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Part III

Clients' perspectives on interfaith spiritual care

III

Chapter 6. Does faith concordance matter? A comparison of clients' perceptions in same versus interfaith spiritual care encounters with chaplains in hospitals[24]

Abstract

In religiously pluralized societies, caregivers frequently care for patients or clients with a religious, spiritual or secular orientation that differs from their own. Empirical studies exploring the implications of this faith diversity for spiritual care interactions between caregivers and clients are scarce. Some literature suggests that similarities in faith orientation between caregivers and clients relate to better professional caring relationships than encounters with dissimilar faith orientations, while other studies suggest that faith similarities do not, or only under certain conditions, relate to the way in which professional caring relationships are perceived. This study supports the second line of thought: based on a survey among 209 clients and 45 chaplains in hospitals in the Netherlands, it shows that clients in faith concordant encounters evaluate the spiritual care encounter just as positively as do clients in faith discordant encounters. This is in line with broader trends of secularization and blurring of boundaries between the religious, spiritual and secular domains.

Keywords

Religion, Spiritual Care, Diversity, Clients, Concordance

Introduction

Diversity is often framed—in scientific literature and in popular debates alike—as something that is challenging, especially when it comes to religious diversity (e.g., Becci & Roy, 2015; Brown & Brown, 2011; Fawcett & Noble, 2004). As such, many argue that specific skills are needed to interact fruitfully with one another in interfaith encounters, and initiatives are undertaken to equip professionals in multifaith and multicultural settings to develop such skills (Anderson, 2004; Flohr, 2009; Ganzevoort, Ajouaou, Van der Braak, De Jongh, & Minnema, 2014; Lartey, 2003). Apparently, when religion is discussed or performed outside of congregations and in interaction between people with different religious or secular worldviews, specific attention needs to be drawn to how such interactions take shape.

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Meanwhile, scholars argue that religion becomes increasingly pluralized in Western societies, leading to a blurring of boundaries between religious, spiritual, and secular (Ammerman, 2013; Taylor, 2007; Woodhead, 2016). While some adhere to one religious tradition without self-identifying as spiritual, others identify as spiritual and religious, or as spiritual but not religious, or secularized, or as belonging to various religious traditions. This situation led us to question how to think of religion and religious differences in interactions where a person's religious, spiritual or secular (R/S) orientation is relevant, such as in spiritual care interactions in hospitals—an "edge" where religion is visible in secular organizations outside of congregations (Bender, Cadge, Levitt, & Smilde, 2013; Cadge & Konieczny, 2014). Understanding the dynamics of interfaith spiritual care encounters and the way in which religious differences are negotiated may function as "analytic starting points" to reconsider how to think theoretically about religion in secular contexts (Cadge & Sigalow, 2013, p. 157).

Our interest in these interactions is twofold: first, we are interested in whether (and if so, under what conditions) religious differences relate to the way in which such interactions are perceived or *evaluated*; and, second, we aim to investigate whether religious differences relate to how these spiritual care interactions are *shaped* in secularized and pluralized contexts. Chaplains form our main focus in this regard. Being experts in spiritual care provision, they frequently meet people with all kinds of worldviews—religious, spiritual and secular—(Cadge, 2012, p. 13), and form an excellent case to study the relationship between faith concordance and the way in which spiritual care encounters are evaluated and take shape. Chaplains often formally affiliate with a religious or Humanistic tradition, thereby representing that specific tradition, while at the same time working in and being employed by a secular organization (Ganzevoort et al., 2014; De Groot, 2018; Swift, 2013). By their presence, they thus function on behalf of both the traditional and the secular, which raises questions about their professional identity as being religiously authorized (Swift, 2013). When in interfaith encounters, where a shared R/S understanding is lacking, how do these chaplains negotiate religious differences between themselves and their clients (Cadge & Sigalow, 2013), and how is this perceived by clients?

Empirical research investigating clients' perspectives on same and interfaith encounters in spiritual care is scarce: in a systematic review of the literature, five studies were identified that focus on this perspective (Liefbroer, Olsman, Ganzevoort, & Van Etten-Jamaludin, 2017). These studies offer different suggestions regarding the role of faith concordance for perceptions of spiritual care encounters: while some suggest that same faith relates to more positive perceptions of spiritual care than interfaith encounters (Ellis & Campbell, 2005; Hodge & Lietz,

2014), others suggest quite the opposite (Mayers, Leavey, Vallianatou, & Barker, 2007; Pesut & Reimer-Kirkham, 2010) (we will explore this in more detail below). Since these studies used qualitative methods exploring clients' perspectives, to our knowledge no study has been conducted empirically *testing* the relationship between faith concordance and evaluations and shapes of spiritual care encounters.

In this study, the role of religious diversity (same versus interfaith encounters) is investigated in chaplain-client interactions via a quantitative survey among 209 clients and their caregivers (n=45) in hospitals in a multifaith, European country, the Netherlands. As in other Western countries, the population of the Netherlands is highly secularized and pluralized in terms of religion, with many not (or no longer) adhering to a religious tradition (53%), and others belonging to a variety of Christian denominations (22% Roman-Catholic; 15% various Protestant denominations), Islam (5%), or other religious traditions (5%) (CBS, 2018), and/or combining elements from various traditions altogether (17-23%) (Berghuijs, 2017). This diversity is reflected in chaplains' authorizations: while some are registered as unaffiliated chaplains, others are ordained by or formally affiliated with a Protestant, Catholic, Muslim, Jewish, Buddhist, Hindu, or Humanistic organization (Ganzevoort et al., 2014; Zock, 2019). Since in Dutch hospitals chaplains often work in a 'territorial mode' caring for all clients of a certain unit, they are likely to meet clients adhering to a variety of religious traditions as well as to no tradition (Liefbroer & Berghuijs, 2019). First, we focus on religious diversity in relation to the way in which spiritual care encounters are evaluated, and explore the conditions under which this may play a role (e.g., is faith concordance only relevant for certain clients or for certain chaplains?). Second, we investigate religious diversity in relation to how spiritual care encounters take shape, specifically regarding clients' experiences with, the activities during, and the content of spiritual care encounters.

