Interfaith spiritual care

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Part II

Spiritual caregivers' perspectives on interfaith spiritual care

II

Chapter 4. Spiritual care for everyone? Personal and organizational differences in interfaith spiritual care[8]

Abstract

In multicultural and multifaith societies spiritual caregivers increasingly meet clients with diverse (non-)religious or spiritual (R/S) orientations. We investigate how this religious and spiritual (R/S) diversity is dealt with by spiritual caregivers working in healthcare settings, the military and prisons. Based on a survey among spiritual caregivers (n=208) in a secularized, European country (the Netherlands), this study shows how spiritual caregivers' personal as well as organizational factors relate to attitudes to R/S diversity. Spiritual caregivers who draw from several religious traditions in their lives have more positive views on spiritual caregiving to patients with another R/S orientation than theirs than those drawing from none or a singular tradition. Furthermore, authorization by a religious or Humanistic institution seldom relates to how R/S diversity is perceived, but the position of spiritual caregivers within various organizational settings and the way in which spiritual caregivers work does.

Keywords

Spiritual Care; Interfaith; Religious Diversity; Multiple Religious Belonging; Organization

Introduction

Due to recent changes in the religious landscape of Western societies, professional spiritual caregivers who work in healthcare settings, the military or prisons often encounter people from a diversity of backgrounds. They meet people from a plurality of religious and cultural backgrounds (Vertovec, 2007; Woodhead, Partridge, & Kawanami, 2016; Ai & McCormick, 2010) as well as people who do not belong to an institutionalized religion and either have a purely secular life orientation or draw on new forms of spirituality (Heelas & Woodhead, 2005). However, such 'interfaith' spiritual care encounters have hardly been investigated empirically (Liefbroer, Olsman, Ganzevoort, & Van Etten-Jamaludin, 2017). How do spiritual caregivers deal with this religious and spiritual (R/S) diversity, and what factors influence their practice? This research focuses on spiritual caregivers' attitudes towards R/S diversity and investigates how individual as well as organizational factors (Cadge & Konieczny, 2014) relate to these.

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On an individual level, research among other professionals suggests that spiritual caregivers' personal R/S orientation plays a role in spiritual caregiving, as personal beliefs may influence whether and in what way R/S topics are addressed. For instance, more than half of the paediatric oncologists in a survey by Ecklund, Cadge, Gage, and Catlin (2007) thought their R/S beliefs influenced interactions with patients; Magaldi and Trub (2018) found that psychotherapists' self-awareness regarding their own R/S identity influenced the extent to which R/S self-disclosure took place during therapy; and Franzen (2016), based on a representative sample of physicians in the US, argued that the discussion of R/S topics depends on physicians' own R/S orientation. Yet it is seldom investigated how spiritual caregivers' personal R/S orientation relates to spiritual caregiving, especially when it comes to caring for patients or clients from a diversity of R/S orientations, including those who hold quite different R/S orientations than the caregiver does (Liefbroer et al., 2017).

On an organizational level, discussions in the literature about who should provide spiritual care—focusing on inter- and multidisciplinary issues (Handzo & Koenig, 2004; Harding, Flannelly, Galek, & Tannenbaum, 2008) as well as on inter- and multifaith issues (Gatrad, Sadiq, & Sheikh, 2003)—suggest that the way in which spiritual care is organized relates to attitudes towards R/S diversity as well. For instance, in some settings it is common to organize spiritual care according to specific units (e.g. in some military settings) or departments (e.g. in some hospital settings), thereby requiring spiritual caregiver to have an open attitude to R/S diversity as they care for all patients or clients of that area. In other settings it is common to assign patients or clients to a spiritual caregiver based on their R/S orientation (e.g. in some prisons or for specific groups of spiritual caregivers) (Ajouaou & Bernts, 2015; Gatrad et al., 2003), thus asking spiritual caregivers to mainly care for patients or clients with the same R/S orientation. This leads to the question how the organization of spiritual care influences the way in which R/S diversity is experienced and negotiated (Cadge & Konieczny, 2014; Cadge & Sigalow, 2013).

The aim of this study is to investigate the relation of both personal and organizational factors with spiritual caregivers' attitudes to R/S diversity. (How) do spiritual caregivers' personal religiosity and the organizational context relate to encounters that are religiously and spiritually diverse? As such encounters have hardly been investigated empirically and as quantitative research on this topic is lacking (Liefbroer et al., 2017), this research fills part of this gap by focusing, via a quantitative survey in the Netherlands, on spiritual caregivers working in various secular contexts (healthcare settings, the military and prisons).

