Interfaith spiritual care

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Part IV

Interfaith spiritual care in practice

Chapter 8. Spiritual talk: Addressing existential themes in interfaith encounters[47]

Abstract

Spiritual caregivers increasingly care for clients with other religious/spiritual (R/S) orientations than their own. It has hardly been explored how they deal with these differences though. Based on an analysis of audio records of 34 spiritual caregiver-patient interactions, this paper describes communication techniques used by spiritual caregivers to address existential themes in conversations with patients with various R/S orientations. The model presented describes these techniques regarding the extent to which spiritual caregivers comply with the patient's R/S orientation and disclose their own R/S orientation. This model can be used to analyze how spiritual caregivers interact with their clients.

Keywords

Spiritual Care; Conversation; Existential Themes; Diversity; Communication Techniques

Introduction

In the field of spiritual care and chaplaincy, there is a growing need for empirically based research into what spiritual caregivers actually do and what the effect of their spiritual care provision is (Damen, Delaney, & Fitchett, 2018; Damen, Schuhmann, Lensvelt-Mulders, & Leget, 2019; Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Gärtner, Körver, & Walton, 2019). The need for empirical studies is even more urgent since spiritual caregivers or chaplains increasingly care for patients and clients with a religious, spiritual, or non-religious/spiritual (R/S) orientation that is different from their own (Ai & McCormick, 2010; Cadge, 2012), requiring empirical research that examines spiritual care in this changed R/S landscape.

In existing literature, several authors focus on spiritual caregiving to patients or clients with various R/S orientations (Aten, Mangis, & Campbell, 2010; Chaplin, 2003; Dijoseph & Cavendish, 2005; Miklancie, 2007; Richards & Bergin, 2014). Cadge and Sigalow (2013), for instance, identify two strategies—neutralizing ("use a broad language of spirituality that emphasizes commonalities rather than differences") and code-switching ("use the languages, rituals, and practices of the people with whom they work")—that are used to deal with differences in interfaith spiritual care encounters. Also, the use of "non-religious language" in

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conversations between a Christian nurse and a non-religious patient (Taylor, Park, & Pfeiffer, 2014), and going along with the care receiver's point of view (or taking a "patient-centered viewpoint") have been reported in this regard (Ellis & Campbell, 2005; Mayers, Leavey, Vallianatou, & Barker, 2007).

However, as shown in a recent systematic review of the literature (Liefbroer, Olsman, Ganzevoort, & Van Etten-Jamaludin, 2017), such empirical studies are scarce, mainly conducted in North-America[48], and often focus on (health) care professionals other than spiritual caregivers or chaplains, such as psychologists, nurses, and social workers. Moreover, it is uncertain to what extent these communication skills reflect caregivers' actual practices, as most empirical studies are based on interview or survey data rather than observational data (Ellis & Campbell, 2005; Mayers et al., 2007; Taylor et al., 2014).

The aim of this study is twofold. First, our aim is to identify communication techniques used by spiritual caregivers when talking about or discussing existential themes in conversations with patients or clients from a variety of R/S orientations, in a secularized and pluralized context. Second, we aim to investigate whether these communication techniques differ when patient and spiritual caregiver both have the same R/S affiliation compared to when they do not affiliate with the same R/S tradition. Insight into these conversation techniques is relevant for researchers investigating the role of R/S diversity in spiritual care encounters, for educators and trainers of spiritual care, and for spiritual caregivers and other caregivers (e.g., ministers, psychologists, nurses). This study may help them to analyze and improve the way in which they interact with and care for their patients or clients. After describing the method and results of this study, we will reflect on the findings from a practical theological perspective and discuss the implications of the results for (research on) the practice of spiritual care.

Method

Design

To identify communication techniques in conversations between patients and spiritual caregivers, conversation analysis was used in which audio records of conversations between spiritual caregivers and their patients that took place in hospitals in the Netherlands were inductively analyzed. In conversation analysis the focus is on analyzing verbal interactions between people in their everyday life or—as in our study—their everyday work situations (see

[48] Since religion is perceived differently in North-America compared to the highly secularized and pluralized Western European context (Berger, Davie, & Fokas, 2008), it is unsure whether the strategies identified in that context can be applied to other contexts, such as the European context.

e.g., Flick, 2014; Heritage & Clayman, 2010). The Netherlands form an ideal setting to identify the way in which R/S differences are dealt with, since they are characterized by a diversified religious landscape. While some affiliate with Roman-Catholicism (24%), a Protestant denomination (15%), or Islam (5%), many others have a secular or non-religious orientation (51%) (CBS, 2017). Another study reports that 17-23% of the Dutch population combine elements from various religious traditions altogether (Berghuijs, 2017). The hospital setting was chosen since spiritual caregivers working in these settings regularly encounter patients from all kinds of backgrounds (Cadge, 2012, p. 13; Doolaard, 2006). They therefore form an excellent case to study the way in which R/S differences are dealt with.