Background

Same and interfaith spiritual care encounters

In line with diversity being framed as a challenge (Becci & Roy, 2015; Brown & Brown, 2011; Fawcett & Noble, 2004), social psychological theory suggests that people are more likely and better able to connect with someone who is similar to and in the same group as them. According to the similarity-attraction hypothesis, the more people are similar to each other, the more they like each other (Byrne, 1971), and following social identity theory (Tajfel & Turner, 1986), people in the same in-group are likely to view themselves more positively than those in other groups. Support for these theories and evidence that this applies to religious diversity is found

in research among Dutch citizens: Respondents felt more attracted to those who were perceived as similar to themselves—on nationality, employment-status, and also for religion—than to those who were dissimilar to themselves (Van Oudenhoven, Judd, & Hewstone, 2000, pp. 293, 294). Other studies suggest that (dis)similarity not only affects liking, but also the quality of the perceived relationship. For instance, Liu, Chua, and Stahl (2010) show that the quality of communication in negotiation was perceived lower in intercultural than in same culture negotiation, and, when it comes to same and interfaith relations, same faith couples report higher marital quality than interfaith couples (Myers, 2006), while interfaith couples report more marital conflict (Chinitz & Brown, 2001; Petts & Knoester, 2007). In literature on caregiver-patient interaction, Ellis and Campbell (2005) interviewed ten patients and report that concordant belief systems facilitate patient-physician spiritual interaction, while discordant belief systems may create barriers. Hodge and Lietz (2014), based on focus groups with 20 patients and 20 therapists, note how differences in R/S beliefs between patients and therapists can lead therapists to impose their beliefs on clients and offending clients because of conflicting belief systems. In a survey among Dutch spiritual caregivers, respondents report a higher estimated satisfaction with their spiritual care provision for clients in same than in interfaith encounters (Liefbroer & Berghuijs, 2019).

Meanwhile, other theory suggests that faith similarity is not that important for the way in which relationships are perceived and that, even if similarity plays a role at first sight, its role may diminish in interactions. The contact hypothesis (Allport, 1954) supposes that differences between people diminish when they get to know each other in person. In line with this, some empirical studies suggest that faith concordance does not play a role in evaluations of spiritual care encounters. For instance, Mayers et al. (2007, p. 317) interviewed ten (religious) clients and note that having the same R/S affiliation as the therapist was not important during therapy, and Pesut and Reimer-Kirkham (2010, pp. 820, 821) report that many patients feel that other, general characteristics—such as kindness, respect and humor—matter more for the quality of the professional caring relationship than R/S characteristics. Also, in a survey among university counseling center therapists, the perceived similarity between therapists' and clients' R/S values was not associated with the strength of the therapeutic relationship (Kellems, Hill, Crook-Lyon, & Freitas, 2010).

These two lines of reasoning lead to contrasting ideas: on the one hand, the idea that faith concordance *does not* relate to the way in which spiritual care encounters are perceived, and on the other hand, the idea that faith concordance *does* relate to this, and in a positive

manner (i.e., when caregiver and client have the same faith, they perceive the encounter more positively than when they do not share the same faith).

Same faith can be conceived in several ways. The first and most direct way is to consider affiliation with the same faith tradition as a form of same faith; we refer to this as *faith concordance* (e.g., a Protestant chaplain with a Protestant client form a faith concordant encounter, and a Humanistic chaplain with a Muslim client form a faith discordant encounter). Straightforward as this measurement may seem, it fails to consider the fact that chaplains often present themselves in general terms, without necessarily explicating an affiliation with a specific tradition (Cadge, 2012). Clients therefore may not always know the affiliation of the chaplain, and/or may have a different *perception of the faith_concordance* than there actually is. Also, assessing a person's faith in a unidimensional way (i.e., affiliation) ignores other aspects of a person's R/S orientation, and many have argued for multidimensional or more nuanced ways of conceptualizing a person's faith (e.g., Glock & Stark, 1965; Smart, 1998). One of the ways to assess someone's faith in a way that is not fixed to religious traditions as such is by using Wulff's (1991 / 1997) model of *approaches to religion*. Wulff (1991 / 1997) differentiates between approaches to religion that include or exclude the transcendence (vertical axis), and between approaches to religion that consider religion in a literal or symbolic way (horizontal axis), combined in a matrix leading to four different approaches. Following these approaches, a third way of assessing same and interfaith encounters is by considering having the same approach to religion (rather than affiliating with a religious tradition as such) as same faith. Based on these lines of thought, to investigate how religious diversity relates to the way in which spiritual care encounters are evaluated, three hypotheses are tested:

H1: Clients in faith concordant spiritual care encounters report more positive evaluations of these encounters than clients in faith discordant spiritual care encounters.

H2: The more clients assume they have the same faith as the chaplain has, the more positive they evaluate spiritual care encounters.

H3: Clients holding the same approach to religion as the chaplain report more positive evaluations of spiritual care encounters than clients holding a different approach to religion.

Conditions: Intrinsic religiosity, exclusivism, and the chaplain's professional opinion

Not all clients and chaplains respond to religious diversity in the same way (Cadge & Sigalow, 2013), and there may be (at least) three factors moderating this relationship. First, clients' R/S motivation may moderate the relation between faith concordance and evaluations of spiritual

care encounters, and commonly a distinction is made between extrinsic and intrinsic religious motives (Allport & Ross, 1967). Whereas extrinsic religiosity refers to instrumental or utilitarian motives for a person to be(come) religious (e.g., for security, sociability, or status), intrinsic religiosity refers to an intrinsically motivated form of religiosity in which other needs are of less significance. The more intrinsically motivated a person is, the more important it may be to discuss R/S themes with someone with whom this faith can be shared.

Second, Merino (2010) reports that theological exclusivism—the view that one's own religious worldview is the only right one—is associated with negative attitudes toward religious diversity and toward including those of other faiths into one's community. This suggests that those holding an exclusive view toward religiosity may be more positive about faith concordant spiritual care encounter (or more negative about faith discordant spiritual care encounters) than others.

