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Chaplaincy in the Netherlands. The search for a professional and a religious identity[1]

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ABSTRACT

This article presents an overview of the state of chaplaincy in the Netherlands. It sketches the history, religious and theological climate, training, organisation, and current practice. Two important recent developments are discussed: The rise of nondenominational spiritual care, and spiritual caregivers becoming involved in community care. Spiritual care in the Netherlands has gone through a long process of professionalisation, in which the relationship between the chaplain's professional and religious identities had to be continually redefined. It is argued that although Dutch spiritual care is still organised denominationally, spiritual caregivers share a common professional identity as professionals who focus on the search for meaning, belief systems, and ethics.

KEYWORDS

Professionalisation, religious identity, pillarisation, nondenominational spiritual care, community care

> *Spiritual care is professional support, guidance and consultancy regarding meaning and belief systems. Spiritual caregivers enter the scene at times when the routine of normal daily life is disrupted: in situations of life and death, parting and loss; when there is an intense sense of belonging, or abandonment; or when moral dilemmas present themselves. They are experts in dealing with existential questions, questions on the meaning of life, spirituality and ethical considerations.*
>
> VGVZ Professional Standard
> (Dutch Association of Spiritual Caregivers),
> 2015, p. 5

INTRODUCTION

Chaplains in the Netherlands are working as employees in healthcare institutions, the military, and the judiciary, and for the past 20 years also as self-employed professionals.[2] Providing spiritual care for people in public institutions is considered to be a public task, and – as in Norway but unlike Denmark, Finland, and Sweden – is financed by the state. However, because of the separation of church and state, organisation and content of spiritual care and the education of those who provide it is seen as the primary responsibility of the churches and other worldview organisations, together with the professional organisations. The presence of chaplains in public institutions is based on the Dutch Constitution, which guarantees freedom of religion and worldview (art. 6).[3] This means, for instance, that every person who resides in an institution such as a hospital, a prison, or the armed

forces for more than 24 hours should have free access to spiritual care, "without control or approval by any third party". This is called the "sanctuary function" of the chaplain (referring to the old practice of people being able to take refuge in churches).[4] In healthcare, professional chaplains have been present since 1970, in the judiciary since 1950, and in the military the first chaplains started some 100 years ago in World War I.

The position of chaplains in healthcare is somewhat different from those in the military and the judiciary. In this article I will focus on healthcare chaplaincy – not only because it is the biggest group of chaplains (around 1,200; there are 150 in the military and 137 in the judiciary), but also because here the process of professionalisation that started in the 1960s, and the impact of the changing religious landscape and societal developments are most clearly visible.

The history and transformation of chaplaincy in the Netherlands is best illustrated by the history of the VGVZ, the Dutch Association of Spiritual Caregivers, which was founded in 1971. At the moment the VGVZ has about 1,000 members. Originally, it was a professional organisation for chaplains in care institutions, but since 2015 it has also been open to spiritual caregivers from other settings – although its Professional Standard (2015)[5] still focuses on chaplains in healthcare. The VGVZ has always played a key role in the professionalisation of Dutch chaplains, and serves as a lobby and pressure group.

Definition and domain: Meaning and belief systems

The Dutch term for chaplain is *geestelijk verzorger,* "spiritual caregiver". "Spiritual" (*geestelijk*; cf. the German *Geist*) is an ambivalent term in Dutch, because it has associations with both the religious, clerical field and that of mental health care.[6] The VGVZ clarifies "spiritual" as pertaining to "the human desire to derive meaning from and assign meaning to life, which expresses itself in an active appreciation of life and a quest for connection and orientation" (VGVZ Professional Standard, 8). Hence, spiritual care is defined as "the professional support, guidance and consultancy regarding meaning and belief systems" (VGVZ Professional Standard, 5). Thus, the term meaning (the search for meaning, meaning-making) is central in this definition. The notion indicates the more active, informal and individual aspects of how people search for orientation and meaning in life. "Meaning" is specified as having four dimensions: Existential (pertaining to existential experiences in everyday life and contingent experiences), spiritual (pertaining to transcendental[7] meaning and experience), ethical (pertaining to values, norms, and responsibility) and esthetical (the formative experiences of beauty in nature and culture).[8] The term belief systems (*levensbeschouwing* – worldview, philosophy of life) stands for the reflective/substantive, formal and collective/social aspects of meaning, as embodied in for instance religious and other worldview traditions.[9]

