Anke I. Liefbroer* and Erik Olsman

Spiritual Talk: Addressing Existential Themes in Interfaith Encounters

<https://doi.org/10.1515/ijpt-2019-0021>

Abstract: Spiritual caregivers increasingly care for clients with other religious/spiritual (R/S) orientations than their own. To date, the ways in which spiritual caregivers deal with these differences have hardly been explored. 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

Zusammenfassung: Seelsorger sorgen zunehmend für Klienten mit einer religiösen / spirituellen (R/S) Orientierung, die sich von ihrer eigenen unterscheidet. Es ist jedoch kaum untersucht, wie sie mit diesen Unterschieden umgehen. Basiert auf einer Analyse von Audioaufzeichnungen von 34 Interaktionen zwischen Seelsorger und Patienten beschreibt dieses Studium die Methoden, die von Seelsorger angewendet werden, um existenzielle Themen mit Patienten mit verschiedenen R/S Orientierungen zu besprechen. Das vorgestellte Modell beschreibt wie Seelsorger sich anpassen an die R/S Orientierung des Patienten, und ihre eigene R/S Orientierung offenlegen. Dieses Modell kann verwendet werden, um zu analysieren wie Seelsorger mit ihren Klienten umgehen können.

Stichwörter: Seelsorge, Interaktionen, Existenzielle Themen, Verschiedenheit, Kommunikationstechniken

***Corresponding author: Dr. Anke I. Liefbroer**, Vrije Universiteit Amsterdam, Faculty of Religion and Theology, Amsterdam, Tilburg University, Tilburg School of Catholic Theology, Tilburg, E-Mail: a.i.liefbroer@vu.nl

Dr. Erik Olsman, Protestant Theological University, Practices, Section of Spiritual Care & Chaplaincy Studies, Groningen, E-Mail: h.j.olsman@pthu.nl

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.¹ 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,² requiring empirical research that examines spiritual care in this changing R/S landscape.

In the existing literature, several authors focus on spiritual caregiving to patients or clients with various R/S orientations.³ Cadge and Sigalow, 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.⁴ Also, the use of “non-religious language” in conversations between a Christian nurse and a

1 Stefan Gärtner, Jacques Körver, and Martin Walton, “Von Fall Zu Fall. Kontext, Methode Und Durchführung Eines Empirischen Forschungsprojekts Mit Casestudies In Der Seelsorge,” *International Journal of Practical Theology* 23, no. 1 (2019): 98–114; Annelieke Damen, Allison Delaney, and George Fitchett, “Research Priorities for Healthcare Chaplaincy: Views of U.S. Chaplains,” *Journal of Health Care Chaplaincy* 24, no. 2 (2018): 57–66; Annelieke Damen et al., “Research Priorities for Health Care Chaplaincy in the Netherlands: A Delphi Study among Dutch Chaplains,” *Journal of Health Care Chaplaincy* 26, no. 3 (2019): 1–16; George Fitchett et al., “Evidence-Based Chaplaincy Care: Attitudes and Practices in Diverse Healthcare Chaplain Samples,” *Journal of Health Care Chaplaincy* 20, no. 4 (2014): 144–60.

2 Amy L. Ai and Thomas R. McCormick, “Increasing Diversity of Americans’ Faiths Alongside Baby Boomers’ Aging: Implications for Chaplain Intervention in Health Settings,” *Journal of Health Care Chaplaincy* 16, no. 1–2 (2010): 24–41; Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago, IL: The University of Chicago Press, 2012).

3 Jamie D. Aten, Michael W. Mangis, and Clark Campbell, “Psychotherapy with Rural Religious Fundamentalist Clients,” *Journal of Clinical Psychology* 66, no. 5 (2010): 513–23; Margaret A. Miklancie, “Caring for Patients of Diverse Religious Traditions: Islam, a Way of Life for Muslims,” *Home Healthcare Nurse* 25, no. 6 (2007): 413–417; Dawn Chaplin, “A Bereavement Care Service to Address Multicultural User Needs,” *Nursing Times* 99, no. 39 (2003): 26–9; Josephine Dijoseph and Roberta Cavendish, “Expanding the Dialogue on Prayer Relevant to Holistic Care,” *Holistic Nursing Practice* 19, no. 4 (2005): 147–154; P. Scott Richards and Allen E. Bergin, *Handbook of Psychotherapy and Religious Diversity*. Second Edition (Washington, DC: American Psychological Association, 2014).

