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Chapter 1. Introduction

> *What do you consider to be the main challenge in the coming years for spiritual caregiving in your organization concerning religious and spiritual diversity?*
>
> "*For me the main challenge is to 'gauge' another person's spiritual need. In what way can you provide appropriate spiritual care? (…)*"
>
> "*How to, from your own, pluriform identity, have an open attitude toward people with any belief and how to be explicit about this*."
>
> "*Stay true to your own sources. Promote professionalism without denying one's own religious or spiritual roots (…)*"[1]

Dutch spiritual caregivers or chaplains are often available to talk with people who are hospitalized, imprisoned, or in a military setting. They discuss life questions and other existential themes, and they perform rituals upon request. In doing so, the spiritual caregiver's main task is to offer "*professional support, guidance and consultancy regarding meaning and belief systems*" (VGVZ, 2015, p. 7). He or she often formally affiliates with a religious or Humanistic tradition (e.g., as Protestant, Catholic, Islamic, Buddhist, Hindu, or Humanist spiritual caregiver), while commonly being employed by a secular organization and providing spiritual care to people with a variety of religious, spiritual, or non-religious backgrounds. This dissertation focuses on the role of these faith differences in their spiritual caregiving, such as how spiritual caregivers care for clients who do not share their religious or spiritual orientation, and how clients perceive this care.

Objective

Over the past decades, the religious landscape in the Netherlands, as in many other Western-European countries, has changed tremendously. Whereas many used to affiliate with a religious, mainly Protestant or Catholic, tradition, nowadays a minority of its population adheres to either of these traditions (e.g., church membership declined from 67% in 1966 to 32% in 2015 (Bernts & Berghuijs, 2016, p. 23)), a large percentage of people affiliates with other, non-Christian, traditions (e.g., 5% Islam, 5% other traditions (CBS, 2018)) and/or combines elements from

[1] Quotes by spiritual caregivers responding to a survey on spiritual caregiving in the Netherlands. Liefbroer and Berghuijs (2017), original in Dutch, translated by Liefbroer.

various traditions in their lives (Berghuijs, 2017), and a majority of the population identifies as secular or non-religious (CBS, 2018; Bernts & Berghuijs, 2016). As such, many institutionalized forms of religiosity are in decline, and the field of religion and spirituality has become highly diversified.

Meanwhile, at critical moments in life, such as when people are in hospitals, prisons, or the military, existential questions can become highly relevant, and care provision for this 'spiritual domain' is to be available to all clients—sometimes provided by general practitioners, nurses, physicians, social workers, or psychologists, and at other times provided by specialized spiritual caregivers such as chaplains, pastors or ministers. Given the plurality of religious, spiritual, and non-religious orientations in current, Western-European society, a main challenge for these professionals is how to provide spiritual care when negotiating these diverse orientations, as exemplified by the quotes above from spiritual caregivers responding to a survey in the Netherlands (Liefbroer & Berghuijs, 2017).

As we will see, the role of religious and spiritual diversity in spiritual care provision has hardly been explored empirically. Although on a conceptual or theoretical level various ideas about how spiritual care is (supposed to be) provided in a religiously pluralized context have been formulated (chapter three), studies that investigate its role based on systematically collected verifiable data or observations are scare (chapter two), thus limiting our knowledge concerning what spiritual care in religiously diversified contexts actually looks like *in practice*. Therefore, this dissertation aims to answer the question *'What is the role of faith differences in spiritual care provision?'* using an *empirical* approach. The following sub research questions are formulated in order to answer this main question: RQ1) What is known about interfaith spiritual care and what central issues are at stake? RQ2) What are spiritual caregivers' perspectives on interfaith spiritual care? RQ3) What are clients' perspectives on interfaith spiritual care? and RQ4) What does interfaith spiritual care look like in practice?

In the following sections, I[2] start by preliminarily describing interfaith spiritual care and how it relates to the way in which spiritual care provision is organized in the Netherlands. This is followed by a section in which the methods used to answer the research questions are described. Finally, I provide an outline of the chapters of this dissertation.