An individualised and de-institutionalised religious climate

It is important to note that the definition given above phrases the profession's domain in general, formal, non-substantive terms rather than religious, theological, pastoral-care language. The definition aims at encompassing all different views of life. This is typical of spiritual care in the secularised, multicultural Netherlands. At the moment only 32 % of the population have an affiliation with a religious or other worldview organisation (Bernts & Berghuijs 2016).[10] However, the 68 % "nones" may be religious/spiritual too: There is much religion and spirituality outside the churches.[11] We see a decline of the established churches, next to a great deal of free-floating spirituality ("new spirituality"). So, religion is to a high degree individualised and de-institutionalised. Spiritual caregivers have had to adapt to this development, and in the process their own religious identity has always been a relevant but highly contested issue.

Preview

First, I will sketch the history of the profession since the 1960s and the societal context in which it arose and was able to develop in its present form. Second, the theological context will be discussed briefly. Third, two recent develop-

ments which have had great influence on the identity, organisation, and practice of present-day spiritual care in the Netherlands will be presented: the turn to nondenominational spiritual care, and the increasing stress on community care/extramural care. I will then discuss current organisation and practice, the required qualifications and training, and present some earlier research on the subject.

HISTORY AND CONTEXT[12]

The 1960s and 1970s: Becoming a care professional; de-pillarisation and the start of professionalisation

The actual position of the spiritual caregiver in Dutch healthcare institutions can only be understood against the background of the so-called *pillarisation*: the organisation of Dutch society in "pillars" (streams) based on religion or worldview. Each pillar (Protestant, Catholic, socialist) had its own schools, hospitals, etc. Until the 1960s, Protestant ministers and Catholic priests/rectors delivered pastoral care in confessional hospitals but were not in the employ of these institutions. They were "guests" representing the churches (either paid or as volunteers).[13] In the confessional care institutions, then by far in the majority, a Protestant minister or Catholic rector/priest often had a seat on the board.

In the 1960s the pillarisation system began to collapse, and in 1969 the pillarised structure of the hospital organisations was disappearing. Protestant and Catholic hospitals merged into public hospitals, working together under the umbrella of the Dutch Council for Hospitals (*Nationale Ziekenhuis Raad,* NZr). The new healthcare structure constituted a challenge for the organisation and identity of the spiritual caregivers. A NZr report stated that pastoral care should be regarded an integral part of hospital care, in which patients' needs should be central rather than a missionary message. Spiritual caregivers were supposed to work for all patients who ask for "spiritual help", not only for those belonging to their own faith/worldview group (NZr, 1974). Integration started at academic hospitals, which organised the different chaplains together in ecumenical and later interreligious "Spiritual Care Services" (*diensten geestelijke verzorging*); other hospitals followed the example.

This was an important turning point: spiritual care was now considered a public service provided by the welfare state, and not primarily the responsibility of the churches. The traditional role and function of pastors in hospitals changed accordingly. Although the chaplains were also office holders on behalf of their own religion/worldview institution, a professional orientation was already visible currently. The importance of paying attention to "the context of ultimate meanings and concerns" for care and wellbeing was emphasised.[14] So, already in the 1970s spiritual caregivers were supposed to work as integrated staff members – for the wellbeing of all patients and the hospital care, rather than and not primarily from the perspective of their own religion/philosophy of life and worldview institutions. This also explains the long tradition of the "territorial approach" – where the wards are divided among the spiritual caregivers, instead of their working along confessional lines – although patients can always ask for a spiritual caregiver of their own denomination.[15]

In 1971 the Protestant and Catholic associations of spiritual caregivers together founded the VGVZ (then called the Dutch Association for Spiritual Care in Hospitals), which was also open to Jewish and humanist spiritual caregivers. In 1975 a "non-church sector" was established for humanist chaplains; their aim was to offer care to patients who were not members of a church. In 1980 the humanist sector of the VGVZ was established, and in 1990 the Jewish sector. Later, when the Netherlands became culturally more varied, Muslim, Hindu and recently Buddhist sectors were established, and finally in 2015 a nondenominational sector.