Background and hypotheses

As in the larger Western world, the religious landscape in the Netherlands has diversified. While belonging to religious (Christian) communities has declined (e.g. church membership declined from 67% in 1966 to 32% in 2015 (Bernts & Berghuijs, 2016)), processes of immigration and multiculturalisation (Entzinger, 2003) lead to an increase of religious diversity. Moreover, hybrid forms of religiosity and 'multiple religious belonging'—a phenomenon in which people draw from various religious traditions in their lives (Cornille, 2002) and which is common for 17-23% of the Dutch population (Berghuijs, 2017)—make the religious landscape in the Netherlands even more diversified.

To answer our main research question we investigate whether multiple religious belonging among spiritual caregivers relates to attitudes to R/S diversity. We think of spiritual caregiving to a R/S diverse group of clients as 'interfaith spiritual care' (ISC), to refer to a situation in which the spiritual caregiver and the client clearly have a *different* R/S orientation, i.e. an Islamic spiritual caregiver caring for an agnostic client or a Humanist spiritual caregiver caring for a Protestant client. For attitudes to ISC we focus on the diversity of contacts spiritual caregivers have, their (positive or negative) views on ISC and their evaluations of ISC encounters. As we assume that spiritual caregivers who draw from various religious traditions in their own lives—to whom we refer as 'multireligious spiritual caregivers'—have encountered and explored different religious traditions and feel positive about those religions, they are expected to be more likely than others to be open to care for clients from various R/S orientations:

Hypothesis 1: Multireligious spiritual caregivers have more diverse contacts, hold more positive views on, and give a more favorable evaluation of ISC encounters than spiritual caregivers who do not draw from several religious traditions.

To study the organizational factors that relate to attitudes to ISC we focus on three key aspects—authorization (the official authority (or ordination) by a specific religious or Humanistic institution), sector and working mode. In the Netherlands, historically mainly spiritual caregivers with Catholic, Protestant and Humanistic authorization, alongside a small number of spiritual caregivers with Jewish authorization, were employed, while spiritual caregivers with Islamic, Hindu and Buddhist authorization only recently gained formal positions within organizations (Doolaard, 2006; Ganzevoort, Ajouaou, Van der Braak, De Jongh, & Minnema, 2014). Consequently, the first mentioned groups, and especially those with Catholic, Protestant and Humanistic authorization, often have stronger positions within

organizations than the second. For instance, within the military spiritual caregivers with Catholic, Protestant and Humanistic authorization are employed for more hours per week than spiritual caregivers with Islamic, Jewish and Hindu authorization (Bernts, Ganzevoort, Leget, & Wojtkowiak, 2014). We assume that, from an organizational point of view, the first mentioned groups—as they are historically the groups who together provided care to all clients—more often position themselves as spiritual caregivers who are open to caring 'for all clients', while those in the second mentioned groups more often position themselves as 'specialists' for clients with the same R/S orientation (Bernts et al., 2014; Doolaard, 2006).

Unaffiliated spiritual caregivers form an exception to this line of reasoning. Just as spiritual caregivers with Islamic, Hindu and Buddhist authorization, they only recently gained formal positions in organizations (Doolaard, 2006; Ganzevoort et al., 2014), yet while most spiritual caregivers are formally authorized by a religious or Humanistic institution, unaffiliated spiritual caregivers do not have—and often do not want—this authorization, as they are likely to see themselves as "existential counselors" for whom a "denominational bond" is not directly necessary nor needed (Zock, 2008, p. 138). Because unaffiliated spiritual caregivers strongly advocate that spiritual care is to be provided to clients regardless of their R/S orientation (Schouten, 2006), they are assumed to have a positive attitude towards ISC:

Hypothesis 2a: Catholic, Protestant, Humanist and unaffiliated spiritual caregivers have more diverse contacts, hold more positive views on, and give a more favorable evaluation of ISC encounters than Muslim, Jewish, Hindu and Buddhist spiritual caregivers.

In addition to differences in authorization, spiritual caregiving in healthcare settings differs greatly from other contexts, such as the military and prisons. Within healthcare settings spiritual care is often provided to clients regardless of their R/S orientation and being able to care for clients from a diversity of R/S orientations seems to be a necessity, for instance as it offers best funding-opportunities and legitimization of one's job position in these settings (Doolaard, 2006; Sinclair, Mysak, & Hagen, 2009). In contrast, within prisons and the military job positions are distributed according to denominational lines based on clients' R/S orientations and preferences (Ajouaou & Bernts, 2015; Bernts et al., 2014; Eerbeek & Van Iersel, 2009), thereby, again from an organizational point of view, limiting the necessity to be able and open to care for clients from various R/S orientations. We therefore hypothesize that:

Hypothesis 2b: Spiritual caregivers working in healthcare settings have more diverse contacts, hold more positive views on, and give a more favorable evaluation of ISC encounters than spiritual caregivers working in prisons and the military.

