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Interfaith spiritual care

Liefbroer, A.I.

2020

document version
Publisher's PDF, also known as Version of record

Link to publication in VU Research Portal

citation for published version (APA)
Liefbroer, A. I. (2020). *Interfaith spiritual care*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

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Chapter 9. General discussion

Synthesis

This dissertation aimed to answer the question '*What is the role of faith differences in spiritual care provision?*' Starting from a systematic review of the literature, chapter two showed that empirical studies investigating interfaith spiritual care (ISC) interactions are scarce, and that, of the twenty-two studies identified, a majority is conducted in North America, uses qualitative methods and focuses on professional caregivers with a variety of professional and spiritual backgrounds. Based on these empirical studies, we identified various reasons for (not) wanting to provide ISC ('normativity'). These included a universalist approach in which the caregiver's identity is characterized by an open attitude to a variety of faiths, and a particularist approach characterizing the caregiver's identity by a clear connection to a particular faith. Also, we identified reasons for (not) being able to provide ISC ('capacity'). These encompassed the competences that health care professionals may need when providing ISC, such as strategies and knowledge of various faiths, as well as contextual possibilities and restraints, such as language differences and institutional funding. The reasons for (not) wanting to provide ISC were further examined in chapter three, in which four positions regarding the integration of spiritual care into healthcare were distinguished. These positions are described following two central questions: a) Who should provide spiritual care? and b) What is the role of caregivers' spirituality when providing spiritual care? Based on these two questions, there are generalist-particularists who see the spiritual domain as a field to be addressed by all professional caregivers and in which caregivers' own spiritual orientations play a vital role; generalist-universalists who advocate for all caregivers to provide spiritual care regardless of these caregivers' spiritual orientations; specialist-particularists who argue that experts should address the spiritual domain in light of their own spiritual orientations; and specialist-universalists who call for experts to provide spiritual care regardless of their spiritual orientations. Each of these positions give different weight to the professional, personal, and confessional roles of the spiritual caregiver, and each position has different implications for integrating spiritual care in a situation with many religious and spiritual differences between caregivers and clients. Based on this line of thought, one of the questions raised was how caregivers and clients perceive spiritual care encounters when they share the same faith compared to when they hold different faiths.

Chapter four investigated spiritual caregivers' perceptions on such issues. Based on a survey among 208 spiritual caregivers in the Netherlands, this study showed that spiritual

caregivers overall are willing and feel able to provide spiritual care to those holding a different religious or spiritual (R/S) orientation than their own. Also, spiritual caregivers estimate that both clients who have the same R/S orientation as well as those clients who clearly have a different R/S orientation as theirs are positive about their work. However, they estimate that this appreciation is significantly lower in the group that differs from themselves than it is in the group that has the same R/S orientation as theirs. Furthermore, this study reported 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 clients with another R/S orientation than theirs than those drawing from none or a single tradition. Authorization by a religious or Humanistic institution seldom relates to how R/S diversity is perceived. Rather, it is the position of spiritual caregivers within various organizational settings and the way in which spiritual caregivers work that matters. Since spiritual caregivers from a Buddhist, Muslim, and Hindu tradition were few or absent in the conducted survey, chapter five described, based on theoretical reflections, perspectives on interfaith spiritual care from each of these traditions. Although the faith-specific content of each tradition differs, the roles and practices of spiritual care provision show several parallels in the way in which spiritual care from each of these traditions is performed. From a Buddhist perspective providing interfaith spiritual care seems to have been common practice from its origin, whereas spiritual caregiving from an Islamic and Hindu perspective primarily focused on adherents of the same faith tradition. However, possibilities for interfaith spiritual care provision are identified within these perspectives as well.

