17th Consultation
European Network of Health Care Chaplaincy
Greece, Chania (Crete), 11-15 May 2022

Connecting Heart to Heart –
Being a Chaplain & Being with Others

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Being Handy or Being in the Way? Reflection of the Experience of Czech Hospital Chaplains during the Pandemic and its Influence on their Self-identity

Ondřej Doskočil
The Catholic Association of Hospital Chaplains in the Czech Republic; University of South Bohemia – Faculty of Health and Social Studies, Czech Republic

Thursday 12th May, 3.15-4.00 pm
Paper on relevant research

Background in chaplaincy
The current pandemic caught the Czech hospital chaplaincy in the phase of institutionalisation pointing out some neuralgic points of this process. Especially, the level of acceptance of the chaplain in the hospital and the willingness to really perceive him/her as part of the hospital team has become evident.

Aim of contribution
The paper deals with the experience of Czech hospital chaplains during the pandemic of Covid-19 in 2020. The goal of the paper is to describe and interpret subjectively perceived changes in the role of chaplain during the pandemic. It also deals with the impact of the pandemic on the chaplain's work with patients and tries to identify potential problem areas or, conversely, sources of support for the chaplain's role.

Method of research
The research is based on a qualitative research strategy. A self-designed questionnaire with mostly open-ended questions and subsequent supplementary semi-controlled interviews were used. The research set included 39 chaplains who actively provide a spiritual care in Czech hospitals. For the purposes of the survey, we constructed the questions which were inspired by the ERICH survey (International Survey of Chaplain Activity and Experience during Covid-19 Pandemic) and were based on our own experience and our previous partial research and studies.

Results of research
The results of the research are presented in four thematic blocks: chaplain and institutions, chaplain and staff, chaplain and patient, and the chaplain himself. We conclude that the pandemic affected the self-concept of many Czech hospital chaplains. It mainly depended on their effectiveness, that is, the possibility of applying their skills, in the hospital during the pandemic. In many cases, the pandemic crisis has accelerated the development of relations with the institution and staff. The position of the chaplain in the hospital before the outbreak of the pandemic proved to be crucial.

Discussion of results
Chaplains in our research felt that their abilities and capacities could be used in a more efficient way if they received a signal from others that there was interest in their service. It is worth noting that the results of the above-mentioned ERICH questionnaire led to a similar conclusion. It is interesting that chaplains formulated the benefits of one's own work less as religious and more at a psychological level, which is a repeated finding in foreign literature.

Questions for discussion
1. Is the chaplain's acceptance in the hospital based more on his professionalism (spiritual care provider) or more on his / her personality (good man / woman)?
2. Can hospital chaplains provide patients with something that other staff cannot, especially in the context of a secularized society and non-religious people?
3. Is the experience of Czech chaplains specific in anything?

References
Our research was published in: DOSKOČIL, O., BELÁŇOVÁ, A. Hospital Chaplaincy during the Covid-19 Pandemic. *Caritas et Veritas*, 2021, roč. 11, č. 1, s. 128-148. For more information about our research see https://www.pastoralezorg.be/page/theology/#Czech

Caring as a "Portmanteau Professional"

Simon Harrison
President, College of Health Care Chaplaincy, United Kingdom

Thursday 12th May, 3.15-4.00 pm
Paper on good practices

Background in chaplaincy

Having delivered Acute and MH Chaplaincy since 1997, I have led the main professional body (UK) for over 4 years. My work is mostly in smaller teams, so direct patient/staff care is still a daily part of life.

Aim of contribution

I am frustrated with attempts to over simplify chaplaincy – reducing to 'spiritual care' or 'pastoral care' for example. These are fine 'shorthand' but good practice is delivering subtle and complex care from within a portmanteau of options, often assessed in the very the moment of an encounter.

Description of good practice

I have developed the CRISP model received well at Blankenberge further. A new CRISPER© model describes what we do in an encounter using a broad range of common English terms (Cultural, Religious, Individual (existential), Spiritual, Pastoral, Emotional and Relational Care). This does not compete with the clarity of the taxonomy work but aims to 'paint a picture' of the *breadth* of what good care looks like.
We may be called to a patient because a nurse thinks they need 'emotional support'- but a competent Chaplain may assess need for 'spiritual and/or religious care', or 'relational care' or something different again and so will plan/deliver this. Such complex assessment and delivery is at the heart of good practice.

Discussion of good practice

If the above is true- it has consequences for workforce development, education, delivery and all our communication about chaplaincy. Chaplains must assess and be skilled in the breadth of what they can deliver, seeking broader ongoing learning, and all our communication must emphasise that we can care in many different ways.

Questions for discussion

- Do we need such a broad and potentially complex self-understanding of Chaplaincy care?
- How does this practice relate to 'generic' and 'faith based' models of providing care?
- How do we stop others who seek to fit us into a single box (e.g. 'religious care' or a vague 'spiritual care'?)

Collaboration, knowledge building and knowledge sharing in primary health care and social care chaplaincy: a knowledge workplace in The Netherlands

Gaby Jacobs, Annelieke Damen & Carmen Schuhmann
University of Humanistic Studies, Utrecht, The Netherlands

Thursday 12th May, 3.15-4.00 pm
Paper on relevant research

Background in chaplaincy
Up until recently, healthcare chaplaincy for people living at home was not available or financial compensation was difficult. With older people and people with chronic disease increasingly living at home, the Dutch government decided to start a pilot with the funding of chaplaincy 'at home' and to start a research programme in this field.
In October 2021, 15 organisations, including nine universities, two professional associations, two university medical centers, a social care foundation and the steering group for chaplaincy 'at home', have started a national knowledge workplace. ZonMw, the organisation for health care research in The Netherlands, has provided funding in addition to the financial contributions of all partners. The aim of the knowledge workplace is the professional development of health and social care chaplaincy 'at home'. To achieve this aim, the knowledge workplace includes three kinds of activities. First of all, the building of a platform for collaboration and knowledge sharing. Secondly, the building of a learning community, based in 10 learning networks around specific chaplaincy interventions. Thirdly, outcome research based on existing data and data from the 10 learning networks.
Recently, ZonMw has invited us to extend the knowledge workplace by including other healthcare and social care professions that provide spiritual care.

Aim of contribution
The aim of this contribution is to highlight the developments in The Netherlands, and how we try to foster professional development of chaplaincy by conducting research and knowledge sharing.

Method of research
A mixed methods and collaborative research approach is used to build knowledge to foster the professional development of chaplaincy 'at home'.

Results of research
Preliminary results show that chaplaincy 'at home' is an interdisciplinary endeavour and takes different forms. Language is developed to articulate client and professional needs, activities and outcomes.

Discussion of results
The extension of the knowledge workplace to other professionals offers the opportunity for chaplaincy to be seen and recognized by other professions and to strengthen the interdisciplinary collaboration. However, there are risks involved as well. The expansion may come too early, as chaplaincy 'at home' is still developing its professional identity. The expansion may also lead to a more diffuse knowledge workplace, with too many different interests and each profession having their own struggles in legitimizing their work.

Questions for discussion
- What do you feel are the primary requirements for an expansion of the knowledge workplace to other professions to be successful?
- Do we have the necessary ingredients (platform, learning community, outcome research) available for the professional development of chaplaincy 'at home' or is something missing?
- How do you feel the professional identity of chaplaincy 'at home' is different from the spiritual care given by other professionals?

Experiences of multidisciplinary sharing and training on spirituality and medical care

Tullio Proserpio
Fondazione IRCCS Instituto Nazionale dei Tumori, Milano, Italy

Thursday 12th May, 3.15-4.00 pm
Paper on good practices

Background in chaplaincy

Spiritual assistance activities are organized in a different way in the various countries of Europe according to the different laws and heterogeneous social realities.
Especially during the period of Covid19 the importance of Spirituality has grown a lot but, unfortunately, this aspect often appears as the last step for patients, family members and staff. The pronouncements of the European Parliament of 2018 show everyone that the centrality of spirituality for patients and for each person is the important and relevant part for them and not only in the last phase of treatment.
In many hospital settings it is the chaplains who carry out the activity of spiritual assistance, being specialists in the spiritual care of the sick and having received specific training. Considering assistance to spiritual needs as part of the care process however requires a review of traditional practices, about it, and the training of all practitioners in recognizing also the spiritual needs of patients. Internationally, particularly in the United States, various efforts are underway to develop research and training on spiritual assistance that also includes training chaplains in scientific research and / or encouraging their participation in scientific activities.