Since the 1980s the professional orientation has become even stronger, and the impact of spirituality on health and wellbeing grew increasingly more important for legitimatising and positioning spiritual care. The role of the spiritual caregivers' own worldview had to be addressed in new ways again.

The 1980s and 1990s: Threats, consolidation, and further professionalisation

In the 1980s the position of spiritual caregivers was questioned again – induced by budget cuts and increasing secularisation. Why should spiritual care be financed publicly? Why should churches not partly pay for the costs of spiritual care? Do not religious practices belong primarily to the private sphere? In the political struggle between Christian and secular political parties about the state financing religious practices such as spiritual care, the CIO (*Contact in Overheidszaken*, Interdenominational contact for governmental affairs) played an important role. In 1987, the NZr found a compromise: The spiritual caregiver should be both a professional and endorsed by[16] a religious or other worldview institution.

Thus, the organisation of spiritual care has been ambiguous until today. On the one hand it is seen as a religious activity: Chaplains are supposed to be office holders as well as staff members, their expertise and legitimation coming from their respective worldview organisations. The old pillarisation structure is still visible: All worldview pillars should be represented, and the proper character of the various denominations should be kept. On the other hand, a clear professional orientation can also be discerned. Spiritual caregivers are supposed to be embedded in the staff ("integrated"), for the benefit of both the care institution and the patients. Yet they are supposed to have "their own authentic spirituality, which they actively maintain, and which constitutes the foundation of their work" (VGVZ Professional Standard, p. 6). This double identity, professional and religious, has frequently led to tensions. For instance, spiritual caregivers may hesitate to share information in multidisciplinary teams, because of the confidentiality linked to the sanctuary position. Also, conflicts with managers and care staff may arise when spiritual caregivers criticise non-patient centred treatment or technocratic management.

It was not only the organisation but also the daily work practices that changed in the 1980s and 1990s. Spiritual caregivers began to contribute to the education of care professionals (for instance giving clinical lessons) and were involved in moral counselling, ethics committees, and the like. The increasing religious diversity led to multicultural, interreligious, and even supra-religious spiritual care being developed. Quality management and improvement became an important issue in healthcare, and this raised the question what competencies to require from chaplains (Smeets 2006). The process of professionalisation was also enhanced by the demand for accountability, evidence-based working methods, and managerial efficiency.[17]

Overall, in the 1980s and 1990s we see a consolidation of the position of spiritual care. Moreover, the spiritual care profession became less denominationally centred and more oriented towards competence and professional development.

THEOLOGY

A consequence of the pillarised religious organisation of spiritual care is, ironically, that there is no joint theological underpinning of the profession, as already appears from the general phrasing of the profession's identity. Each worldview sector of the VGVZ, though, has its own particular theological and/or philosophical inspiration for the work. Notwithstanding the theological variety, there is one theologian who has been hugely influential in the Netherlands since the 1940s: Karl Barth. This may be the reason for the rather ambivalent attitude of Dutch spiritual caregivers towards psychology. Barth's focus on the "otherness" of God led to a distrust of looking at the human foundation of faith. Although since the 1970s psychodynamic knowledge and techniques introduced by the Clinical Pastoral Education movement have been part of the training of spiritual caregivers, there has long been a mistrustful attitude towards a psychological approach and the use of therapeutic techniques.[18] It was argued that spiritual care is radically different from therapy, which is methodical and goal-oriented, leaving insufficient room for the revelatory presence of God in human interactions. This idea also explains the resistance towards pastoral diagnostics and the like (Bouwer 1998).[19] The theological/philosophical motivation for and underpinning of spiritual care was

found in religiously inspired humanity and solidarity – talking to the patient as a fellow human being. Inspirational sources range from Augustine, Thomas Aquinas, Luther and Calvin to Martin Buber and Emmanuel Levinas, Hannah Arendt and Martha Nussbaum, Thomas Halik, Christian Wiman, and Alain de Botton. Until very recently, the theories most frequently used were Rogerian counselling and the so-called "presence approach" promoted by Andries Baart, who emphasised "being present" as the most important method for spiritual care.[20] At the moment, the discussions about psychology and spiritual care have become much more nuanced, and spiritual caregivers use psychological methods and theories more freely.