The third organizational key aspect is the way in which spiritual caregivers are requested to work—either in a 'categorical mode' for clients from the same R/S orientation or in a 'territorial mode' for clients regardless of their R/S orientation. Since spiritual caregivers working in a territorial mode have to be open to caring for clients from various R/S orientations and spiritual caregivers working in a categorical mode mainly have to focus on clients from the same R/S orientation, we expect that:

Hypothesis 2c: Spiritual caregivers working in a territorial mode have more diverse contacts, hold more positive views on, and give a more favorable evaluation of ISC encounters than spiritual caregivers working in a categorical mode, with those working in both modes somewhat in between.

Although from a theoretical and organizational point of view we make a distinction between three organizational aspects—authorization, sector, and working mode—in practice these often interrelate. For instance, spiritual caregivers who have Islamic, Jewish, Hindu and Buddhist authorization more often work in a categorical than territorial mode (Van Buuren & Van Dijk, 2006), a categorical mode is more common in prisons than in healthcare settings (Eerbeek & Van Iersel, 2009; Doolaard, 2006), and both modes are used within the military (Bernts et al., 2014). By distinguishing these three organizational factors from each other and by also investigating caregivers' personal (multiple) religiosity we aim to understand how each of these aspects separately relates to (or does not relate to) attitudes to ISC.

Method

Recruitment

In September and October 2016 an online survey was conducted among spiritual caregivers in healthcare settings, the military and prisons in the Netherlands.[9] An e-mail was sent out via the organization of spiritual caregivers in the Netherlands (the VGVZ) and via heads of spiritual care departments of the military and prisons, inviting about 1,100 spiritual caregivers to participate. The letter of invitation announced that the survey was on the topic of R/S diversity in participants' personal life and in their work, and that it was part of two research projects at the Vrije Universiteit Amsterdam: 'Interfaith Spiritual Care' (ISC) and 'Multiple Religious Belonging' (MRB). The survey took about 20 minutes to complete.

[9] In order to make the survey suitable for all participants, stakeholders / heads of departments of healthcare settings, the military and prisons were asked for feedback before data gathering took place.

Measures

Independent Variables

The measurement of participants' multiple religiosity is derived from research by Berghuijs (2017), in which multiple religiosity is understood as combining elements from more than one religious tradition. Participants indicated to what extent they agreed to the statement "I combine elements from different religious traditions / world views in my life", and, in case of agreement (either "yes, certainly" or "I think so"), reported from which religious traditions they combine elements. Participants choosing two or more religious traditions were classified as 'multireligious'. They could choose from Christianity, Islam, Judaism, Buddhism, Hinduism, Humanism and "other, please specify", and many religious traditions would count as "other" traditions, such as shamanism, Taoism and Shintoism, but with two restrictions. Firstly, 'intra religious' combinations were not counted as separate traditions (e.g. Protestantism would not count as an extra tradition when Christianity was already chosen). Secondly, Humanism—although understood as a *world view* —was not counted as a *religious* tradition to measure multiple religiosity (in line with Berghuijs, 2017). The option 'Humanism' was added to get an idea how often a Humanistic orientation is combined with a religious one. This was the case for 56% of the participants.

For organizational factors three variables were measured. Firstly, participants indicated whether they are authorized by a Protestant, Catholic, Humanist, Jewish, Muslim, Buddhist, or Hindu organization, and/or recognized by the RING-GV.[10] Secondly, participants indicated their sector choosing from healthcare settings, prisons, the military, or "other, please specify". Thirdly, participants indicated in which mode they worked, either territorial, categorical, territorial as well as categorical, or "other, please specify".

Participants' gender and age were included in the analysis to control for those demographic characteristics.

[10] The Dutch 'Stichting RING-GV' examines spiritual caregivers' competence, and although this organization does so independent of spiritual caregivers' R/S orientation, it is seen by the organization of spiritual caregivers in the Netherlands (VGVZ) as equivalent to religious or Humanistic authorization.