In addition to studying caregivers' perspectives, chapter six and seven investigated clients' perspectives on interfaith spiritual care. Through a survey among 209 clients and 45 chaplains in hospitals in the Netherlands, chapter six showed that faith (dis)concordance in the chaplain-client interaction does not significantly relate to clients' evaluations of spiritual care encounters. In other words, clients evaluated interactions with chaplains who affiliated with a different faith tradition equally positive as interactions with chaplains who shared the clients' faith. Furthermore, whether clients affiliated with the same or a different faith as the chaplain did not significantly matter for the way in which they experienced the chaplain (i.e., as spiritual guide, counselor, or companion) nor for the activities that took place during the conversation (e.g., listening, speaking, praying, performing rituals). Also, we did not find empirical evidence that clients in same faith encounters discussed ultimate concerns more often than when in faith discordant encounters. Chapter seven further examined the notion of *interfaith* encounters by describing an exploration of the phenomenon of 'multiple religious belonging'; a phenomenon

identified among around 17-23% of the Dutch population (Berghuijs, 2017) in which people combine elements of various religious traditions in their lives. This exploration was conducted to gain more insight into multifaceted perspectives on *faith*, and into the variety of sources that may be important to clients drawing from such diverse traditions. Data for this exploration were collected among a sample of people who were likely to draw from various religious traditions in their lives. Based on a survey among 472 visitors of Dominican spiritual centers in the Netherlands, this study reported that visitors who combine elements from more than one religious tradition ('combiners') are more likely than 'non-combiners' to: a) see religion as something that is constantly changing during the life course; b) have networks which are religiously diverse; c) place importance on nature, in-depth conversations, personal rituals or practices, and theological, philosophical, and spiritual texts as resources; d) be motivated to attend spiritual centers because of a focus on self-exploration. This study suggests that, for these visitors, their faith develops in a personal and dynamic way, in which a variety of sources may be drawn from, including religious and non-religious or secular ones.

Finally, in chapter eight, the encounter between client and spiritual caregiver was explored through observational research. Based on an analysis of audio records of 34 spiritual caregiver-patient interactions, this chapter described communication techniques used by spiritual caregivers to address existential themes in conversations with patients with various R/S orientations. A model with four quadrants was developed that describes these communication techniques according to two aspects that are particularly relevant. The first regards the extent to which spiritual caregivers comply with the patient's R/S orientation. These include confirming techniques, such as agreeing to and complimenting the patient's R/S orientation, or questioning techniques, such as asking in-depth or critical questions. The second concerns the extent to which spiritual caregivers disclose their own R/S orientation. These include techniques in which the spiritual caregivers' R/S orientation is disclosed, for instance by emphasizing commonalities or differences and by sharing narratives, and communication techniques that do not disclose this, such as by listening or paraphrasing. Overall, communication techniques from all four quadrants were used by spiritual caregivers, both in same and interfaith encounters. This suggests that a similar set of communication techniques is used when spiritual caregivers encounter patients with the same and with a different R/S orientation as theirs.

To conclude, the answer to the question '*What is the role of religious and spiritual differences in spiritual care provision?*' is a multifaceted one. Based on existing literature (chapters two and three), two main positions were distinguished. For those holding a

particularist view on spiritual caregiving, a caregiver's own religious or spiritual orientation is important for providing spiritual care, and, consequently, plays an important role for spiritual care in an interfaith context. By contrast, for those holding a universalist view on spiritual caregiving, generic, universal aspects of spiritual caregiving are focused on, and the caregiver's own religious or spiritual orientation is of much less importance for the practice of interfaith spiritual care. The survey among Dutch spiritual caregivers (chapter four) suggested that—although there are differences with regard to spiritual caregivers' personal and organizational characteristics—most spiritual caregivers are willing and feel able to provide spiritual care to those having a different religious or spiritual orientation than their own. Also, the exploration of Buddhist, Muslim, and Hindu perspectives suggested that there may be opportunities for providing interfaith spiritual care by spiritual caregivers within these traditions as well (chapter five). The examination of clients' perspectives showed that, overall, clients' appreciation of the spiritual care encounter and the shape of these encounters did not depend on whether these clients affiliated with the same or a different faith as their spiritual caregiver (chapter six). This may be explained by the finding that, for many, faith evolves in dynamic ways, and they may draw from a variety of sources rather than from one religious tradition (chapter seven). In the interaction between clients and spiritual caregivers (chapter eight), no obvious differences with regard to spiritual caregivers' communication techniques were identified. Therefore, this dissertation suggests that, although religious and spiritual differences may play a role with regard to certain faith-specific roles and acts, in most spiritual care practices religious and spiritual differences with regard to spiritual caregivers' and clients' religious affiliation play a minor role.