Third, the chaplains' professional opinion may moderate the relationship between faith concordance and the evaluated encounter, and two positions regarding religious diversity in spiritual care are distinguished (Liefbroer, Ganzevoort, & Olsman, 2019; Liefbroer et al., 2017). Some emphasize the particularities of chaplains' own R/S orientation in providing spiritual care— they are referred to as "particularists"—and others focus on generic aspects of spiritual care provision and the importance of spiritual care provision to all—the "universalists". A study among Dutch chaplains suggests that chaplains' opinion correlates with their (perceived) ability to provide interfaith spiritual care, in the direction that higher scores on particularism relate to lower scores on ability, and higher scores on universalism relate to higher scores on ability (Berghuijs & Liefbroer, 2017). Accordingly, we hypothesize that:

H4: The higher the intrinsic religiosity of clients' faith, the stronger the relation between faith concordance and clients' evaluations of spiritual care encounters.

H5: The higher the exclusivity of clients' faiths, the stronger the relation between faith concordance and clients' evaluations of spiritual care encounters.

H6: The more chaplains hold a universalist perspective on and feel able to provide interfaith spiritual care, the weaker the relationship between faith concordance and clients' evaluations of spiritual care encounters.

Experiences with, activities during, and content of spiritual care encounters

In addition to focusing on religious diversity in relation to evaluations of spiritual care encounters, the second aim of this paper is to investigate how religious diversity relates to the

shape of spiritual care encounters. In his study of universal dimensions and functions of religions, Saroglou (2011) differentiates between belonging (identity), bonding (emotions), behaving (morality), and believing (cognitions). In this proposed model, these dimensions and functions are universal aspects of religion across cultural contexts, and we suppose that these dimensions play a role in spiritual care encounters as well. Therefore, we investigate faith concordance (belonging/affiliation) in relation to the shape of spiritual care encounters according to clients' experiences with (bonding/emotional aspect), the activities during (behavioral aspect), and the content of (believing/cognitive aspect) spiritual care encounters.

The chaplain's professional identity is often described according to three roles: the professional, personal, and confessional role (Bidwell & Marshall, 2006; Ganzevoort & Visser, 2007; Heitink, 2001; Liefbroer et al., 2019), or the chaplain as counselor, companion, and spiritual guide. When in faith discordant encounters, this third role—the chaplain as a spiritual guide—may be the most difficult to perform due to R/S differences, and clients may thus be more likely to experience the chaplain in this role in faith concordant than in faith discordant encounters. Furthermore, the activities during and content of spiritual care encounters may differ between faith concordant and discordant spiritual care encounters. In their diary-study of 1440 chaplaincy visits, Idler, Grant, Quest, Binney, and Perkins (2015) identified various chaplains' activities—broadly categorized under 'doing' or spiritual communication (e.g., prayer, performing a ritual) and 'being' or general communication (e.g., active listening)—and topics of the conversation—broadly categorized under 'practical matters' (e.g., work, finance) and 'ultimate concerns' (e.g., emotional wellbeing, existential matters). While activities using general communication, such as listening, may be very common in all encounters, activities using spiritual communication may be more likely when both affiliate with the same faith (e.g., chaplains are more likely to pray with patients with the same faith (Galek et al., 2010)). Also, whereas clients may feel at ease to discuss practical matters with all caregivers, they may be more likely to discuss ultimate concerns only with those affiliating with the same faith. We therefore test the following hypotheses:

H7: Clients in faith concordant spiritual care encounters more often experience the chaplain as a spiritual guide than clients in faith discordant spiritual care encounters.

H8: Clients in faith concordant spiritual care encounters report more spiritual communication activities than clients in faith discordant spiritual care encounters.

H9: Clients in faith concordant spiritual care encounters discuss more 'ultimate concerns' than clients in faith discordant spiritual care encounters.

Data and Method

Design

We used a quantitative, multilevel design, surveying chaplains in hospitals in the Netherlands and, for each of them, some of their clients. The survey for chaplains included questions about their personal characteristics and their R/S orientation. Directly after having a conversation with a chaplain, clients of these chaplains were asked to participate in a survey as well, consisting of questions about the encounter and questions about their personal characteristics and their R/S orientation (see *Measures*).

Procedure

Spiritual care departments were approached by the first author via e-mail and telephone. In case spiritual care departments were unwilling to participate, the first author inquired about their reasons to do so (see *Sampling strategy, response and sample*). If spiritual care departments agreed to participate, the researcher gained permission to conduct the research in agreement with the head of the spiritual care department and (if needed) the ethics review committee of that hospital.

The first author was present during approximately one week in each participating hospital, and during that week chaplains asked their clients directly after a conversation took place if the researcher was allowed to visit the client for a survey about chaplaincy. If clients agreed, the researcher asked the client to participate in the research and to complete a survey on paper (see *Measures*; the researcher assisted the client with the survey when needed or preferred). During that same week, the researcher asked participating chaplains to fill out a survey and a track-list of the clients they met and reasons for non-response.

Sampling strategy, response and sample

Data gathering took place between December 10, 2018 and April 18, 2019. Spiritual care departments of (both academic and non-academic) hospitals in the Netherlands were approached if they met the following inclusion criteria: a) their hospital was in the most urban areas of the Netherlands (in the provinces North-Holland, South-Holland, Utrecht, or Flevoland), where the diversity of R/S worldviews is supposed to be higher than in more rural areas; and b) the spiritual care department consisted of a team with at least three chaplains. Spiritual care departments were encouraged to participate with the entire team, but participation with several members of the team was possible as well. All spiritual care departments that met inclusion criteria (n=19) were approached for the study, and chaplains from 11 spiritual care

departments agreed to participate. Most of the non-participating departments (7 out of 8) mentioned "being too busy" or "not having enough time" as the main reason for not participating in the study. Other reasons mentioned not to take part in the study included hesitation or difficulty to approach and find clients to participate (3 out of 8) and reluctance to use quantitative measures to investigate spiritual care interactions (1 out of 8).

A total of 45 chaplains participated in the study. About half were male (44%) and half were female (56%), and their mean age was 50.40 years (SD=12.00), ranging from 23 to 65. All were highly educated (7% in applied sciences, 93% at university level). The mean years of experience was 13.57 years (SD=8.82), ranging from 0 to 34. Most chaplains were authorized or ordained by a Protestant (31%), Catholic (20%), Islamic (10%) or Humanistic organization (18%), or recognized by the RING-GV, a Dutch organization that examines chaplains' competence for those who are not authorized or ordained by a religious or Humanistic organization (7%). Some respondents (16%) were not authorized.