RECENT DEVELOPMENTS (2000 – present)

Non-denominational spiritual care

The highly individualised and de-institutionalised religious climate in the Netherlands has greatly influenced the organisation and content of spiritual care. Spiritual needs and practices vary widely and are often not recognised; they remain under the surface. A new language and different, more "general", inclusive rituals (such as alternatives for weekly Christian services) had to be developed. Religious services in the care institutions usually have an ecumenical or a general, supra-confessional character, and focus on spirituality and the search for meaning, borrowing liberally from various traditions. The hospital chapels changed into supra-confessional and general "rooms of silence" (Holsappel-Brons 2010), where Christians, Muslims etc. could feel at home, as well as "nones" who want to meditate, burn a candle, or just sit there for a while.

The changing religious climate has also affected the spiritual caregivers themselves: The link with their traditions and institutions became less important, and more and more spiritual caregivers did not want "official" endorsements, because they no longer felt at home in their church or considered their membership irrelevant for their work as chaplain. Moreover, their employers – this applies to care institutions, not the military and the judiciary – often did not require such an endorsement, and traditional chaplaincy services such as official religious services, blessing of the sick, and baptism were less asked for. Further, the number of chaplaincy students enrolled in confessional programs decreased whereas a growing number of students wanted to train for chaplaincy, but not in a confessional program leading to an endorsement. These students may consider themselves Christians, humanists, Buddhists, etc., or see themselves as drawing from different traditions at the same time. They may either have been raised in a religious tradition or not, and either have a religious/worldview affiliation or not. Around 2000, the first academic programs for non-denominational spiritual care were developed.[21]

A problem was that these new spiritual caregivers were not allowed to become members of the VGVZ, which required an official endorsement for membership.[22] The average age of the VGVZ members rose, while the number of non-denominationally working spiritual caregivers increased rapidly.[23] In 2008 the VGVZ established an "Endorsement Committee", and later the so-called *Regiegroep* (steering committee) to solve this issue. The Regiegroep consisted of representatives from the field of spiritual care and the endorsing institutions. Their task was to develop an organisational structure in which the "spiritual competency" of chaplains could be guaranteed (next to a master degree, which guarantees the other competencies), and the sanctuary position and the legal underpinning of the profession could be safeguarded as well. In 2015 a solution was found: A Council for Non-Denominational Spiritual Caregivers (RING-GV) was established to test "spiritual competency", comparable to the testing of Protestant, Catholic and humanist graduates by religious institutions. Since then, the VGVZ requires for membership either an endorsement by a religious or worldview institution, or a "mandate" by RING-GV. A new worldview sector was established: the SING (Sector for Institutionally Non-affiliated Spiritual caregivers). This new "pillar" (it is in fact an ironic remnant of pillarisation) has grown rapidly in four years and now constitutes 20 % of the VGVZ members.

So, since 2015 nondenominational spiritual caregivers can become members of the

VGVZ.[24] We may conclude that the professional identity of the spiritual caregiver in the Netherlands is gradually changing from primarily a religious office holder endorsed by a religious/worldview community and providing religious care, to a specific healthcare professional specialised in meaning-making and belief systems (Zock 2008). However, the discussion about nondenominational spiritual care is still going on. Research needs to be done about the spiritual/worldview background of the nondenominational spiritual caregivers (which is highly varied), how it is being maintained, and what role it plays in the daily work.

Spiritual caregivers in community care

As in other countries, in the Netherlands we see an increasing decentralisation of healthcare. A 2015 act makes municipalities responsible for the distribution of care.[25] The idea is that the patient is treated and cared for at home and if possible, not being interned in a hospital, a nursing home or another care facility. This applies to the care for the elderly and people with chronic diseases (fast-growing groups), but also for palliative care (for patients dying at home or in a hospice instead of in a hospital) and for psychiatric patients. In brief: there is a shift from intramural to extramural care. Regarding the necessary specialised care, there is an increase of outpatient clinics and transmural care.

In the extramural and transmural care, spiritual care does not have a structural place yet. People dealing with serious life problems, illness, and death, or with handicaps at home do not have access to spiritual care. In the multidisciplinary teams in towns and cities there is no spiritual caregiver, and most of the people do not belong to a religious community and hence have no access to pastoral care.