Aim of contribution

In this abstract we report an experience underway in Italy, where the protection of health is a constitutional right, and the need for an evolution of the hospital pastoral care is equally felt to respond to the needs of a community, increasingly multireligious and multicultural.

Description of good practice

Three years ago, the Study Group on Spirituality in Care was established (www.curaspirituale.it), which brings together scholars from different disciplines and clinicians interested in studying the role of spirituality in patient care and healthcare organization. The group aims to promote the promotion of scientific research, training and culture on this topic, according to the methodological parameters currently accredited in the scientific field.

Discussion of good practice

In particular, the planned activities are as follows:

- Creation of a collaborative network between clinicians, chaplains and researchers interested in the subject, with the help of websites and other online resources.
- Drafting of a research program.
- Promotion of training initiatives for health workers and chaplains.
- Promotion of research activities also through scholarships.
- Dissemination and awareness of operators and the population in general on the subject through conferences and media.

Questions for discussion

- What further steps do you think are necessary to make the attention to the spiritual dimension evolve?
- Do you think it may be necessary to better define a shared training program for chaplains to be approved at European level?
- How to include attention to the spiritual dimension in the basic study and training courses for doctors, nurses, social workers, psychologists, care teams, etc.?

Encountering patients: a dynamic process of clarifying their spiritual needs, assessing the processes that take place within the intervention and searching for outcomes

Eva Buelens & Lindsy Desmet
KU Leuven, Faculty of Theology and Religious Studies, Research Unit Pastoral and Empirical Theology, Belgium

Thursday 12th May, 4.15-5.00 pm
Paper on relevant research

Background in chaplaincy
First, at the beginning of each encounter and to provide best possible care for patients, it is needed to recognize the spiritual growth process of people and to assess the current spiritual needs. As a chaplain you get to know the patient: 'who are you?' (Mackinlay, 2001; Monod et al., 2010; Hodge et al., 2012; Erichsen & Büssing, 2013). Second, we want to investigate 'how' the chaplain takes care. The encounter between chaplain and patient is characterized by specific processes within the patient that are triggered by the interventions of the chaplain

Aim of contribution
In this contribution, we distinguish three crucial elements in the encounter between a chaplain and a hospital patient and link them with our outcome-oriented studies that are currently progressing in Belgium. These studies want to provide an answer to the international call in the Salzburg statement (ENHCC, 2014) to invest in outcome-oriented research to promote chaplaincy as a research-informed profession.

Method of research
Literature review + cross-sectional study on spiritual needs and intervention-study on outcomes. The research of Eva Buelens and Lindsy Desmet is part of a shared outcome-research project at KU Leuven on spiritual care in hospitals in Belgium. More specific, the study of Lindsy Desmet focuses on geriatric patients while the study of Eva Buelens includes the general hospital population.

Results of research
Lindsy Desmet will describe her cross-sectional research on clarifying the relation between spiritual needs and aspects of ill-being of geriatric patients.
Eva Buelens will describe the first results of her quasi-experimental research in Belgium whereby 240 inpatients completed self-reported questionnaires at three time points (baseline, post and follow-up).

Discussion of results
1) Research shows that addressing patients' needs has a positive effect on their well-being (Park & Sacco 2017). Unmet spiritual needs, on the other hand, will have a negative impact on patients' well-being and quality of life (Pearce et al., 2012; Astrow et al., 2018). Measuring spiritual needs is encouraged as research indicates that spiritual concerns are not articulated spontaneously, unless the health care team explicitly asks for it (Nelson-Becker,2006). However, in practice, the spiritual needs of patients are often neglected and not identified (Monod et al., 2011).
2) We discussed that, among other things, re-appraisal, acceptance and positive religious coping will be stimulated. These processes going on, can possibly lead to outcomes as less anxiety, less depressive symptoms more hope and inner peace (Massey et al., 2015; Bay et al., 2008). Hospital chaplains are clinically trained to support patients with their spiritual concerns and patients are satisfied with this counselling. However, research on the actual processes and outcomes of spiritual care provided by hospital chaplains is scarce and is hampered by methodological limitations (Jankowski, Handzo, & Flannelly, 2011).

Questions for discussion
- What kind of spiritual needs do you observe as a chaplain?
- What kind of interventions do you maintain as a chaplain to meet these needs?
- What kind of outcomes do you observe as a chaplain after an intervention?

Can Outcome Research Respect the Integrity of Chaplaincy?

Annelieke Damen & Carmen Schuhmann
University of Humanistic Studies, Utrecht, The Netherlands

Thursday 12th May, 4.15-5.00 pm
Paper on relevant research

Background in chaplaincy
In recent years, some within chaplaincy have advocated for a stronger focus on outcomes, including outcome research, whereas others in the field have questioned an outcome-oriented perspective.

Aim of contribution
In this presentation, existing outcome studies are reviewed in relation to the ongoing discussion about a process- or outcome- oriented approach to chaplaincy. A central question emerges from this discussion: how can outcome research be designed that respects the integrity of the profession of chaplaincy? (see for the paper: Damen et al., 2019).

Method of Research
Literature review.

Results of research
So far, most chaplaincy outcome studies have focused on secondary chaplaincy outcomes (e.g., satisfaction) using quantitative designs.

Discussion of results
To respect the integrity of chaplaincy, it is recommended that future studies should also focus on characteristic chaplaincy outcomes, use mixed methods designs, and articulate more clearly how their chosen outcomes, outcome measures, and interventions relate to the work of chaplaincy.

Questions for discussion
The presentation will end with a discussion about experiences with chaplaincy outcome research and next steps in chaplaincy outcome research, such as the formulation of characteristic chaplaincy goals and related outcomes.

- What are your experiences with/ views on chaplaincy outcome research?
- What do you see as next steps in chaplaincy outcome research?
- What are characteristic chaplaincy goals and their related outcomes?

The experiences of mixed professions – chaplain and physician – how this helps the transmission of the values and the faith in a secular hospital

Martin Moravec
Catholic Association of Health Care Chaplaincy, Czech Republic

Thursday 12th May, 4.15-5.00 pm
Paper on good practices

Background in chaplaincy
Secular society with its special demands - mixed professions as a special answer
Czech Republic represents a typical secular society, where religion plays minority role. To be a health care chaplain it is connected with a big probability of misunderstanding and overlooking. But it can be also a chance to present faith and its healing and comforting power, especially in the confrontation with suffering and pain. My position is a little special, while I work not only as a chaplain (catholic priest), but also as a physician (an internist) in one Czech university hospital.

Aim of contribution
Overcoming boundaries
I would like to present my experience of overcoming boundaries between the "secular" and the "religious". My mixed professions make me a part of both those "worlds". For many is the medicine much more comprehensive than the chaplaincy. The trust achieved as a physician (and colleague) can help me to be credible as a chaplain. But this connection also contains pitfalls, e. g. how (and when) to separate both roles.

Description of good practice
Make others feel that their care is unusual and sacred
To do "usual" medicine means to be seen as one of others health care givers. To serve "unusual" as a chaplain (as the same person) means, that this could be seen as a part of the "usual". Both are target at the good of patients. From that point of view are all health care givers also part of that "unusual" care. This can remind them the value of their own profession. Since from the faith point of view these caring is sacred, it is caring of God´s children - and of God Son alone.

Discussion of good practice
Chaplain and his/her opportunity to improve the quality of care
Is the chaplain´s role only to fulfil patients´ and care givers´ spiritual needs? Is it possible something more? Caring of the sick and the suffering is sacred. Do the care givers know that? Can we make them to feel that?

Questions for discussion
- Which means can we used for overcoming boundaries?
- How can we care about health care givers?
- What can facilitate the transmission of values and faith?