Clients were approached for the study if they had received spiritual care by a chaplain in the hospital setting. These clients often were inpatients, but others to whom spiritual care was provided could participate as well, such as outpatients and informal or professional caregivers. Exclusion criteria were: a) age below 18; b) cognitive impairment, like suffering from severe dementia or delirium; c) staying at the Intensive Care Unit; or d) acute crisis in which taking part in a survey was not appropriate. For an overview of response and non-response, see Appendix 2.[25]

A total of 209 clients participated in the study. Half of them were male (49%) and half were female (51%), and 1% "other/don't want to say". The mean age was 64.79 years (SD=17.02), ranging from 18 to 95. Most (44%) had a low educational level, some (18%) had a middle education level, and around one-third (35%) had a high educational level.[26] Compared to the Dutch population (resp. 32%, 38%, 30%; CBS, 2019), those with middle educational level were somewhat underrepresented. Most conversations took 10-20 minutes (26%), 20-30

[25] A possible limitation of this design may be a selection bias due to selection by spiritual caregivers on the evaluation of the encounter (i.e., leading to an underrepresentation of respondents who did not give a favorable evaluation of the encounter). However, Appendix 2 shows that main reasons for non-response are other factors, such as cognitive impairment, non-appropriate situations (e.g., due to illness or sensitivity of the topic), language barriers, or practical reasons (e.g., patient going home), suggesting that such a selection bias is not plausible.

[26] Specifically, respondents' educational level is divided as follows: none: 4%; primary school: 9%; lower-level vocational education: 18%; lower-level+ vocational education: 14%; middle-level vocational education: 14%; high school: 4%; ba/ma applied sciences: 24%; university level: 11%.

minutes (29%) or 30-60 minutes (30%). Few conversations took less than 10 minutes (8%), or longer than 1 hour (8%).

Measures[27]

Dependent variables

Clients' evaluations of the encounter (Cl) were measured using two items. Client satisfaction—a construct commonly used in healthcare evaluation studies (see e.g., Marin et al., 2015; Shen et al., 2018)—was measured by asking clients: 'How satisfied are you with the chaplaincy encounter?', and clients' perceived benefit from the conversation was measured by asking them: 'To what extent did you benefit from the conversation with the chaplain?'.

Clients' experiences with the encounter (Cl) were assessed following the roles of the chaplain as counselor, companion, and spiritual guide (Bidwell & Marshall, 2006; Ganzevoort & Visser, 2007; Heitink, 2001; Liefbroer et al., 2019). Four to seven items were developed for each role to capture the extent to which clients experience the chaplain in each of these roles. Items that related to the chaplain as *counselor* were inspired by the roles described for psychological conversations (e.g., 'I have gained insight into my situation') (Lang & Van der Molen, 2012); items that reflected the chaplain as *companion* were derived from research that focused on the role of expert-volunteer caregivers (e.g., 'I feel I was being listened to') (Post & Liefbroer, 2019); and items reflecting the chaplain as *spiritual guide* were derived from research among church members and their experiences in conversations with pastors (e.g., 'I am reconciled') (Bruinsma - de Beer, 2006).

Activities during the encounter (Cl) were divided into five activities that focus on spiritual communication (e.g., practicing rituals, prayer) and three activities that focus on general communication (e.g., listening, asking questions), inspired by activities identified by Idler et al. (2015). Clients were asked to indicate whether each of these activities took place during the encounter, and for how much of the time.

Based on Idler et al. (2015), for *content of the encounter (Cl)* a differentiation was made between discussing 'practical matters' (e.g., work, finance) and 'ultimate concerns' (e.g.,

[27] Some variables were only included in the survey for clients (referred to as 'Cl'), some only in the survey for chaplains (referred to as 'Ch'), and some in both surveys (referred to as 'ClCh'). Because for many variables no validated and standardized measurements are available, several measures were developed for the purpose of this study and, as much as possible, based on or inspired by previous research. The psychometric characteristics of the measures are described in the results section.

emotions, existential themes). Clients were asked to indicate for eleven of these topics whether, and if so, for how much of the time they had discussed these topics with the chaplain.

Independent variables

Faith concordance (ClCh) was operationalized according to affiliation with a R/S tradition, and both clients and chaplains were asked to indicate with which tradition they affiliate, choosing from: Protestantism, Catholicism, Judaism, Islam, Buddhism, Hinduism, Humanism, other (please specify) or none. In case respondents affiliated with more than one tradition, they were asked to choose the most important one. If both client and chaplain affiliated with the same R/S tradition the interaction was classified as 'faith concordant'. If both affiliated with a different R/S tradition, or either one or both of them did not affiliate with a R/S tradition, the interaction was classified as 'faith discordant'.

The *perceived faith concordance (Cl)* was measured by questioning: 'To what extent do you think your religious or spiritual orientation is the same as that of the chaplain?'.

The *similarity in approach to religion (ClCh)* was operationalized based on Wulff's (1991 / 1997) model of approaches to religion, and a distinction was made between inclusion and exclusion of transcendence, and between a literal or symbolic worldview interpretation, leading to four possible positions. For inclusion versus exclusion of the transcendence, three items were selected based on the Dutch SOCON survey (e.g., 'there is a supreme being who controls life') (Eisinga et al., 2005). For a literal versus symbolic worldview interpretation, three items were formulated inspired by the Post-Critical Belief Scale (e.g., 'Religious and spiritual texts are meant to be followed literally') (Duriez, Soenens, & Hutsebaut, 2005; Fontaine, Duriez, Luyten, & Hutsebaut, 2003).[28]

Moderating variables

Intrinsic religiosity (Cl) was assessed using the 3-item intrinsic religiosity (IR) scale of the Duke University Religion Index (DUREL) (Koenig & Büssing, 2010) (translated version by Ouwehand, Braam, Renes, Muthert, & Zock, 2020).[29]

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[28] The Post-Critical Belief Scale was considered being too long (33 items; 18 items short form) and too Christianity-focused for our (multifaith) sample. We therefore adapted several items of this scale into a shorter formulation that is inclusive for non-Christian respondents.

[29] As a check for other forms of salience of respondents' religiosity, the other subscales of the DUREL—organized religious activity (ORA) and personal (or non-organized) religious activity (NORA)—were included in the survey as well.