[2] In the introduction (chapter 1) and general discussion (chapter 9) of this dissertation, I use the singular form of the first person ('I'). Since the other chapters are coauthored, in these chapters I sometimes use its plural form ('we'). For a description of the contribution by each of the authors to these other chapters, see Appendix 1.

Interfaith spiritual care

This study investigates the role of faith differences in spiritual care provision. *Faith* often appears in relation to *religion* and *spirituality*, and, as we shall see, in some of the following chapters the term *faith* is used interchangeably with *religion and/or spirituality (R/S)*. To briefly describe what is meant by these terms (and without going into too much detail regarding these definitions), *religion* is often used to refer to traditions of faith with a focus on community and social institutions, while *spirituality* often refers to its personalized, subjective aspects. Dein, Swinton, and Abbas (2013), for instance, note: "*While religion describes the social, the public, and the organized means by which people relate the sacred and the divine, spirituality refers to such relations when they occur in private, personally, and even in eclectic ways*" (p. 193). Similarly, Plante and Thoresen (2012) and Mathisen et al. (2015) argue that *religion* has a stronger focus on social institutions and community expressions, while *spirituality* has a stronger focus on individualized experience. As such, *religion* and *spirituality* seem to refer to different aspects of faith, which may or may not overlap in practice. Since in this study I am interested in investigating the role of faith differences in a plurality of forms and in a plurality of settings, I will use it in a broad sense, as a means to include both religious and spiritual as well as nonreligious and nonspiritual (e.g., Humanist or agnostic) aspects (Schipani & Bueckert, 2009, p. 1; Wulff, 2019). However, we will also see that in the studies conducted to answer the research questions, faith is often operationalized in relation to *traditions* (e.g., Protestantism, Buddhism, Islam, Humanism), and in only a few studies we were able to investigate this in a different way (e.g., in relation to Wulff (1991 / 1997) model of approaches to religion). In the discussion chapter of this dissertation we will reflect on the implications of these terms and definitions for future research.[3]

In the Netherlands, most spiritual caregivers work in healthcare settings (around 1200), the military (around 150), and penitentiary institutions (around 140) (Zock, 2019, p. 12). The organizational structure of spiritual care has its roots in the so-called 'pillarized' system. In the past century, each 'pillar' (e.g., Catholic, Protestant) used to have its own services (e.g., political party, hospital, school). Although this pillarization has nowadays largely diminished,

[3] The terms *religion, spirituality* and *faith* are also frequently used interchangeably with *culture* (e.g., (Ai & McCormick, 2010, p. 26; Anderson, 2004; Dijoseph & Cavendish, 2005, p. 147; Flohr, 2009; Hodge, 2004; MacLaren, 2004). People with the same culture indeed often share the same faith, but this is not always and certainly not necessarily the case. Therefore, we see these as two different constructs, and our research focus is specifically on those aspects of spiritual care provision that have to do with similarity and differences between spiritual caregiver and client regarding both their *faiths*.

the organization of spiritual care according to denominational lines still reflects these roots (Zock, 2019). Spiritual caregivers with authorization by a Catholic, Protestant, Humanist, or Jewish tradition were employed in organizations such as healthcare institutions, the military, and prisons. More recently, representatives from other traditions—Islam, Hinduism, and Buddhism—have been employed as well (Doolaard, 2006; Ganzevoort, Ajouaou, Van der Braak, De Jongh, & Minnema, 2014; Zock, 2019). Specifically, in military and penitentiary institutions, where the employment of spiritual caregivers is organized centrally, formal authorization by one of these traditions is a prerequisite for employment. Meanwhile, in healthcare settings, where the organization of spiritual care is decentralized (Ganzevoort et al., 2014), unaffiliated spiritual caregivers are being appointed to provide spiritual care as well[4] (Zock, 2019), which, to our best knowledge, seems to be a phenomenon only present in the Dutch context.

