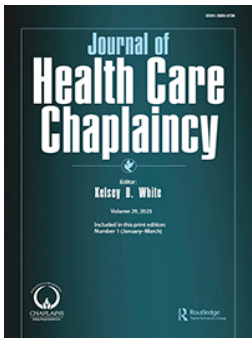


The professionalization of chaplaincy: A Comparison of 1997 and 2017 Surveys in The Netherlands

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The professionalization of chaplaincy *A Comparison of 1997 and 2017 Surveys in The Netherlands*

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ABSTRACT

Chaplaincy has become increasingly professionalized in response to both the standardization in healthcare and the changing religious landscape. Whereas several studies have paid attention to the professionalization of chaplaincy as a whole, no research has been found that describes the implications for individual chaplains. The present article describes the professionalization of Dutch chaplains in the last two decades. We compared the results of two surveys conducted with chaplains in the Netherlands in 1997 and 2017. We describe professionalization by distinguishing between the changed values, expertise, and positioning of chaplains. We found that chaplains' expertise has been developed by a growing but highly diverse body of knowledge. Furthermore, a pluralization of chaplains' worldviews was observed, including non-religious and non-affiliated positions. Lastly, no major changes were observed in the embedding of chaplains.

KEYWORDS

Chaplaincy; pluralization; professionalization; spiritual care; The Netherlands

Introduction

Whereas spiritual care has been provided for a long time, the profession of chaplaincy emerged only several decades ago. With different paces in each country (Kofinas, 2006), chaplaincy has professionalized, establishing professional associations, developing special training programs, and increasingly conducting research (Fitchett, 2017, 2020). Two developments in the Western world are associated with the professionalization of chaplaincy: standardization in healthcare and the changing religious landscape (Zock, 2006). First, the standardization in healthcare, which is apparent in the growing emphasis on accountability and efficiency in recent decades, has demanded chaplains to demonstrate their expertise and their contribution to their clients' wellbeing, preferably in an evidence-based manner (Fraser, 2020; Kelly & Swinton, 2020; Vlasblom, Walton, van der Steen, Doolaard, & Jochemsen, 2015). Chaplains were urged to accept greater accountability for their work and to critically evaluate their effectiveness. Second, the religious landscape has secularized (Taylor, 2007). In Taylor's view, secularization includes both the diminishing role of religion in the public domain and the pluralization of society.

While the pluralization challenges chaplains to relate to the various worldviews of their clients (Danbolt, Demarinis, Rydinger, & Zock, 2019; Liefbroer, 2020), secularization has led to a less obvious place for chaplains in healthcare organizations. As a result, chaplaincy has become “less denominationally centred and more oriented toward competence and professional development” (Zock, 2019, p. 14).

Previous studies have identified various aspects of the professionalization of chaplaincy. Much of the research up to now, however, uses different or implicit views on professionalization, covering a plethora of notions, which makes comparison between these studies difficult. Engelhardt (2003), for instance, understands professionalization as the “surrender” to secular norms of an organization, resulting in the dechristianization of chaplaincy, which was evaluated negatively by Engelhardt. Other studies approached professionalization as acquiring an acknowledged professional status and formally “ensuring that its [the profession’s, NdT] practices are of the highest integrity and competence” (Swinton, 2020, p. 160; Snowden et al., 2020). Furthermore, research on professionalization has often used a sociological approach at the level of the professional association (e.g., Cadge, 2019; Fraser, 2020), but no research has been found that describes what this implies for the individual chaplains in their organization. To our knowledge, no previous study has investigated how developments in healthcare and the religious landscape have affected the professionalization of chaplains. An empirical study on the professionalization of individual chaplains that uses a clear definition of professionalization is needed.