Dependent Variables

Participants indicated for nine different R/S groups how often they come into individual contact with those groups of clients on a scale from 1 to 5 (1=almost never; 5=nearly always).[11] The R/S groups were: people who do not have an explicit R/S orientation; Christians; Muslims; Jews; Buddhists; Hindus; Humanists; people who show they are inspired by more than one religious tradition; people who adhere to another (not specified) tradition. To measure the diversity of contacts, the R/S groups that participants meet at least 'sometimes' (a score of 2 or higher) were counted as '1' and others were counted as '0'. Then the scores for the R/S groups were added up and one variable was formed on a scale from 0 to 9 (0=meets clients from no R/S group at all; 9=(at least sometimes) meets clients from 9 different R/S groups).

Views on ISC were investigated both directly and indirectly. In a direct way, participants were asked: "Are you willing to provide spiritual care to people who clearly have another religious / spiritual orientation than yours?" and "Do you think you are able to provide spiritual care to people who clearly have another religious / spiritual orientation than yours?" (1=No; 2=No, but there may be exceptional cases; 3=Yes, but there may be exceptional cases; 4=Yes). In a more extensive, indirect way, views on ISC were measured using twelve statements—based on a systematic review (Liefbroer et al., 2017)—on a range from 1 to 5 (1=completely disagree; 5=completely agree). The first eight statements were about being *willing* (or not being willing) to provide ISC and the last four statements about being *able* (or not being able) to do so.[12]

Evaluation of ISC encounters was measured by asking participants to indicate how they perceive the appreciation of spiritual care by their clients on a range from 1 to 5 (1=very negative; 5=very positive), focusing on two groups of clients: 1) clients who have the same R/S orientation as the caregiver has; and 2) clients who clearly have another R/S orientation than the caregiver has. To adjust for individual differences in how appreciation was rated (e.g., some participants may overall give a more positive rating of appreciation of their care than others), evaluation of ISC encounters was based on the difference per participant between perceived appreciation by clients with another R/S orientation and clients with the same R/S orientation as the caregiver has. A positive score implies that participants evaluate their contacts with clients with another R/S orientation as more positive than their contacts with clients with the

[11] The options 'Don't know' and 'Not applicable' were also provided, but participants answering those options were either left out of the analysis (for calculating an overall mean score) or counted as '0' (for measuring the diversity of contacts).

[12] For statements, see *Results*, Table 3.

same R/S orientation. A score of zero means that the perceived evaluation of these contacts is exactly the same for clients with and without the same R/S orientation. A negative score indicates that participants' perceived appreciation is more positive for contacts with clients with the same R/S orientation than for contacts with clients with another R/S orientation.

Analysis

Linear regression analyses were performed to investigate whether the dependent variables relate to participants' personal and/or organizational characteristics. The key independent variables were included in the analysis as a set of categorical variables, with the largest group being used as a reference category. Reference categories were: multireligious for multiple religiosity; females for gender; participants between 46 and 59 years for age; Protestants for authorization; healthcare for sector; and working in a territorial mode for working mode. To examine the effect of authorization several groups were combined in the analysis, because participants were not equally distributed among the traditions and some groups were very small (n<10). Participants with an Islamic, Jewish or Buddhist authorization were taken together as the 'minority traditions' category and those without authorization and those recognized by the RING-GV as the 'unaffiliated' category.

Results

Sample

A total of 275 spiritual caregivers participated in the study. As a result of incomplete surveys and missing demographic characteristics, 24% (n=67) of participants are excluded from the analysis, leading to a response of n=208.[13] The majority of participants are women (59%) and the average age is 51 years (SD=9.79). Most participants (88%) have a Master or PhD degree. These demographic characteristics resemble those of the VGVZ (986 members; 83% of our sample are members of the VGVZ), where 64% are women, the average age is 54 years and most participants have a Master or PhD degree.[14]

[13] No indication of selectivity was found, as there were no differences between participants with complete and incomplete surveys on their views on religion. Specifically, both groups did not differ regarding their answers to the statements "For me, religion is something that is constantly changing during your life" ($chi^2(4)=6.66$; p=.16), "In my opinion, religion is a personal quest, in which you can combine elements from different religious traditions in your life" ($chi^2(4)=4.35$; p=.36), and "I combine elements from different religious traditions in my life" ($chi^2(3)=1.41$; p=.70).

[14] Data from the VGVZ were provided via personal correspondence (2017).

Descriptive Results

Independent Variables

A total of 74% agree to the statement "I combine elements from different religious traditions in my life", and 63% choose two or more religious traditions on the follow-up question—those 63% are referred to as the 'multireligious'. The difference between the two percentages is due to some participants choosing only one religious tradition (e.g. Christianity) on the follow-up question, or participants combining one religious tradition with Humanism. The combination of Christianity and Buddhism is most common (47% of the total sample), followed by a combination of Christianity and Judaism (38% of the total sample).