4 Wendy Cadge and Emily Sigalow, “Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare,” *Journal for the Scientific Study of Religion* 52, no. 1 (2013): 146–158.

non-religious patient,⁵ and going along with the care receiver's point of view (or taking a "patient-centered viewpoint"), have been reported in this regard.⁶

However, as shown in a recent systematic review of the literature,⁷ such empirical studies are scarce, mainly conducted in North-America,⁸ 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.⁹

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.

⁵ Elizabeth J. Taylor, Carla G. Park, and Jane B. Pfeiffer, "Nurse Religiosity and Spiritual Care," *Journal of Advanced Nursing* 70, no. 11 (2014): 2612–2621.

⁶ Mark R. Ellis and James D. Campbell, "Concordant Spiritual Orientations as a Factor in Physician-Patient Spiritual Discussions: A Qualitative Study," *Journal of Religion and Health* 44, no. 1 (2005): 39–53; Claire Mayers et al., "How Clients with Religious or Spiritual Beliefs Experience Psychological Help-Seeking and Therapy: A Qualitative Study," *Clinical Psychology & Psychotherapy* 14, no. 4 (2007): 317–27.

⁷ Anke I. Liefbroer et al., "Interfaith Spiritual Care: A Systematic Review," *Journal of Religion and Health* 56, no. 5 (2017): 1776–93.

⁸ Peter L. Berger, Grace Davie, and Effie Fokas, *Religious America, Secular Europe? A Theme and Variation* (Aldershot, United Kingdom: Ashgate, 2008). Since religion is perceived differently in North America compared to other contexts (e.g., the highly secularized and pluralized Western European context) it is unsure whether the strategies identified in that context can be applied to other contexts, such as the European one.

⁹ Taylor et al., "Nurse Religiosity" (n. 5); Ellis and Campbell, "Concordant Spiritual Orientations." (n. 6); Mayers et al., "How Clients" (n. 6).

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.¹⁰ The Netherlands form an ideal setting to identify the way in which R/S differences are dealt with, since it is 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 %).¹¹ Another study reports that 17–23 % of the Dutch population combine elements from various religious traditions altogether.¹² The hospital setting was chosen since spiritual caregivers working in these settings regularly encounter patients from all kinds of backgrounds,¹³ providing an excellent context in which to study the way in which R/S differences are dealt with.

Recruitment

Spiritual caregivers working in either academic or regional medical centers 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,¹⁴ and with an equal distri-

10 See e.g., Uwe Flick, *An Introduction to Qualitative Research*. Fifth Edition. (London, UK: SAGE, 2014); John Heritage, and Steven Clayman, *Talk in Action: Interactions, Identities, and Institutions* (Chichester, UK: Wiley-Blackwell, 2010).

11 “Religieuze betrokkenheid” [Religious affiliation], Centraal Bureau voor de Statistiek (website), accessed June 19, 2019, <https://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=82904ned&D1=8-12&D2=0&D3=a&VW=T>.

12 Joantine Berghuijs, “Multiple Religious Belonging in the Netherlands: An Empirical Approach to Hybrid Religiosity,” *Open Theology*, no. 3 (2017): 19–37.

13 Cadge, *Paging God* (n. 2), 13; Jaap Doolaard, *Nieuw Handboek Geestelijke Verzorging* [New handbook of spiritual caregiving] (Kampen, The Netherlands: Kok, 2006).

14 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.

bution 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 an 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 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, for example, 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 about their own gender, age, denominational affiliation or ordination, and years of experience, and also 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., psychologists¹⁵ or physicians¹⁶, in this “open-coding” phase¹⁷ 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”¹⁸). 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”¹⁹). 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) fit 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

15 Gerrit Lang and Henk T. van der Molen, *Psychologische Gespreksvoering. Een Basis voor Hulpverlening [Psychological Conversation Techniques. A Guide for Caregiving]* (Amsterdam, The Netherlands: Boom, 2012).

16 Bernard Lo et al., “Discussing Religious and Spiritual Issues at the End of Life: A Practical Guide for Physicians,” *JAMA: Journal of the American Medical Association* 287, no. 6 (2002): 749–54.

