Perceptions of Chaplains and Patients on Working with a Narrative Method in Spiritual Care

Thesis

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Abstract

Whereas spiritual care often entails using non-directive, open conversational formats, the present study aimed at acquiring more insights in chaplains' and patients' preferences and experiences in case of the use of a narrative method. The main research question was: How do chaplains and patients in palliative, home-based spiritual care perceive using a narrative method in their counselling sessions? Two chaplains and five patients were interviewed regarding their experiences in giving and receiving spiritual care according to the method. Overall, patients were very positive about the spiritual care they received with the method. They also highly appreciated the chaplains and the profound conversations they had with them. Patients noticed changes on many levels, including their perspectives on life, their selves, their illnesses, the relationships with other people, what is of value, and the future. Furthermore, they acquired new insights, and felt more peace after the sessions. The chaplains expressed generally positive views about the narrative method as well. One chaplain was more sceptical of using such a methodology in spiritual care, as they considered it as potentially interfering with the chaplain-patient connection and hampering the natural flow of conversation. Contrarily, the other chaplain deemed working with the model supportive of their work and of added value. Both chaplains emphasized the need for flexibility in using the narrative method, when it comes to the order of and timing when the topics are presented, and the need for sufficient time to address the topics. Patients and chaplains favourably recalled specific elements of the narrative model, including the lifeline, discussing the relationships with other people, future imaginations, ritual, and the meditations. Altogether, the results provide encouragement for further development and future use of the narrative method in spiritual care.

Perceptions of Chaplains and Patients on Working with a Narrative Method in Spiritual Care

1. Introduction

In this thesis, I examined the views and experiences of chaplains and patients who provided and engaged in spiritual counselling according to a newly developed narrative method. As an introduction to this topic, I will first sketch a background in which spiritual care has developed over the past decades. Next, I will address how this has provided challenges for chaplains, followed by a current debate on the chaplaincy profession. I will outline the elements of a chaplain's competence, and then explain the focus of the present study. The study was conducted in and applies to the Netherlands, although the dynamics and findings may provide interesting input for spiritual care in other countries as well.

1.1 Societal background of spiritual care

Over the past decades, the landscape of Dutch spiritual care has changed dramatically. First of all, there are global developments that affect the Netherlands too. Currently, maybe more than ever, there is a strong need for addressing meaning-making questions and dealing with spiritual distress. This is among others due to the continuously rising number of people who have to cope with chronic and fatal diseases (World Health Organization, 2018). When confronted with (potentially) fatal diseases, people's lives change promptly and meaning-making becomes crucial (Freiback & Reinert, 1999). As spirituality is a key factor in coping with chronic illnesses (Unantenne, Warren, Canaway, & Manderson, 2013), the World Health Organization (2018) acknowledges the importance of spiritual care to support people who have to deal with life-threatening diseases, and chaplains are designated as the professionals most apt to carry out this task (Vereniging van Geestelijk VerZorgers, 2015).

These pressing demands for spiritual care take place in a world of ever-increasing globalisation and pluralism. Especially in the Netherlands, the secularization of society has influenced the chaplaincy profession (De Groot, 2018; Den Toom et al., 2021). Chaplains are not always affiliated to a church, and the way to address meaning-making is less straightforward than in for example the predominantly Christian communities of the past. The spiritual affiliations and needs of patients are quite diverse nowadays (De Groot, 2018; Den Toom et al., 2021; Woodhead, Partridge, & Kawanami, 2016). Moreover, in this tempestuous landscape, the role of the chaplain has become less obvious. With secularization, the once ubiquitous presence

of the religious to guide people through their lives faded. Additionally, with rapid developments in medical science and psychotherapy, rationality replaced 'magic', and herewith the position of the chaplain became marginalized in caregiving (Vereniging van Geestelijk VerZorgers, 2015, pp. 41).

1.2 New challenges for the chaplaincy profession

With these continuous demands and changes in the landscape of spiritual care, it is clear that the chaplaincy profession faces some challenges. The model of a chaplain who works solely from one religious denomination, without exploring and broadening their spiritual horizon, does not suffice anymore (Körver, 2014). Chaplains constantly need to adapt to a particular patient's life situation, spiritual background and needs, and are required to investigate and develop insights in various life philosophies. Also, they need to (re)establish themselves as professional and necessary players in the field of caregiving (Kruizinga et al., 2016).

As such, flexibility and lifelong learning skills become more important for chaplains. These so-called 21st century skills include, but are not limited to, research skills, including working methodologically, communication skills, and critical thinking (Scardamalia, 2001). This does not differ from global trends in virtually all other current and future professions: Employees are dealing with tasks of increasing complexity in intricate workplaces, so they have to develop the competences to handle this (Frerejean et al, 2019). Chaplains are no exception to this rule. However, multiple sources reveal that there is a lot of confusion and debate going on as to whether or not chaplains should indeed become (more) proficient in lifelong learning skills.

1.3 Debate on the chaplain's approach

Braakhuis, Körver, and Walton (2019) found that in professional practice, chaplains usually work non-directively from a relational attitude (i.e., listening, a relational demeanour, attention and empathy), or a 'theory of presence'. This is neither surprising nor problematic, as the Dutch Chaplaincy Association describes a part of the therapeutic competence of a chaplain as: "Being able to be attentively present with and while listening to others." ([Vereniging van Geestelijk VerZorgers], 2015, pp. 14). However, Braakhuis and colleagues (2019) also brought to light that many chaplains tend to overemphasize the relational attitude at the cost of other important aspects of their work such as methodological working (i.e., strategic skills, goal-oriented working), or even considered the two approaches mutually exclusive. The authors stressed that this sole focus on the relational attitude can have detrimental effects on the counselling success by avoiding necessary confrontations, losing touch with the essential emphasis on meaning-making and spiritual well-being, and crossing healthy chaplain-patient

boundaries. This aversion of methodological working is not instructed by the Dutch Chaplaincy Association, that also describes a part of the therapeutic competence of a chaplain as: "Being able to *systematically* clarify and analyse life questions and crises." ([Vereniging van Geestelijk VerZorgers], 2015, pp. 14), and even includes the methodological competence in their professional profile: "Being able to organize, register, document and evaluate the own professional practice, aimed at quality improvement; using results of research and participating in research, […] etc." (Ibid., pp. 15).

The findings of Braakhuis and colleagues (2019) are not unique though. For example, Mackor (2009) found that chaplains often were against using standards, seldomly (consciously) used standards themselves, and initially conceived standards as interfering with their sanctuary position and theory of presence, which are characteristic for the chaplaincy profession. In a study by Murphy and Fitchett (2010), chaplains showed anxiety and feelings of inadequacy concerning research, and thought these would replace the more 'original' (i.e., relational and religious) chaplain skills. Chaplains who participated in research by Kruizinga and colleagues (2016), demonstrated struggles when they had to work with a structured model to help their patients. And Körver (2014) also encountered a lot of resistance towards working strategically, which a telling quote of one of the chaplains illustrates: "*It is all about presence, and restraint of the chaplain is key. Making interventions is something for caregivers*." (pp. 7).

Contrarily, Mackor (2009) also found that in practice, the use of standards did not impede with the sanctuary position and being present at all. Participants in the Murphy and Fitchett study already became more positive about research after a one-day workshop (2010). Goosen (2020) discovered that in spite of the general preference for working from a theory of presence, chaplains frequently appeared to use a goal-oriented approach unconsciously. And there are also chaplains and scholars who do agree that more 'research literacy' is required in the chaplaincy profession to improve the counselling practice and the positioning to other professions (e.g., Meyers & Roberts, 2014; Kruizinga et al., 2014).

