Interfaith Spiritual Care in Post-Secular Societies.[1]

R.Ruard Ganzevoort

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Introduction

The history of spiritual care has a strong tradition-specific dimension. Both providers and receivers of spiritual care were considered to belong to a particular religious denomination which would define the content and methods of spiritual care. Protestant-Christian spiritual care was different from Roman-Catholic spiritual care and even more different were Islamic, Buddhist, Jewish, Hindu, and secular spiritual care. Quite often they would not even use the same term. Although this makes sense in societies where the various religious traditions are clearly distinguished, it is much more complicated in post-secular societies like The Netherlands where religious affiliation is very nuanced and complex.

In my presentation, I will first describe the religious landscape of my country. In a second step I will discuss the emergence of the notion of "interfaith spiritual care" within the international debates about religious and spiritual care. I will also look at similarities and differences between the various traditions in their views of spiritual care and the question whether it is possible to develop a shared basic conceptualization of spiritual care across denominations and across working contexts.In the last part of the presentation, I will describe the MA-program in interfaith spiritual care at Vrije Universiteit Amsterdam, of which I am one of the coordinators. This program combines generic and tradition-specific elements for students from various backgrounds (Christian, Islamic, Hindu, Buddhist, and others, including secular humanists).

Changing concepts of spiritual care in a (post-)secular society

The role of religion in (post-)secular societies like The Netherlands is changing rapidly and the field of spiritual care arguably shows some of the more dramatic consequences. One reason for this is the fact that health care, the main context in which formalized spiritual care is offered, is more and more governed by a

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[1] Parts of this presentation are based on Ganzevoort et al. (2014)

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functionalist paradigm which is characterized by instrumental and economic rationality. This rationality shows up in evidence-based policies and efficiency structures. This functionalist paradigm of health care has little mercy for spiritual care that is often not considered to be measurable and evidence-based.This challenges spiritual caregivers to define and present their contribution to the health care system in terms heretofore alien to the spiritual nature of the discipline.Religious traditions usually don't describe their meanings in functionalist terms. Parallel processes can be observed in the other traditional institutional contexts of spiritual care (army, prison), especially when economic circumstances ask for austerity and result in budget cuts.

The most important reasons, however, relate to the changing face of religion itself. For decades it was common to speak of secularization as a description and explanation of the religious changes in Western countries, implying that the modernization of society would automatically play out in a decrease of religious saliency as observed in belonging, activity, and conviction. This is no longer considered to be a proper interpretation of what is happening, at least in Europe and some other parts of the world (Berger et al. 1999). One can indeed witness such a decrease, but also newer forms of commitment and spirituality. A significant part of those newer forms is represented by the non-western migrant population. In the Netherlands, these migrants are usually Christian - 3% of the total population (Stoffels & Jansen 2007) - or Muslim - 6% - and they bring with them a traditional and often relatively conservative religious life (Jewish and Hindu communities constitute much smaller religious contingents in this country). There is a growing number of native Dutch persons that become interested in Buddhism, but their interest may or may not materialize in formal affiliation, which makes it difficult to calculate numbers.

According to a study published last month (Bernts & Berghuijs, 2016), 40 % of the Dutch population consider themselves to be secular, while 32 % belongs to a religious tradition (Christianity 25 %; other religions 7%) and 27% is religious or spiritual without affiliation. Membership of religious denominations is thus no longer a proper way of assessing spiritual or religious needs. Moreover, 24% of the Dutch combination combines elements from two or more religious traditions, usually Christianity and Buddhism. For some this is so intense that it may be called "Multiple Religious Belonging".

Two processes seem particularly important when we sketch the changing face of religion in light of the developments in the field of spiritual care: deinstitutionalization and pluralization. Deinstitutionalization refers to the process in which the traditional religious institutions lose control over the religious/spiritual domain in society (Heelas&Woodhead 2005; McGuire 2008; Streib 2007). They may have been the guardians, gatekeepers, and gracious providers of the spiritual repertoire (although even that image can easily be debunked as a backward projection), but in our days they are humble representatives of a wisdom of bygone days. Contemporary believers (if that is

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still the correct term) create their bricolage (Hervieu-Leger 2001), patchwork (Wuthnow 1988), or off-road-religion (Streib 1999). They may claim to belong to one, multiple or no religious tradition, and choose the degree and shape of their affiliation. It is less and less clear that they can or should be identified as groups based on a shared affiliation. Many of them adhere to religious or spiritual traditions that are not acknowledged socially and legally as formal traditions and that do not yield the recognition and privileges that older traditions have secured for themselves. All this implies that the religious institutions today have lost not only their authoritative position regarding religion but also their representative power (Ganzevoort 2011). Although traditional churches and similar institutions from the main worldview traditions (including humanism) are still seen as the formal counterparts of the government in religious matters, including spiritual care, their constituency becomes weaker.