Involving meaning in rehabilitation practice

Elsbeth Littooij
Amsterdam Rehabilitation Research Center Reade / OLVG Amsterdam, The Netherlands

Friday 13th May, 11.00-11.45 am
Workshop

Background in chaplaincy

In her PhD thesis, chaplain Elsbeth Littooij studied global meaning in people with spinal cord injury or stroke. She describes what global meaning comprises and how rehabilitation clients experience global meaning as important in their rehabilitation.[1]
Goalsetting is a key characteristic of modern rehabilitation. Based on this thesis, we developed a tool to set goals that are *meaningful* for the client. [2,3]

Aim of contribution

Using this tool fosters motivation in both clients and clinicians, and helps counter the drive toward exclusively *functional* goals.

Content of workshop

In the workshop, the tool and its background are explained. Experiences of clients and clinicians with working with the tool are shared.

Course or working method of workshop

The participants are invited to experience working with the tool, exploring each other's global meaning.
After the workshop the participants

- are familiar with the aspects of global meaning in rehabilitation clients
- have an initial perception of a way to address global meaning and to set meaningful goals

Questions for discussion

- (How) would this be applicable in your own context?
- What advantages and possible problems do you see?

References

1. Littooij EC. Global meaning in people with spinal cord injury or stroke: content, changes and perceived influence on rehabilitation. Uithoorn, 2019.
2. Dekker J e.a.. Setting meaningful goals in rehabilitation: rationale and practical tool. Clinical Rehabilitation 2020; 34(1):3-12.
3. Littooij EC, e.a.. Setting meaningful goals in rehabilitation: A qualitative study on the experiences of clients and clinicians in working with a practical tool. Clinical Rehabilitation 2021; 1-14.

New chaplain charting models in the context of a national research-project in Switzerland

Pascal Mösli
Verantwortlicher für Spezialseelsorge und Palliative Care, Reformierte Kirchen Bern-Jura-Solothurn, Switzerland

Friday 13th May, 11.00-11.45 am
Paper on relevant research

Background in chaplaincy

Healthcare chaplaincy documentation is developing rapidly in Switzerland: it is now an established part of the palliative complex treatment required of hospitals by guidelines drawn up by spiritual care teams in the interprofessional context of mainly large hospitals and endorsed by pastoral expert committees.
Because many conceptual and practical questions still remain unanswered in this field, an ecumenical research group was formed by representatives of the Swiss Healthcare Chaplaincy Association and at the Faculty of Theology of the University of Zurich and the Theological Faculty of Chur to lead a research project on documentation, which was funded by the Swiss National Science Foundation.

Aim of contribution

The contribution has two objectives:
- Central questions about chaplaincy documentation in medical records will be discussed
- A concrete documentation model that integrates the findings of the research project will be presented and discussed.

This is intended to contribute to promoting cooperation within the profession of healthcare chaplaincy in Europe and across professions (interprofessionally) in a changing environment (digital development). The contribution is also intended as a continuation of the process initiated by the white paper on the documentation of ERICH.

Method of research

The research work comprised various phases:
In the first phase, the attitude of the professional group towards documentation was documented with an online survey among all healthcare chaplains in the German part of Switzerland.
In the second phase, various leading documentation systems worldwide were compared in an international workshop and criteria for good documentation were developed.
In a third phase, the results were discussed and further developed in two national workshops with chaplains in Switzerland.
In the last (still ongoing) phase, documentation models are being developed at various hospitals in Switzerland, which will be evaluated this year.

Results of research

Prerequisites and criteria for the development of documentation as well as for the introduction process at the institution were described.
In addition, exemplary models were developed or supported in their development, which show the concrete implementation and can promote further development.

Discussion of results

The research has inspired and deepened the discussion within healthcare chaplaincy in Switzerland. It became clear that the different settings must be included in the development of documentation (palliative care, somatics, psychiatry, depth of integration in the institutions, etc.).
Based on the documentation, the discussion of further topics was initiated: assessment, the effect of pastoral interventions, interprofessional cooperation, language in the interprofessional context (taxonomy) and others.

Questions for discussion

Basics of documentation: A thesis paper on chaplaincy documentation (findings of the research project) will be discussed.
Concrete documentation tool: Questions:

- Do the conceptual foundations make sense?
- Do the structure and elements of the tool make sense?
- Is the documentation of the case study convincing?

Chaplaincy in palliative care – proving our worth and standing our ground

Karen Murphy
President, College of Health Care Chaplaincy, United Kingdom

Friday 13th May, 11.00-11.45 am
Paper on good practices

Background in Chaplaincy

I have been a practicing palliative care chaplain since 1999, currently working full time in an independent hospice in the south west of the UK since 2005. During the past 20 years, perceptions and the practice of palliative care chaplains has changed considerably. The understanding and value of chaplaincy in palliative care has been dramatically visible during the past 2 years of Covid 19, which will hopefully lead to a re-evaluation of the need for spiritual care provision in healthcare.

Aim of contribution

The aim of this paper is to present evidence, and invite discussion, as to how spiritual care delivered by skilled and experienced professional chaplains makes a difference to patients and families in a palliative care setting. The discussion will also be relevant to general healthcare practice.

Description of good practice

Good practice for spiritual care is rooted in chaplaincy being visible, available and responsive to need, however that presents itself. Spiritual care needs to be seen as an integral and essential component of holistic care, demonstrated by inclusive chaplaincy practice in assessing and meeting spiritual need.

Discussion of good practice

The discussion element of this paper is to present some models of good practice at work and have the opportunity to share our experience of success, difficulties and outcomes of good spiritual care. My hope is to encourage participants to share examples of situations during the pandemic particularly, where something changed in their practice to enhance the acceptance and visibility of spiritual care. The questions below will act as a guide to sharing examples of how chaplaincy has supported patients, families and staff through difficult experiences. This will hopefully enable us to be more confident in standing our ground and demonstrating the value of spiritual care within our organisations. The model of chaplaincy in practice is key to the perception of spiritual care being fully integrated into patient care, so discussion around our personal development may be possible.

Questions for discussion

- Who are we to our organisations?
- How is our role and purpose perceived by colleagues as well as patients and families?
- What do we offer to our organisations that makes a difference?

Interpretation of chaplaincy care by clients

Martin Walton, Elly Snaterse & Maaike de Goei
Protestant Theological University, The Netherlands

Friday 13th May, 11.00-11.45 am
Paper on relevant research

Background in chaplaincy
The researchers, a university teacher and two master students, conducted research among clients in psychiatric care (Walton), care for persons with intellectual disabilities (Snaterse) and eldercare (De Goei), three fields in which they respectively were or had been active as a chaplain.

Aim of contribution
The purpose of the research was to learn from clients what meaning they attribute to chaplaincy and to see how the understandings and expectations of clients relate to understandings of chaplaincy in literature.

Method of research
The research consisted of three distinct studies, a more extensive study by Walton and two brief studies in the frame of master theses. Empirical explorations were done with individual interviews (psychiatric care), individual and group interviews (eldercare) and individual and group interviews with the help of pictograms and illustrations (intellectual disabilities). The interview material was coded and analysed, submitted to member checks and compared to relevant literature on chaplaincy.

Results of research
Psychiatric care: Chaplains were considered to be good listeners and empathizers but specifically in relation to human meaning. Besides issues of spirituality, clients talked with chaplains about identity and their sense of humanness (dignity). Clients spoke of the outcomes of chaplaincy care in strongly existential and spiritual terms. Various relations of chaplaincy to treatment were indicated.
Eldercare: In contacts with chaplains about seemingly daily matters, the chaplains bring depth and reflection into play. The chaplains play a role in nurturing connections between clients and between clients and care providers.
Intellectual disabilities: The clients placed emphasis on 'ritual' and embodied aspects of chaplaincy care (funerals, worship, groupwork) and on relational aspects, especially the chaplain as a confidant.
In all three studies: dealing with grief, relational aspects and specific roles of chaplains were emphasized.

Discussion of results
Whereas clients with intellectual disabilities more closely identified the person and (functional) roles of the chaplain, all clients placed emphasis on relational aspects and authenticity, resulting in a variety of role perceptions on mediation, companionship, wisdom, etc. Especially the mediating role in relation to institutions is less present in the literature, as is the emphasis on daily concerns and experiences of (in)dignity.