The decentralisation of care has been accompanied by enormous budget cuts, especially in nursing homes and psychiatric hospitals. Many spiritual caregivers lost their job and became entrepreneurs in extramural settings. They work as self-employed professionals, but also together in independent practices ("centres for life questions"), and collaborate with general physicians, organisations for home care, local communities, palliative teams, churches, and volunteer organisations.

The background to this decentralisation is a financial one, but it is also related to a new philosophy of care, focusing on the needs of the patient as a person, in his/her specific context. Further, a new view on health is embraced: health is no longer defined as the absence of symptoms or disease, but as *positive health*; i.e. the ability to adapt and self-manage (Huber 2014).[26] This new philosophy is linked to dominant cultural values, such as autonomy, being able to participate in society, and the ability to cope for oneself.

The new care philosophy and community care do not always work out well. The process of decentralisation of care is still in its infancy, and there are many people who are left by the wayside. Yet the concepts of person-centred care and positive health fit in with what spiritual caregivers have always being doing in hospitals: assisting in handling life crises, dealing with existential questions, and finding spiritual sources for coping. So, they can form alliances and help develop good extramural care.

There are about 70 private, independent spiritual care practices now. They offer individual guidance, group work, advice and training of care professionals. However, financing is a problem, because spiritual care has not yet been integrated into the extramural care system. The constitutionally based regulation that every person who is staying in a public institution (such as a care facility) for more than 24 hours is entitled to spiritual care, does not apply here. Spiritual care is reimbursed by some health insurance companies but is not included in the Health Insurance Act.

The present Dutch government recognises the value of spiritual care in the home environment. In 2018, the ministry of Health, Welfare and Sport (VWS) has decided that spiritual care should also be available for people at home, and that it should be financed and become an integrated part of extramural care. The ministry has made available 15 million euros to get this implemented, starting with the palliative care and the care for the elderly. This means that the self-employed spiritual caregivers – working inde-

pendently, organised in centres or transmurally from hospitals – can get paid for their services to patients and for educational and advisory services to care professionals. The two-year program will be evaluated and a new financing system for spiritual care in the home environment must be developed.

The consequences of this new development for the identity, competencies and training of the spiritual caregivers will have to be further investigated. Competencies such as entrepreneurship, teaching, and interdisciplinary working will have to be further developed and introduced in the training programs.

CURRENT ORGANISATION AND PRACTICE

PROFESSIONAL ORGANIZATIONS SPIRITUAL CARE IN THE NETHERLANDS

VGVZ – Dutch Organization of Spiritual Caregivers https://vgvz.nl/

- 8 sectors: Catholic, Protestant, Humanist, Jewish, Hindu, Muslim, Buddhist and the non-denominational sector
- 7 fields: hospitals, psychiatry, nursing homes, youth care, people with a disability, revalidation, community care (extramural care).
- Professional Standard (2015): professional profile, quality standard, professional code.
- Journal: Journal for Spiritual Care [Tijdschrift Geestelijke Verzorging]

SKGV: Foundation Quality Register Spiritual Caregivers www.skgv-register.nl/

RING-GV: Council of Institutionally Non-Commissioned Spiritual Caregivers www.ring-gv.nl/

UCGV: University Centre for Spiritual Care https://ucgv.nl/

ENHHC: European Network of Health Care Chaplaincy http://www.enhcc.eu/

The practice of spiritual caregivers in the Netherlands differs depending on the specific care setting. Generally, functions on micro-, meso- and macro-levels are distinguished: Guidance and support of individual patients and their family (micro), support and training of care staff (meso), and giving advice concerning care management and the policy and identity of an institution (macro). In many hospitals, spiritual caregivers are involved in ethical committees, conduct moral consultation, and work as confidential advisors. Also, in many institutions Sunday services – ranging from traditional Christian services by office holders to ecumenical services or secular ceremonies – are held. There are special services focusing on sensorial experiences for people with dementia and mental handicaps. Spiritual caregivers perform traditional rituals such as baptisms, ritual blessings, and the extreme unction. Further, spiritual caregivers are involved in group work, such as support groups talking about existential issues. They frequently work with art, poetry and music –important media for addressing spirituality in a secularised context. Many old hospital chapels have been transformed into "rooms of silence" intended to appeal to people with various backgrounds.