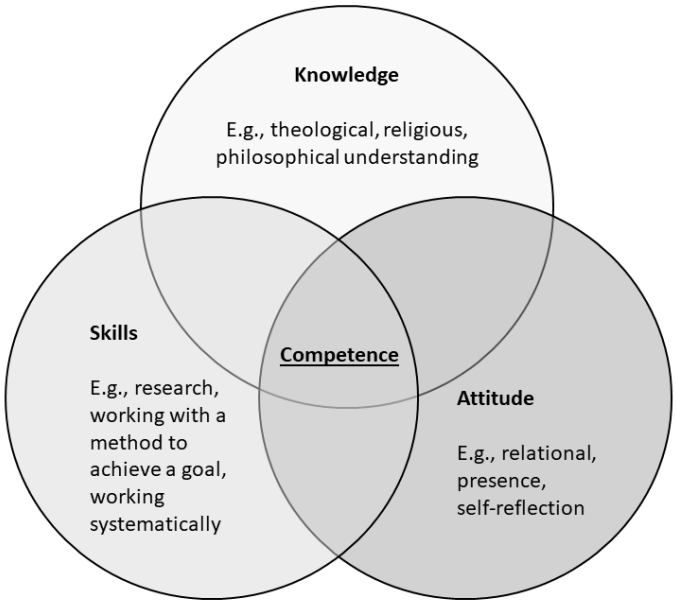
1.4 Understanding chaplain competences

The dynamics described above suggest that there is a misconception: Working from a relational attitude or theory of presence is put into contrast with a methodological goal-oriented approach towards counselling in the chaplaincy profession. A dichotomy is perceived while in fact, the two ways of working could and should complement each other to ensure the counselling success (Braakhuis et al, 2019; 'O Connor & Meakes, 1998). Moreover, one could argue that the theory of presence is also a method. The different terms that are used in literature to address the dichotomy (methodological working, research, standards, goal-oriented approach

versus theory of presence, relational attitude, non-directive working) may furthermore contribute to the confusion and misconceptions of what should be the focus in chaplaincy work. And although there are nuances in the sense that the several terms can point to slightly different aspects, when looking at it from a professional *competence* perspective, one can detect the 21st century *skills* on the one hand, versus the relational *attitude*, on the other.

The words competence, attitude, and skills are very important here. In the debate described above, these are used interchangeably. Not knowing exactly what these words encompass, and how they relate, could be a major factor in the perceived dichotomy and confusion. Professional competences consist of knowledge, skills, and attitudes (Baartman & De Bruijn, 2011; Hunter 2004). Roughly, knowledge entails knowing what, skills encompass knowing how, and attitudes refer to knowing why. True ability or competence takes places where these three meet. Figure 1 illustrates how this can be translated to the current debate in the chaplaincy profession.

Figure 1. Elements of professional competence with chaplaincy examples.



Working *solely* from a relational attitude thus does not fully fulfil the competence of a chaplain. Next to up to date knowledge and understanding about religion and life philosophies for example, methodological skills are necessary to complete the professional profile. When looking at the prescribed professional profile of a chaplain by the Dutch Chaplaincy Association, this triad is visible as well. Indeed, they speak of professional competences, and

they distinguish between contents (therapeutic and spiritual aspects of the profession), process, (e.g., communicative and methodological aspects of the profession), and person (e.g., self-reflective and dialogical aspects of the profession) ([Vereniging van Geestelijk VerZorgers], 2015, pp. 13-15).

1.5 The present study

In this study, I addressed the debate by evaluating how chaplains and patients perceived working with a newly introduced, narrative method in their counselling sessions. As for terminology, the designations of working methodologically, versus a relational attitude or theory of presence, are used. The study was explorative in nature, aiming at a preliminary orientation of experiences with working methodologically in spiritual care. The narrative method, 'In dialogue with your life story' ['*In dialoog met je levensverhaal'*], included six thematic conversations between a chaplain and a patient in palliative, home-based care, and focused on spirituality and meaning-making (Wierstra et al., 2021). It was developed in the context of the national research program PLOEG-2 (Palliatief Landelijk Onderzoek Eerstelijns Geestelijke Verzorging [*Palliative National Research Primary Spiritual Care*]; ZonMw, 2021), in which the current study was embedded. The overall PLOEG-2 study focused largely on spiritual well-being; the present study zoomed in on methodological working specifically.

The use of a methodology like this was new for the chaplains. Whereas the methodology used in this study was pre-structured and chaplain-led, commonly they worked with freestyle, open conversations directed by the patients (i.e., working predominantly from a relational attitude and theory of presence). The main research question of the present study was: How do chaplains and patients in palliative, home-based care perceive using a narrative method in their counselling sessions? The main goal was to acquire more insights in chaplains' and patients' preferences and experiences concerning the use of a methodology, instead of non-directive, more open conversational formats. The sub questions included:

1. What are the patients' perceptions of the narrative method?
2. (Why) would patients prefer to work with a narrative method or without a methodology?
3. What are the chaplains' perceptions of the narrative method?
4. (Why) do chaplains prefer to work with a narrative method or without a methodology?

Given the controversy on working methodologically in spiritual care, it is valuable to know how viable a methodology actually is for patients. In addition, knowing more about clients' and chaplains' views on methodological working may provide useful information for future education of chaplains.

2. Method

In this section, I will outline the method I used to address the research questions. First, I will provide participant information, and then I will address some ethical considerations. The narrative method and the procedure for data collection are described, and the approach for analysing the data is explicated.

2.1 Participants

The participants included five patients (3 women, 2 men, age range: 19-67 years) and two chaplains (2 women in their sixties and seventies) in home-based, palliative spiritual care. Researchers of the PLOEG-2 study recruited chaplains to work with the narrative method, provided that they were: a.) willing to participate in the study; b.) registered at the Dutch Quality Register for Chaplains (SKGV); and c.) connected to Networks Palliative Care in The Netherlands (Liefbroer et al., 2021). The chaplains contacted their clients and proposed working with this method to them. In case of consent, the inclusion criteria for the clients were: a.) a diagnosis of a life-limiting illness; and b.) aged above 18 years. The exclusion criteria were: a.) a current psychiatric disorder or cognitive disability; b.) a life expectancy of less than six months; c) an inability to speak Dutch or an inability to speak for one hour (Ibid.). From this sample, the clients and chaplains who first completed working with the narrative method were selected for the present study.

2.2 Ethics

All participants signed a declaration of informed consent that addressed the goals of the study and the implications of participation, possible pros and cons, voluntariness, and personal data use (Liefbroer et al., 2021). The study was part of the overarching PLOEG-2 project, which received approval by the ethical review board of Tilburg School of Catholic Theology, Tilburg University, with the identification code: ERB-TST # 2020/6 (Ibid., pp.12).

2.3 Materials and procedure

Chaplains and patients were presented with an interfaith narrative method for spiritual, palliative home-based care. The method consisted of six thematic sessions, concerning narrativity and the life story; materiality, ritual, and embodiment; and imagination (Wierstra et al., 2021). The first of the six thematic conversations of the narrative method, ‘Starting together’, was aimed at the chaplain and the patient becoming acquainted. It involved addressing expectations and goals for the counselling trajectory, and an elaboration of the current situation by the patient, in order to give room to the patients’ experiences and the meaning they addressed to this. For the second meeting, ‘Who am I?’, patients brought an item that symbolized themselves. As an exercise, a lifeline was drawn. This meeting was focused on

how patients connected to themselves. Meeting three was named ‘I and the other’. Patients brought a picture of a loved one and wrote down what this person meant to them, and engaged in a meditation about feeling at home. This session was dedicated to how patients connected to others. For the fourth conversation, ‘I in the greater scheme’, patients brought an item that comforted them or gave them strength in difficult times. They also did a breathing exercise. This meeting was focused on transcendence. As a preparation for meeting five, ‘The time to come’, patients did an imagination exercise of an event they looked forward to in the future. This was discussed during the meeting, as well as wishes and goals for the future. The chaplains and the patients also briefly looked back on the lifeline. The central theme encompassed the hopes and fears patients had for their future. For the sixth and final meeting, ‘Letting go and holding on’, the patients brought the items of the former meetings, and wrote themselves a postcard with their hopes and dreams for the future. The chaplains brought a symbol for the patients. The patients engaged in a ritual and the chaplains and patients said goodbye. The central theme of this meeting involved feelings of gratitude but also regrets patients had regarding their lives and themselves (Ibid., pp. 8-9).