Recruitment

Spiritual caregivers working in medical centers (either academic or regional) in urban areas of the Netherlands (with greater diversity of worldviews than in rural areas) were approached to participate in this study. A purposive sampling method was used to have spiritual caregivers participating from various R/S orientations (Protestant, Catholic, Islamic, Humanist, unaffiliated[49]) and with an equal distribution in terms of gender. Spiritual caregivers were approached via webpages of medical centers and/or via participants already agreeing to take part in this study (via snowball sampling). They received an e-mail about the research project and were subsequently called by telephone to ask them to participate.

Eligible patients were approached via their spiritual caregivers. Spiritual caregivers selected patients to participate in this study, and asked them to participate (a maximum of three patients were included per spiritual caregiver). Spiritual caregivers were instructed to select these patients according to purposive sampling as well, aiming at variation of patients' R/S orientations. Patients younger than 18 years old were excluded from the study.

Research ethics

According to Dutch law on research involving human subjects (CCMO), a review by a review ethics committee was not required for this study, which was confirmed by the research ethics committee of the Amsterdam University Medical Center, location Vrije Universiteit. The researcher informed eligible spiritual caregivers orally and by email. Spiritual caregivers informed eligible patients about the research orally and by written letter, which included

[49] It was not feasible to have Jewish and Hindu spiritual caregivers participating in this study, because the number of spiritual caregivers affiliated with or ordained by these traditions and employed by medical centers in the Netherlands is very low.

information on confidentiality and the right to withdraw from the study at any moment. When patients were willing to participate, the spiritual caregiver asked them to sign an informed consent form.

Data collection

Data collection took place between March and July 2018. Conversations took place at hospital wards or in the room of the spiritual caregiver and were audio recorded. Spiritual caregivers were instructed to ask their patients at the end of the conversation to briefly describe their R/S orientation or worldview, e.g., by asking them, "Can you tell me about your religious or spiritual orientation, or about your worldview?" Also, they were asked to report to the researcher (after the conversation took place) their own gender, age, denominational affiliation or ordination, and years of experience, and their patient's gender, age, R/S orientation, and how many conversations they had had with the patient.

Analysis

Recorded conversations were transcribed by the first author (AIL), assisted by transcription program F4. Both authors read and discussed four randomly selected transcripts and made a strategy to analyze the data. Data were analyzed using qualitative data-analysis program Atlas.ti.

The first author (AIL) coded the transcripts by adding codes to the communication techniques that were used by spiritual caregivers when talking about or discussing spiritual or existential themes, including religious and spiritual topics (e.g., affiliation to a religious tradition, ideology, R/S practices), ethical themes (e.g., euthanasia), and topics concerning identity, purpose, and meaning-making. Rather than using a deductive approach based on communication techniques used by other caregivers, e.g., psychologists (Lang & Van der Molen, 2012) or physicians (Lo et al., 2002), in this 'open-coding' phase (Boeije, 2012) inductive codes were used, since we wanted to assure that the communication techniques would fit the practices of spiritual caregivers. The codes were listed and a code tree was formed and discussed by both authors ('axial coding' (Boeije, 2012)). In an iterative process of going back-and-forth between the data and the code tree, additional codes were identified and/or codes were merged or refined. Then, the findings were integrated and relationships between codes were analyzed and discussed by both authors ('selective coding' (Boeije, 2012)). This led to a matrix that categorized and described relationships between the codes.

When deciding on how to categorize the codes, we aimed to find a categorization that a) fitted the data best as possible (e.g., a categorization that could be applied to most or all codes), and b) seemed relevant with regard to the study's second aim, namely that of investigating whether different techniques were used by spiritual caregiver-patient interaction with the same R/S affiliation compared to interactions where both had a different R/S affiliation. (By using the matrix chosen, we could, for instance, investigate whether spiritual caregivers in conversations with patients with the same R/S affiliation used R/S disclosing techniques more often compared to other conversations.) For the study's second aim, the final step of the analysis included a comparison between conversations in which the spiritual caregiver and the patient clearly affiliated with a different R/S tradition (e.g., a religious patient with a non-religious spiritual caregiver), conversations in which both affiliated with a the same R/S tradition (e.g., a Protestant patient with a Protestant spiritual caregiver), and conversations where both R/S affiliation were possibly similar or the same (e.g., a Protestant patient and a Catholic spiritual caregiver).

Results

Sample characteristics

13 spiritual caregivers participated in the study, from four medical centers (for sample's characteristics, see Table 1). Nearly half were men (n=6) and half were women (n=7). The mean age was 49 years (SD=12.61). Participants affiliated with[50] Protestantism (n=4), Roman-Catholicism (n=3), Islam (n=3), and Humanism (n=3). Respondents had a mean of 13 years (SD=10.75) experience as a spiritual caregiver.