This article describes how Dutch chaplains have professionalized against the background of developments in healthcare and the religious landscape, based on a clear definition of professionalization. We understand professionalization in line with recent literature as entailing *expertise, values, and positioning* (De Jonge, 2015). Contemporary understandings do not regard professionals as those who strive solely for monopoly or status but as people with ideological vocations that are driven by central values transcending particular interests (Duyvendak, Knijn, & Kremer, 2006; Evetts, 2011; Freidson, 2001). Based on these values, professionals employ their expertise, which they usually have acquired through long training, consisting of knowledge and skills allowing for discretionary-judgement (Freidson, 2001). Professionalization also seeks to position the profession in a way that safeguards and embeds professional practice in a sustainable way. Examples of this “positioning” are professional associations and codes of conduct on a meta-level. In Western societies, this is increasingly illustrated by the integration of an institution (Evetts, 2011), for instance, through charting and collaboration.

We have several expectations regarding the direction of professionalization. First, we expect chaplains to be affected by an emphasis on accountability and efficiency within healthcare. We assume that chaplains are, therefore, challenged to reformulate a distinct domain of *expertise*, including the development of knowledge, delineating a clear profile of chaplaincy to demonstrate chaplaincy’s value. Second, we expect that the changing religious landscape has influenced the *values* of chaplains with three results. First, more diverse worldview backgrounds of chaplains, that is, fewer Christian chaplains and a greater number of chaplains from other religious traditions (Buddhist, Muslim, Hindu) due to pluralization, and more humanist or non-affiliated chaplains due to secularization. Second, chaplains identifying less with explicit religious roles, and, third, chaplains

having more colleagues from diverse worldviews. Lastly, as healthcare organizations increasingly demand professional accountability for the joint care for their clients, we expect a changed *position* of chaplains, that is, posed for increased collaboration (e.g., by means of multidisciplinary consultations) and increased involvement in charting, and therefore greater hours chaplain spend on accountability.

The context of the Netherlands is suitable for this research, as it encompasses both changes in healthcare and changes in the religious landscape (De Groot, 2021; Huijzer, 2017; Zock, 2019). Dutch society is one of the most secularized across the world in terms of church attendance and religious affiliation, as church membership declined from 67% in 1966 to 32% in 2015 (Bernts & Berghuijs, 2016). In the Netherlands, chaplains are usually endorsed by a worldview denomination (e.g., religious, humanist), and since 2015, chaplains can also receive authorization as non-affiliated chaplain, given by the Council for Non-Denominational Chaplaincy (RING). As such, the Netherlands may also serve as an indicative for other countries where the “nones” are rising and evidence-based medicine is highly integrated.

To answer the primary research question, *How can we understand the professionalization of Dutch chaplains between 1997 and 2017 against the background of changes in healthcare and the religious landscape?*, we compare the results of two surveys held in 1997 and 2017.

Methods

The results of the two surveys among Dutch chaplains were described and compared. The first survey was conducted in 1997 by the Trimbos-Institute (De Roy, Oenema, Neijmeijer, & Hutschemaekers, 1997) and was one of the first empirical studies on chaplaincy in the Netherlands. It focused on the profession and employment of chaplains within healthcare settings working in the Dutch context. The second survey was conducted in 2017 in relation to the Dutch Case Studies Project (Kruizinga, Körver, Den Toom, Walton, & Stoutjesdijk, 2020; Walton & Körver, 2017), studying the practices, purposes, and outcomes of chaplaincy. The 2017 survey was developed to study changes between 1997 and 2017. However, as the 1997 survey was outdated in several respects, various items were adjusted to the current context of chaplaincy (see measures). We present the findings of the 2017 survey and interpret them against the background of the 1997 survey.

Ethical issues

At the time, ethical approval was not required by law, nor by our institutions as the research did not intervene in respondents' life sphere. We did receive approval from the professional association. Nonetheless, we took the following measures to safeguard respondents' privacy. Dutch law was observed in managing data, as well as current standards of scientific integrity.