Questions for discussion
- What roles do chaplains fulfil in relation to clients and to organizations?
- How do the aspects of daily affairs and dignity relate to definitions of chaplaincy care (e.g., as spiritual care)?
- How central are experiences of loss and grief to an understanding of what chaplaincy is about?

Exploring the reasons why patients choose to access or decline chaplaincy services in an acute NHS hospital.

Elizabeth Allison
Leeds Beckett University / NHS Highland, United Kingdom

Friday 13th May, 12.00 am - 00.45 pm
Paper on relevant research

Background in chaplaincy
Previously worked as a mental health chaplain and currently work as an acute hospital chaplain.

Aim of contribution
To present findings of doctoral research exploring patients' experiences of being offered hospital chaplaincy services and their reasons for accepting or declining.

Method or research
Semi-structured interviews using interpretive phenomenological analysis with ten patients who had accepted chaplaincy services and ten patients who had declined. Ethical approval was obtained from HRA/IRAS Research Ethics Committee (Ref. no. 18/NW/0268).

Results of research
The sample who accepted chaplaincy services were predominantly female and in the older age groups whereas those who declined were younger. Participants who accessed chaplaincy services used chaplains for pastoral, religious and spiritual care which contributed positively to their wellbeing.
Participants who declined chaplaincy services reported having personal religious or spiritual beliefs. Reasons given for declining included: the offer was made close to discharge; they had different support mechanisms; they were unaware of what the chaplaincy service offered.
Participants identified skills and attributes they associated with chaplains. They perceived them as being religious but available to all, somebody to talk to who was impartial with a shared knowledge and understanding. Chaplains were identified as having strong interpersonal skills, which included listening and relationship building.

Discussion of results
National guidelines and chaplaincy services are promoted as generic services, offering spiritual care which can be religious or non-religious. Therefore, there is a mismatch between what chaplains believe they are offering and what is being perceived and received by patients. This has implications for the design, delivery and promotion of chaplaincy services. A number of attributes of chaplains emerged from the data which suggests they are operating across faith and health care organisations as "boundary spanners".

Questions for discussion
- What are the pros and cons of a generic spiritual care service as opposed to a multi-faith based service?
- Do you think there is a mismatch between what the chaplaincy service believes it is offering and staff and patients perceptions of the service?
- Is the term "boundary spanner" a helpful concept in describing how chaplains work?

Digital sharing of spiritual data in mental healthcare

Axel Liégeois
Faculty of Theology and Religious Studies, KU Leuven, & Brothers of Charity, Belgium

Friday 13th May, 12.00 am - 00.45 pm
Paper on relevant research

Background in Chaplaincy

In the past, the absolute confidentiality of the information was paramount in order to safeguard the sanctuary place for spiritual care. Today, however, chaplains want to integrate more and more into the multi-disciplinary teams. As a result, they are expected to share data from the spiritual care relationship in the patient's digital file.

Aim of contribution

Because of this tension, we will answer the following question: how can chaplains share spiritual data with other caregivers without breaking the crucial confidentiality towards the patient?

Research method

The method is an ethical reflection on the confidentiality question of chaplains on the basis of a guideline of the ethics committee in mental healthcare of the Brothers of Charity in Flanders, Belgium.

Results of research

The guideline lays down three conditions for the shared confidentiality among caregivers, including chaplains. The same conditions apply to a team of caregivers in one organisation as to a network of caregivers who cooperate across different care organisations, although the conditions will be more difficult to meet in a network.

1. Who? Chaplains clearly demarcate the team or network in the digital file of the patient so that the patient can see who shares the data. In addition, only these caregivers who themselves actually are in a care relationship with this specific patient and are bound by the individual duty of confidentiality can take part in sharing data.
2. How? Chaplains inform the patient in advance about the shared confidentiality and its consequences, and the patient gives consent to sharing data during a certain period of time. Asking consent in this matter is not easy in practice and is therefore conceived as an ongoing process of informing and motivating.
3. What? Chaplains limit themselves to sharing 'relevant' data that increases the responsibility of the other caregivers towards the patient, and refrain from sharing merely 'pleasant' data.

Discussion of results

We clarify the application of the three conditions of the chaplain's shared confidentiality on the basis of a case study in mental healthcare.

Questions of discussion

- How do you actually share data from spiritual care with other caregivers?
- How can we make the group in which we share data as transparent as possible?
- How can we get consent from the patient?
- What data are relevant to share with other caregivers?

Reference

Axel Liégeois. *Ethics of Care: Values, Virtues and Dialogue*. Newcastle upon Tyne: Cambridge Scholars, 2021.

How to approve existential health among patient and personal staff?

Thomas Sjöberg
Hospital Chaplain & Priest in Church of Sweden, Sweden.

Friday 13th May, 12.00 am - 00.45 pm
Paper on good practices

Background in chaplaincy

The last 13 years I have been Chaplain in Swedish hospital Ryhov in Jönköping and during this time I have been working in a psychiatric ward with weekly visiting patients with in-house care. Since 2015, I have gathered patients in groups to talk about the WHO's (World Health Organisation) 8 dimensions of existential health. (WHO-QOL-SRPB 2002). In 2018, I and Anna-Karin Jeppsson, a developer of psychiatric care, started with group sessions for staff members. We have met these groups at seven occasions of two ours each, during worktime. The goal is to get a language for existential health and the courage to stay when patients struggle with life questions.

Aim of contribution

I want to show the material and method for this group sessions and hopefully encourage other to meet the need for a language and words for our life (existential health).

Description of good practice

At the in-house psychiatric care, we use conversations cards with eight different dimensions (WHO's). The group decides one dimension and then we take the card and read the text that describes the dimension, for example "hope". Every dimension has three cards: thoughts, feelings, and actions. In three rounds you pass the cards around, each person is free to talk as long the card is in your hand. The experience of being listened to, respected and heard is very helpful for the participants. When you listen to the other members in the group, give words to things you have not done before is valuable when you are searching for a better understanding of your existential life.
As a leader of this group, you participate with a compassionate mindset and support the participants own self-confidence to take care of themselves and their life in short and long terms.
In groups for staff, we gather the groups seven times and talk about the eight dimensions. The aim is that personal staff get the opportunity to progress these matters of existential health in their own life and get a language that can be helpful in their professional meetings with patients. The staff come from all categories in hospital care system as doctors, nurses, psychologist etc. The chaplains in our three hospitals are group leaders together with personal from the developing department. Since we started, we have had approximate 22 groups of eight persons in each group. This work is growing and takes some effort to provide time and energy, but we think this is a good way of implement good practice that make difference for patient and for staff.

Discussion of good practice

Reflections from patients:

- *"It's nice to shift focus from the sick to the healthy"*
- *"Listening to each other has given me new insights and ideas, I thought I was alone in feeling this way"*
- *"By talking about mental illness I feel less ashamed"*
- *"When I hear myself tell, I get an understanding of why I'm having a hard time right now"*

Reflections from personal staff:

- *"Something everyone had to go on. Rewarding for one as an individual. Benefits for patients."*
- *"Important issues to address both for myself and for my work. Is about the life that affects the mental feeling. Need to be talked about in health care to reduce mental illness in the long term."*
- *"Finally, the existential dimension is beginning to find its way into healthcare. These issues are a major part of a person's life and affect their health to the greatest extent. Big THANKS for this course !!!"*

Questions for discussion

- Connection between religion and existential health?
- Is our time missing talks, reflections about life?
- What responsibility can we as chaplain take in hospitals to inspire personal to listen to patient's need of existential health.

Spiritual care integrated in the quality system of hospital and elaboration of a tool to help healthcare address spiritual issues.

Ervik Haavard, Odd Arne Skogen & Odd Erling Vik Nordbrond
Norway

Friday 13th May, 3.45-4.30 pm
Workshop

Background in chaplaincy
We are fulltime chaplains in tree hospitals in a hospital trust in the western part of Norway. Odd Erling have currently 5 years in chaplaincy in Volda, Odd Arne 11 years in Ålesund and Håvard 15 years working in Molde. We have all completed the Norwegian standard for "specialist in chaplaincy".

Aim of contribution
We would like to give a presentation of the implementation of the procedure and assessment tool at the consultation and have a workshop on how to proceed.