17 Hennie Boeije, *Analyseren in Kwalitatief Onderzoek. Denken en Doen. [Analysing in Qualitative Research. Thinking and Acting.]* (Den Haag, The Netherlands: Boom Lemma, 2012).

18 Ibid.

19 Ibid.

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 with²⁰ 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.

Table 1: Sample’s characteristics.

<i>Spiritual caregivers (n=13)</i>		<i>Patients (n=34)</i>	
Mean age	49.31 (SD=12.61)	Mean age ^{21, 22}	66.25 (SD=13.31)
Men	6 (46 %)	Men	17 (50 %)
Women	7 (54 %)	Women	17 (50 %)
<i>Affiliates with denomination:</i> ²³		<i>Religious/spiritual orientation:</i> ²⁴	
Protestant	4 (31 %)	Protestant	11 (34 %)
Catholic	3 (23 %)	Catholic	6 (19 %)

20 They were formally ordained or in an educational program to become ordained by this tradition.

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

22 n=32 (for two respondents their age is missing).

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

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

Table 1: (continued)

<i>Spiritual caregivers (n=13)</i>		<i>Patients (n=34)</i>	
Islam	3 (23 %)	Islam	1 (3 %)
Humanism	3 (23 %)	Other	5 (16 %)
		None	9 (28 %)
Mean years of experience	12.69 (SD=10.75)		

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’s Witness 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).

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 22 hours 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’s Witness; 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).

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

<i>Category^a</i>	<i>Spiritual caregiver's affiliation²⁵</i>	<i>Patient's R/S affiliation</i>	<i>N</i>
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
	<i>Subtotal</i>		<i>12</i>
2	Protestant	Catholic	3
	Humanist	Unaffiliated	3
	Protestant	Christian origin	2
	Humanist	Unknown	2
	Catholic	Protestant	1
	Catholic	Spiritual	1
	<i>Subtotal</i>		<i>12</i>
3	Protestant	Protestant	6
	Catholic	Catholic	3
	Muslim	Muslim	1
	<i>Subtotal</i>		<i>10</i>

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.

²⁵ Affiliation refers to the tradition from which respondents were formally ordained or were in an educational program to become ordained.

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. 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.

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 ²⁶) 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)

26 Cv=Conversation

Table 3: (continued)

<i>Technique</i>	<i>Examples</i>
Paraphrasing	<p><i>"Somehow for you, certain processes in life are becoming more important actually."</i> (Cv7)</p> <p><i>"And it was... so in your perception is, perception, yes, your experience is, is important to you. That you hear the voice (...)." (Cv12)</i></p>
Complimenting	<p><i>"Yes, those are... two fine words that you use. Sincerity and compassion."</i> (Cv13)</p> <p><i>"Yes, beautiful. Yes, yes."</i> (Cv21)</p>
Clarifying/explicating	<p><i>"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."</i> (Cv13)</p> <p>Sc: <i>"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?"</i> Pt: <i>"Yes, yes. That's what I experience, yes. But I hadn't thought of it like this."</i> (Cv24)</p>
Emphasizing the patient's perspective (not the spiritual caregiver's)	<p>Pt: <i>"And er, and perhaps that's superstition or something like that."</i> Sc: <i>"But for you it is (...) associated with it."</i> (Cv20)</p> <p>Pt: <i>"Isn't that what we're still living for?"</i> Sc: <i>"Yes, yes. That's what you're doing it for. Yes, yes."</i> (Cv5)</p>
Reflecting emotions	<p><i>"Yes, so that makes you feel restless."</i> (Cv29)</p> <p><i>"You feel safe here."</i> (Cv23)</p>
Agreeing	<p><i>"Well, then you're unable to, to... yes, I agree with you on that. Then it gets very difficult."</i> (Cv20)</p> <p><i>"Yes. Yes. No, I agree with you on that. (...) Tolerance is a vaporous... (...) layer."</i> (Cv24)</p>
Showing admiration / being inspired	<p><i>"Are you aware that this is wonderful for me as well? It's also some sort of wisdom in life you offer me."</i> (Cv5)</p> <p><i>"Well, that I can learn from you, I must say."</i> (Cv13)</p>

Table 3: (continued)