Most participants are authorized by a Protestant, Catholic or Humanist institution and a small percentage are authorized by an Islamic, Buddhist or Jewish institution (see Table 1). Some are recognized by the RING-GV or have no authorization or recognition. These numbers mainly reflect the characteristics of VGVZ-members. Most participants are employed in healthcare settings, which is also where most spiritual caregivers in the Netherlands work.

Some of the independent variables are related. For instance, sector and authorization relate, as participants authorized by an Islamic, Jewish or Buddhist institution mainly work in prisons, whereas participants from the military are either Protestant or Humanist. However, the relatedness between independent variables does not lead to a too high multicollinearity in the regression analyses (see the 'Multivariate Results' section), as neither of the Variance Inflation Factors (VIFs) yield high scores (all were below 3) (O'Brien, 2007).

Dependent Variables

On average, participants meet clients from five to six different R/S groups. Specifically, participants have most contact with 'people who do not have an explicit R/S orientation' and 'Christians', followed by 'people who show they are inspired by more than one religious tradition' (see Table 2). Participants meet clients who have a Humanistic orientation less often, followed by clients who have an Islamic orientation. Buddhist clients are met rarely, and Hindu or Jewish clients the least.

Nearly all participants are willing (96%)[15] and consider themselves able (95%)[16] to provide ISC. 1% are not willing to provide this care, or only in exceptional cases (3%), and 5% indicate that their ability to provide ISC is limited to exceptional cases. On the twelve

[15] 'Yes' (59%) and 'Yes, but there may be exceptional cases' (37%).

[16] 'Yes' (35%) and 'Yes, but there may be exceptional cases' (60%).

Table 1. Organizational Characteristics of the Sample and of the Organization of Spiritual Care Providers in the Netherlands (the VGVZ)[a]

		Sample (%, n=208)	VGVZ (%, n=986)
Authorization[b]	Catholic	16	30
	Protestant	36	42
	Islamic	3	2
	Jewish	1	1
	Buddhist	3	1
	Hindu	0	0
	Humanist	15	12
	Not authorized	19	-
	Recognized by RING-GV[c]	6	18
Sector[d]	Healthcare	78	-
	Prisons	10	-
	Military	7	-
	Other	5[e]	-
Working mode	Categorical	26	-
	Territorial	35	-
	Categorical and territorial	33	-
	Other	7[f]	-

[a]Data from the VGVZ, the Dutch organization of spiritual care providers, were provided via personal correspondence (2017).
[b]Three respondents were authorized by a Catholic or Protestant institution as well as recognized by the RING-GV. They are categorized as 'Catholic' or 'Protestant'.
[c]The RING-GV is a Dutch organization that examines spiritual caregivers' competence for those who are not authorized or ordained by a religious or Humanistic organization.
[d]Three respondents were employed in a healthcare setting as well as the military. They are categorized under the military, since this is the smaller group. Respondents who were employed in healthcare settings, prisons or the military and also chose 'other', were categorized under the first.
[e]E.g. "self-employed" or "street ministry".
[f]E.g. as "lecturer-supervisor", "self-employed", or "specialized".

Table 2. Frequency of Individual Contact with Clients from Various R/S Orientations (n=208)

Clients' R/S orientation	Mean[a]	SD
People who do not have an explicit R/S orientation	3.50	.92
Christians	3.36	.93
People who show they are inspired by more than one religious tradition	2.56	1.05
Humanists	2.31	.94
People who adhere to another (not specified) tradition	2.21	.96
Muslims	1.84	.85
Buddhists	1.61	.77
Hindus	1.45	.65
Jews	1.42	.71

[a]Statements could be answered on a range from 1 to 5 (1= almost never; 5= nearly always).

statements regarding ISC (see Table 3) results show that participants are most positive about the main goal of providing care to everyone, irrespective of someone's R/S orientation (statement 4) and about being open to people who clearly have a different R/S orientation than theirs (statement 3), while being least positive about the main goal of providing care to clients

with the same R/S orientation as theirs (statement 1). Most see possibilities to pray (statement 7) and practice rituals (statement 8) with people across their own R/S orientation, while a minority would only or mainly want to practice rituals with people who have the same R/S orientation as theirs (statement 6). Participants score relatively high on the estimation of their abilities to provide ISC, such as being able to connect (statement 11) and deal (statement 9) with people with another R/S orientation and being able to place their own R/S orientation into the background (statement 12).