Content of workshop
Beliefs and worldviews have a major impact on how patients understand and deal with illness. Spiritual and existential needs often arise or are strengthened when we are in crisis. Patients with serious illness, limited life expectancy, or chronic illness may have a special need for spiritual and existential care. Research shows that this type of care can contribute to overcoming fear and anxiety, and be health-promoting.
In our experience nurses and doctors often omit these private issues in conversation with the patient because of their own lack of experience in dealing with spiritual care. The procedure expresses the responsibility to assist patient's spiritual needs and provide tools to do so. The procedure also expresses the option to involve the chaplain in the spiritual care.
During 2021 we have elaborated a procedure to formalize the spiritual assessment as a key task for nurses and doctors in our hospital trust in Norway. The procedure is integrated in the quality system of the trust and indicates how to uncover and assist patients in spiritual issues. As a part of this work, we have designed a tool to be used in evaluating patients' spiritual needs. The tool consists of eight questions to be answered in a scale from 0 to 10. The workshop will consist of conversation following questions bellow.

Course or working method of workshop
Conversation following questions about how to best use and implement tools and procedure for spiritual care in hospital.

Questions for discussion
- How does these questions cover the need for spiritual care? (see the translation of the screening tool)
- In what degree should healthcare reveal spiritual issues which patients do not express themselves?
- How do we best inspire healthcare to address spiritual care?
- How to train nurses and doctors in spiritual care?

The integration of chaplains within the healthcare team
A qualitative analysis of a survey study among healthcare chaplains

Renske Kruizinga, Tina Glasner, Carmen Schuhmann & Gaby Jacobs
University of Humanistic Studies, Utrecht, The Netherlands

Friday 13th May, 3.45-4.30 pm
Paper on relevant research

Background in chaplaincy
Within the changing field of healthcare chaplaincy, several shifts are taking place at the patient, healthcare staff and organizational level. These changes may also affect the way hospital care is organized.

Aim of contribution
Our aim is to describe these changes from the chaplains' perspective to detect the challenges and opportunities hospital care faces to improve interdisciplinary collaboration.

Method of research
Analysis of open-ended questions of a survey among healthcare chaplains regarding professional self-understanding. 107 Dutch chaplains working in a healthcare setting completed the five open-ended questions in the survey.

Results of research
The majority of respondents were female, and the largest group were in the age category of 51-60 years. On average, respondents had 14.1 years of work experience in chaplaincy and worked as a chaplain for 28.7 hours a week.
Several respondents expressed hope that in the future, chaplains will become less focused on individual counseling and more involved in other tasks such as ethical decision making and staff training. The latter involves training health professionals to recognize spiritual needs in patients and loved ones, and to make referrals to spiritual care professionals when needed. Sometimes these new activities were described as challenging when the chaplain did not feel competent enough; sometimes these changes are embraced as new and exciting
At the organizational level, the importance and the lack of a clear professional profile is mentioned several times. The unclear and false images of the healthcare chaplain are experienced as a burden to their daily practice. Furthermore, being embedded as a healthcare chaplain in the organization is considered important.

Discussion of results
This study shows the shift within healthcare chaplaincy from mainly activities that take place at micro level such as individual patient contact, to more activities at meso and macro level, i.e. staff training, involvement in ethics and policy advice. These changes come with opportunities as well as challenges for the way health care is organized. Other healthcare professionals should be aware of this new role of the chaplain and support this specific expertise to be embedded in the organizational structure.

Questions for discussion
- Should one-on-one contact with patients remain the most important, main part of a chaplain's job?
- What training is needed to equip chaplains for the new tasks at macro and meso level?
- Is the far-reaching integration of chaplains in a care team in conflict with the sanctuary function of chaplains?

Religious experiences and bipolar disorder: occurrence and significance

Eva Ouwehand
Groningen University, Faculty of Theology and Religious Studies, Groningen, Hospital Chaplain of Altrecht Mental Health Care, Utrecht, The Netherlands

Friday 13th May, 3.45-4.30 pm
Paper on relevant research

Background in chaplaincy
In clinical mental health practice and in theory on religious experiences, often a distincition is made between healthy and pathological religious experiences. Persons with bipolar disorder struggle to disentangle hyperreligiosity from genuine religious experiences and are often reluctant to discuss the topic in treatment.

Aim of contribution
The current study explores religious and spiritual experiences, interpretations thereof and treatment expectations.

Method of research
A mixed method design, including 34 qualitative interviews and a questionnaire conducted in a specialist bipolar outpatient department (n=196), built on the results of the qualitative study.

Results of research
The qualitative study showed various kinds of religious experiences and how persons with bipolar disorder interpret those experiences: as only spiritual, only pathological or both religious/spiritual *and* pathological (the largest group). In regard to mental health care, many participants did not have positive experiences with discussing their religious experiences in treatment, although they expected both acknowledgment and a critical sounding board from health care professionals. The quantitative part of the study showed how often religious or spiritual experiences occur in patients with bipolar disorder and this was different for the various religious experiences. They are often related to mania and bipolar I disorder. The lasting influence of the religious experiences varied, they partly have a transient character and no lasting influence on people's lives. Almost half of the participants affirmed that the experiences had both a pathological and a religious/spiritual character. Religious background and affiliation, mood swings, course of the illness and communication about the experiences all influence an ongoing interpretation process over years.

Discussion of results
Findings point to a view that religious experiences - related to illness experiences in bipolar disorder-, can both have pathological and religious features and may have positive transformative power in persons with this disorder. Half of the outpatients with such experiences wish to explore the positive and negative influence of this process with mental health professionals, but clinical practice is not yet equipped to do this adequately.

Questions for discussion
- How can patients with bipolar disorder or psychotic illness find more balance with regard to religious experiences that are related to the illness?
- How can hospital chaplains connect to patients and help them finding balance with regard to religious or spiritual experiences in the long term?
- How can hospital chaplains coach mental health professionals with regard to addressing the topic in treatment respectfully?

Meeting on Meaning: Collaborative learning of chaplains 'at home' and practice nurses mental healthcare

Gaby Jacobs, Stefanie de Cuba, Ilse Frank, Ria Mous, Marieke Steerenberg & Suzette van Ijssel
University of Humanistic Studies, Center for Life Questions Central Netherlands, GP practices, The Netherlands

Friday 13th May, 4.45-5.30 pm
Paper on relevant research

Background in chaplaincy

In this paper, we will outline a participatory action research (PAR) project with chaplains 'at home' and practice nurses mental health care that work in GP practices. Most practice nurses are not familiar with spiritual care and do not feel competent in recognizing spiritual needs. Chaplains at home are developing their profession and want to be known by other professionals in primary health and social care. The aim of the project was to strengthen the collaboration between these two professions on spiritual care by collaborative learning.

Aim of contribution

To reflect on the collaboration between chaplains and practice nurses and its outcomes.

Method of research

Participatory action research (PAR) is an approach to change, learning and knowledge development that takes participation of the stakeholders as key, as well as reflexivity, the use of narratives and flexibility in the process (Van Lieshout, Jacobs & Cardiff, 2017).

Results of research

In the first year of the project, two learning communities started within two regions in the center of The Netherlands, each consisting of six chaplains and 6 practice nurses. They developed building blocks for spiritual care development, including existential, professional and theoretical learning. Also, in the first year, 27 interviews were held with clients about their experiences with the spiritual care provided by chaplains at home and practice nurses. In the second year of the project, two new learning communities started consisting of chaplains, practice nurses, researchers, educators and clients. One of these developed, with the input from the client interviews, a toolbox for the participatory evaluation of spiritual care. The other community developed a two-day training for practice nurses on spiritual care.

Discussion of results

The results included: a) insights into the clients' perspectives on spiritual care. These showed that clients do not make a strong distinction between characteristics of 'good care' in general and indicators of spiritual care; b) a toolbox for the participatory evaluation of spiritual care, with the aim to strengthen the reflection and learning of the chaplain and practice nurse but not measuring the quality of spiritual care; c) a collaboratively developed training in spiritual care for practice nurses which raised the question what the collaborative learning adds to this particular outcome.