The second, related, process is pluralization. This refers to the increasing diversity of religious traditions and perspectives. The Netherlands has a long history of multidenominationalism, culminating in the pillarized society of the twentieth century. Protestants (subdivided in a wide array of denominations), Roman Catholics, and seculars (socialists and liberals) defined public debate and the structures of society. Education and health care institutions accommodated these three main perspectives. Through the centuries, immigrants from diverse religious traditions added to the plurality, notably the sixteenth and seventeenth century Jewish refugees from Spain and Portugal, and the twentieth century migrant workers and asylum seekers from Islamic countries, but also many migrants with a charismatic Christian background, quite different from the historical versions of Christianity in the Netherlands. (Stoffels & Jansen 2007).

These two processes of deinstitutionalization and pluralization have resulted in a religious landscape that is increasingly difficult to define. There is a variety of denominations from all kinds of religious traditions, each with various degrees of affiliation and participation, crossovers and combinations, atheistic, agnostic, and spiritual secularism, and so on. This is not so much a problem for researchers who increasingly turn to concepts like 'lived religion' (Grözinger&Pfleiderer 2002; McGuire 2008) as it is for policy makers, for example regarding spiritual care. How can we accommodate this religious diversity if we cannot take as a starting point a limited number of clearly distinguished denominations? How can we provide care to individuals from a different tradition than our own (Schipani&Bueckert 2009)? Or who adhere to more than one tradition? Or who have no formal affiliation but live their own idiosyncratic configuration of religious beliefs, experiences, and behaviors? These questions play out differently in the various contexts in which spiritual care is organized. Hospitals and other health care institutions are decentralized and usually appoint spiritual caregivers from the main traditions represented among their patients although they increasinglyalso appoint unaffiliated

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spiritual caregivers. The Dutch army and justice systems have a centralized organization that until now only accepts spiritual caregivers that are duly recognized (ordained) by the institutions of their tradition. In all cases however, the spiritual caregivers have to provide care to these widely diverse populations.

The developments in the domain of religion and spirituality correlate with the transition in nomenclature from pastoral care to spiritual care. Historically, pastoral care was provided within the faith community by ordained clergy. This was extended into the realm of health care, which in the Middle Ages was primarily ecclesial. When modern hospitals developed as secular

institutions, pastoral care was usually provided by local parish clergy visiting their own parishioners. The last four decades have shown a gradual integration of attention to existential/religious issues in the institutional health care system, which led to the usage of the broader name of spiritual care. It also led to a better cooperation between spiritual caregivers and other health care professionals and a professionalization of the discipline of spiritual care. More specifically, in several contexts spiritual caregivers participate in multidisciplinary teams alongside medical and psychosocial professionals. All this led to a long and profound debate about the relation between professional and confessional dimensions of spiritual care, including the question whether ordination in a recognized world view tradition should be required for all spiritual caregivers. At stake is the core question how intrafaith and interfaith perspectives to spiritual care function in a contemporary pluralized society like the Netherlands.

Interfaith Spiritual Care

The concept of interfaith spiritual care emerged as a consequence of these developments in post-secular societies. Religion and spirituality are still important dimensions of society and they become even more important in critical situations where existential questions come to the fore. This happens for example when our health is at stake, when military personnel are brought into dangerous situations, or when we are in prison. There is growing awareness that spirituality and the search for meaning remain important factors for many people, even when religious denominations lose their ground. In post-secular contexts, spirituality is more and more acknowledged as an important aspect of health care (Cobb, Puchalski&Rumbold, 2012; Huber, 2014; Van Leeuwen, 2008). This means that spiritual caregivers have to cross the boundaries of their own religious tradition and reach out to people in need of spiritual care, regardless of their spiritual background. This is what we mean by interfaith spiritual care. It does not necessarily mean that both the provider and the receiver of care have an explicit affiliation to a specific but different tradition. It simply means that they don’t share the same affiliation.

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Obviously this challenges the whole concept of spiritual care and raises many questions. To identify these questions, my co-researchers and I have performed a systematic review of empirical studies of interfaith spiritual care (Liefbroer et al. submitted). As this review has not yet been published, I cannot give you the full details, but it is clear that two major issues emerge from all this empirical research.

The first issue regards the normative question whether interfaith spiritual care is acceptable or even desirable. Both spiritual caregivers and patients receiving care display different opinions about this. Some claim that spiritual care is primarily defined by the content and regulations of the religious tradition and the religious authorities so that interfaith spiritual care is not really possible or even allowed. How can a catholic priest speak with religious authority to a Muslim patient? What is the position of an Imam when speaking to a Buddhist? This view thus places authority in the tradition from which the caregiver receives his or her mandate. The opposite view claims that authority is not so much the central issue but instead the spiritual needs of the patient. Moreover, in a more universalist approach to pluralism, it is claimed that the differences between religious traditions need not lead to mutual exclusion. The interfaith encounter can instead be enriching for both the caregiver and the patient, and meditation and prayer are powerful ritual activities that cross the boundaries of traditions. Obviously this raises questions about credibility and authenticity when one uses words and gestures from a tradition not one's own.