Prior to their counselling sessions with their patients, the chaplains received a training and a manual on how to use the method. The patients received a workbook complementary to the sessions, in which they filled out exercises before, during, and after each counselling session. Upon completion of the sessions, each participant was invited for an evaluative interview (Liefbroer et al., 2021). When the selected participants were approaching the completion of their sessions, I contacted them and inquired whether they were willing to take part in the evaluative interview. By mutual agreement we scheduled a date and time for the interview. Due to COVID-19 restrictions, all interviews were carried out online and recorded via Zoom. The interviews were semi-structured and contained open format questions regarding patients’ and chaplains’ views and experiences of the narrative method. For the larger PLOEG-2 study, questions regarding spiritual well-being were included in the interviews as well, since this was aligned with the overall study goals. As the current study zoomed in on working methodologically, I selected the questions that fit these purposes to report and analyse in this thesis, and I added one study-specific question for the patients and two for the chaplains. This resulted in a total of 10 interview questions for the patients and 11 questions for the chaplains, that were used for this study. The questions are presented in chronological order in Appendix A. The right columns of the tables include the references to the concerned research questions.

2.4 Data analysis

The qualitative data analysis was conducted by means of thematic analysis (Pope, Ziebland & Mays, 2000), which includes the transcribing of, familiarizing with and thinking about, and coding of data, and writing up of results. In a first stage, I familiarized myself with the data. First, I transcribed the Zoom recordings of the patients' interviews. Subsequently, I read the transcripts carefully, and I selected the text fragments that provided answers to the interview questions for this study. Then, I attached labels to the text fragments that summarized the contents of the answer. For example, if a patient responded with: "*The conversations [with the chaplain] made me look at things differently*…" to question 2, I labelled this as: 'Change of perspective'. This process resulted in a preliminary coding scheme that comprised several answer categories for each interview question. To increase the reliability of the coding scheme, another researcher from the PLOEG-2 study independently rated the answers of two patients with this scheme. We compared our findings and added one response category for question 8 and one category for question 10. I rated the interviews once more with the revised coding scheme, and renamed a category for question 5 to better cover the content of the responses. I also removed one answer option that combined two other response categories ('both') for questions 5 to 10, as this category did not add any value. The final coding scheme is presented in Table 3 of Appendix B. Please note that it was possible for a patient to provide more than one answer category per interview question. For instance, when answering interview question 2, a patient could mention they acquired both a change of perspective and new insights. I rated all patient interviews (again) with this final version of the coding scheme.

For analysing the chaplain interviews, I followed a similar procedure individually. This process resulted in the coding schema presented in Table 4 of Appendix B

3. Results

Below, the answers to the interview questions will be clustered and presented per research question. The patients' and chaplains' answers are presented according to the categories of the coding scheme, illustrated by some representative quotes.

3.1 What are the patients' perceptions of the narrative method?

Overall, the patients were quite satisfied with the counselling they received by means of the narrative method. When answering the first interview question ("How do you look back on the meetings with the chaplain?'), all five patients pronounced they were positive. This is illustrated for example by the expressions of one patient:

"Very nice, we had a really good time. I wish she [the chaplain] would come more often. Profound conversations about life and also about death, and about how you live and exist here on earth. A bit of philosophizing, and also down to earth and in practice et cetera, we just addressed so many things."

For the second interview question ("If you had to say in one sentence what was the added value of the conversations with the chaplain, what would it be?"), three respondents reported they experienced a change of perspective as a result of the counselling sessions.

"They [the sessions] made me think in a different way about the future, and related to the symptoms, how do you deal with that and how do you feel about that."

Two persons mentioned they acquired new insights.

"Yes, I think some more insights about life. About life, because we, me and my chaplain, discussed a lot about how you think about life. And I actually never dwelled upon that before, but after I spoke with her I did."

One participant said they felt more peace after the sessions.

With the third interview question, I inquired what about the sessions was most valuable for the patients. All patients emphasized the value of the attitude and expertise of the chaplain.

"Yes, the insights that she had in all areas of life, I really thought that was great. There was not anything she did not understand, or not anything that made her insecure, or whatever. Yes, very committed."

Two patients also indicated that the topics or exercises in the workbook were of added value, but even after some additional questions from me about this, they found it hard to express what exactly helped, and why.

"Well, they [the exercises] direct you to think about certain things."

"If we discuss certain topics, the puzzle becomes more complete. Suddenly I realized certain things, that is rather nice."

The fifth interview question concerned whether and how the counselling sessions helped the patients in their spiritual well-being and meaning-making. One patient only affirmed an increased spiritual well-being and meaning-making, without explicating this. Four patients reported an increase in their consciousness. This consciousness mainly included an awareness of the positive and important aspects of their lives (i.e., focusing on what really matters).

"Yes, an emphasis of what we already knew of course, how rich we are. In spite of everything. Mainly that. That you have children and grandchildren. That is quite something."

"Well, the quality of the here and now, she [the chaplain] made me more conscious of that."

"The very positive, positive approach. Making me conscious of the other side of the coin."

As the catalyst for their increased consciousness, all respondents appointed the words and the steering of the chaplain.

"Yes, so to speak, certain expectations I had of myself. And you have positive or negative judgments about that, but then she [the chaplain] asked: 'What is the power of expectations?'. And I think: Wow, that is very nice."

"That she [the chaplain] told things about herself. What she encountered, and how she dealt with that. And, yes, also the candour about that. I really appreciated that, yes. I could certainly learn something from that, yes."

One patient also mentioned the structure the workbook as an element that helped increase their consciousness.

"That we had a specific topic every time, and because we had that topic I could consider: OK, what do I have in common with this topic? What is my relation to that?"

Interview questions 6 to 10 covered whether the counselling sessions induced different views in the patients of themselves or their lives, their illnesses, the relationships with other people, what is of value, and the future, respectively. With regard to their selves and their lives, three patients said they changed their views after the sessions. One of them reported an increase in assertiveness and two of them experienced a more positive attitude. Two patients ascribed these changes to the words, steering, and attitude of the chaplain, one ascribed it to an exercise in the workbook.

"Well, you know [the chaplain was] not only non-judgmental, but also accepting, and with joy. Yes, that sounds very strange, but sometimes she looked at me with joy. Then I thought: Yes, I can do that, too. […]"

"I think the moments in which we made a time line. In there I wrote: OK, what happened then, and when is it actually good? Well, I am [age] years old and actually most of my life is good. And when you see the time line and realize: That is also actually a very small part that is bad, but the rest is very good. Well, then you realize something."

Concerning their illnesses, three people noticed changed views. Two felt more acceptance, and one acquired more sense of perspective. They all ascribed this to the words or steering of the chaplain.

"Yes, I think I started to accept more. I think I was already doing that to some extent, but on the other hand I was still ruminating: Could it [the illness] stop yesterday?"

"But you know, she [the chaplain] says: If that is your choice [to stop taking medications], and you are completely behind that, yes, then it is a different story and you must think carefully whether that is what you want. And that is, I think that is good help, you see. […] She says, whichever choice you make, it must be a choice that is good for you."

As for the relationships with other people, three respondents noticed increased consciousness (comparable to an outcome category of interview question 5), and one mentioned more proactivity. One person did not further elaborate on the reasons for this change, one ascribed it to the words or steering of the chaplain, and one tentatively referred to an exercise in the workbook.

"Well, it should have been in one of those sessions, 'I and the other', or something. I do not recall exactly, of course it has been a little while. But I did realise that people are important to me, and yet I do not speak with them, or I do not hear anything from them. Well, if you wish you keep those contacts or whatever, you must do something about it. Then you have to call them, or anything. You must let them hear from you, you must be there."

Regarding what is valuable to them in life, two patients experienced changes. The value of people and relations was emphasized for one, and the other could not express what this comprised exactly. The words and steering of the chaplain were indicated as one catalyst for this, and an exercise in the workbook as another.

"Yes, there was an exercise, you had to close your eyes. I am not sure, it was for two or three minutes, let me think. If you want to be where you want to be, then you picture a year in which you have everything you desire. And yes, that is a nice and quiet moment to see: OK, this is important to me. So yes, a kind of meditation exercise it was. Yes, that helped."