The statements relate to each other (based on a principal components analysis, with Oblimin rotation), and three components can be distinguished of which the first accounts for 30%, the second for 15%, and the third for 12% of the variance. Statements about a *willingness* to provide ISC consist of two components. The first component—referred to as "universalism" (Liefbroer et al. 2017)—is about a willingness to provide spiritual care for everyone, irrespective of someone's R/S orientation (statement 3 and 4). The second component—referred to as "particularism" (Liefbroer et al. 2017)—includes statements that focus on the particularities of the own R/S tradition and a preference to provide spiritual care to those who share the same R/S orientation (statement 1, 5, 6, and 8). The third component—referred to as "competence" (Liefbroer et al. 2017)—has to do with the *ability* to provide ISC and includes statements about competences needed to provide ISC, such as having skills and knowledge to care for clients from various R/S traditions (statement 9, 10, and 11).[17] To test the hypotheses, a higher score on particularism is interpreted as being less positive about ISC, while higher scores on universalism and competence are interpreted as being more positive about ISC.

Overall, participants estimate that clients who have the same R/S orientation as theirs are positive about their work (M=4.34, SD=.51). The appreciation by clients who clearly have another R/S orientation is perceived positively as well (M=3.95, SD=.55), though significantly lower than the appreciation from clients with the same R/S orientation ($t(199)=8.31$; $p<.01$). Specifically, one-third of participants (33%) rate the appreciation by clients who clearly have another R/S orientation than theirs lower than by clients who have the same R/S orientation. For most participants (66%) the perceived appreciation does not differ between clients with and without the same R/S orientation.

[17] Alpha score is .64 for universalism; .62 for particularism; and .69 for competence.

Multivariate Results

Results of the regression analyses are presented in Table 4. In reporting the results, we focus on one personal or organizational characteristic at a time, and directly link the results to our hypotheses.

Hypothesis 1 was partly confirmed. In line with the hypothesis, multireligious participants hold more positive views on ISC encounters than participants who do not draw from several religious traditions. Specifically, they scored lower on particularism than the non-multireligious, while scoring higher on competence. However, they did not have more diverse contacts, and they did not evaluate ISC encounters more positively than non-multireligious participants.

Hypothesis 2a was not confirmed by the findings, since Catholic, Protestant, Humanist and unaffiliated participants did not have more diverse contacts, did not hold more positive views on, and did not give a more favorable evaluation of ISC encounters than participants of the minority traditions (with Muslim, Jewish, or Buddhist authorization). The only difference on authorization concerns unaffiliated participants who scored higher on universalism than Protestant participants, indicating that unaffiliated participants hold a more positive view on ISC than Protestant participants.

Hypothesis 2b was partly confirmed by the results. Participants working in healthcare settings indeed have more diverse contacts than those working in the military, and they do hold a more positive view on ISC than participants from prisons, as particularism is rated lower by participants in healthcare settings than in prisons. However, for evaluation of ISC encounters no differences were found between the groups, and for the diversity of contacts among participants from prisons the contrast of the hypothesis was found, as they report more diverse contacts than participants working in healthcare settings.

Hypothesis 2c was mainly confirmed. Participants working in a territorial and territorial as well as categorical mode indeed have more diverse contacts than participants working in a categorical mode, and they also evaluate ISC encounters more favorable. However, participants working in a territorial mode did not hold more positive views on ISC than participants working in a categorical mode.

Table 3. Components and Factor Loadings for Statements about ISC (n=208)[a]

Item	Statement	Mean[b]	SD	Component[c]	Factor loading
1	I think my main goal is to provide spiritual care for clients with the same R/S orientation	1.84	1.04	Particularism	-.56
2	I think it can be helpful to have a conversation with a spiritual caregiver who does not explicitly belong to the same R/S orientation	3.65	.94	-	-
3	From my R/S orientation I am open to people who clearly have another R/S orientation	4.50	.72	Universalism	.82
4	I think my main goal is to provide spiritual care to everyone, irrespective of someone's R/S orientation	4.53	.89	Universalism	.84
5	I am eager to share my R/S orientation with people who have another R/S orientation	3.12	.98	Particularism	-.69
6	I would only or mainly want to practice rituals with people who have the same R/S orientation as I have	2.57	1.07	Particularism	-.75
7	I see possibilities for prayer with people who clearly have another R/S orientation than I have	3.51	1.02	-	-
8	I see possibilities to practice rituals that cross borders of R/S orientations	3.83	.87	Particularism	.59
9	I am sufficiently skilled in dealing with people who clearly have another R/S orientation	3.87	.70	Competence	.84
10	I have sufficient knowledge of other R/S orientation	3.53	.76	Competence	.76
11	I am well capable of connecting with people who clearly have another R/S orientation	4.05	.57	Competence	.73
12	I am able to place my own R/S orientation into the background	4.11	.80	-	-

[a]Statements originally in Dutch, translated by AIL.