The mean age of the 34 patients (17 female; 17 male) was 66 years (SD=13.31). Nearly half affiliated with Christianity, either Protestantism (n=11) or Catholicism (n=6), and some respondents (n=6) had another R/S orientation, such as Islam, Jehovah or spiritual (not explicitly linked to any of the world religions). Around one-third of respondents did not have an explicit R/S orientation (n=9).

[50] They were formally ordained or in an educational program to become ordained by this tradition.

Table 1. Sample's characteristics.

Spiritual caregivers (n=13)		*Patients (n=34)*	
Mean age	49.31 (SD=12.61)	Mean age[51][52]	66.25 (SD=13.31)
Men	6 (46%)	Men	17 (50%)
Women	7 (54%)	Women	17 (50%)
Affiliates with denomination:[53]		*Religious/spiritual orientation:*[54]	
Protestant	4 (31%)	Protestant	11 (34%)
Catholic	3 (23%)	Catholic	6 (19%)
Islam	3 (23%)	Islam	1 (3%)
Humanism	3 (23%)	Other	5 (16%)
		None	9 (28%)
Mean years of experience	12.69 (SD=10.75)		

Each spiritual caregiver recorded one to three conversations, leading to a total of 34 recorded conversations between spiritual caregivers and patients. About half (47%) of the conversations were first encounters and the other half (53%) were follow-up encounters. A total of 22hrs and 51.13 minutes of conversation were analyzed. The mean duration of the recorded conversations was 40.19 minutes (SD=16.23). The shortest conversation took 12.49 minutes and the longest 82.23 minutes.

In half of the records the spiritual caregivers asked the patient at the end of the conversation to briefly describe his or her R/S orientation. In most other recorded conversations, the patient's R/S orientation was talked about during the encounter and/or the spiritual caregiver had reported the patient's R/S orientation to the researcher, and could therefore be identified as well. In around one-third of records the spiritual caregiver and patient seemed to have the same R/S orientation (e.g., both Catholic, both Muslim; 29%), in around one-third of conversations they seemed to have quite a different R/S orientation (e.g., a Muslim with a Protestant, a Humanist with a Jehovah; 35%), and in around one-third of records they may have had a similar R/S orientation (e.g., a Protestant with a Catholic, a Humanist with someone who is unaffiliated; 35%) (see Table 2).

[51] For few respondents the exact age was estimated by the spiritual caregiver, so this is a rough indication of the mean age.

[52] n=32 (for two respondents their age is missing).

[53] Were formally ordained by this tradition or were in an educational program to become an ordained chaplain from that tradition.

[54] n=32 (for two respondents their spiritual/religious orientation is unknown).

Table 2. Characteristics and categorization of R/S affiliations in spiritual care interaction (n=34).

Category[a]	*Spiritual caregiver's affiliation*[55]	*Patient's R/S affiliation*	*N*
1	Protestant	Unaffiliated	2
	Catholic	Unaffiliated	2
	Muslim	Unaffiliated	2
	Humanist	Protestant	2
	Muslim	Christian/multiple religious belonging	1
	Muslim	Protestant	1
	Humanist	Catholic	1
	Humanist	Jehovah	1
		Subtotal	*12*
2	Protestant	Catholic	3
	Humanist	Unaffiliated	3
	Protestant	Christian origin	2
	Humanist	Unknown	2
	Catholic	Protestant	1
	Catholic	Spiritual	1
		Subtotal	*12*
3	Protestant	Protestant	6
	Catholic	Catholic	3
	Muslim	Muslim	1
	Subtotal		*10*

a. Category 1=the spiritual caregiver and patient seem to have different R/S affiliations; category 2=the spiritual caregiver and patient may have a similar R/S affiliation; category 3=the spiritual caregiver and patient seem to have the same R/S affiliation.

Communication techniques

The communication techniques that were used in the audio recorded conversations by spiritual caregivers to address and discuss spiritual and existential themes are listed in Table 3. Many of these techniques were characterized by a focus on either confirming or questioning the patient's R/S orientation. For instance, techniques such as agreeing to, clarifying/explicating and complimenting the patient's perspective mainly functioned as a means to empower or confirm the patient's point of view. Other techniques, such as asking in-depth or critical/provocative questions, providing a different perspective, and advising, focused much more on questioning the patient's R/S orientation. Also, there were some techniques—e.g., listening or repeating—that did not explicitly confirm nor question the patient's perspective.

The communication techniques that were used by spiritual caregivers also differed regarding the extent to which the spiritual caregiver disclosed his or her own R/S orientation.

[55] Affiliation refers to the tradition from which respondents were formally ordained or were in an educational program to become ordained.