Three respondents looked differently towards the future after the sessions. One felt a larger ability to let go, and two had a more positive attitude. The words and steering of the chaplain were mentioned twice as a reason; an exercise in the workbook once.

"First of all, if I am correct it was a question in the [work] book, not so much from [name chaplain]. But like: How do you look at those things? And when I thought about that, I realized I had a fear of losing people. And as time progressed I also realized: What good will that fear do? You are only hurting yourself with that, you cannot live in fear, or at least I do not want that, living in fear. And cherish that there are still people around now. You have lost friends, but there are still people here. And cherish them. Yes. Because I realise: You cannot stop life."

To summarize, all patients looked back on the counselling sessions with the chaplains in a positive way. The patients experienced changes in perspective, new insights, or more peace as a result of the sessions. On a spiritual level, the patients noticed an increase in their consciousness. All respondents praised the qualities and the work of the chaplains. In the beginning of the interview, when the questions were more general, the respondents were less verbose concerning the influence of the workbook. As the interview progressed and the questions became more specific, the patients became more pronounced in mentioning the structure, exercises, or contents of the workbook as well. In varying albeit positive degrees, people witnessed changes in themselves or their lives, their illnesses, the relationships with other people, what is of value, and the future.

3.2 (Why) would patients prefer to work with a narrative method or without a methodology?

The fourth interview question addressed the preference for either working methodologically, or with an open format. Three patients preferred working methodologically with a model.

"I found the structure quite convenient actually, yes."

"It does have an advantage. If you have a structure, then you know what you are dealing with, so you have a basis."

Two patients indicated they would rather work with an open format. One patient explained that the structured model might work very well for others, but not for them as they were already quite advanced in their own spiritual development. The other patient was a young student, and they associated filling out the workbook with homework, which made them a little reluctant to do this.

Interestingly, as a side remark to their preferences, four of the participants added that the narrative model, although it was structured, nevertheless provided sufficient flexibility and space.

"Well, for myself it was very good that the structure of the [work] book was there, and the conversations evolved naturally. Sometimes that was according to the model so to speak, and sometimes that was just not quite under discussion. And then you could look back on that later: How can I see the question of the chapter in that again, or clarify it in the report? But as such I considered it nice that there was something to prepare, and you entered the conversation openly."

So, patients' preferences for working with or without a methodology were mixed. However. Regardless of their preference, most patients deemed the model sufficiently flexible.

3.3 What are the chaplains' perceptions of the narrative method?

In the first interview question, I asked the chaplains how they looked back on working with the narrative method. Both chaplains were generally positive. Curiously though, one chaplain experienced the model provided sufficient flexibility, whereas the other stated the opposite.

"I experienced that as, yes of course that is also because the clients are so enthusiastic, I experienced it myself, I am very happy with the research. […] What I like about the method is that it is just 1-2-3-4-5-6. Now we do this, now we do that, and now we do that. It provides me with a guideline. […] And it [the conversation] still can divert from the research. And the research then provides me with, then I say: Yes, we will get back to this later, but now I would really like to stick with this topic. Do you agree? And well then they always do come back again.[…] But the research or structure also provides that space itself."

The other chaplain expressed a caveat. They were concerned the model would get in the way of a natural conversation, and stipulated that the model required more flexibility to adapt to the patient. This had mainly to do with the prestructured order in which the topics were presented to the clients. They claimed the model could benefit from holding on to the main topics, while being lenient as to when these topics should be addressed. According to them, the model needs more flexibility in the encounter, the contact.

"I experienced it as pleasant, in the first place. What I did notice however is that, because you follow a certain thread, it on the one hand provides direction, and on the other hand does not completely fit the factual situation. Because a conversation progresses differently."

"[…] as long as the thread is being followed, as long as these aspects are addressed, then you cover a large part of what is important. The order of that, that is an idea. And that idea then sometimes gets in the way of the emotional expression of the client. You go from feeling to thinking."

Interview question 2 covered the impact of spiritual care according to the model on the patients. One chaplain perceived increased insight and clarification in the patients, although the chaplain initially did not ascribe this to the narrative method.

"Well, really insight in themselves. Clarification of themselves, they also all say they appreciate the good conversations. And I can say frankly, that is not caused by the research, haha. Because people always say that to me. Yes I am a little proud of that, but they always say that to me. But they really appreciated the substantial conversations. And yes, insight I do think."

The other chaplain repeated the danger of risking to fail to establish the encounter or contact with the patient.

"Because I have been doing this work for such a long time, I have become very skilled in maintaining the flexibility and adapt, so. But I imagine that, if you no hot have this to that degree, or if you are a beginning chaplain, that you run the risk of not being able to properly establish the contact, the encounter with others. That risk is there. That risk is always there with a model, right? And yes, I have heard back [from the/a patient(s)], I actually expected to be speaking more myself, to be invited more. Instead of that I have to follow what is being asked here."

The third interview question inquired whether the impact would be different without any guidance or method. One chaplain confirmed this.

"Well, of course I am vain and I would like to say no, but I will say yes anyway. Because I also appreciate it myself that there is some guidance in there. That gives me tools, but I also think that for the people I have counselled in this, for one more than for the other, this certainly had an impact, yes. More impact."

The other chaplain confirmed it would be different as well, but claimed this would not necessarily be better or worse.

"So you take it [the model] with you, you can use it. And also, if you do not do that, if you do not have a framework at all, you run the risk of getting stuck. […] Because the other person is your focus, you direct your attention to the other. And then sometimes things can stay put."

In interview question 4, possible hindrances in the model were addressed. One chaplain felt that six session were not enough. At least a seventh was needed, as the patients should be proposed and introduced to the model properly. Also, more time was required for the sessions; one hour was not deemed sufficient. The sequence was considered too fast as well.

"Yes I think it is a wonderful format. I also think the meditative part in there is beautiful. And I never used to do that, I will certainly keep doing that, in other moments. A piece of meditation. I have seen how much good that does for people, to wind down. […] So that is not a hindrance, but the time is. It cannot be done in one hour. It is too much. […] No matter how beautiful the sessions are, it is too much in one hour."

"Having to do it [the sessions] every week, is actually not feasible. For me that was not feasible with people who are so ill. […] Once every two weeks would be better. I think."

The other chaplain emphasized the importance of adaptability of the method to the client, and the current lack thereof. Offering options to the client could solve this.

"As for the contents, no. Because everything comes that is relevant, by past, by a time line, by present, and to name future… […] Yes, as for content, it is not always adapted to the client. So that is a content-related lack. How you solve that methodologically then, so you should actually have a kind of workbook in which you offer several options to address certain contents. So not: We do it like that, we do this, but if these are the contents, you could do this with it, or you could do that with it."

With the fifth interview question, I asked the chaplains whether they would want to use the narrative model more often. One chaplain confirmed wholeheartedly.

"Oh, I am sure I am going to use it more often."

The other chaplain confirmed as well, though a little more reserved.

"Certain elements, certain elements of the model. And why, because I noticed these really touched the people and mattered."

After I asked which elements these might be, they clarified:

"Ehm, the meditation. The dwelling on something, the together, together right, I joined the people, dwelling on something together in silence. Or a fantasy, a world, where is your dream, things like that. And the end ritual. For all, all clients, the end ritual touched them. Because I also gave back quite something from myself in that. And summarizing what the journey we made together meant for them. And what they had said and done in that.

And their strengths in that, what I considered beautiful in that, what I granted them for the future, et cetera. So then it became very personal, yes. And that was a conclusion of our encounter. Yes."

When asked whether they deemed the model suitable for spiritual care (interview question 6), both chaplains agreed. One chaplain remarked however that the workload was too high for the clients.

"Yes, I do. […] And certainly helpful. I certainly think, well I just think it is a beautiful model. Of course you can polish it. Polishing with regard to time, I would, for people who are in the final stage of their life, I would not send them such a journal, a book, it is way too much work. Some think from their…, because they used to do their best, did their best, that they have to fill out everything."