In practice, spiritual caregivers in such multifaith teams work in different ways. On the one hand, there are spiritual caregivers working in a so-called *categorical* mode or *faith-specific* manner, implying a team consisting of spiritual caregivers from various faith traditions, with each member caring for clients with the same faith (Eccles, 2014; Rennick, 2010). In such a situation, mainly same faith spiritual care encounters take place, e.g., a Protestant spiritual caregiver caring for a Protestant client, or a Muslim spiritual caregiver caring for a Muslim client. Also, the diversity of faiths present among clients is to be represented in spiritual caregivers' teams as much as possible. On the other hand, there are spiritual caregivers working in a *territorial* mode or *generic* manner, who provide spiritual care to everyone, regardless of their clients' faiths (Gatrad, Sadiq, & Sheikh, 2003). In a religiously pluralized society, this manner implies that *inter*faith encounters will often take place, in which spiritual care is provided to clients from another faith (Ganzevoort et al., 2014), such as a Catholic spiritual caregiver providing care to an agnostic client, or a Humanist spiritual caregiver caring for a Buddhist client. In the Netherlands, working in a territorial mode is common for many spiritual caregivers in healthcare settings (e.g., in hospitals).

[4] These unaffiliated spiritual caregivers are officially authorized by a council for non-denominational spiritual caregivers (RING-GV), that tests spiritual caregivers 'spiritual competency' (Zock, 2019, p. 15).

Methods

The main focus of this dissertation is on the role of faith differences in the *actual practices* of spiritual caregivers and, therefore, an empirical approach is used to answer the research questions. To investigate spiritual caregivers' practices, I conduct an interdisciplinary study, using theories and methods from the fields of psychology of religion, sociology of religion and organizations, and practical theology. My main interest is not so much on gaining in-depth knowledge on one person or case, as would be a common focus when using an idiographic approach, but rather to yield knowledge in breadth about many people regarding the role of faith differences in spiritual caregiving in general. Therefore, this study mainly uses a nomothetic approach (Paloutzian, 2017, pp. 110, 111) to study interfaith spiritual care. An implication of this focus is that most of the empirical studies conducted here use a quantitative research method (e.g., statistical analysis of responses to a survey) to study relatively large groups of respondents. However, this approach does not limit itself to such methods: when required for answering certain research questions—especially regarding practices of interfaith spiritual care (RQ4)—a qualitative research method (i.e. inductive analysis of audio-records) is used as well.

First, to investigate what is known about interfaith spiritual care and what central issues are at stake (RQ1), a systematic search of the existing literature is conducted to identify studies that address the topic of interfaith spiritual care. After identifying these studies, they are analyzed with regard to the central issues that are at stake in interfaith spiritual care, both in practice (based on 22 empirical studies) and in theoretical debate (based on 74 theoretical and conceptual studies).

Second, to examine spiritual caregivers' perspectives on interfaith spiritual care (RQ2), spiritual caregivers' perspectives are explored using quantitative survey data collected among 208 spiritual caregivers in Dutch healthcare settings, the military, and prisons. This survey focuses on questions relating to spiritual caregivers' perspectives on interfaith spiritual care. Statistical analyses are performed to draw conclusions about relationships between spiritual caregivers' perspectives and their personal and organizational characteristics. In addition, to deepen our understanding of spiritual caregivers' perspectives on interfaith spiritual care from a Buddhist, Muslim, and Hindu perspective, a lecturer and/or practitioner in each of these denominations reflects on their perspective, and similarities and differences between their perspectives are compared and discussed.

Third, to investigate clients' perspectives on interfaith spiritual care (RQ3), a quantitative survey is conducted among 209 clients and 45 spiritual caregivers in hospital

settings in the Netherlands. After encountering a spiritual caregiver, clients are asked to fill out a survey containing information about their evaluations of the encounter and the content of, activities during, and experiences with the encounter, as well as about their personal characteristics (e.g., gender, age, religious affiliation). Spiritual caregivers are requested to fill out a survey about their personal characteristics as well. I combine information from both clients and spiritual caregivers, and perform statistical analyses to test whether faith similarity between clients and spiritual caregivers relates to the evaluations of the encounter and to the content of, activities during, and experiences with the encounter. In addition, a relatively new phenomenon in the Dutch religious landscape is so-called 'multiple religious belonging' (Berghuijs, 2017), in which people combine elements from various religious traditions in their lives. To gain a better understanding of clients' perspectives on this form of religiosity, a quantitative survey is conducted among 472 visitors of Dominican spiritual centers in the Netherlands. Statistical analyses are performed to investigate differences between respondents who 'combine' and those who do not 'combine' elements from various religious traditions in their lives.