The measurement of *exclusivism of clients' faith (Cl)* was inspired by the measurement of religious tolerance (Broer, De Muynck, Potgieter, Wolhuter, & Van der Walt, 2014), subscales 'inclusivism' and 'exclusivism', as well as by the World Value Survey.[30] Six items were developed, consisting of three items that focused on inclusivism (e.g., 'I like to connect with people who have a different religious or worldview orientation than my own') and three items that focused on exclusivism (e.g., 'I am convinced that only my religious or worldview orientation is the right one').

The chaplain's *professional opinion with regard to R/S diversity (Ch)* was based on a survey conducted by Liefbroer and Berghuijs (2019).[31] 12 items were included of which four focused on particularism, four on universalism, and four on the ability to provide interfaith spiritual care.

Control variables

Similarity in gender (ClCh), age (ClCh) and educational level (Cl) were included as control variables. The similarity between chaplains' and clients' gender was recoded into a dichotomous variable (different vs same gender), the similarity in age was recoded into a continuous variable based on difference scores between the age of clients and chaplains, and for educational level clients' level was used (all chaplains are highly educated). In addition, *clients' gender (Cl), age (Cl)* and *religious affiliation (Cl)* were included as control variables.

In Dutch healthcare settings, although many chaplains work in a territorial manner (providing care to all clients), some work in a categorical manner (primarily providing care to those affiliating with the same tradition) (Liefbroer & Berghuijs, 2019). From a client's perspective, some may feel that faith concordance is important and therefore may have asked for a chaplain with the same background. To control for the bias this may create (e.g., those who initiate a faith concordant encounter may be more likely than others to evaluate such conversations positively), we included a question regarding *who initiated the encounter (Cl).*

[30] The items included in these surveys were reformulated to make the items suitable for our sample (e.g., formulating shorter sentences than the ones used in the religious tolerance measurement (Broer et al., 2014)).

[31] Some of the items were adjusted based on the findings by Liefbroer and Berghuijs (2019) (e.g., 'I think it can be helpful to have a conversation with a spiritual caregiver who does not explicitly belongs to the same R/S orientation' was deleted from their factor analysis because of a communality of <.20, and was adjusted by us to 'I think that for conversations it makes no difference whether the chaplain and the client belong to the same or a different R/S orientation').

Analysis

The data was analyzed using SPSS. Factor analyses with Oblimin rotation were used to investigate homogeneity of the constructs. The dataset was hierarchically organized, with several observations of clients for each chaplain. Linear mixed models (LMM) were used to test the hypotheses, including the clustering within chaplains as a random effect, and control variables (sex, age, educational level, religious affiliation, and similarity in sex and age) in all analyses. In case of positive effects of faith affiliation on the dependent variable, a robustness check was performed on responses by those clients who did not ask for a chaplain with a specific faith affiliation, to make sure that such effects were not due to this selection.

Results

Below, we first describe the descriptive results of our study for each of the variables. A summary of descriptive statistics is presented in Table 1. Second, we describe the results of our study for the multivariate analyses that correspond to the hypotheses.

Descriptive results

Dependent variables (C)

Overall, respondents were positive about encountering the chaplain. Specifically, clients rated their satisfaction with the encounter as an 8.22 (SD=1.23) on a 1 (very dissatisfied) to 10 (very satisfied) scale, and how much they benefitted from the encounter as a 7.36 (SD=1.94) on a 1 (not at all) to 10 (very much) scale. Since these items are highly correlated ($r=.66$; $p<.01$), the average of the scores on both questions was taken as a measure of the *evaluation of the encounter* (Cronbach's alpha=.75).

The results of the factor analysis for experiences with, activities during, and content of the encounter are described in Appendix 3A, 3B, and 3C. Based on a factor analysis of 19 items concerning *experiences with the encounter*, three scales were constructed that fitted the data and the theoretical roles of the chaplain as companion, spiritual guide, and counselor. The chaplain as companion was most prominent in the way in which respondents experienced the chaplain, followed by the chaplain as counselor. The chaplain as spiritual guide was experienced the least by respondents.

Factor analysis of 8 items focusing on *activities during the encounter* led to a two-factor solution in line with our theoretical concepts consisting of activities that focused on spiritual communication and activities that focused on general communication. Overall, activities that

focused on spiritual communication were relatively rare compared to activities that focused on general communication.

The factor analysis of 9 items concerning the *content of the encounter* yielded two factors relating to the theoretical concepts of ‘practical matters’ and ‘ultimate concerns’. Overall, ‘ultimate concerns’ were discussed more often in the encounters than ‘practical matters’.

Table 1. Overview of descriptive statistics for dependent, independent, moderating, and control variables.

	Variable[1]	*Range*	*M or %*	*SD*
Dependent variables	Evaluation of the encounter (H1-H6)	1-10	7.80	1.45
	Experiences with the encounter (H7):			
	Spiritual guide	1-5	2.19	1.28
	Counselor	1-5	2.47	1.14
	Companion	1-5	4.07	.80
	Activities during the encounter (H8):			
	Spiritual communication[2]	1-5	1.21	.55
	General communication[2]	1-5	4.65	.63
	Content of the encounter (H9):			
	‘Ultimate concerns’	1-5	2.66	.85
	‘Practical matters’	1-5	1.98	.75
Independent variables	Faith concordance (H1, H4-H6)	0, 1	24	
	Perceived faith concordance (H2)[3]	1-10	6.65	2.81
	Match in approach to religion (H3)	0, 1	40	
Moderating variables	Intrinsic religiosity (H4)[3]	1-5	3.38	1.52
	Exclusivism of clients' worldview (H5):			
	Exclusivism[3]	1-5	2.06	1.23
	Inclusivism[3]	1-5	3.71	1.12
	The chaplain's professional profile (H6):			
	Perspective on ISC[3]	1-5	4.31	.66
	Ability to provide ISC[3]	1-5	3.95	.65
Control variables[4]	Same gender	0, 1	53	
	Age similarity[3]	-55-0	-20.31	14.13
	Educational level[3]	1-8	4.94	2.11

[1] N for each variable ranges from 179 to 207, except for the chaplain's professional profile (n=45).
[2] In the multivariate analyses, ranked scores are used for this variable (because of relatively large skewed distribution of these items).
[3] In the multivariate analyses, centered scores are used for this variable.
[4] Clients' gender, age (see ‘*Sampling Strategy, Response and Sample*’) and religious affiliation (see Table 2) are also used as control variables.