The other chaplain outlined which elements fitted spiritual care in particular.

"Yes, in essence I do. Because you anyway, the starting point is the life story of the client, as I understood it. That is a connection with spiritual care in any case. That is always the starting point. What is the life story. What I also find suitable for spiritual care, is that it is not a treatment model. It is a model for reflection. I deem that suitable for spiritual care. Yes."

With interview question 7, I asked for (more) ways in which spiritual well-being and meaning making were addressed in the model. One chaplain provided several personal examples of how clients' spiritual well-being and meaning-making improved after counselling with the model. Sometimes they provided a specific link to this and the exercises/elements, such as the time line, and the theme relationships with other people ('I and the other'). The other chaplain added to their answer of the previous question that they were not quite sure whether the patients' gains were due to the model, or due to the chaplain.

"Still, of course I do not mean that I am already flattering myself, but just the feedback [from clients]: Yes, it matters a lot that it is you, how you do it. And I think it is always like that, to be honest. It is like, whether you are a musician and have a violin in your hand, yes that is an instrument, but how do you play it? And I think that it is very important, if you have a model, to be aware of that as well. How can you, and that is very difficult, integrate that in your model in any case? I would be urged to say: Make sure the model allows that space. Because it is much more important in the encounter, as something happens there between you and the other. And how that can happen, that is not that you talk with one another about that, but that is how you talk with one another about that."

Question number 8 then, zoomed in on the model's potential tools for spiritual well-being and meaning-making. One chaplain was positive about this.

"Yes, I do think so. It is a structure for me. It provides me with, I do not want to say that otherwise I do not do that, but this does provide me with more structure. And I can imagine that I, when I arrive at a client's next time, maybe not at the time of someone's life end, that I think: Well, where is this client? And that I think: Well, now we are going to talk about meaningful relations, or: Why, what does that photograph that is hanging there mean to you? Of course I already used to do that, but it does provide me with more structure. I do gain something from that, yes."

The other chaplain did not really think the model provided any tools for this.

"No. I do not think so much, no. An underlying vision is provided, it is related that it is important for this and that. But a tool could be for example: If you find it difficult to discuss this, then you could do this or that. […] Or then you could use this format, for example. Then you provide tools."

In distinguishing which elements of the model were more or less meaningful and helpful for addressing patients' spiritual well-being and meaning-making (question 9), one chaplain mentioned the extraneous workload of the questionnaires the patients had to fill out for the research. Of course, these questionnaires are inherent to the research, and would not be expedient if the model is applied regularly. Apart from this, they were positive.

"I thought that everything was meaningful. Only it differs for each client what has more focus and what less."

The other chaplain mentioned a positive and a negative aspect.

"Well, what contributes is absolutely attention, that you give attention to that. That there is time and space, and attention for those aspects of someone's life."

"Some things were overlapping. Then there was a next step, an assignment, I am trying to make it concrete… Take a picture, or take… and then that had actually already happened. So then you felt a sense of repetition. We already covered that."

In sum, on many topics, the two chaplains expressed different views. Whereas one was very positive about the narrative model and about working methodologically in general, the other placed more value in the demeanour of the chaplain and the importance of connecting with the patient. Both respondents uttered positive and negative aspects of the method, including time, structure versus flexibility, and attention.

3.4 (Why) do chaplains prefer to work with a narrative method or without a methodology?

The final two questions of the interviews for chaplains included the preference to work with or without a model (question 10), and the position of working methodologically in the curriculum of the chaplain's education (question 11). As for working methodologically or not, one chaplain opted for a 'blended' format:

"Yes, I am pro models. But I am con protocols. So I am not in favour of the obligation of a model. But I think it is very good that chaplains have some models in the back of their minds. You see, I did a course last week, the masterclass [chaplain-related course]. And of course oftentimes, then the Diamond model of Carlo Leget is discussed. How do you use that. And I use that as well. […]"

The other chaplain expressed a somewhat different mindset, focusing more on contents than on method:

"I prefer working according to a, not structure or method, but content. It is preferable that certain contents are addressed. And I am very much an advocate of content and freedom of format. Because that allows much more that the clients can express from themselves. So I always use a content-related process."

In their chaplaincy education, one chaplain confirmed the place of working methodologically in their curriculum, and provided the examples of the religious-diagnostic model of Michel Scherer-Rath, and the Yucel method. The other chaplain denied this (in their own words). They mentioned that there was some attention for the theoretical background of certain methods, but not the conversational skills which are crucial for the work of a chaplain. The focus was more on academic skills, and according to the chaplain unfortunately, less or not on attitude and theory of presence.

To summarize, when asked directly, the chaplains' preferences for either working methodologically or not were not black-and-white. Contents and flexibility were considered vital. The curricula of both chaplains included at least some education on methodology.

4. Conclusions and Discussion

Before returning the research questions, it is important to consider some limitations of the present study, as the reader should keep these in mind when interpreting the results. After outlining these, I will discuss the results for each research question subsequently. I will also address some findings that are not directly related to the research questions, but are nevertheless

important to mention regarding the debate on the chaplaincy profession. I will finish by providing some overall conclusions of the study and giving some suggestions for future applications of the narrative model and for the debate on the chaplaincy profession.

4.1 Limitations of the study

First of all, as mentioned in the Introduction, the study was a first exploration of the views of patients and chaplains on working with a narrative method. Although this pioneering provided interesting data as well a first step towards further research, the inferences I will draw below are based on a small sample size (i.e., 5 patients and 2 chaplains) in a very specific setting (home-based, palliative care). Moreover, the two participating chaplains were both in their sixties and seventies, which raises the question whether their answers were representative for younger generations of chaplains. These issues diminish the generalisability of the findings.

Also, the design of the study prevents making legitimate recommendations for working either with or without a narrative method. All participants used the narrative model, so there were no comparisons between two groups (i.e., giving/receiving spiritual care with a narrative model versus giving/receiving spiritual care without a narrative model). The study provided information about first impressions of working with the narrative method, but research questions 2 and 4 on the patients' and chaplains' preferences respectively were hypothetical. Therefore, they were intentionally phrased in a conditional way ("*Would* you prefer…"). Accordingly, interview question 4 for the patients, and interview question 10 for the chaplains appealed to the respondents' imagination, since the respondents were not presented with an alternative way of working.

Third, I used interviews to collect data, but I did not observe chaplain-patient interactions. As such, we have to rely on the self-reports from the interviewees, which has some implications. It is quite possible that the participants did not always remember everything (correctly), or that they provided socially desirable answers on occasion. We cannot know for sure what actually happened in the conversations between the chaplains and the patients. It should be noted here that the researchers of the PLOEG-2 study did contact several chaplains with the request to allow a researcher to observe some conversations they had with clients. The anonymity and confidentiality agreements were, of course, identical to the ones made for the interviews. However, none of the chaplains consented for observations. They were all resistant towards this, and indicated that this would violate the privacy of the clients. This is very interesting, as in other professions in which conversations between a caregiver and a patient are also of a highly sensitive nature (for example in medicine or in the field of psychology), it is more common practice to observe the conversations for learning and research purposes. This

underlines the friction there is in the current debate of the chaplaincy profession about being used to, and embracing, the participation in research.

Finally, a disclaimer is in place. The chaplains worked with the narrative method, but were both very advanced in their career. They spent many years of working predominantly from a theory of presence, so it is reasonable to assume that they used this modus operandi while guiding the patients with the narrative model. The findings of this study should be seen in this light: They do not reflect the results of working solely from a narrative model, but most likely, of working from a *combination* of methodological working and relational attitude. For counselling success, this combination is probably ideal (Braakhuis et al, 2019; 'O Connor & Meakes, 1998).