Much-used methods and theories in the care for clients are: The "presence" approach ("listening and being present"); narrative approaches, such as life-review, personal "books of life" (life reconstruction books) in nursing homes; mindfulness; working with art and music. Spiritual caregivers increasingly use spiritual diagnostic instruments, such as the FICA[27], for interdisciplinary work and are involved in the developing of standards and guidelines, such as the Interdisciplinary Guideline for Spiritual Care in Palliative Care (Van de Geer 2017, p 53ff).

TRAINING

Since the 1970s the training of spiritual caregivers, as in Finland and Norway, has built heavily on the CPE tradition and methods, both in the initial and advanced training of pastors and chaplains. The Council for CPE and Pastoral Supervision emphasised the autobiographical approach: Learning to use oneself as an instrument via analysis of verbatims and case studies, group dynamics and autobiographical work. Internships combined with a CPE-type training

and supervision are generally part of the initial training, and many spiritual caregivers follow a full CPE trajectory afterwards. Further, each spiritual caregiver who has just started work is supposed to follow a one-week "spiritual care in organisations" course in their specific field (hospital, psychiatry, nursing home). In the past twenty years the focus of the professional training has become broader, including knowledge about management and institutions, various psychological and agogical methods, and advisory and teaching skills.

Initial training

The various MA and BA Spiritual Care programs (both confessional and nondenominational) may differ in focus but are all oriented on the VGVZ Professional Standard.

Required competencies

For membership the VGVZ requires:

- Competence: An academic or a professional master's degree in Theology, Humanistic Studies or Religious Studies, at an institution accredited by the SKGV. Spiritual caregivers with a professional BA degree can become prospective members; to become a regular member, they should have acquired an MA degree (or reached a corresponding MA level) within five years.
- Authorisation: An endorsement by a religious or spiritual organisation, or a mandate from RING-GV.
- Permanent education: Maintaining an adequate level of knowledge and skills through continuous further training (demonstrated by, e.g., a registration in the quality register SKGV).

General competencies

Each area of activity (hospital, nursing home, youth care etc.) requires its own specific competencies. However, the VGVZ Professional Standard (2015, 9f). states that all spiritual caregivers should

- be capable of reflecting on religious, spiritual and ethical issues that present themselves in their personal lives as well as within organisations.
- have a broad knowledge of meaning and belief systems, religion, spiritual resources, and ethics;
- be capable of sharing their knowledge and reflections with others, and of bringing people together;
- have their own authentic spirituality, which they actively maintain.

Three categories of competencies are distinguished:

1. Substantive competencies (hermeneutical/worldview, therapeutic, spiritual – i.e. the ability to help people discover and renew sources of spirituality and belief – ethical).
2. Process-oriented competencies, such as communicative, educational and organisational competencies.
3. Personal competencies, pertaining to integrity and self-reflection.

Becoming "research-literate" is a new requirement, as the government and the health institutions increasingly demand research on the function and effects of spiritual care, to legitimate funding and its integration in healthcare.

Permanent education

Permanent education is offered by the universities, the Council for CPE and Pastoral Supervision, and various private organisations.

Regarding permanent education the SKGV quality register requires every five years:

- a supervision trajectory;
- participation in an intervision group;
- maintaining one's spirituality (e.g. a spiritual guidance trajectory, a meditation week in a convent);
- other training or courses amounting to 50 points in total (1 point = 4 hours), such as a CPE trajectory, a master's or post-master's program in "Ethics and Policy", a training in Contextual Pastoral Care or Bibliodrama, advanced training in group dynamics or counselling techniques, becoming a mindfulness trainer, specialising in palliative care, attending symposia, workshops and conferences, or participating in research.

RESEARCH

Research on spiritual care has started some twenty years ago and has gained momentum over the last five years. In 1997 the Trimbos Institute published the first inventory of spiritual care in the Netherlands (De Roy etc. 1997), which made the profession visible and formed the basis for later research.