Procedure, participants, and response

The 2017 survey was distributed using the online survey software Survey Monkey. It was distributed among members of the Dutch Association for Spiritual Caregivers (VGVZ) who are working more than 8 hours a week ($N=738$), to the army ($N=123$), and to prison chaplains ($N \sim 110$), via the head chaplains at the Ministry of Defense and the Ministry of Justice and Safety. A total of 373 chaplains responded to the 2017 survey, leading to a response rate of approximately 38%. Additional data regarding the population of the VGVZ in 2017 were derived from Liefbroer and Berghuijs (2019) and retrieved from the VGVZ.

The 1997 survey was distributed on paper among chaplains working in healthcare settings in the Netherlands. They received the questionnaire either via their employer or via their membership of the VGVZ. A total of 851 chaplains received the questionnaire, and 524 responded, leading to a response rate of 62%.

Measures

Expertise

Expertise consists of three components: chaplains' professional development with post-academic education, theories and models used by chaplains in their work, and the used interventions in accompanying clients.

Education was assessed by asking respondents what post-academic training they had followed, choosing from Clinical Pastoral Education, Contextual Pastoral Care, Pastoral Supervision, Training in Ethics, other (please specify), and none. In 1997, a training in Pastoral Formation was mentioned, which did not exist anymore in 2017 and was interpreted as a Training in Pastoral Interviewing.

Theories and methods were asked in an open-ended question ("The following theories or models guide me in my work"), in which respondents mentioned up to three theories, preferably mentioning the author. The 1997 survey asked respondents to mention a model, theory, or frame of reference they use in their practice.

Interventions were assessed using an open-ended question in which respondents were asked to indicate their most commonly used interventions (a maximum of three, rated in order of importance). A question on interventions was not included in the 1997 survey.

Values

The values of a profession entail the ideals and goals of a profession (Kole & de Ruyter, 2009) as well as the normative frame that guides the professional (Kunneman, 2012). Therefore, we assessed the chaplains' values by focusing on three main aspects, that is, by asking respondents: (a) what symbolic role they identify with, expressing their role ideals; (b) what goals they pursue in accompanying clients; and (c) what worldview they adhere to, expressing the normative frame of reference.

Chaplain roles were identified using an open-ended question in 2017 by asking respondents to mention up to three "symbolic roles that I mostly take on in accompanying clients" and rate these in order of importance. In the 1997 survey, respondents

were asked to indicate to what extent the following role aspects applied to their daily work: being present, vigilant, empathic, a therapist, a confidant, a mediator, a counter voice, an advocate of the client, empowering, a professional expert on meaning, a representative of tradition, an office bearer of a tradition, a generic chaplain, and being one that bears witness to one's values. Responses were scored using a Likert-style scale, with anchors of 1 = totally not applicable ranging to 5 = totally applicable. To compare the *chaplain roles* mentioned in 2017 with those of 1997, we used the overarching categories of the chaplain as spiritual guide (emphasizing the spiritual dimension), companion (emphasizing the relational dimension), and counselor (emphasizing the therapeutic dimension), which is an adaptation of the triad of witness, companion, and counselor modeled by Ganzevoort and Visser (2007). When a role could not be assigned to one of the categories, we chose the category "other."

Worldview was operationalized according to affiliation, choosing from Catholic, Protestant, Humanistic, Jewish, Islamic, Hindu, Buddhist (only in 2017 survey), non-affiliated (only in 2017 survey), other (please specify) or none. Respondents were also asked how many worldview denominations were present among chaplains in their organization (Christian denominations counted separately).

Goals were assessed using an open-ended question in which respondents were asked to indicate their main goals in the accompaniment of clients (a maximum of three, rated in order of importance). A question on goals was not included in the 1997 survey.

Positioning

Positioning was operationalized on two levels: the organizational level and that of inter-professional collaboration regarding clients' care.

Organizational situation was assessed in the 2017 survey by asking respondents to report the distribution of working hours over different tasks, using the same distinction as in 1997 in various client-related and non-client-related tasks.