Independent variables (C/S/CS)

For the first measure of interfaith versus same faith encounters, see Table 2. Around one-fourth of conversations were faith concordant conversations (24%)—implying that both chaplain and client affiliated with the same R/S tradition—and around three-fourth of conversations were faith discordant (77%). Most of the faith concordant encounters are between Protestants (7%), Catholics (10%), or Muslims (6%). In the analyses (see below), we also checked for faith concordance that included Catholic-Protestant combinations as faith concordance (46% faith concordance; 54% faith discordance).

Table 2. Overview of faith concordant and discordant encounters, in percentages (%).[1,2,3]

		Clients' R/S affiliation (n=204)							
		Catholicism	*Protestantism*	*Islam*	*Judaism*	*Buddhism*	*Humanism*	*Not applicable*	*Total*
Chaplains' R/S affiliation (n=43)	*Catholicism*	***7***	*11*	-	-	1	-	6	25
	Protestantism	*11*	***10***	1	1	-	2	17	41
	Islam	-	1	***6***	-	-	-	1	7
	Buddhism	1	-	-	-	-	-	1	2
	Humanism	3	5	1	-	1	***1***	10	20
	Not applicable	2	2	1	-	-	-	3	7
	Total	23	29	7	1	1	2	37	100

[1] Faith concordant encounters in ***italics and bold***.

[2] Faith concordant encounters including Christian (Catholic-Protestant) encounters in *italics*.

[3] The total scores may differ slightly from the separate scores, because rounded numbers are used.

For the second measure, most clients had the perception that their faith was more similar to than different from the chaplain's faith (M=6.65; SD=2.81, on a range from 1 (completely different) to 10 (completely the same)). The *perceived* faith concordance correlated positively with the *actual* faith concordance, but only moderately so (r=.30, p<.01).

For the third measure of interfaith versus same faith encounters, the factor analysis of 6 items focusing on respondents' *approach to religion* led to a two-factor solution (see Appendix 3D and 3E). The first scale concerns the inclusion versus exclusion of transcendence, and the second scale concerns respondents' literal versus symbolic interpretation of religion. On average, both clients and chaplains assume inclusivism rather than exclusivism of transcendence, and interpret religion in a symbolic rather than literal way. The similarity in

approach to religion between clients and chaplains was calculated using the scores on each axis (exclusivism-inclusivism and literal-symbolic)[32] to divide respondents over the four quadrants. 40% of the encounters consisted of spiritual care interactions in which both client and chaplain had the same approach to religion; in most of these encounters both included the transcendence and had a symbolic interpretation of religion (Q2; see Table 3).

Table 3. Overview of matches in approach to religion, in percentages (%).[1]

		Clients' approach to religion (n=179)				
		Q1	*Q2*	*Q3*	*Q4*	*Total*
Chaplains' approach to religion (n=44)	*Inclusivism + literal (Q1)*	***2***	8	-	2	12
	Inclusivism + symbolic (Q2)	11	***27***	3	13	54
	Exclusivism + literal (Q3)	-	-	-	-	-
	Exclusivism + symbolic (Q4)	5	16	3	***11***	34
	Total	18	50	6	26	100

[1] Matches in approach to religion in ***italics and bold***.

Moderating variables

Descriptive results for intrinsic religiosity, exclusivism, and chaplains' profile are presented in Appendix 3F, 3G, and 3H. For *intrinsic religiosity*, clients' R/S orientation was of moderate importance to them.

The factor analysis of 6 items concerning the inclusivism and *exclusivism* of clients' R/S orientation yielded one factor for each. Overall, respondents score higher on inclusivism than on exclusivism.

The factor analysis of 12 items concerning *the chaplain's professional profile* led to two factors in line with our theoretical concepts: one concerning a universalist perspective on interfaith spiritual care—in which a lower score indicated a more particularist and a higher score indicated a more universalist perspective—and another concerning the ability to provide interfaith spiritual care. Overall, respondents are very much willing to provide spiritual care to clients with a variety of R/S orientations, and feel quite able to do so.

[32] Cut-off scores were below 3 or above 3 (scale ranged from 1 to 5). In case the mean score on the subscale was exactly 3, respondents were randomly selected (using SPSS randomization) into one side of the axis.

Results of hypotheses testing

Interfaith spiritual care encounters (H1, H2, and H3)

Results of the tests of H1, H2, and H3 are presented in Table 4. First, we hypothesized that clients in faith concordant spiritual care encounters would report more positive evaluations of spiritual care encounters than clients in faith discordant encounters. Table 4 shows that no significant differences are found between faith concordant and discordant encounters on clients' evaluations of spiritual care encounters, thereby rejecting H1.[33] By contrast, the more respondents have the *perception* that there is faith concordance, the more positive they evaluate the spiritual care encounter, thus supporting H2. Third, no significant differences are found between having or not having the same approach to religion on the evaluation of the spiritual care encounter, which rejects H3. Effect sizes (betas) for these hypotheses are respectively 05, .36, and .07.

In addition, the findings presented in Table 4 indicate that educational level is related to the way in which spiritual care encounters are evaluated, and the higher the client's educational level, the higher the evaluation of the spiritual care interaction (beta is respectively .20, .14, and .20).

Intrinsic religiosity (H4), exclusivism (H5), and the chaplain's professional's opinion (H6)

Results of the tests of H4, H5, and H6 are presented in Table 5. First, it was hypothesized that the higher the intrinsic religiosity of clients' faiths, the stronger the relation between faith concordance and clients' evaluations of the spiritual care encounter would be. However, no significant differences on this interaction are found.

Second, the extent to which clients think of their faith in an exclusive manner did not moderate the relation between faith concordance and clients' evaluations of the spiritual care encounter. The interaction effects of inclusivism as well as exclusivism with faith concordance on clients' evaluations are both not significant.[34]

Third, it was hypothesized that the more chaplains hold a universalist perspective and perceive themselves as being able to provide interfaith spiritual care, the weaker the relationship

[33] This hypothesis is also checked using Christian combinations (Protestant-Catholic) as faith concordant rather than discordant encounters. This did not change these findings.