A subject of fierce debate is the question if and to what extent the work of spiritual caregivers and the effects of spiritual care can be empirically researched. Do not the highly dialogical and contextual listening and interventions by spiritual caregivers elude empirical research? And is not spiritual care above of all a very private and personal affair? Besides, is it not dangerous to make the availability of spiritual care dependent on its effects? Does it not rather represent "another" domain in healthcare, based on the value of humane support? These doubts explain that at first only qualitative, descriptive research was done. However, this has changed over the last ten years, under pressure of the demands for accountability regarding financing, quality improvement, and interdisciplinary working. Evidence-based working in the field of spiritual care may not be that easy, but we can aim at getting practice-based evidence, as argued by George Fitchett. Fitchett has visited the Netherlands several times and inspired the current case studies project (See Muthert in this volume). Research on PROMs spiritual care is also being done (See Visser-Nieraeth in this volume).

Recent PhD studies concern, for instance, the basic methodology of spiritual caregiving (Smit 2015), the worldview of Protestant chaplains (Huijzer 2017), training spiritual care within palliative care (Van de Geer 2017), and the question of what makes life worth living, according to elderly people dependent on intensive care (Van der Wal 2018).

Further, a great deal of other research is being carried out about such varying subjects as moral distress in the military, working with "life stories" and other narrative interventions, religious coping, religious experiences of psychiatric patients, spiritual care in extramural care,[28] and spiritual care in the Groningen earthquake area.

CONCLUSION

Spiritual caregivers in the Netherlands may draw on a variety of religious and philosophical traditions for inspiration and the underpinning of their work, but they share a common professional language of meaning-making and a sound professional standard and organisation. This is a strong foothold from which to address the requirements for the profession to acquire a new, permanent place in public institutions, which is necessitated by the changing religious and societal landscapes. Current challenges are finding a new legal foundation as to financing, becoming integrated in extramural care, and further developing new practices to address religion and spirituality in a secular and multicultural context. Training and research should respond to these developments; international exchange and cooperation will be indispensable.

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NOTES

1 I would like to thank my Groningen colleague Dr. Brenda Mathijssen and all the colleagues of the ReChap group for their helpful comments on this article.

2 For the past twenty years there have also been a few chaplains in the Dutch police force. Currently, eight new chaplains are being appointed there.

3 The responsibility of healthcare institutions is to provide adequate and high-quality care. Spiritual care is further specified in the Healthcare Quality, Complaints and Disputes Act (WKKGZ), article 6 and in the Healthcare Clients Participation Act, article 3.

4 "Spiritual caregivers help safeguard the constitutional freedom of religion and belief for people living in a healthcare institution, for detainees, and for military personnel. This is referred to as the "sanctuary" function, as it offers access to spiritual assistance to all citizens, without control or approval by any third party." VGVZ Professional Standard 2015, p. 5.

5 Quotes in this article are from the draft English translation (2017) of the VGVZ Professional Standard 2015. The first edition of the Professional Standard is from 2002.

6 The term "spiritual care" is increasingly favoured over "chaplaincy". As Constanze Thierfelder (2017) states: "favouring of the term 'spiritual care' is not only a tribute to the changing situation in German-speaking countries, but also a way pastoral care takers want to deal with the challenges they face in a secular, multicultural Society".

7 The term "transcendent" is used in a very broad sense, referring to both "vertical transcendence" (such as belief in a divine being) and "horizontal transcendence" (transcending the self, for instance in relationships with others or nature).

8 "Meaning", in this broad sense of the word, equals the American term "spirituality". See for instance the definition of spirituality by Christina Puchalski (2009) and the Dutch multidisciplinary guideline for spiritual care in palliative care, which is based on this definition: https://www.pallialine.nl/zingeving-en-spiritualiteit.

9 The domain of spiritual care is also summarised in the Professional Standard (p 42) as "context of ultimate meanings and concerns".

10 Protestant: 13 %, Catholic: 12 %, Islam: 5 %, other religions: 2 %.

11 About 42 % of the population consider themselves "believers", about 30 % say they are "spiritual", and almost 50 % report praying.

12 This section is mainly based on Doolaard 2006 and the VGVZ Professional Standard 2015.

13 Besides, there were a few representatives of the Jewish organisations and the Dutch Humanist Association.

14 However, this integrated way of working was questioned from a religious perspective. Protestants asked, for instance, if the minister's "office" could be combined with integrated working, and if the hierarchical structure of the spiritual care services (with one of the chaplains as head) did not conflict with ecumenic cooperation, which implied equality.