Table 3: Overview of communication techniques and examples used by spiritual caregivers in spiritual care conversations when discussing or talking about existential themes.

Technique	*Examples*
Listening	"*Hm*", "*Yes*"
Repeating	Pt: "*Scared*." Sc: "*Scared*?" (Cv27[56]) Pt: "*To do things differently, and er, more consciously and er…" Sc: "More consciously?*" (Cv32)
Showing understanding/ following	"*No, no, exactly*." (Cv21) "*I see what you mean. Yes, yes*." (Cv18)
Paraphrasing	"*Somehow for you, certain processes in life are becoming more important actually*." (Cv7) "*And it was… so in your perception is, perception, yes, your experience is, is important to you. That you hear the voice (…).*" (Cv12)
Complimenting	"*Yes, those are… two fine words that you use. Sincerity and compassion*." (Cv13) "*Yes, beautiful. Yes, yes.*" (Cv21)
Clarifying/ explicating	"*But it is a, yes, a certain generosity I hear while listening to you, so er… about traditions (…) and and, that you, of course, also despite criticism on your own faith, you also try to (…) bring the beautiful aspects (…) with you. (…) And also the beautiful things which, that you notice with your friend*." (Cv13) Sc: "*You've looked around, you know what life has to offer. (…) Er and then, sometimes, you arrive at a certain point, in the middle of your life (…) and you think: How do I continue from here? Is this it?*" Pt: "*Yes, yes. That's what I experience, yes. But I hadn't thought of it like this*." (Cv24)
Emphasizing the patient's perspective (not the spiritual caregiver's)	Pt: "*And er, and perhaps that's superstition or something like that."* Sc: *"But for you it is (…) associated with it*." (Cv20) Pt: "*Isn't that what we're still living for?*" Sc: "*Yes, yes. That's what you're doing it for. Yes, yes*." (Cv5)
Reflecting emotions	"*Yes, so that makes you feel restless*." (Cv29) "*You feel safe here*." (Cv23)
Agreeing	"*Well, then you're unable to, to… yes, I agree with you on that. Then it gets very difficult*." (Cv20) "*Yes. Yes. No, I agree with you on that. (…) Tolerance is a vaporous… (…) layer*." (Cv24)
Showing admiration / being inspired	"*Are you aware that this is wonderful for me as well? It's also some sort of wisdom in life you offer me*." (Cv5) "*Well, that I can learn from you, I must say*." (Cv13)
Sharing own experience/ perspective	Pt: "*That hurts, yes. Without any, er, compassion.*" Sc: "*Yes, but yes, compassion that is er… yes, for me the essence (…) of what it should be all about, right?*" (Cv1) "*My heart is also a bit moved.*" (Cv13)
Sharing narrative	Sc: "*It reminds me of this story, from the Bi-… in, the story from the Bible about a hundred sheep, but there were nineteen nine…*" Pt: "*…found, and one was lost. Then he went searching, and found*." (Cv9)

[56] Cv=Conversation

	"*We then sang 'what the future may bring' [Christian song]. She told about… (…).*" (Cv30)
Emphasizing commonalities	"*Yes, indeed. And you own priest (…) and a humanist. (…) Yes. But still, we're all concerned with the things that, yes, that really matter, right.*" (Cv12) "*No, but this is a (…) …this is a joined quest, isn't it*?" (Cv23)
Offering ritual	"*Would you like me to pray with you?*" (Cv28) "*Well, we could also pray together and the communion (…) you can receive it from me (…).*" (Cv15)
Asking question about the patient's R/S orientation	"*What's your outlook on life?*" (Cv16) "*No, and er… Buddhism, how, how did you get in touch with that, or encountered that?*" (Cv13)
Asking clarifying question	"*Is the baby still closely connected to you, is that what you're saying?*" (Cv27) "*And is reformed er… is not liberal, right?*" (Cv12)
Asking in-depth question	"*Yes. And can you also, can you also tell what it means to you? What it means for, well yes, why you're so touched by this?*" (Cv21) "*And and what did it bring you? What wisdom er…?*" (Cv15)
Asking critical or provocative question	"*Yes, and you don't consider that in opposition with the [Islamic] fate?*" (Cv34) "*No. Yes. But what, what er, because I asked 'what is your ehm faith'. And you said: 'I'm a protestant.' (…) But you're not really involved, yet you're still a protestant?*" (Cv17)
Asking different question / changing topic	Pt: "*(…) it are only certain people who the Qur'an and the, the Bagavad Gita, and the holy books, who understand and fight against each other. (…)*" Sc: "*How are things at home? Do you have people who help you, or are you alone (…)?*" (Cv19) Pt: "*Because I pray for them every day, that they will help the people, and that sort of things. And also that I may get better. Yes*." Sc: "*You have been here for a while, haven't you?*" (Cv28)
Advising	"*Yes, well, yes, exactly. Look, it's just, it's an insight and (…) …er you do have your worries. (…) Mustn't you also consider the other side, that you did care for those who needed it, right? (…) In your work and in your family.*" (Cv21) Sc: "*Did you not already make a choice, sir [X], if I listen to you carefully?*" Pt: "*Well, I very much tend not to do that operation*." Sc: "*Exactly, that is what I hear you, between the lines, that is what I hear you saying.*" (Cv8)
Providing different perspective	"*I think that we perhaps er know around 10% of ourselves, once we've become a little old and wise. And that there is still a very rich world within ourselves, which we call our subconsciousness, which we do not know, that we're not aware of. (…) No, but that is my er… (…) that's just a theory that I place against it, right?*" (Cv23) "*But some people think they know what God, what God does exactly, right, (…) whereas others, yes, they keep it more open, so to say*." (Cv12)
Emphasizing differences	"*As an outsider it does seem er tough, yes.*" (Cv12) "*And of course I'm scared of that as well, but er yes, no, it's not something that occupies me actually*." (Cv31)