[34] This may in part be due to the low reliability of the scale for inclusivism (alpha = .52; see Appendix 3G).

Table 4. Evaluation of the encounter: Overview of multivariate results for H1, H2, and H3.[1]

		Evaluation of the encounter										
		B		SE		B		SE		B		SE
	Constant	7.87		.51		8.13		.48		8.44		.50
Same versus interfaith	*Faith concordance (H1)*	.17		.27	*Perceived faith concordance (H2)*	.19	**	.04	*Same approach to religion (H3)*	.21		.20
	Faith discordance	-		-					*Different approach to religion*	-		-
Gender	*Same gender*	.05		.20		.09		.20		.23		.19
	Different gender	-		-		-		-		-		-
Age	*Age similarity*[2]	.00		.01		.00		.01		-.00		.01
Educational level	*Clients' educational level*	.14	*	.05		.10	*	.05		.14	**	.05
N		197				186				177		

*Significant at p<.05; **Significant at p<.01.

[1]All LMMs presented here are controlled for clients' religious affiliation, gender and age.

[2]A higher score indicates more age similarity (or less age difference).

Table 5. Evaluation of the encounter: Overview of multivariate results for H4, H5, and H6.[1, 2]

	Evaluation of the encounter																		
	B		SE		B		SE		B		SE		B		SE		B		SE
Constant	8.49		.52		8.69		.51		8.57		.50		7.91		.50		7.86		.52
Faith concordance	.11		.30		.26		.26		.16		.26		.19		.27		.17		.27
Faith discordance	-		-		-		-		-		-		-		-		-		-
IR[3]	.38	*	.19	*Inclusivism*	.36	$^{+}$	.19	*Exclusivism*	.24		.18	*Universalism*	.60	$^{+}$	.36	*Ability*	-.52	$^{+}$	.31
*IR*Faith concordance (H4)*	-.26		.20	*Inclusivism *Faith concordance (H5)*	-.01		.20	*Exclusivism *Faith concordance (H5)*	-.26		.19	*Universalism *Faith concordance (H6)*	-.47		.46	*Ability*Faith concordance (H6)*	.70		.43
N	190				179				178				197				197		

$^{+}$Significant at p<.10; *Significant at p<.05; **Significant at p<.01.

[1]All LMMs presented here are controlled for clients' religious affiliation, gender, age and educational level, and similarity between client and chaplain in terms of gender and age, as well as the interaction effects of the similarity variables and clients' educational level with respectively intrinsic religiosity (H4), inclusivism/exclusivism (H5), and professionals' perspective on and ability to provide ISC (H6).

[2]Centered scores are used for intrinsic religiosity (H4), inclusivism/exclusivism (H5), and professionals' perspective on and ability to provide ISC (H6).

[3]As a check for other forms of salience of respondents' religiosity, the same analysis is also conducted using the subscales organized religious activity (ORA) and personal (or non-organized) religious activity (NORA). No significant results on these variables were found.

Table 6. Shape of the encounter: Overview of multivariate results for H7, H8, and H9.[1]

	Experiences with the encounter (H7)						*Activities during the encounter (H8)*				*Topics of the encounter (H9)*					
	Spiritual guide		Counselor		Companion		Spiritual communication		General communication		'Ultimate concerns'			'Practical matters'		
	B	SE	B	SE	B	SE	B	SE	B	SE	B		SE	B		SE
Constant	1.68	.42	3.45	.39	4.47	.27	2.98	.28	2.58	.34	2.95		.29	2.67		.26
Faith concordance	.23	.22	.03	.20	-.04	.14	-.09	.14	-.00	.18	-.32	*	.15	-.25	+	.14
Faith discordance	-	-	-	-	-	-	-	-	-	-	-		-	-		-
N	192		194		197		193		197		195			194		

+Significant at $p<.10$; *Significant at $p<.05$.

[1]All LMMs presented here are controlled for clients' religious affiliation, gender, age and educational level, and similarity between client and chaplain in terms of gender and age.

between faith concordance and clients' evaluations of spiritual care encounters would be. However, these hypothesized interaction-effects for chaplains' professional opinion are both not significant. Therefore, hypotheses H4, H5, and H6 are all rejected by the findings of this study (beta is respectively -.24, -.00, -.18, -.11, .18).

Experiences with (H7), activities during (H8), and content of spiritual care encounters (H9)

Results of the tests of H7, H8, H9 are presented in Table 6. First, this table reports that there is insufficient evidence that clients who encounter a chaplain with a concordant faith would experience him/her more in the role as spiritual guide than would clients in faith discordant encounters do, thus rejecting H7. No significant differences are found between faith concordant and discordant encounters with regard to experiencing the spiritual caregiver as counselor and/or companion (beta is respectively .08, .01, and -.02).

Second, Table 6 indicates that H8 is rejected by our findings, because respondents in faith concordant encounters do not report significantly more spiritual communication activities than do respondents in the discordant condition.[35] For activities relating to general communication also no significant differences are found between faith concordant and discordant encounters (beta is respectively -.05 and -.00).

Finally, contrary to H9, 'ultimate concerns' and 'practical matters' are not discussed more often in faith concordant than discordant conditions (beta is respectively -.16 and -.14).[36]

Discussion and conclusion

This study investigates whether (and if so, under what conditions) religious differences relate to the way in which spiritual care interactions are evaluated and shaped in secularized and pluralized contexts. The analyses of responses by clients in hospitals after receiving spiritual care by a chaplain show that, overall, affiliating with the same religious tradition and having the same approach to religion (Wulff, 1991 / 1997) does not significantly relate to clients' *evaluations* of spiritual care encounters (H1, H3)—also not when considering moderating effects such as clients' intrinsic religiosity, their inclusivism or exclusivism of their religion or worldview orientation, or chaplains' professional opinion regarding interfaith spiritual care provision (H4, H5, H6). Furthermore, whether clients affiliate with the same or a different faith

[35] This may in part be due to the rare occurrence of these activities.

[36] By contrast, they are discussed significantly more often in faith discordant than concordant encounters.

as the chaplain does not significantly matter for the way in which they experience the chaplain (i.e., as spiritual guide, counselor or companion) nor do the activities that take place during the conversation (e.g., listening, speaking, praying, performing rituals) (H7, H8). Also, clients in same faith encounters do not discuss more ultimate concerns than when in faith discordant encounters (H9).