Questions for discussion

- Is spiritual care in essence a different construct and if it is, on what aspects?
- Re the toolbox, would we – additionally - need an instrument to measure the quality of the spiritual care, in order to further strengthen the professional development of chaplaincy?
- Can PAR make a lasting difference, in this case for the collaboration between chaplains and nurse practitioners?

Connecting with men's hearts: critical insights for gender-sensitive spiritual care and chaplaincy with men

Armin Kummer
Faculty of Theology and Religious Studies, KU Leuven, Belgium

Friday 13th May, 4.45-5.30 pm
Workshop

Background in chaplaincy

In their ministry, health care chaplains encounter persons at various intersections of age, class, sex, ethnicity, etc. This workshop will focus on the dimensions of sex and gender.

Aim of contribution

This workshop aims to raise participants' gender-sensitivity in their care relationships and stimulate further thinking about how such insights can be fruitfully integrated into the practice of spiritual care and health care chaplaincy.

Content of workshop

In August 2018, the American Psychological Association issued its Guidelines for Psychological Practice with Boys and Men. The guidelines represent a culmination of 30 years of -mostly North American- research into the psychology of men and masculinities, and a recognition that psychological counseling and therapy are more effective if practiced in a gender-sensitive fashion. While these insights have slowly moved towards the mainstream in clinical psychology, they remain still largely neglected in pastoral and spiritual care.
This workshop will introduce several men-specific issues that can play an important role in the establishment of a heart-to-heart relationship with male patients. We will look at masculinity codes and how they shape men's identity, spirituality, coping strategies and help-seeking behaviours.

Course or working method of workshop

After this conceptual introduction, we will engage in interactive case discussions based on the rich professional experience of the workshop participants (possibly in breakout groups, depending on the number of participants). We will seek case examples of "typical" and "atypical" male behaviours, try to interpret them, and explore their implications for our own professional practice.

Questions for discussion

- Have you experienced differences in how you connect with men and women?
- What men-specific behaviours have you experienced?
- Which masculinity codes and coping mechanisms are at play?
- What are the implications for the spiritual lives of these men?
- What are the implications for connecting with men?
- How do we stop others who seek to fit us into a single box (e.g. 'religious care' or a vague 'spiritual care'?)

A Set of Indications for Pastoral Care in Healthcare Institutions Using the Delphi-Method for interprofessional spiritual care

Traugott Roser & Pascal Mösli

Roser: Westfälische Wilhelms Universität Münster, Germany
Mösli: Verantwortlicher für Spezialseelsorge und Palliative Care, Reformierte Kirchen Bern-Jura-Solothurn, Switzerland

Friday 13th May, 4.45-5.30 pm
Paper on relevant research

Background in chaplaincy
Ten pastoral care practitioners from different fields and academic scholars in Switzerland and Germany got together reflecting on their experience as chaplains. Dissatisfied with the way non-chaplaincy staff referred patients to them, the group set out to develop a set of indications for transferral to pastoral care.

Aim of contribution
We want to 1) introduce healthcare chaplains from other countries to the "set", and 2) report on the use of the Delphi-Method.

Method of research
The Delphi-Methodolgy (Niederberger, Renn 2018) has been used in Palliative Care (Jünger, Payne et al 2017; Radbruch et al 2020) and Spiritual Care (Grossoehme 2008; Roberts DL, Kovacich J 2018). Experts from different backgrounds in health care (chaplains and other healthcare professionals) followed a 3-step protocol ("brainstorming", "narrowing down", "ranking") in two separate panels. The inclusion of healthcare experts from non-chaplaincy professions ensured soundness, understandability, and practical use.

Results of research
A set of seven indications was developed. Indications belong to four dimensions: meaning, transcendence, identity, values. A short version of the tool describes how patients with possible needs can be identified from their appearance. A longer version describes a) what aspects of spiritual needs and resources can be related to the observation and b) suggestions for pastoral care interventions.
The aim of the set is to support healthcare professionals in identifying spiritual struggles, needs, and resources of patients and promote the access to healthcare chaplaincy. The tool is useful for interprofessional cooperation and suitable for training. The tool in German, French, Italian, and English versions is already in use (Aebi, Mösli 2020).

Discussion of results
It was not possible to apply the criterium of anonymity within expert-panel 1, as panelists all belonged to Reformed churches. Panel 2 was anonymous. It will be important to discuss the applicability of the set to other religions and countries. We think the tool allows for patient centred provision of spiritual care.

Questions for discussion
- What kind of interprofessional indications for pastoral care are you familiar with in your professional context and culture?
- How do you judge the benefit of the set of indications within your institution?
- Working with the Delphi-Method for consensus building in healthcare chaplaincy: any experience or ideas for further use?

Literature
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- Aebi R, Mösli P, Roser T, Fankhauser A-K, Folini S, Gurtner U, Meier R, Minder H, Schmidt-Aebi M, Wild T (2019), Indikationen-Set für Spiritual Care und Seelsorge. Ein Instrument für Pflege und Medizin zum Beizug der Seelsorge, in: Pflege Zeitschrift 72.6, 53-56
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Living hope Tim's story: a case study

Rosie Morton
Anglican, United Kingdom

Saturday 14th May, 11.00-11.45 am
Paper on relevant research

Background in chaplaincy

I am a Hospital Chaplain with sixteen years' experience and have had an interest in the role of the chaplain as a hope bearer since I began this ministry.[1] I selected Tim for a case study because I was his chaplain for six years and he was articulate about the importance of being hopeful while living with a long term, incurable cancer. This study is a pilot for future research on hope with relatives bereaved during the Covid 19 pandemic.

Aims of contribution

- To explore in depth what hope means for one haematology patient.
- To discern the possibilities of wider application of results beyond a single case study.
- To work on developing a hope assessment tool.

Method of research

Patient case study.[2]

Results of research

- Hope was critical to enduring illness and treatment.
- Key sources of hope identified: outlook on life; personality; life experience; Christian faith.
- Factors which helped sustain hope: the importance of family and friends; online learning courses; prayer; times of silence; space for creativity.
- Defining hope was not achieved.
- Lament as an expression of hopelessness and spiritual distress.

Discussion of results

- Limitations of single case study.
- Hope was not defined but other dimensions of hope were identified, e.g ways to sustain hope.
- Potential for wider application: developing a hope assessment tool for piloting. Asking how important being hopeful is; identifying sources of hope; what sustains hope; what discourages hope.

Questions for discussion

- Discuss potential definitions of hope which aim to be inclusive for those with/ without faith
- As a Chaplain, how do you engage with hope in your ministry to patients?
- What are your suggestions on the hope assessment tool?

References

[1] Olsman, E. 2020. "Witnesses of hope in times of despair: chaplains in palliative care, a qualitative study." *Journal of Healthcare Chaplaincy DOI: 10.1080/08854726.2020.1727602.*
[2] Fitchett, G. & Nolan, S. 2015. *Spiritual Care in Practice: case Studies in Health Care Chaplaincy* London: Jessica Kingsley Publishers.

Humanist chaplaincy? Towards an inclusive understanding of chaplaincy in secularizing contexts

Carmen Schuhmann & Annelieke Damen
University of Humanistic Studies, Utrecht, The Netherlands

Saturday 14th May, 11.00-11.45 am
Paper on relevant research

Background in chaplaincy
As the role and place of religion in (Western) societies is shifting, and humanist and unaffiliated chaplains are entering the field of chaplaincy, the place of religion in chaplaincy is no longer obvious.

Aim of contribution
To arrive at and discuss an inclusive understanding of chaplaincy in post-secular societies that includes religious, humanist and unaffiliated chaplains.

Method of research
Thematic analysis of seventeen questionnaires, filled in by humanist chaplains from Belgium, the UK, Ireland, and Denmark; combined with an overview over the philosophical foundations of humanist chaplaincy in the Netherlands, where humanist chaplaincy has a history of several decades and is meanwhile firmly integrated in public institutions (see: https://www.tandfonline.com/doi/full/10.1080/08854726.2020.1723190).