The second issue regards the more practical question whether caregivers are able to provide interfaith spiritual care. Some caregivers and patients state that there is a lack of knowledge among caregivers about other religious traditions. This may imply that the patient does not get the proper advice or is not treated according to the assumptions and expectations of the patient. On the other hand, it can be a liberating experience when the caregiver is not bound by the sometimes repressive rules of a religious tradition, which also allows the patient to talk about issues like sexuality that he or she wouldn't dare to talk about with spiritual caregivers from his or her own tradition.

Between these normative and practical issues, the question arises what precisely spiritual care entails within and across traditions. Several modalities can be distinguished that can have more or less prominence in a specific tradition (Ganzevoort et al., 2014). In protestant Christianity and Humanism, the main modality of spiritual care is individual counseling with a strong psychological perspective. In Catholic and Orthodox Christianityand Hinduism the main modality of spiritual care is ritualistic, possibly combined with the counseling modality. In Islam and Judaism, the main modality is

advisory, clarifying for patients which food, behavior, and medical interventions are acceptable according to the tradition. Of course the ritual dimension is never absent and becomes prominent for example when someone

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has died and ritual washing of the body is required. In Buddhism, finally, the main modality is contemplative, expressed for example in meditation and mindfulness. These four modalities are not mutually exclusive, but neither can they be reduced to one single profile. The counselor is not a ritual agent and the moral advisor is not a teacher in meditation. The risk in discussions about spiritual care is that one of these modalities is taken as essential for the discipline of spiritual care. This also raise new questions regarding interfaith spiritual care. The possibility to offer care beyond the boundaries of one's religious tradition varies between these modalities. The counseling modality seems to be more transferrable than the ritualistic modality, but what to do if the caregiver offers counseling and the patient is looking for ethical advise?

Teaching Interfaith Spiritual Care

All this complexity comes together in the efforts to build a curriculum for the MA-program in spiritual care. Coming from a protestant background, the theological faculty of Vrije Universiteit in Amsterdam has become the most religiously diverse faculty in the Netherlands with students and staff from Protestant, Russian Orthodox, Roman-Catholic, Muslim, Buddhist, Hindu, and Humanist backgrounds as well as people without a specific religious affiliation. The newly developed MA-program in spiritual care has accredited and government funded tracks preparing for Islamic, Buddhist, and Hindu ordained chaplaincy and an open track for students wishing to become unaffiliated spiritual caregivers (the Christian track is offered by a sister institution and therefore not incorporated). In 2013 the newly developed integrative Master in spiritual care was launched.

The aim of the program is to facilitate students to become professional spiritual caregivers working in a modern, secular, and multifaith society. This requires a hermeneutical competency to connect existential questions and experiences with world view traditions, a communicative competency to engage in pastoral/spiritual conversations, a tradition-specific ritual competency, tradition-specific theological knowledge, and general reflective-professional competencies. The one-year MA-program is complemented by BA and pre-master programs and tradition-specific postmaster ordination tracks.

The added value of this approach is that students are exposed to the broad curriculum of the established theological program. Students wanting to become spiritual caregivers not only attend lectures in their specific theological tradition, but also study philosophy, sociology, psychology, and interreligious topics. The learning environment with its many religious and worldview traditions present by definition fosters interreligious and inter-cultural skills. This in itself contributes to training spiritual caregivers well versed in intercultural and interreligious conversations.

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The program starts with a course in (inter)religious hermeneutics, focusing on the meanings of religious rituals and/or sacred texts, in which students learn to reflect on the fundamental process of developing religious meaning and practices. The next two courses focus on the history and central features of the profession of spiritual care and on the student's spiritual biography in light of the spiritual models offered by various traditions. The fourth course is an elective, allowing students to study tradition specific aspects or topics like leadership or trauma. The fifth course teaches academic research skills related to the MA thesis. Together these five courses of the first semester have a strong interfaith or generic dimension, nevertheless incorporating many tradition-specific assignments. The second semester has a strong intrafaith dimension and is tailored to the individual learning objectives. The main elements are an internship, MA thesis, and master seminar. Several elements are organized in interfaith mode, like a training in pastoral conversation and interfaith communication. Other elements are structured in intrafaith mode, like Qur'an recitation and Buddhist meditation.

Conclusion

Post secular societies pose specific challenges to spiritual care. A purely denominational approach will lead to marginalization within the health care system. A purely secular approach does not adequately meet the spiritual needs of the patients. An interfaith approach tries to address these challenges and in doing so it needs to connect tradition-specific and generic dimensions of spiritual care, taking into account the differing modalities of spiritual care that are prominent in the various religious traditions.

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