There are several explanations for these findings, which may complement one another. First, it could be supported by the notion that religious differences diminish when people get to know each other (e.g., following the contact hypothesis (Allport, 1954)). However, it is uncertain what 'getting to know *each other'* implies in spiritual care encounters that are sometimes single events and that occur in a relationship where there is a clear role difference between the chaplain and client. Second, it may be explained in relation to participating chaplains' expertise: on average, chaplains were very positive about their ability to provide interfaith spiritual care, and their (self-reported) good capacity may explain why faith concordant encounters were not evaluated more positively than faith discordant encounters. A third, more sociological way to account for this finding is by considering the context in which these encounters take place. In a secularized and pluralized Western-European context as the Netherlands, for many people religious traditions may not (or no longer) play a central role in addressing existential themes. Rather, people draw from a variety of sources, including religious and non-religious or secular ones (e.g., Liefbroer, Van der Braak, & Kalsky, 2018; Berghuijs, 2017). In line with this trend, many chaplains in secularized societies seem to be inclined to use a broad spiritual language when providing spiritual care (Cadge & Sigalow, 2013; Idler et al., 2015; Christensen, Høeg, Kühle, & Nordin, 2019), thereby transforming the chaplaincy profession from a "*religious model*" to a more "*existential model*" of care (Stifoss-Hanssen et al., 2019). In such a context, for most people religious differences may not (or no longer) be of much importance for discussing existential themes and for evaluating spiritual care encounters.

This study is one of the first to investigate clients' perspectives on religious diversity in spiritual caregiving in a quantitative way. Yet it is limited in several ways as well. First, with a sample size of 209 spiritual care encounters, this study only identified large and moderate effect sizes for the independent variables regarding religion (betas of approximately .3 and above). There could be smaller differences with regard to religious differences in spiritual care encounters (with effect sizes below .3) that we may not have been able to identify. However, if by conducting this study with larger sample sizes we would possibly identify such smaller

differences (and not large or moderate differences), it is questionable whether such findings would still be of any clinical significance for clients when encountering chaplains in practice.

Second, most respondents to the survey affiliated with Catholicism, Protestantism, Humanism (for chaplains) or no tradition (for clients), and only a small percentage affiliated with other traditions (Islam, Buddhism, Judaism). The investigation of same versus interfaith encounters thus mainly seems to be a comparison between caregivers and patients who both affiliate with a Christian tradition compared to those who do *not* affiliate with a Christian tradition. Therefore, we are unsure to what extent the findings apply to adherents of other religions as well, such as to Islam, Judaism, Hinduism or Buddhism. Findings by Abu-Ras and Laird (2011) suggest that spiritual care provision for Islamic patients may require specific knowledge of Islam (e.g., regarding ritual performances or discussing issues of life and death), and Ganzevoort et al. (2014) suggest that providing Muslim, Hindu, or Buddhist spiritual care may require specific roles and competencies of the chaplain. Empirical research among clients affiliating with these religious traditions is needed to investigate how spiritual care is perceived by these clients more in-depth.

Third, since the empirical data for this study have been collected in the Netherlands among clients after being visited by a chaplain, questions arise concerning the applicability of this study's findings for other contexts and other professions. To the extent that other countries, such as other European countries, or the USA and Canada, are pluralizing and secularizing, the findings are relevant for these contexts as well. However, in contexts where the society is less pluralized, or where pluralization of the organizational structure (e.g., chaplains working in a territorial mode for all clients regardless of their faiths) is less common, clients may respond differently to interfaith encounters. Furthermore, by choosing client-chaplain interactions as our main focus, this study included encounters in which spiritual or existential themes were specifically aimed at and in which professionals were trained to address these themes. In encounters with other professional caregivers—e.g., for whom addressing spiritual or existential themes is less central to their practice—faith concordance may have a different role (e.g., Van Nieuw Amerongen-Meeuse, Schaap-Jonker, Schuhmann, Anbeek, & Braam, 2018). Future research is needed to examine the extent to which the findings of this study are applicable to the practice of (spiritual) caregiving in other contexts and by other healthcare professionals.

For the practice of spiritual care our findings suggest that, within the religiously pluralized context of the Netherlands, for most clients spiritual care encounters do not have to be same faith in order for them to give a positive evaluations of the spiritual care encounter. For most clients, other aspects of the spiritual care encounter seem to be more important for

their perception and evaluation of the spiritual care encounter, such as whether they feel *as if* their faith correspondents to the chaplain's faith (H2; although this could have been also the result of a positive evaluation), which may be a form of experiencing a 'personal connection'. Indeed, in a survey among chaplains in the Netherlands most chaplains reported that other aspects were more important for the establishment of a spiritual care encounter than their religious orientation, such as their availability, whether they met before, and whether there is a personal connection (Liefbroer & Berghuijs, 2017). Also, our study shows that the client's educational level often plays a role for how spiritual care encounters are evaluated. One of the questions related to this is whether the more positive evaluations of these encounters is caused by the similarity between chaplains' and clients' educational levels (e.g., similarity-attraction hypothesis (Byrne, 1971)), and/or by the client's educational level (e.g., the more highly educated clients are, the more they appreciate addressing spiritual or existential themes), and/or by the highly educated chaplains (e.g., they may be more likely to focus on cognitive rather than other forms of spiritual caregiving, as exemplified by the finding that, overall, spiritual communication activities are performed much less than general communication activities in spiritual caregiving (see also Idler et al., 2015)). Further research, including (quasi-)experimental rather than correlational designs, is needed to unravel the relation between these and other factors for clients' evaluations of spiritual care encounters.

The main findings of this study—that differences with regard to religious affiliation do not significantly relate to clients' evaluations of spiritual care encounters in hospital settings—urge scholars to rethink the role of religion for addressing spiritual and existential themes outside of congregations. Being experts in addressing existential themes, the findings among these chaplains suggest that referring to religious affiliation as such is not (or no longer) of central relevance in these contexts, and future research is needed to identify how existential and spiritual themes are addressed, and what factors are important for effectively discussing and communicating such topics in secularized and religiously pluralized contexts.

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Appendices

Appendix 2: Flow-chart of clients' response and non-response.

Appendix 3 (3A to 3H): Overview of results of factor analyses.

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