15 "Spiritual caregivers can be called on by anyone, irrespective of the caller's religion or convictions. In principle, each spiritual caregiver can provide spiritual care to each client. A client who specifically wishes to see a spiritual caregiver of the same background will be referred accordingly" (VGVZ Professional Standard 2015, p 4).

16 An endorsement testifies that the spiritual caregiver has been educated and trained within his/her own religious/spiritual tradition, and may act as (ordained) representative of the endorsing organisation, and in some cases as a celebrant/officiating priest leading ceremonies, performing particular rituals and rites (VGVZ Professional Standard 2015).

17 In 1994, the VGVZ established a Professionalisation Committee to specify professional requirements and advance the professional expertise and working methods of spiritual caregivers.

18 In Denmark there has long been a similar distrust of psychology in spiritual care, also due to the influence of dialectical theology (See Thomsen in this volume). In Norway and Finland, on the other hand, psychological and psychotherapeutic theories have always been more welcomed in spiritual care (See in this volume Stifoss-Hanssen, Danbolt & Frøkedal, and Saareleinen respectively). In Norway the strong tradition of psychology of religion has been an influential factor in this respect. In Finland psychology and psychotherapeutic techniques constitute an important part of the chaplaincy training program.

19 Jan Hein Mooren, formerly teaching at the University of Humanistic Studies, has written an influential booklet on the tension between psychology and spiritual care (1989). He argues that theology/worldview constitutes the primary frame of reference of the spiritual caregiver, and psychology the secondary frame of reference. For the psychologist this is the other way around.

20 Baart's agogical method was developed in the field of urban mission, carried out in several poor and disadvantaged neighbourhoods and districts in the Netherlands, and is presented as an alternative for the theory- and goal-driven intervention approach. For an English-language introduction to this approach see http://www.presentie.nl/publicaties/item/283-presence-approach-introduction.

21 The first nondenominational master's program was established in 2004 in Groningen. At the moment there are three master's programs in spiritual care which are not connected to a confessional, denominational school such as a theological seminary or the University of Humanistic Studies. An important incentive for the universities to develop these new master's programs was to compensate for the decrease of students in confessional training programs.

22 Many of the spiritual caregivers who would not or could not receive an endorsement became members of the alternative professional organisation Albert Camus, which was established in 1995 for spiritual caregivers who had a professional bachelor's degree in theology (They could not become members of the VGVZ either, because of the requirement of a master's degree).

23 The nondenominational chaplain has been a highly disputed figure in the VGVZ for years. Various practical and principled arguments were heard (such as who would control education and worldview expertise; what the nondenominational approach meant for the sanctuary position and the legal foundation and financing of spiritual care; and that the identity of the "general" spiritual caregivers was unclear to patients).

24 This solution was possible because of the position of spiritual caregivers in healthcare: They are neither paid by nor appointed by the churches. This is different in the military and the judiciary; the spiritual caregivers there are employees, but for the content of their work accountable to their church, the Humanistic Association etc. This is called the *duaal-paritaire structuur* in the judiciary (Van Iersel & Eerbeek 2009). In the military, there is a similar structure. See *Professional Standard for spiritual caregivers in the military,* 2017–2021. In both cases it is the CIO which appoints the spiritual caregivers.

25 It starts with so-called "kitchen table conversations": If you suffer from a chronic disease, are in the early stages of dementia, or have a handicap (either mental or physical), members of the local multidisciplinary care team come to your house, talk about what kind of care you need, and not in the last place about what you can do yourself and who in your social network can help you.

26 Huber and colleagues (2014) speak of *positive health,* arguing that the WHO definition of health as complete well-being is not adequate, given the rise of chronic diseases. They propose changing the emphasis towards the ability to adapt and self-manage in the face of social, physical, and emotional challenges. Huber distinguishes six dimensions of health: Bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning. She considers the spiritual/existential dimension the factor which contributes most to health.

27 FICA: *F*aith and Belief, *I*mportance, *C*ommunity, and *A*ddress in Care or Action (Puchalski and Romer, 2000).

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