefly explain why this topic is important to the community.
5. **Theme tables for in-depth discussion**
   a. Participants are free to choose a topic table.
   b. The table discussions are moderated in a low-threshold manner: focus on experiences, ideas, possibilities.
6. **Fill out suggestion cards**
   Write down specific suggestions, concerns or measures.

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7. **Collect, bundle and, if necessary, prioritize suggestions**
   Joint review, consolidation and initial weighting.
8. **Outlook**
   a. Brief statement by political representatives on their impressions and initial feedback.
   b. Clarification: *What happens next?* Transparency about next steps and responsibilities.

For detailed procedures and activities in preparation for and follow-up to a citizen-forum, we refer to the relevant tools and manuals provided by platforms for citizen participation[64,65,66,67] . However, what is crucial is not so much the perfect adherence to a format, but rather the attitude with which a forum is conducted: the willingness to make concerns visible, to bring people with different life realities into conversation with each other, and to allow shared knowledge and shared responsibility to emerge from existential experiences. A citizens' forum is thus not only a technical instrument of participation, but also a practical expression of a concern-conscious, democratic culture. It concludes the chapter on self-care in communities with the perspective that self-care is strongest where it can be shared, heard and become politically effective.

Summary in key sentences

1. **The source of self-care lies first and foremost in the quality of the caring relationship itself.**
   a. Self-care and care for others cannot be separated.
   b. Those affected give those who help them food for thought – this "gift" is the most important key to self-care and existential growth, as well as to the development of a shared culture of care.

2. **Philosophically deep self-care requires the courage to push boundaries.**
   a. Contemplating life from the perspective of death (meditatio mortis) initially arouses fear and is painful – but ultimately reveals the preciousness of life, what is important to us and which values are even more important than our own (survival).
   b. Contemplating life in wonder at the fact that something exists rather than nothing (the perspective of birth), reveals a sense of existence, a desire for the elementary acts of being – and consequently leads to a critical reduction of our own and society's activities to the essentials.

3. **Self-care as self-management is important, but it harbors dangers.**
   a. Knowledge about work-life balance, basic rules for healthy living and the regulation of closeness and distance in healthcare professions are well known and the most common focus in the "self-care" discourse.
   b. The overemphasis on measures relating to individual lifestyle and "psychoeducation" leads to a technical, objectified relationship between people and themselves and shifts problems of social *conditions* to individual *behavior*.
   c. Well-founded self-care embeds self-management in deep philosophical reflection on the one hand, and in shared concern for care (teams, organizations, communities) on the other.

4. **Self-care requires an understanding of oneself as a caring citizen and critical thinking.**
   a. Self-care is directed not only at the private self, but also at the political self.
   b. Many stresses arise not from individual incompetence, but from social conditions.
   c. Care work is still structurally disadvantaged and made invisible by society.
   d. Personal and collective awareness of care must be heightened if self-care is to be possible.

5. **Self-care is a task for teams and organizations**
   a. Rule of thumb for self-care and care culture: Measures addressed to the individual (training, self-management) are overestimated – work on a shared organizational

culture is underestimated.

   b. *Moral distress* is a significant source of stress – and the reasons and causes for this can only be addressed *collectively* and in line with organizational ethics.
   c. For self-care, it is advisable to go beyond previous problem-centered ethics and establish an "ethics of success" and a positively lived culture in organizations.

6. **Caring communities can create cultures of care and work together to address local and global care challenges in a participatory manner.**
   a. Self-care has a social and communal dimension – and also means advocating for *care-friendly environments*.
   b. Among many other activities, caring communities also open up space for dialogue – and creatively combine these spaces for dialogue with a view to genuine participation and structural effectiveness.
   c. Care dialogues give those affected a voice and enable understanding of direct *existential experiences*.
   d. Citizen forums (or care councils) develop *structural solutions* and feed back into the political and economic system through consistent participation processes.

Care is not a necessary evil; it is the origin and expression of our humanity. It deserves attention at all levels.

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[23] The version presented here as an individual meditation is inspired by and modified from a "found object" – a short set of instructions for a retreat session, without name or context, dated December 1989. I found the sheet during the time I was working there, in the comprehensive documents of the educational department "Hospice, Palliative Care, Dementia" at the Kardinal König Haus, an educational institution in Vienna that has a long tradition and great influence in education and training in this field, https://www.kardinal-koenig-haus.at/bildungsprogramm/hospiz-palliative-care-demenz/programm/. When one considers how far back the core of such a retreat, to "practice living and dying", goes and how it has been passed on, changing again and again, it also becomes clear that in the innermost matters of human existence (love, death, morality ...) there are no "innovations" or need for them, but rather a reference back to the history of general humanity – a humble practice of passing on, reappropriating, and transmitting. This "hermeneutic" practice is not only existentially significant in its logic but can also be understood as an act of resistance in a time when "spirit" is reduced to "technology" and "development" to (supposed) "progress". See also: Gadamer, H-G (1960/2010) Wahrheit und Methode. Grundzüge einer philosophischen Hermeneutik. Gesammelte Werke. Band 1 *[Truth and Method. The Basic Structure of a Philosophical Hermeneutics. Collected Works. Volume 1]*. Tubingen: Mohr Siebeck

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