There are at least three ways to interpret these findings, which may complement one another. First, these findings could indicate that religion and spirituality in relation to faith traditions are not (or no longer) of much importance for the practice of spiritual care, for instance because spiritual care in pluralized and secularized society is about existential themes in a broader sense—I reflect on this line of thought in the section on theoretical implications below. Second, these findings may indicate that spiritual caregivers usually deal with religious and spiritual differences without difficulty by addressing existential themes in a general rather than faith-specific manner—an explanation I will discuss in the section on practical implications. Third, as these findings are based on few empirical studies conducted in this field thus far, and since these have their own methodological strengths and weaknesses, a final explanation is that these findings may in part be due to methodological limitations of this study—an issue I will reflect upon in the section on methodological strengths and limitations

of this study's design. I will end this general discussion by providing an overall conclusion to the thesis.

Theoretical implications

As noted in the introduction, spiritual care concerns "*professional support, guidance and consultancy regarding meaning and belief systems*" (VGVZ, 2015, p. 7). In doing so, and as described in chapters three and six, spiritual caregivers often function according to three main roles: (a) as a professional caregiver or counselor, (b) as a confessional caregiver or spiritual guide, and (c) as a personal caregiver or companion (Bidwell & Marshall, 2006; Ganzevoort & Visser, 2007; Heitink, 2001). Although these roles are derived primarily from research on spiritual caregivers from Christian backgrounds, we see these roles paralleled in descriptions of Buddhist, Muslim, and Hindu spiritual care as well (chapter five). On a theoretical level, the findings of this dissertation challenge the role of the spiritual caregiver as a spiritual guide and, as a consequence, the character of spiritual care provision as a religious practice.

Specifically, the overall findings of this study suggest that in most spiritual care practices the evaluation of the spiritual care encounter by the client does not depend on whether the spiritual caregiver affiliates with the same faith tradition as the client or not (chapter six). Furthermore, the role of the spiritual caregiver as companion seems to be the most central role, and the role as spiritual guide (and counselor) seems to be less central in the way in which clients perceive the spiritual caregiver. In addition, the survey of clients' perspectives showed that performance of faith-specific acts such as rituals and prayers are relatively rare in practices of health care chaplaincy compared to more generic acts such as talking and listening to one another. Also, the content of these spiritual care encounters is more often about issues that touch upon things that matter to the client's personal life, how they emotionally or mentally feel, their family business and/or friendships, and their life stories, and less often about issues relating to their faith tradition (see Appendix 3C).

These findings suggest that, in spiritual caregiving, the 'spiritual domain' of meaning and beliefs systems covers a broad array of existential themes that are addressed in various ways. An emphasis on themes central to faith traditions may be one of these ways, but not the most important one. This is in line with the notion that chaplaincy has moved from a "*religious model*" to a more "*existential model*" of care (Stifoss-Hanssen, Danbolt, & Frøkedal, 2019). Rather than defining chaplains' main task in terms of providing religious support and services, chaplains seem to understand their task as contributing to clients' overall health and wellbeing, by addressing their needs "*for meaning, existential and spiritual support, and comfort*" (p. 65).