Some techniques, such as emphasizing commonalities or differences, sharing narratives, providing different perspectives, showing that one is inspired by the patient's R/S orientation, or offering rituals, implied that the spiritual caregiver disclosed (some of) his or her own R/S orientation. Meanwhile, other techniques, such as listening, asking clarifying questions, and paraphrasing, often did not require the spiritual caregiver to disclose their R/S orientation.

These two ways of describing the communication techniques used by spiritual caregivers were combined in a matrix with two axes (see Figure 1). The first, horizontal axis concerns the patient's R/S orientation, and the second, vertical axis is about the spiritual caregiver's R/S orientation in the encounter. The first axis describes the extent to which the spiritual caregiver complies with the patient's R/S orientation (by either confirming or questioning this perspective) and the second axis describes the extent to which the spiritual caregiver discloses his/her own R/S orientation. The combination of these two axes lead to four quadrants: 1) quadrant I represents techniques used to empower the patient's R/S orientation without the spiritual caregiver disclosing his/her own R/S orientation, such as paraphrasing, clarifying/explicating, and showing understanding/encouragement; 2) quadrant II includes techniques used to question the patient's perspective, also without the spiritual caregiver disclosing his/her own R/S orientation, such as asking clarifying or in-depth questions; 3) quadrant III contains confirmative techniques with regard to the patient's R/S perspective in which the spiritual caregiver discloses his/her R/S orientation, such as by explicitly agreeing to what the patient is saying, focusing on commonalities, sharing (R/S) narratives, and performing rituals; 4) and quadrant IV concerns techniques in which the spiritual caregiver questions the patient's perspective explicitly from his/her own R/S orientation, such as noting an opposing viewpoint, giving advice, and focusing on differences.

Of course, the quadrant that is most fitting to the communication technique depended on the way in which the technique was carried out. For instance, emotional reflections at times showed the spiritual caregiver's perspective (QIII, e.g., "*It's just so sad. Isn't it? (…) Yes. Yes. I'm a bit moved into tears myself as well.*" (Cv20), but did not always have to (QI, e.g., "*Yes, that's very painful indeed*." (Cv14)). Similarly, critical questions were sometimes asked while disclosing one's own R/S orientation (QIV, e.g., "*But I do think it's c-, eh, curious or remarkable that you say: 'Well, you know, you must do penance for your sin', to use that heavy word. But I think that the thing with sin is that you can only, eh, sin if you know what you've done wrong*." (Cv32)), but at other times they were asked in such a manner that the spiritual caregiver's perspective was not explicated (QII, e.g., "*Yes. You're telling me two things now, right, that is, you're saying that it was very frightening and also that is was very beautiful. (…)*

Because what made it so beautiful?" (Cv29)). In a similar vein, advising the patient was sometimes done in a way that it disclosed the spiritual caregiver's R/S orientation (QIV, e.g., "*And then it, it's most helpful if you try to focus less on the negative aspects… (…) and that's also, I think, something the good Lord says*." (Cv33[57])), but at other times this was done without doing so (QII, e.g., "*I also say this with regard to your surgical operation. (…) Perhaps you could find that woman in yourself again. (…) That woman that thinks: 'Ah, it will be allright'*." (Cv26)).