Results of research
The research shows 1) that these humanist chaplains see their profession as a calling; 2) that their focus is on caring for all fellow human beings; 3) that their faith in (inter)personal potential is key in their practice, and 4) that they struggle with a non-supportive environment.
Discussion of results: Based on these findings, we propose what we call 'building blocks' for an inclusive understanding of chaplaincy that allows for open dialogue between all chaplains and identification of common ground, for instance: all chaplains put into practice a moral aspiration towards a 'better life' of people and a 'better world'; all chaplains represent a transcendent belief/faith, whether in humanity of in G(g)od(s); all chaplains work together towards equal availability of and access to chaplaincy care for all people.

Questions for discussion

- What are your experiences with/view of humanist and unaffiliated chaplaincy?
- How can you, on the basis of your religious/worldview background, relate to the proposed four building blocks of present-day chaplaincy?
- What is your perspective on the desirability and possibility of a shared understanding of chaplaincy in secularizing contexts?

The 'small goodness' as DNA for what constitutes good pastoral care

Martijn Steegen & Filip Vermeire
University Hospitals Leuven & Catholic University Leuven, Belgium

Saturday 14th May, 11.00-11.45 am
Workshop

Background in chaplaincy

The corona pandemic also struck hard in Belgium. At the University Hospitals Leuven, Belgium, the pastoral service plays an important role in supporting covid patients and their families, especially when the patient is critical. Staff members also make repeated appeals for support.
Now, looking back at the five covid waves that Belgium has known so far, our contribution in covid care appears to consist mainly of seemingly small details. However, it turns out that precisely these small details change fundamentally the experience of patient, family members and caregivers. These details bring a little humanity and warmth to dehumanizing procedures. It almost feels like a silent resistance against the necessary, but so cold, safety regulations.

Aim of contribution

In this workshop we would like to introduce the concept ‘small goodness’ of Emmanuel Levinas (1906-1995) as an important perspective in pastoral/spiritual care (R. Burggraeve 2020, L. Vanlaere 2020).

Content of workshop

The workshop will consist of three parts. First, the concept of 'the little goodness' will be explained using some practical examples from UZ Leuven. Secondly, we will invite participants to recognize aspects of ‘the small goodness’ in their own work as spiritual caregiver. Thirdly, we will give participants floor to share experiences about the importance of ‘the small goodness’ on their work.

Course or working method of workshop

We will facilitate a round-table discussion based on the material presented and encourage participants to ask questions and share knowledge and experiences with each other.

Questions for discussion

Possible questions for discussion in group are:

- Do you recognize aspects of ‘the small goodness’ in your own practice as spiritual caregiver?
- Do you think that the ‘small goodness’ is possible in our healthcare institutions that are increasingly tightly structured and managed?
- What are the conditions for this ‘small goodness’ to have space in chaplaincy and to have impact?
- The small goodness criticizes (c)lean structures and in this sense is always somewhat contradictory. As chaplains we prefer to work integrated in the care team. Can we then still fully choose to integrate the small goodness as part of spiritual care?

Report on Scoping Study of Spiritual Care Services in NHS Scotland

Iain Telfer
NHS Education for Scotland, United Kingdom

Saturday 14th May, 11.00-11.45 am
Paper on relevant research

Background in chaplaincy

A 'deep dive' was conducted by the Scottish Government into NHS Scotland Spiritual care services in 2021. Their report 'commended and held in high regard' the vital role of Spiritual Care in supporting both patients and NHS Staff throughout the COVID-19 pandemic. Stakeholders were unanimous in their shared vision of Scotland maintaining its place as an international leader of good practice and innovation in Spiritual Care. However, not all agreed on how to articulate this vision. Differing views on the place of professional registration could prevent Spiritual Care achieving its full potential on the scale the Scottish Government now recognise as being required. NHS Education Scotland therefore commissioned a scoping study to explore issues impacting on current workforce, and to map current spiritual care services. Using routinely collected data, a bespoke survey and follow up interviews with chaplains and their leads, the study articulated the current provision and its impact on patients, carers, families, and staff. To help commissioners develop an equitable, robust, and sustainable service for the future the study focused primarily on transferable examples of good practice, but also identified differences in provision across Scotland to obtain an accurate baseline for any subsequent activity. The review examined issues of governance, workforce support, supervision, and succession planning to identify core training and educational needs.

Aim of contribution

- To share with a wider audience of spiritual care practitioners
    - the results of this recent scoping study into the shape of spiritual care services currently being provided in Scotland and
    - subsequent plans for strategic development of these services
- To encourage discussion with colleagues and benefit from their insights

Method of research

Not so much a piece of formal research as a scoping study using

- a bespoke survey and
- follow up interviews with chaplains and their leads, the study articulated the current provision and its impact on patients, carers, families, and staff.

Results of research

Results of the study are currently being collated for a report due to be published in April of this year.

Discussion of results

It is intended these will be presented to the Consultation in May.

Questions for discussion

- Please comment on what you perceive to be the benefits of this kind of study.
- Can you identify outcomes from the Scottish study, which resonate with the shape of spiritual care provision in your own situation and would benefit from further investigation?
- Are you able to suggest specific aspects of spiritual care, which might become areas of shared research across the ENHCC?

Pastoral Presence, Character Virtues and Engendering Hope

Mark Newitt
Free Churches Group, United Kingdom

Saturday 14th May, 12.00 am - 00.45 pm
Paper on relevant research

Background in chaplaincy

I have over fifteen years' experience of working within healthcare chaplaincy. I work part-time for the Free Churches Group (FCG) engaging at a strategic level to shape the professional direction of chaplaincy in England and working to equip chaplains from a Free Church background. Alongside my FCG work, I am employed as part of the chaplaincy teams at Sheffield Teaching Hospitals and St Luke's Hospice.

Aim of contribution

The aim of my contribution is to describe what a virtue-based approach has to offer chaplaincy through thinking about the moral qualities a chaplain might exhibit and aspire to; how these are manifested in our relationships and actions; and how these qualities can be promoted and developed.

Method of research

Using semi-structured interviews my research investigated how chaplains support bereaved parents following the death of their baby. My analysis showed that the bearing and presence of a chaplain in being with bereaved parents was as important as the provision of liturgy and ritual. Because within virtual ethics '*how* one does *what* one does is as important as what one does,' I explored connections between virtual ethics and my findings.

Results of research

In the complex environment of supporting bereaved parents, I suggest that a chaplain's character can guide them to know the right way to respond and proposed three regulatory virtues – attentiveness, openness and probity – that I believe are key to the character of a chaplain.

Discussion of results

As a way of understanding how character (a key notion within virtual ethics) acts as a driver for decision-making I discussed the notion of a 'regulative ideal.' While developed in relation to supporting bereaved parents, I suggest 'engendering an encounter with hope' as a regulative idea that may be widely applicable with chaplaincy.

Questions for discussion

- What virtues (attitudes, personal qualities, ways of being) do you think are important within chaplaincy?
- How might those virtues be developed within training and CPD?
- Does 'engendering an encounter with hope' work as a regulative ideal for other contexts?

Chaplaincy in a (post)secular age: How to take care of 'non-religious' patients

Carmen Schuhman, Annelieke Damen & Job Smit
University of Humanistic Studies, Utrecht, The Netherlands

Saturday 14th May, 12.00 am - 00.45 pm
Workshop

Background in chaplaincy

As the religious landscape in Europe is rapidly changing, chaplains feel the need to develop adequate and convincing language to explain the relevance of their work and its unique contribution to the care for all patients, non-religious patients in particular.

Aim of contribution

Chaplains have reflected on their work with 'non-religious' patients using a new conceptualization of chaplaincy in a (post)secular age, and have explored how to use an intervention for patients who are not affiliated with religion in a traditional way. The overall aim is that participants feel more confident providing chaplaincy care to 'non-religious' patients.

Content of workshop

We start the workshop by introducing a model for chaplaincy in a (post)secular age in which existential meaning-making is the central notion, leaving room for discussion of these central notions with the participants. We then present a basic methodology for working with non-religious patients and invite the participants to apply this methodology to a case of their own or a case that we provide.

Course or working method of workshop

Introduction of model and basic methodology of chaplaincy with non-religious patients, working with the presented notions in smaller groups, plenary group discussion.

Questions for discussion in group

1. How do you understand the role of chaplains when working with patients who are not traditionally religious or 'non-religious'?
2. What are the challenges you face and your best practices when working with non-religious patients?
3. How may the model and basic methodology of (post-)secular chaplaincy inform your practice?