[b]Statements could be answered on a range from 1 to 5 (1=strongly disagree; 5=strongly agree).

[c]Three items are not included in one of the three components: item 2 has a communality of <.20; item 7 gives a biased impression of the results—respondents who have a Humanistic orientation respond differently than was intended with this item, i.e. for this group this item is an indication of a willingness to *pray* instead of an indication of a willingness to pray with clients with *another R/S orientation*; and item 12 does not belong to any of the components—or belongs to all of them (factor loading on component 1=.37; component 2=.32; component 3=.17).

Table 4. Regression Analyses for Diversity of Contacts, Views on ISC, and Evaluation of ISC (n=208)

			Diversity of Contacts		*Views on ISC: Particularism*		*Views on ISC: Universalism*		*Views on ISC: Competence*		*Evaluation of ISC*	
		Dummy:	B	SE	B	SE	B	SE	B	SE	B	SE
Constant			5.93	.30	-.34	.16	-.10	.17	.26	.17	-.16	.12
Personal characteristics	(Multiple) religiosity (H1)	Non-multireligious	-.27	.27	.28 *	.14	-.14	.15	-.38 *	.15	-.10	.10
		Multireligious	-	-	-	-	-	-	-	-	-	-
	Gender	Male	.17	.27	.26 +	.14	.10	.15	.10	.15	-.12	.10
		Female	-	-	-	-	-	-	-	-	-	-
	Age	Lower than 46	-.34	.32	.03	.17	.11	.18	-.41 *	.18	-.08	.12
		Between 46 and 59	-	-	-	-	-	-	-	-	-	-
		Higher than 59	-.53	.33	-.16	.17	-.17	.19	-.24	.18	.01	.13
Organizational context	Authorization (H2a)	Catholics	.24	.38	-.19	.20	.33	.21	.09	.21	.00	.14
		Protestants	-	-	-	-	-	-	-	-	-	-
		Minority traditions	-.39	.77	.24	.40	.09	.43	.32	.43	-.11	.29
		Humanists	-.10	.41	-.17	.22	-.01	.23	-.30	.23	-.14	.16
		Unaffiliated	-.36	.34	-.26	.18	.43 *	.19	-.20	.19	-.03	.13
	Sector (H2b)	Healthcare	-	-	-	-	-	-	-	-	-	-
		Prisons	1.63 *	.69	.86 *	.36	-.58	.39	-.33	.38	.17	.26
		Military	-1.30 *	.54	-.25	.28	.23	.30	-.15	.30	.22	.22
		Other	-.42	.59	.32	.31	-.72 *	.33	-.03	.33	.28	.23
	Working mode (H2c)	Categorical	-.72 *	.34	.20	.18	.11	.19	.30	.19	-.43 **	.13
		Territorial	-	-	-	-	-	-	-	-	-	-
		Categorical and territorial	.11	.30	.29 +	.16	-.01	.17	-.10	.17	-.14	.12
		Other	.74	.53	.45	.28	.08	.30	.49 +	.29	.24	.20
R^2			.16		.24		.11		.13		.11	

Note. +Significant at p<.10. *Significant at p<.05. **Significant at p<.01.

Discussion

The aim of this study was to investigate spiritual caregivers' attitudes to interfaith spiritual care (ISC) in relation to personal and organizational factors, and the results show that both factors do indeed relate to caregivers' attitudes to ISC. As hypothesized (H1), multireligious spiritual caregivers hold more positive views on ISC than the non-multireligious. Their lower score on particularism and their higher score on self-rated competence indicates that caregivers who draw from various religious traditions in their own lives may be more open to and capable of providing spiritual care to a R/S diverse client population.

The organizational context plays a role in attitudes to ISC as well, but not always as hypothesized. Authorization seems less related to ISC than expected (H2a). This may be due to a methodological limitation: since relatively few spiritual caregivers with an Islamic, Jewish or Buddhist authorization (and none with Hindu authorization) participated in this study, the possibilities of distinguishing among those groups and between them and other groups of spiritual caregivers are limited. However, it may also be due to our hypothesized model in which we assumed that Islamic, Jewish, Buddhist and Hindu spiritual caregivers would have a similar stance towards ISC. Instead, it may be that each group approaches ISC differently. For instance, perhaps Buddhist spiritual caregivers use meditation and yoga as a means to approach large groups of clients (Ganzevoort et al., 2014) instead of focusing primarily on clients with the same R/S orientation.