Finally, to explore what interfaith spiritual care looks like in practice (RQ4), audio records of 34 spiritual caregiver-patient interactions are collected and transcribed. These records include same as well as interfaith encounters. The analysis consists of an 'open-coding' phase in which inductive codes are used to identify communication techniques used by spiritual caregivers. This is followed by a process in which the codes are categorized and relationships between the codes are described in a matrix ('axial' and 'selective' coding (Boeije, 2012)).

Outline of this dissertation

This dissertation is divided into four main parts, relating to the four research questions.[5] Part I answers the question '*What is known about interfaith spiritual care and what central issues are at stake?*' by providing an overview of existing literature in the field of spiritual care in a religiously pluralized context. Based on a systematic review of the literature, chapter two describes findings from empirical studies conducted in this field over the past decade (2000-2016). It presents reasons for professional caregivers to (not) be willing to provide interfaith spiritual care, as well as reasons for them for (not) being able to do so. In chapter three, theoretical and conceptual studies identified in the systematic review are analyzed to provide

[5] Since chapters two to eight have been published or submitted to different journals, some of these chapters are written in British English and others in American English.

an overview of the different perspectives on integrating spiritual care in an interfaith context that exist in the literature. This chapter distinguishes four positions that represent different views on who should provide spiritual care and on what the role of caregivers' own faith is when providing spiritual care.

Part II focuses on the question '*What are spiritual caregivers' perspectives on interfaith spiritual care?*' Chapter four presents findings from a survey conducted among spiritual caregivers in the Netherlands, and it outlines their views about interfaith spiritual care provision. It also shows how their perspectives relate to their personal religious or spiritual orientation and to the organizational setting in which they work. Most respondents to this survey are authorized by a Protestant, Catholic, or Humanist institution, which are well-established in the Netherlands. Therefore, chapter five describes perspectives on spiritual care provision from a Buddhist, Muslim, and Hindu perspective, which are perspectives from faiths that are established more recently in Dutch spiritual care contexts and which are less well-represented in the survey. After outlining the particularities of spiritual care provision in each of these traditions, implications for spiritual care provision in an interfaith context are discussed and the three perspectives are compared to one another.

Part III answers the question '*What are clients' perspectives on interfaith spiritual care?*' Chapter six presents findings from a survey among clients in a hospital setting after they met with a spiritual caregiver. It investigates whether faith similarity in the chaplain-client interaction relates to clients' evaluations of spiritual care encounters and to the content of, activities during, and clients' experiences with these encounters. This study mainly focuses on faith (dis)concordance in relation to affiliating with *one* religious or Humanist tradition (such as a Muslim, Humanist, or no tradition), but does not investigate whether perspectives on *faith* may be more multifaceted. Therefore, chapter seven explores the phenomenon of *multiple* religious belonging. It does so by focusing on a specific sample in the Netherlands, namely visitors of Dominican spiritual centers. Based on survey data, this study describes how and why these visitors combine elements from various traditions in their lives, and how this relates to their views on religion, their (religious) networks, the sources they draw from, and their motivations to attend spiritual activities. Chapter seven thereby assists in deepening our understanding of clients' faith when these clients are not, or no longer, affiliated with *one* religious or Humanist tradition.

In part IV the question '*What does interfaith spiritual care look like in practice?*' is answered by presenting, in chapter eight, an analysis of records of conversations between spiritual caregivers and patients in hospital settings. This chapter describes communication

techniques used by spiritual caregivers to address existential themes in conversations with patients with various religious or spiritual orientations. The model presented outlines these techniques regarding the extent to which spiritual caregivers: a) comply with the patient's religious or spiritual orientation; and b) disclose their own religious or spiritual orientation.

In the final chapter, I present a general discussion of the findings, by synthesizing the findings and reflecting on the methods used. In addition, theoretical and practical implications of the study as well as directions for future research are discussed.

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