Collaboration was operationalized using four items. First, in an open-ended question, respondents were asked to name three other disciplines with which they usually collaborate. In 1997, a question was included regarding which other disciplines join in the multidisciplinary consultations in which chaplains participate. Second, the 2017 survey included a question in which respondents could indicate how often they experienced competition with other professionals (never, seldom, sometimes, regularly, very frequently) and an open-ended question on with which other disciplines they experienced competition (seldomly, sometimes, and very frequently). In 1997, respondents were asked to indicate the extent to which they experienced problems of collaboration with medical professions and social professions on a 5-point scale (1 = totally disagree, 5 = totally agree). Third, respondents were asked to indicate which forms of consultation they structurally participate in, including team consultation, peer supervision, psychosocial consultation, multidisciplinary consultation, moral deliberation, and consultation with the executive board. Fourth, in 2017, respondents were asked to indicate whether they were charting and if they used a taxonomy, either the software's taxonomy, a self-developed taxonomy, or no taxonomy.

Table 1. Background characteristics.

Baseline characteristic	1997	2017	VGZ (2017) ^b
<i>N</i>	524	373	986
Gender (%)			
Male	66	38	36
Female	34	62	64
Age (years)			
Mean	49	55.3	54
Minimum	*	29	*
Maximum	*	73	*
Std. deviation	*	9.6	*
Field of work (%)			
Nursing home/Hospice	38	35	47
Hospital	36	28	28
Defense	X	8	X
Mental health care	18	7	11
Prison chaplaincy	X	7	X
Mental disability care	8	5	6
Primary spiritual care	X	2	9
Revalidation care	X	1	3
More than one work setting	X	7	*
Worldview (%) ^b			
Protestant	46	42	42
Catholic	46	27	30
Humanistic	8	15	12
Not affiliated	X	6	18
Buddhist	X	2	1
Islamic	X	1	2
Jewish	X	1	1
Other background ^a	1	5	*

* = Unknown. X = not included in the 1997-survey.

^aFor the 1997 survey "other" included Jewish, Islamic, and Hindu affiliations. Hindus are <1% in the 2017-survey and of the members of the VGZ.

^bThe figures of the VGZ in 2017 were used from Liefbroer and Berghuijs (2019) and retrieved from the VGZ and exclude the figures of Defense and Military chaplaincy, which are more pluriform regarding worldviews. Regarding the worldview, the figures consist of the members of the denominational sector within a professional association.

Data analysis

The 2017 survey was analyzed using the IBM SPSS 26 computer program for descriptive analysis. Open questions regarding theories and models, goals, interventions, symbolic roles, collaboration, and experience of competition were analyzed first by either RK or NdT, and subsequently, each author crosschecked the other's analysis, ensuring reliability. The results of 2017 were compared to the results of the 1997 survey, based on the frequency tables by De Roy et al. (1997) (by AL). The results were discussed by NdT, RK, and AL.

Results

Descriptive characteristics

Table 1 presents an overview of the respondents' background characteristics. Based on these characteristics, the 2017 survey appears to be representative of the members of the professional association, with an underrepresentation of respondents working in nursing homes and non-affiliated. More women responded compared to the 1997 survey. The

Table 2. Overview of post academic training.

Post-academic training	1997	2017
<i>N</i>	~420 ^a	224
	%	%
Clinical pastoral education	48	61
Ethics training	14	21
Contextual pastoral care	11	13
Ecclesiastical training	–	9
(Pastoral) supervisor training	5	8
Care ethics	–	4
Pastoral psychological course	6	3
Chaplaincy 2.0	–	3
Spiritual care for the Elderly	–	2
Buddhist chaplaincy	–	2
Training in pastoral interviewing	6	2
Spiritual guidance training	–	2
Palliative care	–	2
Other	12	21

^aThe exact *N* is not clear in the 1997-report but consists of at least 80% of the total *N* (524).

mean age was slightly higher (6.3 years) in 2017. More working fields were included in the 2017 study, but nursing homes and hospitals were still predominant. Further, Christian affiliations decreased, whereas several other affiliations were newly represented in the 2017 survey: Buddhist, Jewish, Islamic, and non-affiliated chaplains.¹

Expertise

Education

In the 2017 survey, 60% followed post-academic training and 37% did not (3% was missing). From the respondents who followed one or more post-academic training courses, Clinical Pastoral Education was most frequently mentioned, followed by training in Ethics, see Table 2. In comparing these outcomes to those of the 1997 survey, the involvement in post-academic training decreased from more than 80% in 1997 to 60% in 2017. The various types of education, however, seem to remain roughly the same.