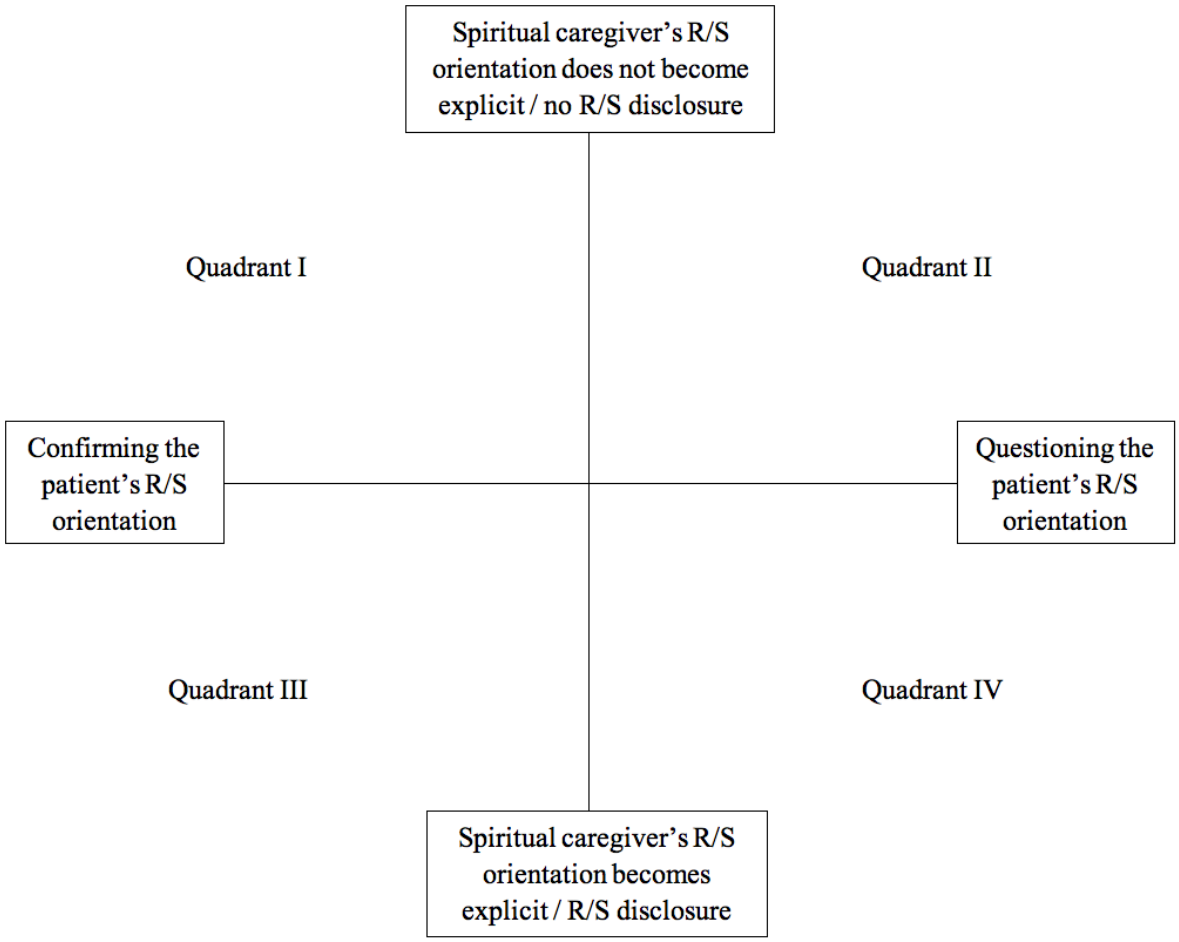

Figure 1. Matrix of communication techniques used by spiritual caregivers in spiritual caregiver-patient interactions. The horizontal axis represents the extent to which the spiritual caregiver complies with the patient's R/S orientation, and the vertical axis represents the extent to which the spiritual caregiver discloses his or her own R/S orientation.

[57] Cv=Conversation

Comparing same and interfaith encounters

When comparing the records of conversations in interfaith (category 1), possibly same faith (category 2), and same faith interactions (category 3; see Table 2), there were various similarities and some differences between the communication techniques used by spiritual caregivers. Overall, techniques in all quadrants were used by all three groups. Specifically, for confirmative techniques without disclosing the spiritual caregiver's R/S orientation (QI), most techniques—such as complimenting, clarifying/explicating, emphasizing the patient's perspective, and reflecting emotions—were used just as often in all groups. Other techniques—paraphrasing, repeating, and listening—were carried out more often in same than in interfaith encounters, whereas showing understanding/following was used more frequently in interfaith encounters.

Confirmative techniques that did disclose the spiritual caregiver's R/S orientation (QIII) seemed to show the most variability between the groups. Overall, techniques in this quadrant were used just as often by all groups. However, when looking at specific techniques, several differences were found. In same faith encounters spiritual caregivers more often shared narratives and offered rituals compared to interfaith encounters. Specifically, offering rituals as a technique was only used in same faith or possibly same faith encounters, and was not recorded in interfaith encounters. Meanwhile other techniques, such as complying with the patient's perspective via agreeing to this and sharing one's own experience or perspective, were used more often in interfaith than in same faith encounters. Showing admiration or explicating that one is inspired was only used by respondents in interfaith and possibly same faith encounters. Emphasizing commonalities was used by all groups.