This broadening of the self-understanding and practice of spiritual caregivers from a rather strict focus on a religious model to a more inclusive existential model can be placed in light of the broader trend of secularization and deinstitutionalization within Western-European contexts. Within the changing field of religion and spirituality, the boundaries of the religious, the spiritual, and the secular have become increasingly blurry (Ammerman, 2013; Taylor, 2007; Woodhead, Partridge, & Kawanami, 2016). My exploration of multiple religious belonging emphasizes this 'blurring of boundaries'. In the context of the Netherlands, many people draw from a variety of sources in their lives (Berghuijs, 2017), and these may include religious as well as non-religious ones, such as nature, in-depth conversations, personal rituals or practices, and theological, philosophical and spiritual texts (chapter seven). Therefore, in addition to challenging the character of spiritual care as a religious practice, this study also challenges the notion of *interfaith*: when both clients and spiritual caregivers[59] draw from a variety of (religious and non-religious) sources, it could be argued that all encounters are (at least somewhat) interfaith. This would make interfaith an intrinsic aspect of all spiritual care provision, in which the spiritual caregiver assists the client in processes of meaning-making that encompasses a dialogue between a variety of sources. Future studies are needed to more extensively examine the changing face of the religious landscape in secularized and pluralized contexts, and the consequences of these changes for spiritual care provision. In particular, it would be important to explore the ways in which those who do not affiliate with traditional religions reflect upon existential issues and spiritual themes.

Practical implications

The findings of this study have practical implications as well, and I will discuss these in relation to the practices of spiritual caregivers, to the institutional organization of spiritual care, to the authorization of spiritual caregivers, and, finally, to the education of (future) spiritual caregivers. For each of these actors, this dissertation's findings have different implications.

First, regarding practices of interfaith spiritual care provision, this study suggests that spiritual caregivers are overall willing and feel able to provide interfaith spiritual care (chapter four). This view is confirmed from the client's perspective (chapter six). However, when examining the practices and content of spiritual care encounters as reported by clients (chapter six), and the communication techniques used in encounters (chapter eight), it becomes clear

[59] The survey among Dutch spiritual caregivers (chapter four) showed that 63% of respondents combine elements from two or more religious traditions in their lives.

that it remains a challenge to sufficiently address clients' *faith-specific* needs. In their study of interfaith practices in a hospital in the US, Cadge and Sigalow (2013) differentiate between communication techniques aimed at "*neutralizing*" and "*code-switching*". Neutralizing includes using "*a broad language of spirituality that emphasizes commonalities rather than differences*", whereas code-switching includes using "*the languages, rituals, and practices of the people with whom they [spiritual caregivers] work*" (p. 146). The findings of this dissertation suggest that spiritual caregivers mainly use the first strategy, by addressing existential themes in a broad sense, whereas the second strategy, including practicing faith-specific acts such as rituals, seems to be quite rare. Although such a strategy may work well for most clients, for some—e.g., for those drawing from one or more traditions the spiritual caregiver is not familiar with (Abu-Ras & Laird, 2011; chapter seven)—it may work less well. Furthermore, if faith-specific acts and content are not (or no longer) a central part of spiritual care provision, another, related, challenge is how to position spiritual caregivers in such a manner that they are clearly distinguished from other professionals (e.g., psychologists, social workers, counselors; chapter three). This may require (further) developing and articulating spiritual caregivers' expertise in addressing existential themes and questions of meaning in a broad sense, while also equipping spiritual caregivers with sufficient knowledge and skills to address clients' diverse faith-specific needs.

Second, in relation to institutions, this study raises questions concerning the so-called 'pillarized system' used for spiritual care provision, which is mainly reflected in the centralized organization of employment within the Dutch military and prison system (Ganzevoort et al., 2014; Zock, 2019). In this system, only spiritual caregivers with a formal affiliation to certain traditions are employed, and—especially in the prison system—spiritual care is mainly provided to those clients adhering to the same tradition as the spiritual caregiver (Ajouaou & Bernts, 2015; Eerbeek & Van Iersel, 2009). Chapter four shows that spiritual caregivers working in a territorial mode and/or in healthcare settings are more positive about interfaith spiritual care provision than those working in a categorical mode and/or in prisons. These differences in perspectives on interfaith spiritual care yield questions about how to organize spiritual care in such a way that clients' diverse religious and spiritual needs are fully addressed. Specifically, these findings call for reflection on the organization of spiritual care. The key issue is how spiritual care should be organized so that sufficient attention is being paid to the spiritual needs of clients (a) who do not belong to a religious tradition, (b) who belong to a minority tradition (Beckford, 2015), and (c) who draw from a variety of religious traditions or sources

(chapter seven). This is particularly a challenge for those institutions that are (still) organized along denominational lines.