4.2 Patients' perceptions of the narrative method

Patients were very positive on receiving spiritual care by means of the narrative method. They reported changes in perspective concerning for example their lives, diseases, and the relationships with other people. They acquired new insights and an increase in consciousness, among others. As mentioned before, the design of the study prevents ascribing these positive results in patients to either the spiritual care in itself, the narrative method, or both. But at the very least, it can be said that working with the narrative method was not considered at all detrimental for their progress or hampering the connection between the chaplain and the patient, from the patients' perspective. This underlines the findings of Mackor (2009), as mentioned in the Introduction, who found that the use of standards did not interfere with working from presence. It suggests that the concerns of working with a prestructured format may be less valid than uttered by some in the debate on the chaplaincy profession, when it comes to research and working methodologically. The positive responses of the patients to the spiritual care they received by the narrative method provide encouragement for using this method in the future.

Most patients ascribed the positive results they achieved through their counselling sessions to the chaplains. The patients regarded the chaplains very highly. Especially in the beginning of the interviews, they referred to this, and as the interviews progressed, more concrete examples of the exercises and the workbook were mentioned as well. The latter finding might (at least in part) be due to the simple reason that patients had to 'warm up' a little bit throughout the interview, and only once they were more in the flow of the conversation, they were able to recall and express the concrete examples. Especially since the contents of the counselling sessions, and thereby the topics of the interviews, are not everyday conversation pieces for many people. But the favourable attributions to the chaplains also emphasize the importance and value of the chaplain in times of spiritual distress by severe illness.

Looking specifically at which elements of the narrative method patients deemed valuable, the lifeline (or time line) of the second meeting was mentioned several times, in relation to developing a more positive attitude or perspective on life. Patients also recalled session three ('I and the other') in general now and then, with regard to consciousness of the relation with other people. Also, the future imagination exercise of conversation five contributed to realizing what was important to the patient. Overall, patients appreciated the in-depth conversations about illness, life, and death. Patients also expressed positive views about the structure and contents of the workbook, and the fact that the contents covered past, present, and future. These results suggest that in future applications of the narrative method, these elements should be maintained.

4.3 Patients' preferences for working with or without a methodology respectively

The patients in this study had mixed views on working with a methodology. Some deemed the model preferable, as they considered the structure of a model supportive, whereas others would favour working with an open format. As mentioned above, these results are based on the patients' imagination, as they did not actually work with an open format. None of the patients showed any aversion on working with a model though, and none of the patients experienced the relationship with the chaplain as obstructed or artificial. These results do not discourage working methodologically in the future, but certain considerations may be taken into account when applying the narrative model again. These include the level of spiritual development of the patient (e.g., for more advanced or experienced patients, the exercises may be adapted to a higher level), and the 'homework' association some patients may have with filling out the workbook (e.g., changing the format of the workbook to make it look less scholarly, or emphasizing that the workbook is not a means to perform).

4.4 A side note: Transference

Although it was not the focus of the current study, in the data a curious additional finding emerged. Even though seemingly obvious at first sight, the patients' estimation of and attributing results to the chaplain, are interesting and interpretable from two angles. First and foremost, listening to the patients and to the chaplains left me with no doubt that the chaplains worked with great integrity and skill, and that they made a significant contribution to the quality of life of the patients, during turbulent periods in the patients' lives. In this respect, the praise for the chaplains cannot be denied. This also underlines the importance of providing spiritual care to people when they have to face disease and distress, as the World Health Organization (2018) already pointed out, and stresses the importance of the chaplaincy profession. Chaplains

may as well take pride and courage from this, in establishing their identities as solid and necessary players in the multidisciplinary teams of caregivers they work in.

Yet, another way of looking at this result may make a word of caution necessary. The patients were very positive about the chaplains, and ascribed most parts of their progress to them. Although it is of great value to look at what the patients said during the interviews, it is also quite interesting to consider what they did *not* say. None of the patients ascribed their increase in well-being to their own hard work, their commitment during the sessions, or their willingness to open up and grow. To some extent, this might be due to the wording of the interview questions, which could have directed the patients to seek for external factors of their results rather than internal ones. However, in any counselling relationship, be they between a patient and a psychotherapist, a doctor, a teacher, or a chaplain, it is of the utmost importance to emphasize the patients' own accountability for their progress. After all, they have to make the changes themselves, no caregiver can do this for them externally. The role of the caregiver is merely to guide them in this process, and to withdraw when the patient is sufficiently empowered to continue by themselves (Boswijk-Hummel, 2014).

When confronted with life difficulties, it can be quite a relief for people to receive some help. It is not uncommon that there is no one else they can really go to with their problems, and when a caregiver finally shows up and provides non-judgmental sympathy and support, the caregiver can be seen as a gift from heaven. Notwithstanding the actual value of this, there is a danger of seeing the caregiver as a substitute for a perfect parent, who will help them and solve their problems. All kinds of feelings (which can be either positive or negative) are projected onto the caregiver subconsciously, which fosters dependency, hampers a healthy patient-caregiver relation, and impedes the accountability and self-reflection of the patient. This is the mechanism of transference (Boswijk-Hummel, 2014; Wiener, 2009). The utterances of the patients during the interviews gave me the impression that there was at least some degree of transference going on between the patients and the chaplains. Given the current debate about the focus on the chaplain-patient relationship and the desirability of research-oriented approaches, I find it relevant to mention this observation here.

These data are in agreement with the warning Braakhuis et al. (2019) uttered about the hazard of crossing healthy chaplain-patient boundaries, as pointed out in the Introduction. Interestingly though, they expressed this warning for circumstances in which there was an overemphasis on relational attitude, at the cost of working methodologically. Apparently, the insertion of the narrative method in the counselling sessions of this study in itself did not prevent crossing these lines. This might suggest that chaplaincy education should pay more attention to

the mechanism of transference (and countertransference, as will be discussed in the following), how to recognize and how to deal with this.

4.5 Chaplains' perceptions of the narrative method

The two chaplains had quite a different perspective on working with the narrative method. Coincidentally, they each seemed to represent one particular voice in the debate on the chaplaincy profession. One was a research enthusiast, pro working methodologically, while the other was more critical on working methodologically, and emphasized the importance of the chaplain-patient connection (and how working methodologically could hamper this). These findings underline the existence of the current debate, and point out that the relational attitude on the one hand, and the methodological skills on the other, are to a certain extent still seen as two separate and conflicting entities, instead of complementary elements that contribute to overall competence.

Both chaplains offered valid points for improvement of the model. The model could benefit from increased flexibility and using it in a demand-based way. The narrative model then serves as a repository of topics that can be addressed when the chaplain and the patient see fit. Also, some if-then guidelines (i.e., "If this situation arises, then you could do this as a chaplain…") would improve the usefulness of the model. Moreover, in future applications, providing more time and more sessions to complete the counselling by means of the method would be advisable.

Zooming in on the specific elements of the model that chaplains mentioned during the interviews, the meditations of the several sessions were deemed valuable. Like the patients, the chaplains expressed the meaningfulness of the lifeline (or time line) of session two. Also, chaplains recognized the importance of ritual (meeting six) for the spiritual counselling. The chaplains expressed their appreciation for these elements in terms of for example 'touching', and 'beautiful'. The fact that the narrative method overall covered the patients' life story was considered very suitable for spiritual care. These findings support the maintenance of these elements in future applications of the model.

4.6 Chaplains preferences for working with or without a methodology respectively

Although one chaplain was more inclined during the interview towards working without a method, and the other was in favour of this, when specifically asked for their preference, none of the chaplains gave a straightforward choice for either working methodologically or not. They wanted to focus on content rather than structure, and emphasized the necessity for flexibility of the model. Methodological working did have a small place in the curriculum of the chaplains, with a theory-based academic approach. So both chaplains were not unfamiliar with working

methodologically. It seems that for the chaplains, there is value in using a model, in so far that they can select for themselves what to use during the counselling sessions and when to use it. As mentioned in the discussion of the previous research question (Section 4.5), a model can then be used as a kind of tool box, and flexibility is key. When a model becomes too rigid, it would be considered a straitjacket instead of an aid.