Grief among children and young people

Birgitta Strelert
University Hospital of Malmö, Sweden

Saturday 14th May, 12.00 am - 00.45 am
Paper on good practices

Background in chaplaincy

I have been a Hospital Chaplain in a large University City in Malmö, in Sweden. I have worked here for 14 years and I have been an ordinary priest for 25 years. Before I was a priest and during my studies I worked as an assistant nurse in a suicide ward and a psychosis/neurosis ward.
I have also studied psychotherapy and have education about Children and Youth grief and grief reactions. I educate social workers, priests and deacons in Children and Youth griefs and grief reactions. Me and my colleagues lead mourning groups for children, youth and adults in separate but parallel groups.

Aim of contribution

The aim of this presentation is to inform colleagues in Europe about Children and young people's griefs and reaction when it comes to their grief. Their reactions are almost always different from adults. I will tell you about common reactions among children and what is not common - and when you need to take help from professionals such as a psychologist.

Description of good practice

I will describe how we "speak with" children by using small tools so that they can process their grief without just sitting upside down and talk. I will explain why this is so important and yes- with children and youth – you can do wrong things that will make their grief even worse. I will describe some examples that you should not do.
I will according to the subject for the conference describe my role as a hospital chaplain in these mourning groups.

Discussion of good practice

I am sure that there are questions to discuss. But these groups are based on evidence. All children that have grief don't want to participate in groups. They who do participate often feel that they before felt lonely, and that no one really understood what they went through. A child that has lost a parent or sibling feel lonely in their situation. When they meet other children - that are in similar situations they see that they not are alone. They recognize themselves in other children's stories.

Questions for discussion

- Do you recognize the reactions I described?
- Give an anonymous example.
- I will give the audience a case that they can discuss.

A shared resource - “singing” as an example of a pastoral intervention

Maria Borghi-Ziegler
Swiss-German Association of Protestant Hospital Chaplaincy, Switzerland

Saturday 14th May, 3.45-4.30 pm
Workshop

Background in chaplaincy
Pastor and counsellor, active in hospital chaplaincy for 10 years, in nursing home, home for the disabled, rehabilitation clinic and university hospital areas of burns and neurology.

Aim of contribution
The participants of this workshop realize that there is a correlation between the awareness of one’s own resources and the mindfulness of the patients. When they match, encouragement occurs and grace can be felt.

Content of workshop
“Singing” as an example of a pastoral intervention, based on the accompaniment of a severely burned woman and mother of young children, who had to stay for more than a year in the intensive care unit and in the nursing department for burn injuries.
Example of intensive support for a patient over approx. 1 year. Importance of the shared resource "singing" for the patient's experience of resilience.
Reflecting on own resources that can be shared with patients.

Course or working method of workshop
Narration
I will narrate a situation from my practice with a focus on finding and working with resources shared by the counsellor and the patient.
Video clip
A film clip from an interview with a patient will illustrate the topic
Depending on the size of the group, we will apply what we have heard to our own experiences in different settings and develop our own scenarios.

Questions for discussion
- What have I experienced a similar situation?
- How did I notice this?

Describing effects and outcomes of healthcare chaplaincy: A mixed-method research project

Raphael Olberding
PhD-Student at the Chair of Practical Theology (Prof. Dr. Traugott Roser), Faculty of Protestant Theology, University of Münster, Germany

Saturday 14th May, 3.4 -4.30 pm
Paper on relevant research

Background in chaplaincy

A growing body of research focuses on outcome-oriented health care chaplaincy (HCC), asking for characteristic chaplaincy outcomes and favouring a process-outcome-oriented research approach [1].

Aim of contribution

Presentation of further thoughts of a sequential mixed-method research project on effects of HCC, which has already been presented at ENHCC at an earlier stage [2].

Method of research

The project consists of three major stages: Stage 1 (case studies) and stage 2 (interviews) applied qualitative methods. Stage 3 will transform the results into a quantitative measurement instrument.

Results of research

We have prepared the data of stage 1 and stage 2 for the further instrument development and brought it together with relevant research on HCC. We have found similarities with the PROM instrument introduced by Snowden & Telfer [3]. Hence, we aim to integrate it. Additionally, our data suggest elaborating new measurement constructs underlying the instruments items and adding especially religious-spiritual (r-s) HCC-intervention items. We suggest differentiating two process factors of HCC ("quality of intervention" and "quality of relationship") and propose the new construct "subjective awareness of vulnerability" to describe outcomes of HCC.
By May, we will have completed an expert review of the itempool, and pretests with patients. The pilot study of a larger sample is planned for autumn 2022.

Discussion of results

As Snowden & Telfer have suggested, HCC-outcomes are similar to the concept of "wellbeing" but still different from it [4]. Our inductively elaborated outcome construct can be useful as it takes up recent theological research on vulnerability [5] as well as from other disciplines. Hence, we might facilitate the interdisciplinarity in describing outcomes and process factors in care settings.

Questions for discussion

- How can we transfer a patient's perception of r-s intervention (e.g. prayers, sacraments) into measurable items?
- How does the construct "subjective awareness of vulnerability" correlate with other commonly used constructs in research such as "wellbeing" or "quality of life"?

References

[1] Damen et al. (2020). Can Outcome Research Respect the Integrity of Chaplaincy? Journal of Health care Chaplaincy, 26. 131-158.
[2] See contribution of Höfler/Roser at ENHCC consultation in 2018.
[3] Snowden & Telfer (2017). Patient Reported Outcome Measure of Spiritual Care as Delivered by Chaplains. Journal of Health care Chaplaincy, 23. 131-155.
[4] Snowden & Telfer, 146.
[5] e.g. Springhart (2017). Exploring Life's Vulnerability, or Bieler (2017). Verletzliches Leben. Horizonte einer Theologie der Seelsorge.

The Future of Christian Identity in Caring: Encountering the Other in a Pluralist Context

Stijn Van den Bossche
vzw Zorg-Saam ZKJ, Belgium

Saturday 14th May, 3.45-4.30 pm
Paper on relevant research

Background in chaplaincy
In March 2020 I started as the coordinator of pastoral care, ethics, and Christian identity in a group of 15 Catholic nursing homes (mainly for the elderly) in Flanders, Belgium. The main challenge facing myself and our chaplains, directors, and Board of Trustees, is what our Christian identity will and can mean now and in the future. Belgium was until a few generations ago almost entirely Catholic, and this is still visible in the fact that about 80% of 'care' institutions (hospitals of all kinds, homes for the elderly or disabled, etc.) are Catholic of origin.
The same question surrounding the future identity of Catholic institutions played a role in my former work, as national director for catechesis in a Belgian Church that found itself in transition, from 'presupposing faith' to 'proposing faith'. The answer for catechesis was the need for a new missionary dynamic.

Aim of contribution
To explore an answer to the question: what can the Christian identity of care institutions mean, especially given our current and future pluralist context?

Method of research
Literature review and pastoral theological reflection

Results of research
Several models of Christian identity can be identified in Belgian Catholic institutions:

- a counter-cultural model, involving gently 'fighting back' at secularization while at the same time hoping that the tide might change after all.
- a Christianity of (Christian) values
- exploring 'the human' by introspection, hoping to retrieve the Christian that (according to this model) lives inside everyone.
- the treasure of the social teaching of the Church.
- transcendence replaced by the call or need of the other (person)
- a hermeneutical model in which various interpretations of reality, experience and tradition are brought into dialogue with each other

Discussion of results
I discuss the merits and advantages of each model, as well as what each model lacks.
I end by proposing a new model: a diaconal-missionary presence in our own Catholic institutions, which grounds our view of the human person on Christian faith and 'adds the Word to the deed' by making faith explicit while still respecting others.

Questions for discussion

- What does it mean to make 'space' for the Christian identity of a Christian care institution, both literally (in terms of rooms, building) and figuratively (in terms of staff), in a pluralist context?
- How can we constructively work with pluralism *within* the Christian option? In other words, what if staff and/or patients/residents subscribe to one of the other models of Christian identity which I critique?
- How can we become missionary in our way of being Christian care institutions, without instrumentalizing charity for proclamation?