Third, for the authorization of spiritual caregivers by religious or Humanist institutions ('*zendende instanties*' in Dutch), this study calls for a rethinking of the role of the spiritual caregiver as confessional caregiver or spiritual guide (chapter three and six) as part of their professional identity. In the Dutch context, most spiritual caregivers are ordained or authorized by a religious or Humanist institution[60] and function as representatives of that tradition. However, the empirical findings of this dissertation showed that the views towards interfaith spiritual care provision by spiritual caregivers from various authorizations do not differ much (chapter four), and that most spiritual caregivers see possibilities for caring for clients with a different faith than their own.[61] Also, from a client's perspective, the evaluation of spiritual care encounters does not depend on whether the spiritual caregiver affiliates with the same or a different faith tradition (chapter six). Therefore, the empirical findings of this study suggest that in practice no clear differences are found with regard to spiritual caregivers' authorization. This challenges the importance of spiritual caregivers' authorization for the performance and identity of their profession. Specifically, it questions what the precise role and function of the spiritual caregivers' authorization is for spiritual care provision in a pluralized and secularized context as the Netherlands. The model provided in chapter three—which distinguishes four different ways of addressing the spiritual domain that each imply a different view on the caregiver's role—may create a useful framework for rethinking such a question.

Finally, this study has three types of practical implications for the education of future spiritual caregivers. First, this study suggests that spiritual caregivers need to be trained in general skills to provide spiritual care to a broad client population. The communication techniques identified in chapter eight suggest that spiritual caregivers use a variety of techniques in their daily practice, and making the acquisition of such skills a compulsory element of the curriculum may assist them in addressing clients' diverse needs. Second, if spiritual caregivers are to provide spiritual care with faith-specific content and acts to their clients as well (see above), this requires education in which such faith-specific skills are taught. When considering the changing field of religion (in which the boundaries between traditions and between the religious and the secular are blurring (Ammerman, 2013; Taylor, 2007; Woodhead, et al. 2016)), this requires learning not only about spiritual caregivers' *own*

[60] Unaffiliated spiritual caregivers form an exception to this (Zock, 2019).

[61] From a Buddhist, Muslim, and Hindu perspectives, possibilities for interfaith spiritual care are identified as well (chapter five).

tradition, but learning about a *variety* of other traditions and secular sources as well. Doing so may create possibilities for spiritual caregivers not to limit themselves to "*neutralizing*" strategies, but also to apply forms of "*code-switching*" in their interfaith practice (Cadge & Sigalow, 2013).[62] Third, the findings from chapter six showed that one important factor defining clients' appreciation of spiritual care encounters is clients' educational level. The lower this educational level, the less they appreciate the spiritual care encounter. Therefore, teaching spiritual care should imply a reconsideration of how well the methods learned serve this group of lower-educated clients, in order for spiritual caregivers to be(come) able to provide spiritual care to clients from a variety of religious and spiritual orientations as well as educational levels.

Methodological strengths and limitations

This is one of the first studies to investigate the practice of interfaith spiritual care in a Western-European context using an empirical approach. Its design included perspectives from various views and methods. Literature review studies were used to provide state-of-the-art overviews from an empirical and theoretical point of view, and quantitative as well as qualitative research methods were used to collect relevant data. Perspectives from spiritual caregivers from various traditions (e.g., respondents from Catholic, Protestant, Humanist traditions) as well as from caregivers and clients were included, as were perspectives from various working settings (healthcare, military, prisons). Therefore, a major strength of this study is that it provides a rich and multifaceted picture of interfaith spiritual care in the Netherlands and beyond.