Techniques that question the patient's R/S orientation—both from a non-disclosed point of view (QII) as well as from a R/S disclosed point of view (IV)—were applied by all groups, although overall respondents in same faith encounters questioned the patient slightly more often than respondents in interfaith encounters. Specifically, they more often asked clarifying and critical questions. Meanwhile, in interfaith encounters respondents more often gave advice and focused on R/S differences. There were no differences regarding other questioning techniques, such as questioning the patient about R/S topics as such, asking in-depth questions, changing topic and providing a different perspective.

Discussion

This study was conducted to identify communication skills or techniques used by Dutch spiritual caregivers working in hospitals, when they discussed spiritual and existential themes

with patients or clients from a variety of religious, spiritual, or non-religious/spiritual (R/S) orientations, and to compare these with regard to same and interfaith interactions. The findings suggest that spiritual caregivers use several techniques. These techniques can be described in a matrix with two axes, reflecting differences in the extent to which the technique used by the spiritual caregiver a) complies with the patient's R/S orientation, and b) discloses the spiritual caregiver's R/S orientation. Combining these two axes, we delineated four quadrants. Overall, in both same and interfaith encounters communication techniques from all four quadrants were used by spiritual caregivers, although some techniques were more often used in either of these encounters.

The description of spiritual caregivers' communication techniques along two axes provides us with new insight, for instance when compared to communication techniques used by other professionals. The horizontal axis—reflecting the compliance of the spiritual caregiver with the patient's R/S orientation—shows parallels with therapeutic styles used by spiritual and pastoral caregivers as well as other professionals. The distinction between confirming and questioning the patient's R/S orientation reminds us of the distinction between making 'facilitative' or 'directive' use of power in the Helping Style Inventory (HSI), and 'being with' the patient versus 'doing something for' the patient (VanKatwyk, 2003). The notion of confirming the patient's perspective is also reflected in the Rogerian assumption of 'unconditional positive regard' (Rogers, 1951). Nevertheless, we should keep in mind the practical-theological notion of presence: through his/her presence, the spiritual caregiver may already either confirm or question the patient's R/S orientation. In this regard, it is worth referring to Nolen (2011; 2012) who found four moments in the spiritual caregiver's or chaplain's being with the patient, of which the first was *evocative presence*. Through his/her presence, which often includes his/her ordination, the spiritual caregiver evokes certain responses in the patient, which show that he/she either confirmed or questioned the R/S orientation of the patient. Nolan's studies show that bearing or enduring these responses of patients is an important first step towards the spiritual caregiver becoming a hopeful presence for the patient.

The vertical axis—reflecting the extent to which the spiritual caregiver discloses his/her own R/S orientation—differs from common caregiving practices by other professionals. For many professional caregivers, like psychologists, physicians, social workers, it is common *not* to disclose one's own R/S orientation as a caregiver. Reasons for not disclosing one's own R/S orientation may be a lack of self-awareness regarding R/S topics (Magaldi & Trub, 2018), fear to antagonize the patient or client with a different R/S tradition (Cohen, Wheeler, & Scott,

2001), or the risk of imposing one's R/S orientation on the care receiver (Raab, 2007). By contrast, our study indicates that for nearly all spiritual caregivers (although to a varying degree) it *is* common to disclose one's R/S orientation, which may indicate a unique aspect of the spiritual care encounter, and which raises questions about why these spiritual caregivers disclose their own R/S orientation and how this relates to their understanding of the spiritual care encounter. Conversation analysis shows *how* spiritual caregivers disclose their own R/S orientation but it cannot show *why* spiritual caregivers do so. We offer some practical-theological reasons for why they may do so. A first reason is authenticity, which according to Taylor in his 'A secular age' is a central value of the age we live in (Taylor, 2007, pp. 473-504). In that case, explicating one's own R/S orientation is important for connecting with the patient and being authentic in the encounter, thereby highlighting the personal role of the spiritual caregiver and the importance of 'bearing witness' in the spiritual care encounter (Bidwell & Marshall, 2006; Ganzevoort & Visser, 2007; Heitink, 2001; Lartey, 2003; Liefbroer, Ganzevoort, & Olsman, 2019). For others, which marks a second practical-theological reason, disclosure of one's R/S orientation may be part of understanding one's position as spiritual caregiver in terms of one's confessional role, emphasizing the link to the R/S tradition to which one may affiliate and seeing spiritual care for instance as a form of ministry (Bidwell & Marshall, 2006; Ganzevoort & Visser, 2007; Heitink, 2001; Lartey, 2003; Liefbroer et al., 2019). Further research is needed to gain more insight into the relation between the communication techniques spiritual caregivers use in practice and their theological understanding of their profession, as well as patients' interpretations of spiritual caregivers' disclosure of their R/S orientation.