Theories and methods

In 2017, 36% of the respondents mentioned three guiding models or theories, 21% mentioned two, 15% mentioned one, and 28% did not mention any model or guiding theory. Table 3 provides an overview of the guiding models and theories named by participants. The *presence approach* of Andries Baart (2002) was the most frequently mentioned theory. Other frequently mentioned theories were the *ars moriendi* model (Leget, 2017), narrative models (e.g., Ganzevoort & Visser, 2007), and contextual counseling.

Compared to the responses to a similar question in the 1997 survey, many more 2017 respondents mentioned a model or theory that guided their practice. In 1997, 30% of the chaplains mentioned a method or theory, which increased to over 70% in 2017. Of the 30% who mentioned a method or theory back then, there was a large variety of responses, with “counseling” (14%) and “contextual pastoral care” (6%) being mentioned most often.

Table 3. Overview of guiding theories and models in 2017 ($N = 617$).

Model or Theory	%
Presence approach (Baart)	22
Narrative and hermeneutics theories (e.g., Ganzevoort, Van Knippenberg)	14
Diamant model/Ars Moriendi/Spiritual care guideline (Leget)	11
Contextual counselling	7
Religious/Spiritual sources	7
Religious/Spiritual counseling (e.g., Groot, Evers, Rogers, Heitink)	6
Care ethics literature, moral deliberation	5
Humanistic literature	4
Psychological literature (e.g., Huber)	4
Pastoral interviewing models	3
Thematic literature (e.g., Elderly Care, Grief, and Loss Theories)	3
Assessment models (e.g., Fitchett)	3
Listening model (e.g., Weiher, Smit)	3
Philosophical literature	2
Other	5

Table 4. Overview of most used interventions ($N = 843$).

Intervention	%
Religious actions (e.g., prayer, blessing, text reading)	17
Conversation skills (listening, summarizing, asking questions)	17
Reframing	11
Performing rituals	6
Music/Art/Singing	5
Life review	4
Mirroring/Confronting	4
Empowerment	4
Presence	3
Connecting to religious/Spiritual/Philosophical stories	3
Reflection/Philosophizing	2
Search for sources/Values	2
Mindfulness/Meditation	2
Searching for words	1
Learning/Insight	1
(Non-)religious services	1
Group conversations	1
To advise	1
Acknowledging	1
Initiation	1
Humor	1
Other	9

Interventions

The survey also asked for the most used interventions, of which respondents could indicate a maximum of three. Religious actions (e.g., prayer, blessing, text reading) (17%), conversation skills (17%), and reframing (11%) scored highest (see [Table 4](#)). In 1997, a question regarding interventions was not included.

Values

Chaplain roles

A variety of symbolic roles were named by respondents in the 2017 survey, of which the ten most prevalent are presented in [Table 5](#). Overall, the roles in the category

Table 5. Overview of the top 10 of chaplain roles ($N = 778$).

Role	%	Category
Fellow traveler/Human being	17	Companion
A ready ear	9	Companion
Connector to the holy	8	Spiritual guide
Guide	8	Spiritual guide
Counselor	7	Counselor
Pastor	6	Spiritual guide
Midwife ^a	4	Spiritual guide
Confidential advisor	4	Companion
Advisor	3	Spiritual guide
Clergyman	3	Spiritual guide

^aThe role of the midwife resembles a Socratic, maieutic approach.