<i>Technique</i>	<i>Examples</i>
Sharing own experience/perspective	Pt: <i>"That hurts, yes. Without any, er, compassion."</i> Sc: <i>"Yes, but yes, compassion that is er... yes, for me the essence (...) of what it should be all about, right?"</i> (Cv1) <i>"My heart is also a bit moved."</i> (Cv13)
Sharing narrative	Sc: <i>"It reminds me of this story, from the Bi... in, the story from the Bible about a hundred sheep, but there were nineteen nine..."</i> Pt: <i>"...found, and one was lost. Then he went searching, and found."</i> (Cv9) <i>"We then sang 'what the future may bring' [Christian song]. She told about... (...)." (Cv30)</i>
Emphasizing commonalities	<i>"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."</i> (Cv12) <i>"No, but this is a (...) ...this is a joined quest, isn't it?"</i> (Cv23)
Offering ritual	<i>"Would you like me to pray with you?"</i> (Cv28) <i>"Well, we could also pray together and the communion (...) you can receive it from me (...)." (Cv15)</i>
Asking question about the patient's R/S orientation	<i>"What's your outlook on life?"</i> (Cv16) <i>"No, and er... Buddhism, how, how did you get in touch with that, or encountered that?"</i> (Cv13)
Asking clarifying question	<i>"Is the baby still closely connected to you, is that what you're saying?"</i> (Cv27) <i>"And is reformed er... is not liberal, right?"</i> (Cv12)
Asking in-depth question	<i>"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?"</i> (Cv21) <i>"And and what did it bring you? What wisdom er...?"</i> (Cv15)
Asking critical or provocative question	<i>"Yes, and you don't consider that in opposition with the [Islamic] fate?"</i> (Cv34) <i>"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?"</i> (Cv17)

Table 3: (continued)

<i>Technique</i>	<i>Examples</i>
Asking different question / changing topic	<p>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)</p> <p>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)</p>
Advising	<p>“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)</p> <p>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)</p>
Providing different perspective	<p>“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)</p> <p>“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)</p>
Emphasizing differences	<p>“As an outsider it does seem er tough, yes.” (Cv12)</p> <p>“And of course I’m scared of that as well, but er yes, no, it’s not something that occupies me actually.” (Cv31)</p>

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 de-

scribes 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 their 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 their 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 their 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 their 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 their 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, advising the patient was sometimes done in a way that 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."* [Cv33²⁷]), 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 all right'"* [Cv26]). 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, 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]).

27 Cv=Conversation

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.

Comparing Same and Interfaith Encounters

When comparing the records of conversations in interfaith (category 1), possibly same-faith (category 2), and same-faith (category 3) interactions (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 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 the 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 with communi-

cation 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.²⁸ The notion of confirming the patient's perspective is also reflected in the Rogerian assumption of “unconditional positive regard.”²⁹ Nevertheless, we should keep in mind the practical-theological notion of presence: through their presence, spiritual caregivers may already either confirm or question the patients' R/S orientation. In this regard, it is worth referring to Nolan³⁰ who found four moments in the spiritual caregiver's or chaplain's “being with” the patient, of which the first was *evocative presence*. Through their presence, which often includes their ordination, spiritual caregivers evoke certain responses in the patient, which show that they 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 their 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,³¹ fear of antagonizing the patient or client with a different R/S tradition,³² or the risk of imposing one's R/S orientation on the care receiver.³³ By contrast, our study indicates that for nearly all spiritual

28 Peter L. VanKatwyk, *Spiritual Care and Therapy: Integrative Perspectives* (Waterloo, ON: Wilfred Laurier University Press, 2003).

29 Carl R. Rogers, *Client-Centered Therapy: Its Current Practice, Implications and Theory* (Boston, MA: Houghton Mifflin, 1951).

30 Steve Nolan, “Hope Beyond (Redundant) Hope: How Chaplains Work with Dying Patients”, *Palliative Medicine* 25, no. 1 (2011): 21–25; Steve Nolan, *Spiritual Care at the End of Life: The Chaplain as a ‘Hopeful Presence’* (London, UK: Jessica Kingsley Publishers, 2012).

31 Danielle Magaldi and Leora Trub, “(What) Do You Believe?: Therapist Spiritual/Religious/Non-Religious Self-Disclosure,” *Psychotherapy Research* 28, no. 3: (2018): 484–98.