The finding that in spiritual caregiver-patient interactions—both with and without the same R/S affiliation—communication techniques from all four quadrants can be used suggests that having the same or a different R/S orientation does not—or not necessarily—require a spiritual caregiver to carry out a different set of communication skills. However, when looking with more detail at the findings, the comparison between same and interfaith encounters does suggest that certain techniques more often are applied in either of these encounters. Although some of these differences may be due to methodological limitations (see below), some of the findings seem relevant for studying same versus interfaith encounters and raise questions that could be investigated into more detail in future research. This specifically regards findings in quadrants III and IV. When affiliating with the same R/S tradition, it could be expected that spiritual caregivers are more likely to apply techniques from QIII, whereas in interfaith encounters it seems more likely that techniques from QIV are to be carried out. Our study

suggests indeed that the sharing of narratives and offering rituals[58] (QIII) is more common in same than in interfaith encounters, whereas focusing on R/S differences (QIV) is more likely to occur in interfaith encounters. Nevertheless, the finding that in interfaith encounters respondents seem more likely to *agree* with the patient's R/S orientation, to explicate that they are being inspired by this, to share their own experiences or perspectives, and to give advice, may seem less obvious at first glance. Future studies could investigate such differences more in-depth, for instance by taking into account the specific content of the conversations in relation to the communication techniques used.

Although this is one of the first studies to identify strategies based on actual recorded encounters, this study is limited in several ways. By analyzing audio records the focus was on the verbal techniques used by spiritual caregivers in their conversations, thereby ignoring other, non-verbal aspects of the conversation (e.g., the spiritual caregiver's attitude, manner of approaching the patient, making eye-contact, etc.), while these may have a significant impact on the way in which the conversation is shaped. Future studies could therefore explore the way in which spiritual caregivers interact with their patients or clients using other empirical methods, e.g., by analyzing video records.

In addition, due to the observational data used in this study, we do not know how patients experienced the way in which the spiritual caregiver interacted with him or her. We therefore cannot be sure whether a certain set of communication skills is indeed required for spiritual caregivers in order to address the spiritual and existential needs of a R/S diverse patient or client population. Also, we cannot ascertain what the effect is of disclosure of the spiritual caregiver's R/S orientation or questioning the patient's R/S perspective on the way in which patients experience the encounter. Future research may inquire into the patient perspective.

Finally, caution is needed when interpreting the findings with regard to the comparison between the groups due to methodological limitations. Since our sample consisted of 34 records, with 10 to 12 conversations per group in the comparison, this sample size is relatively small to draw definitive conclusions (e.g., for testing for significant differences between groups). Also, since the records were gathered by 13 spiritual caregivers, and the conversations may have been a bit longer than usual conversations (e.g., the mean encounter length in a sample in the USA was 22.5 minutes (SD=15.60) (Idler, Grant, Quest, Binney, & Perkins,

[58] Offering rituals is recorded in same faith encounters, while being absent in the recorded interfaith encounters. Although a survey in the Netherlands shows that many spiritual caregivers see possibilities for interfaith rituals (Liefbroer & Berghuijs, 2017; 2019), the results of this study suggest that—in practice—performing rituals is much more common for same faith than interfaith encounters.

2015), whereas in our sample the mean duration was 40.19 minutes (SD=16.23)), the records may not be representative of all encounters. Future studies with larger sample sizes could investigate the communication techniques used by spiritual caregivers in conversation with patients or clients from various R/S orientations.

One of the strengths of the model presented in this study is that it can be used not only by spiritual caregivers or chaplains, but also by other caregivers, such as other religiously authorized caregivers (e.g., priests and ministers), and healthcare professionals (e.g., psychologists, social workers, psychiatrists, physicians) who are asked to address the spiritual or existential domain as part of their patient-centered or whole-person care (Chuengsatiansup, 2003; De Haan, 2017; Huber et al., 2016; WHO, 2002; Puchalski, Vitillo, Hull, & Reller, 2014; Sulmasy, 2002). They can use the model as a means to analyze the way in which they interact with their clients, and to consider the extent to which they comply with the client's R/S orientation and share their own R/S orientation. Being able to use communication techniques from each of the quadrants may, in addition, assist caregivers in addressing the existential domain with patients or clients with a variety of R/S orientations.

This study has offered a first step in making visible what spiritual caregivers actually do when caring for patients with a diversity of R/S orientations. The presented model, which is based on a qualitative conversation analysis of spiritual care encounters, contributes to theory on spiritual care in a spiritually diverse context and supports caregivers, be it spiritual or other caregivers, to reflect on how they provide spiritual care and when and how they disclose their own R/S orientation during encounters with patients or clients. Based on our findings, future studies may formulate and test hypotheses. Our hope is that more empirical research will be conducted in order to show what spiritual care actually looks like in practice.

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