Table 6. Overview of most frequently mentioned goals of chaplains ($N = 866$).

Goal	%
Empowerment/Enhancing resilience	17
Acceptance (of oneself)	12
Coping/Accepting a situation	9
Recognition/Attention	7
Connecting to sources (of inspiration)	7
(Self-)insight	5
Finding (inner) rest/Space	5
Meaning/Life questions	4
Finding a new perspective/Hope	4
(Self-)confidence	3
Comfort/Proximity	3
Belonging	2
Clarification of a situation/Taking stock	2
Integration in life narrative	2
Connecting to faith/Transcendent	2
Expressing emotions	2
Wellbeing/Happiness	1
Reframing	1
Good death	1
Providing security	1
Taking responsibility	1
Making choices	1
Maintaining relations	1
Other	10

spiritual guide (41%) and companion (38%) prevailed, of which the role of companion had the first priority for the respondents. This corresponds with the outcomes of the 1997 survey, showing that the role of companion ($M = 4.4$, range 1–5, 1 = lowest, 5 = highest) was most applicable to daily practice, followed by spiritual guide ($M = 3.1$) and counselor ($M = 2.6$).

Goals of accompaniment

Of the goals chaplains pursue for their clients, empowerment and enhancement of resilience (17%) were most often mentioned as the main goal (see Table 6), followed by acceptance of oneself (12%), coping (9%), recognition (7%), and connecting to sources (7%).²

Table 7. Overview of distribution of working hours.

Task and activity	% of working week 1997 N = 524	% of working week 2017* N = 333
Client-related task		
Providing spiritual care to clients	37	41
Communal liturgical and ritual performance	13	9
Reporting, charting and desk work	6	9
Providing spiritual care to relatives of a client	6	5
Team consultation	6	5
Multidisciplinary consultation and collaboration	6	5
Individual liturgical and ritual performance	4	3
Providing outpatient care	2	1 ^a
Non-client-related task		
Other tasks and activities	4	6
Developing their own knowledge and skills	4	3
Committee and policy tasks	3	3
Keeping in touch with extramural relations	3	2
Management tasks	2	2 ^a
Teaching and supervision	2	2
Accompanying other professionals	2	1 ^a

*Distribution of working hours was calculated as a percentage of the sum of all distributed working hours, excluding outliers with the sum of >50 h a week. Due to rounding up, the sum for 2017 is 97%.

^aThe relatively few respondents with management tasks (N = 50), outpatient contacts (N = 70), or accompanied other professionals (N = 94) spend respectively 16%, 5%, and 5% of their time on these tasks.

Values

Table 1 presents an overview of the distribution of worldviews that respondents adhere to. Regarding the denominations represented in institutions in the 2017 survey, three or more denominations were present in 53% of the cases. The number of denominations within a chaplaincy team differed per working field. Within prison and military chaplaincy, six or more denominations were often represented within one chaplaincy team. In healthcare institutions, one or two denominations were represented in 44% of the cases, whereas in 46%, three or more denominations (10% were missing or not valid). In 1997, three denominations or more were present in 18% of healthcare institutions, revealing an increase of represented denominations.

Positioning

Organizational level

Table 7 presents an overview of the distribution of working hours over tasks and activities. In 2017, chaplains spent on average 41% of their time accompanying clients, followed by rituals with groups (9%) and charting and administration (9%). No large differences appear when this division of working hours was compared to the 1997 situation, except for a slight increase in charting, reporting, and desk work (3%).

Collaboration

Respondents indicated that they mainly collaborated with the primary caretakers, such as nurses or guards (26%), followed by doctors or physician’s assistants (20%), psychologists (15%), social workers (11%), and activities coordinators (7%). In the 1997 survey,

nurses, doctors/physician's assistants, psychologists/pedagogues, and social workers were also mentioned most often as collaboration partners (in the context of multidisciplinary consultations).