32 Cynthia B. Cohen, Sondra E. Wheeler, and David A. Scott, “Walking a Fine Line: Physician Inquiries into Patients' Religious and Spiritual Beliefs,” *Hastings Center Report* 31, no. 5 (2001): 29–39.

33 Kelley A. Raab, “Manic Depression and Religious Experience: The Use of Religion in Therapy,” *Mental Health, Religion and Culture* 10, no. 5 (2007): 473–87.

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 will now offer some practical-theological reasons for why they may do so. A first reason is authenticity, which according to Charles Taylor in his *A Secular Age*, is a central value of the age we live in.³⁴ 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.³⁵ For others, marking 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.³⁶ 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 does not necessarily—require a spiritual caregiver to carry out a different set of communication skills. However, when looking at the findings in greater detail, 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

34 Charles Taylor, *A Secular Age* (Cambridge, MA: The Belknap Press, 2007), 473–504.

35 R. Ruud Ganzevoort and Jan Visser, *Zorg voor het Serhaal. Achtergrond, Methode en Inhoud van Pastorale Begeleiding [To Care for the Story. Background, Method and Content of Pastoral Counseling]* (Zoetermeer, The Netherlands: Meinema, 2007); Anke I. Liefbroer, R. Ruud Ganzevoort, and Erik Olsman, "Addressing the Spiritual Domain in a Plural Society: What Is the Best Mode of Integrating Spiritual Care into Healthcare?," *Mental Health, Religion & Culture* 22, no. 3 (2019): 244–60; Gerben Heitink, *Biografie van de Pominee [Biography of the Pastor]* (Baarn, The Netherlands: Ten Have, 2001); Duane R. Bidwell and Joretta L. Marshall, "Formation: Content, Context, Models and Practices," *American Journal of Pastoral Counseling* 8, no. 3–4 (2006): 1–7. Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling* (London, UK: Jessica Kingsley Publishers, 2003).

36 Ibid.

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 rituals³⁷ (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 considering 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 such as 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, for example, 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 them. 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 about the way in which

37 Anke I. Liefbroer and Joantine Berghuijs, "Religieuze en Levensbeschouwelijke Diversiteit in het Werk van Geestelijk Verzorger," [Religious and Worldview Diversity in the Work of Spiritual Caregivers] *Tijdschrift Geestelijke Verzorging* 20, no. 3 (2017): 24–33; "Spiritual Care for Everyone? An Analysis of Personal and Organizational Differences in Perceptions of Religious Diversity among Spiritual Caregivers," *Journal of Health Care Chaplaincy* 25, no. 3 (2019): 110–129. This survey conducted in the Netherlands shows that many spiritual caregivers see possibilities for interfaith rituals. However, the results of the current study suggest that—in practice—performing rituals is much more common for same-faith than interfaith encounters.

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],³⁸ 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 health-care 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.³⁹ 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.

38 Ellen L. Idler et al., "Practical Matters and Ultimate Concerns, "Doing," and "Being": A Diary Study of the Chaplain's Role in the Care of the Seriously Ill in an Urban Acute Care Hospital," *Journal for the Scientific Study of Religion* 54, no. 4 (2015): 722–38.

39 Komatra Chuengsatiansup, "Spirituality and Health: An Initial Proposal to Incorporate Spiritual Health in Health Impact Assessment," *Environmental Impact Assessment Review* 23 (2003): 3–15; M. Huber et al., "Towards a 'Patient-Centred' Operationalisation of the New Dynamic Concept of Health: A Mixed Methods Study," *BMJ Open* 5, no. 1 (2016): e010091; Christina M. Puchalski et al., "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (2014): 642–656; Sanneke de Haan, "The Existential Dimension in Psychiatry: An Enactive Framework," *Mental Health, Religion & Culture* 20, no. 6 (2017): 528–35; "WHO Definition of Palliative Care," World Health Organization (website), accessed 17 May, 2018, <http://www.who.int/cancer/palliative/definition/en/>; Daniel P. Sulmasy, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," *Gerontologist* 42, no. 3 (2002): 24–33.

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.

Acknowledgement: The authors would like to thank R. Ruud Ganzevoort for his valuable comments and advice on earlier versions of this manuscript.