Meanwhile, there are limitations to the methods used as well, and—in addition to the limitations discussed in each of the chapters themselves—here I will discuss some of them that require future research. First, since the empirical data for this dissertation has been collected in the Netherlands, questions arise concerning the relevance and applicability of this study's findings for other contexts. To the extent that other countries, such as other European countries, but also the US and Canada, are pluralizing and secularizing, this dissertation's theoretical and empirical findings have relevance for these contexts as well. However, whether the same empirical findings will also be applicable to other countries remains to be seen. For instance, this dissertation showed that clients' evaluations of spiritual care encounters do not differ between same and interfaith encounters (chapter six). Yet in contexts where the society is less

[62] In both the Netherlands (Ganzevoort et al., 2014) and Norway (Grung & Bråten, 2019) initiatives are undertaken to implement both these general and faith-specific aspects in educational programs for spiritual caregivers.

pluralized, or where pluralization of the organizational structure (e.g., spiritual caregivers working in a territorial mode for all clients regardless of their faiths) is less common, clients may respond differently to such encounters. Therefore, future research should examine the extent to which these findings are applicable to the practice of spiritual care in other contexts.

Second, one of the major limitations of this study is that the empirical studies conducted among both clients and spiritual caregivers (chapter four, six, seven, and eight) mainly included respondents with Protestant, Catholic, Humanist, and unaffiliated orientations, and some respondents from Muslim orientations. To account for other perspectives, e.g., Buddhist and Hindu, chapter five described these perspectives from a theoretical point of view, but it would be important to supplement these theoretical views on interfaith spiritual care with empirical research on spiritual caregivers and clients from these underrepresented faith traditions. In addition, perspectives from other faith traditions, such as Jewish, Orthodox and Pentecostal ones, are nearly absent. Since rituals may play an important role in spiritual caregiving in these traditions, empirical research on these traditions may be especially relevant for the investigation of interfaith spiritual care practices.

Third, although the sample sizes of the studies included in this dissertation were sufficient for a first exploration of interfaith spiritual care, the sample sizes may not always have been large enough to identify more fine-grained but still important differences between groups of respondents. For instance, in chapter four, 208 spiritual caregivers responded to the survey; although this sample size was large enough to draw general conclusions, future studies should include larger samples to also differentiate between respondents from various denominations (e.g., by examining perspectives from respondents from Muslim, Buddhist and Jewish traditions separately rather than jointly). Also, in chapter eight, 34 records of conversations were analyzed, and the comparison between same and interfaith encounters regarding conversation techniques did provide relevant insights, but comparing these encounters more thoroughly would require larger sample sizes.

Fourth, in many instances, no validated instruments were available to measure constructs (chapter four, six, and seven). Therefore, some of these instruments were developed for this study's purpose alone (e.g., a measurement for particularism and universalism; clients' experiences with, activities during, and content of spiritual care encounters; sources of meaning relevant for investigating 'multiple religious belonging'). Using factor analysis, we explored the reliability of these constructs. However, for future research it is advisable to further develop these instruments to assure they are reliable and valid instruments to measure each construct.

Conclusion

This dissertation investigated the role of religious and spiritual differences in spiritual care provision in a pluralized and secularized Western-European society. Overall, the findings of this study suggest that religious and spiritual differences between clients and spiritual caregivers with regard to religious affiliation play a minor role. In most spiritual care practices clients appreciate the care they receive regardless of whether this is a same or interfaith encounter, and spiritual caregivers use similar conversation techniques in each type of encounter. These findings indicate that religion and spirituality in relation to faith traditions are not (or no longer) of central importance to the practice of spiritual care, for instance because spiritual care in pluralized and secularized society is mainly about existential themes in a broader sense. Also, it suggests that spiritual caregivers usually deal with religious and spiritual differences without difficulty by addressing existential themes in a general rather than faith-specific manner.

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