4.7 Counter transference

Comparable to the patients, the chaplains were very positive about their own contributions. The chaplains uttered they were highly skilled, had a lot of experience, received many compliments from the patients, and had a positive influence on the patients' wellbeing. They ascribed the success of the counselling sessions largely to their own abilities. Considering the fact that both chaplains were in their sixties and seventies, they had built quite a track record, and accordingly, this confidence in their own abilities is certainly not uncalled for. Like the patients though, none of the chaplains made remarks about the patients' efforts as a contributing factor to the counselling successes. Again, this could in part be due to the wording of the interview questions. Again however, the transference issue I noticed in the patients, also became apparent in the discussions with the chaplains.

For caregivers, it can be quite tempting to see themselves as a kind of 'saviour' for their patients, rendering them self-worth. The years and years of gratification they receive from the patients can reinforce this process. If they do not reflect upon this consciously, their desire to help other people can result in counter-transference. They then project their own emotions subconsciously onto the patient, and are satisfying their own needs instead of the patients' needs. This can have negative consequences on the relation with the patients and the success of the counselling (Boswijk-Hummel, 2014; Wiener, 2009). Every caregiver should be aware of this, and focus on the patients' empowerment and - as far as possible - their independence (Boswijk-Hummel, 2014). As mentioned in the discussion of the patient data, the chaplain data suggest that incorporating this issue (more) in chaplaincy education may be advisable.

4.8 Conclusions and future directions

In general, working with the narrative method was perceived as beneficial by both the patients and the chaplains. Patients expressed positive effects on their overall and spiritual well-being after working together with a chaplain by means of the narrative method. The patients did not experience the model as hampering the relation they had with the chaplain. One chaplain agreed with this, whereas one chaplain did perceive the model as partly hindering the natural flow of conversation with the patients. The overall results suggest that the apprehensive attitude to use a methodological approach that some have in the current debate, is not necessary. Rather,

it would be beneficial to improve chaplains' knowledge about and self-efficacy in working methodologically, by paying more attention to this in their basic education, refresher-training and in-service training (Murphy & Fitchett, 2010). Although the scope of the current study was too limited to make inferences about chaplaincy curricula, the current debate on the chaplaincy profession and the results of this study suggest that awareness of the three elements of competence (including knowledge, skills, and attitudes) may not be ubiquitous in the chaplaincy field. It would be interesting for future research to examine if and how curricula deal with this triad, and it might be beneficial to educate chaplains more on these different aspects of their professions, and how they relate to one another. The issues of transference and counter-transference may receive a more prominent position in chaplaincy education as well.

Chaplains were seen as important and valuable contributors to the patients' wellbeing. In general, the in-depth discussions about important aspects of past, present, and future life were esteemed highly. Aspects of the narrative method that were of particular value included the lifeline, meditations, relating to other people, imaginings of the future, and ritual. Therefore, it is advisable to preserve these elements when the model is used in the future. The narrative model could benefit from more flexibility: Allowing chaplains and patients to choose topics from a repository to discuss at will, rather than prescribed a specific order in advance. Also, reserving more time for the counselling sessions would improve the results, according to the chaplains. Since the patients' health situation, their limited energy resources made them experience a high workload with the exercises in the book. As a future suggestion, the exercises could be offered in lower levels of intensity, or demand-based.

References

Baartman, L. K. J., & De Bruijn, E. (2011). Integrating knowledge, skills and attitudes: Conceptualising learning processes towards vocational competence. *Educational Research Review, 6*(2), 125-134.

Braakhuis, M., Körver, S., & Walton, M. (2019). Professionele nabijheid. Integratie van een relationele grondhouding en concrete doelgerichtheid binnen geestelijke verzorging. *Tijdschrift Geestelijke Verzorging, 22*(95), 14-22.

Boswijk-Hummel, R. (2014). *Liefde in Wonderland: Overdracht en tegenoverdracht in de hulprelatie*. Haarlem: De Toorts.

Damen, A., Schuhmann, C., Lensvelt-Mulders, G., & Leget, C. (2020). Research Priorities for Health Care Chaplaincy in The Netherlands: A Delphi Study Among Dutch Chaplains. *Journal of Health Care Chaplaincy, 26*(3), 87-102.

doi:10.1080/08854726.2018.1473833

De Groot, K. (2018). Geestelijke verzorging voor ongelovigen: Religie en zingeving in recente onderzoeken. *Tijdschrift Geestelijke Verzorging, 21*(92), 56-60.

Den Toom, N., Walton, M., Körver, J., Vos, P., & Kruizinga, R. (2021). Rearranging the Domain: Spiritual Care in Multiple Dimensions. *Health and Social Care Chaplaincy, 9*(1), 42-59. doi:10.1558/hscc.40482

Freiback, P. B., & Reinert, B. R. (1999). Spirituality and people with potentially fatal diagnoses. *Nursing Forum, 34*, 13-22.

Frerejean, J., Van Merriënboer, J.J.G., Kirschner, P.A., Roex, A., Aertgeerts, B., & Marcelis, M. (2019). Designing instruction for complex learning: 4C/ID in higher education. *European Journal of Education, 54*, 513-524.

Goosen, R. (2020). *Geestelijke verzorging volgens plan*: *De verhouding tussen de relationele grondhouding en de concrete doelgerichtheid in de beroepspraktijk van geestelijk verzorgers in een ziekenhuiscontext* (Master's thesis, Tilburg University, Tilburg, the Netherlands). Retrieved from https://www.vgvz.nl/wp-content/uploads/2020/10/Thesis-Geestelijke-Verzorging.pdf

Hunter, W. D. (2004). *Knowledge, Skills, Attitudes, and Experiences Necessary to Become Globally Competent* (Doctoral dissertation, Lehigh University, Pennsylvania, USA). Retrieved from https://search.proquest.com/openview/82ebcaf19aef8d7a006227ad905882c6/1?pq-origsite=gscholar&cbl=18750&diss=y

Körver, J. (Ed.) (2014). *In het oog in het hart. Geestelijke verzorging 2.1.* Nijmegen: Valkhof Pers.

Kruizinga, R., Helmich, E., Schilderman, J. B. A. M., Scherer-Rath, M., van Laarhoven, H. W. M. (2016). Professional identity at stake: A phenomenological analysis of spiritual counselors' experiences working with a structured model to provide care for palliative cancer patients. *Support Care Cancer, 24*, 3111-3118.

Liefbroer, A. I., Wierstra, I. R., Janssen, D. J. A., Kruizinga, R., Nagel, I., Olsman, E., & Körver, J. W. G. (2021). A spiritual care intervention for chaplains in home-based palliative care: design of a mixed-methods study investigating effects on patients' spiritual wellbeing. *Journal of Health Care Chaplaincy (Online),* 1-14. Doi :10.1080/08854726.2021.1894532

Mackor, A. R. (2009). Standardization of spiritual care of healthcare facilities in the Netherlands: Blessing or curse? *Ethics and Social Welfare, 3*(2), 215-228.

Murphy, P. E., & Fitchett, G. (2010). Introducing chaplains to research: “This could help me.” *Journal of Health Care Chaplaincy, 16,* 79-94.

Myers, G. E., & Roberts, S. (2014*). Handbook: An invitation to chaplaincy research: Entering the process*. HealthCare Chaplaincy Network.

O’Connor, T. S., & Meakes, E. (1998). Hope in the Midst of Challenge: Evidence-Based Pastoral Care. *Journal of Pastoral Care, 52,* 359–367.

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analyzing qualitative data. *British Medical Journal, 320,* 114-116.

Scardamalia, M. (2001). Big change questions: Will educational institutions, within their present structures, be able to adapt sufficiently to meet the needs of the information age? *Journal of Educational Change, 2,* 171–176.

Steinhauser, K. E., Olsen, A., Johnson, K. S., Sanders, L. L., Olsen, M., Ammarell, N., & Grossoehme, D. (2016). The feasibility and acceptability of a chaplain-led intervention for caregivers of seriously ill patients: A Caregiver Outlook pilot study. *Palliative and Supportive Care, 14*, 456-467.

Unantenne, N., Warren, N., Canaway, R., & Manderson, L. (2013). The strength to cope: Spirituality and faith in chronic disease. *Journal of Religion and Health, 52,* 1147-1161.