The sector spiritual caregivers work in relates to attitudes to ISC, and, as expected (H2b), in healthcare settings a more diverse group of clients is encountered than within the military, and participants in healthcare settings hold more positive views on ISC than participants working in prisons. Yet in contrast to our hypothesis, within prisons a more diverse group of clients is met than within healthcare settings. A possibility to account for this difference—supposing both settings to be equally R/S diverse—could be that both groups meet a variety of clients (e.g. during group activities and ceremonies), but that in prisons spiritual caregivers get to know their clients better—due to a longer stay—and are therefore more *aware* of clients' diverse R/S orientations than in healthcare settings and the military. Another explanation could be that within prisons the diversity among clients is higher than in healthcare settings, and that spiritual caregivers within prisons therefore meet a more R/S diverse group than within healthcare settings. However, to fully account for these differences further research is required, exploring spiritual caregivers' positions and clients' R/S orientations within the various sectors in more depth.

As hypothesized (H2c), spiritual caregivers working in a territorial mode indeed have more diverse contacts and give a more favorable evaluation of ISC encounters than spiritual caregivers working in a categorical mode. Only spiritual caregivers' views concerning ISC do not differ significantly between working modes. This suggests that the range of clients spiritual caregivers would like to care for or to whom they feel they are able to care for is not necessarily reflected in their actual practice.

Although this study is the first to quantitively investigate both personal and organizational factors in relation to spiritual caregivers' attitudes towards operating in a diversified religious landscape, a number of limitations have to be identified. In this study the measurement of clients' evaluation of spiritual care was limited, as caregivers were asked to estimate how clients would evaluate the care they provide. Although this does provide some indication of clients' evaluations, it is not as accurate as clients' own, self-reported, evaluations. Furthermore, few spiritual caregivers with an Islamic, Jewish or Buddhist authorization and none with Hindu authorization participated, thus limiting the possibilities of comparing these groups among themselves and with other groups of spiritual caregivers. Caution is needed when interpreting the results regarding prisons and the military and generalizing those to other spiritual caregivers in those sectors, as relatively few participants from these sectors participated. In addition, the finding that nearly all participants are willing and consider themselves able to provide ISC raises questions concerning the generalizability of the results to the total population of spiritual caregivers in the Netherlands. Since the topic of the survey was mentioned in the announcement, it seems reasonable to expect that spiritual caregivers who were positive about ISC and multiple religious belonging would have been more likely to respond, thus potentially causing a response bias. However, participants' demographic and organizational characteristics are comparable to the total population of spiritual caregivers in the Netherlands, suggesting that, based on those characteristics, there is some legitimacy in generalizing the results.

The results of this study evoke at least three questions for further inquiry, which are relevant for spiritual caregivers and other professional caregivers dealing with R/S diversity alike. Firstly, future qualitative studies should investigate the role of caregivers' personal R/S orientation in relation to spiritual caregiving in more detail. Does someone who draws from several religious traditions in his or her life provide spiritual care in another way than someone who draws from one religion or from no religion at all? And how do caregivers' personal R/S orientation relate to their role as professional caregivers? Secondly, as this study is based on cross-sectional data the causal direction of the relationship between attitudes to ISC and the

organizational structure of spiritual care cannot be ascertained and needs further exploration. Do spiritual caregivers choose a specific kind of organization because of their attitude to ISC, or do they develop their attitude while working in a specific organization and working mode? The same applies to the role of 'multiple religiosity' in this study. Should it indeed be treated as an independent variable, unrelated to the characteristics of one's organization, or is being (or not being) 'multireligious' rather dependent on the organizational setting and working mode? Thirdly, to understand the role of R/S diversity more fully it is necessary to investigate not only caregivers' but clients' perspectives as well. What are their preferences, for instance regarding spiritual caregivers' authorization? How do they evaluate ISC encounters?

This study provides new insights into spiritual caregivers' attitudes to caring for a diversity of clients while working in secular organizations within an increasingly complex and diverse religious landscape. It shows how caregivers' own personal religiosity and the organizational context relate to attitudes towards R/S diversity. These findings help us understand the way in which religion and religious diversity function in current Western societies and provides valuable information for discussions in the different sectors (healthcare settings, prisons and military) about optimization of the organization of spiritual care.

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