Vereniging van Geestelijk VerZorgers. (2015). *Beroepsstandaard geestelijk verzorger 2015*. Retrieved from https://vgvz.nl/wp-content/uploads/2018/07/Beroepsstandaard-2015.pdf

Wiener, J. (2009). *The therapeutic relationship: Transference, countertransference, and the making of meaning*. ProQuest Ebook Central https://ebookcentral.proquest.com

Wierstra, I. R., Liefbroer, A. I., Post, L., Tromp, T., & Körver, J. W. G., (2021). *Addressing spiritual needs in palliative care: Proposal for a narrative and interfaith spiritual care intervention for chaplaincy*. Manuscript submitted for publication.

Woodhead, L., Partridge, C., & Kawanami, H. (*Eds.*). (2016*). Religions in the Modern World: Traditions and Transformations*. New York: Routledge.

World Health Organization (2018). *Palliative Care*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/palliative-care

ZonMw (2021). *Project Palliatief Landelijk Onderzoek Eerstelijns Geestelijke Verzorging (PLOEG) Deelproject 2: In Dialoog met je Levensverhaal*. Retrieved from https://www.zonmw.nl/nl/over-zonmw/onderwijs/programmas/project-detail/palliantie-meer-dan-zorg/ploeg-palliatief-landelijk-onderzoek-eerstelijns-geestelijke-verzorging-deelproject-2-in-dialoog/

Appendix A:

Interview questions for patients and chaplains

Table 1

Interview Questions for Patients

	Interview question	Research question
1	How do you look back on the meetings with the chaplain?	1
2	If you had to say in one sentence what was the added value of the conversations with the chaplain, what would it be?	1
3	If you think back to the meetings, what was most valuable for you? Why? In which way? What did this have to do with?	1
4	You have had meetings following a narrative method (clear structure, six thematic meetings, workbook and homework). Did you appreciate this, or would you have preferred, when looking back, the format to be more open and the topics of the conversations to be more incidental?	2
5	Did the conversations help you with regard to spiritual well-being and meaning-making? If yes, how? Which elements or moments in the meetings did this have to do with?	1
6	Did you start looking at *yourself or your life* differently, because of the conversations with the chaplain? If yes, what has changed? Which elements or moments in the meetings did this have to do with?	1
7	Did you start looking at *your illness* differently, because of the conversations with the chaplain? If yes, what has changed? Which elements or moments in the meetings did this have to do with?	1
8	Did you start looking at *the relationships with people around you* differently, because of the conversations with the chaplain? If yes, what has changed? Which elements or moments in the meetings did this have to do with?	1
9	Did you start looking at what is *valuable for you in your life* differently, because of the conversations with the chaplain? If yes, what has changed? Which elements or moments in the meetings did this have to do with?	1
10	Did you start looking at *the time to come* differently, because of the conversations with the chaplain? If yes, what has changed? Which elements or moments in the meetings did this have to do with?	1

Note: Question 4 was added to the original interview for the purposes of this study.

Table 2

Interview Questions for Chaplains

	Interview question	**Research question**
1	How did you experience participating in the study and offering spiritual care according to the narrative model? How do you look back on this?	3
2	How would you describe the impact of spiritual care according to the new narrative model on the participants? How do you notice that?	3
3	Do you think the impact is different without any guidance or method? If yes, why do you think that is?	4
4	Are there elements in the narrative model (either content-related or methodological) that hindered you? What does this have to do with?	3
5	Would you want to use the narrative model more often?	4
6	Did you consider the new narrative model to be compatible with spiritual care?	3
7	According to you, in which way were meaning-making and spiritual well-being expressed in the narrative model? Can you give any examples of this?	3
8	Did the narrative model provide you with tools to counsel clients and let them experience more meaning-making and spiritual well-being? Why (not)?	3
9	According to you, which elements in the narrative model contribute to the spiritual well-being of clients? Which elements were less or not meaningful according to you?	3
10	If you had the choice, would you generally prefer to work with or without any method or model? Why?	4
11	Was working methodologically addressed in your chaplain education? If yes, how?	4

Note: Questions 10 and 11 were added to the original interview for the purposes of this study.

Appendix B:

Coding schemes

Table 3

Coding Scheme for Patient Interviews

	Interview question	Answer category
1	How do you look back on the meetings with the chaplain?	A: Positive B: Negative C: Neutral
2	If you had to say in one sentence what was the added value of the conversations with the chaplain, what would it be?	A: Change of perspective B: New insights C: More peace
3	If you think back to the meetings, what was most valuable for you? Why? In which way? What did this have to do with?	A: Chaplain (attitude and expertise) B: Workbook (topics/exercises/structure)
4	You have had meetings following a narrative method (clear structure, six thematic meetings, workbook and homework). Did you appreciate this, or would you have preferred, when looking back, the format to be more open and the topics of the conversations to be more incidental?	A: Preference for narrative model B: Preference for open format C: No preference D: Model offered flexibility nonetheless
5	a. Did the conversations help you with regard to spiritual well-being and meaning-making? If yes, how? b. Which elements or moments in the meetings did this have to do with?	a. A: Yes, increased consciousness B: No b. A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)
6	a. Did you start looking at *yourself or your life* differently, because of the conversations with the chaplain? If yes, what has changed? b. Which elements or moments in the meetings did this have to do with?	a. A: Yes, increased assertiveness B: Yes, more positive life attitude C: No b. A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)
7	a. Did you start looking at *your illness* differently, because of the conversations with the chaplain? If yes, what has changed? b. Which elements or moments in the meetings did this have to do with?	a. A: Yes, increased acceptance B: Yes, increased sense of perspective C: No b. A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)
8	a. Did you start looking at *the relationships with people around you* differently, because of the	a. A: Yes, increased proactivity B: Yes, increased consciousness C: No

		conversations with the chaplain? If yes, what has changed?	b.	A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)
	b.	Which elements or moments in the meetings did this have to do with?		
9	a.	Did you start looking at what is *valuable for you in your life* differently, because of the conversations with the chaplain? If yes, what has changed?	a.	A: Yes, more emphasis on people/relations B: No
	b.	Which elements or moments in the meetings did this have to do with?	b.	A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)
10	a.	Did you start looking at *the time to come* differently, because of the conversations with the chaplain? If yes, what has changed?	a.	A: Yes, more letting go B: Yes, more positive attitude C: No
	b.	Which elements or moments in the meetings did this have to do with?	b.	A: Chaplain (words/steering/attitude) B: Workbook (topics/exercises/structure)

Table 4

Coding Scheme for Chaplain Interviews

	Interview question	**Answer category**
1	How did you experience participating in the study and offering spiritual care according to the narrative model? How do you look back on this?	A: Positive, sufficient flexibility B: Positive, but insufficient flexibility
2	How would you describe the impact of spiritual care according to the new narrative model on the participants? How do you notice that?	A: Positive impact on patient insight B: Negative impact on chaplain-patient contact
3	Do you think the impact is different without any guidance or method? If yes, why do you think that is?	A: Yes, as the model provides a certain direction
4	Are there elements in the narrative model (either content-related or methodological) that hindered you? What does this have to do with?	A: Yes, insufficient time B: Yes, insufficient flexibility
5	Would you want to use the narrative model more often?	A: Yes, indisputably B: Yes, certain elements
6	Did you consider the new narrative model to be compatible with spiritual care?	A: Yes, though time issues B: Yes, relation to life story
7	According to you, in which way were meaning-making and spiritual well-being expressed in the narrative model? Can you give any examples of this?	A: By the exercises B: By the chaplain
8	Did the narrative model provide you with tools to counsel clients and let them experience more meaning-making and spiritual well-being? Why (not)?	A: Yes, structure B: No, tools should be if-then suggestions
9	According to you, which elements in the narrative model contribute to the spiritual well-being of clients? Which elements were less or not meaningful according to you?	A: All elements were meaningful B: Attention is positive, repetition is negative
10	If you had the choice, would you generally prefer to work with or without any method or model? Why?	A: Model, as long as it is not a protocol B: Content suggestions but free format
11	Was working methodologically addressed in your chaplain education? If yes, how?	A: Yes, certain models B: Theoretical models but no crucial conversation skills