More than half of the respondents indicated having "sometimes" (33%) or "seldom" (35%) experiences of competition with other professionals. A small percentage experienced this regularly (9%) or very regularly (1%). If they experienced competition, it was most often with psychologists (37%) or social workers (31%). In the 1997 survey, respondents mostly disagreed (Mean = 2.3, range 1–5, 1 = totally not-agree, 5 = totally agree) on experiencing difficulties in collaboration. Regarding structural forms of consultation, in 2017, chaplains most often joined chaplaincy meetings (50%), followed by peer supervision (21%) and multidisciplinary consultations (20%). Regarding ethics, chaplains were involved with moral deliberation (17%) and ethics committees (12%). This suggests a decrease in structural participation in most forms of consultation compared to 1997, when 89% joined chaplaincy meetings, 57% peer supervision, 47% multidisciplinary consultations, and 68% an ethics committee.

In 2017, 89% of respondents were charting. Differences can be observed among various working fields. Charting was most reported in hospitals and nursing homes (90%), followed by revalidation care and primary spiritual care (33%), mental disability care (26%), and mental health care (19%). No respondents positioned in prison chaplaincy and army chaplaincy stated that they were charting in a way that professionals or colleagues could read the charts. In 40% of the cases in which chaplains were charting, all involved professionals were allowed to read the charts, in 23% only fellow chaplains could read them, and in 12% only the chaplains themselves could read the charts.

Discussion

The current study aimed to describe the professionalization of Dutch chaplains between 1997 and 2017 against the background of the standardization of healthcare and changes in the religious landscape. We discuss our main results in terms of expertise, values, and positioning and assess whether the expectations from the introduction are being met. Finally, we provide recommendations for further research.

Expertise

Our results show that three developments can be seen with regard to expertise. First, consistent with our expectations, respondents have developed their knowledge, establishing a domain of expertise, as indicated by the rise of theories and models that are mentioned in 2017, compared to the 1997 survey. Where in 1997 the body of knowledge seemed to be primarily pastoral literature, a new field of "chaplaincy literature" has emerged, and research on chaplaincy is increasing in response to changes in healthcare (Fitchett, 2020; Poncin, Brandt, Rouiller, Drouin, & Dandarova Robert, 2020). Second, the theories and interventions named are highly diverse, as in 1997, which might cause difficulties in demarcating the profession's expertise from other professionals' (e.g., psychologists). The diversity of theories and interventions in the 2017 survey contrasted our expectation that chaplains would have delineated a clear profile to distinguish

themselves from other professions. Based on our data, we cannot draw the conclusion that the chaplains clearly expressed their domain. This finding can have several explanations. First, chaplaincy might have a hybrid expertise, including theories from other disciplines, as it is a “companion” profession (Cadge, 2019). Another reason might be that various working fields demand different theories and methods (cf. Glasner, Schuhmann, Van der Vaart, & Jacobs, 2020). Lastly, the role of worldviews in chaplaincy, which is pluralizing, might cause idiosyncratic practices. Further research is needed to examine the diversity of theories and methods.

Values

We expected that chaplains were affected by the changes in the religious landscape, leading to fewer Christian chaplains, more chaplains from other religious traditions, and more Humanists and non-affiliated chaplains. A slight pluralization of worldviews can be observed, as more worldview traditions were included in the survey in 2017. Further, compared to 1997, chaplaincy teams were more pluriform, as we expected. Yet, the majority of chaplains still work from a Christian worldview, which differs from the contemporary religious landscape. This could be explained by the relatively high age of the respondents of 55 years old. We expect therefore that among newly trained chaplains, a much stronger pluralization may be seen. Additional research is needed to assess this expectation. Furthermore, we expected that chaplains would identify less with explicit religious roles, which was not confirmed with our data. Chaplains continue to indicate a preference for the roles of companion and spiritual guide over that of a counselor. This could be an indication that the “spiritual” dimension is not disappearing in a pluralized and secularized context, but is taking on a different shape. The finding that of all interventions, the religious interventions were mentioned most frequently (in addition to conversational skills) is noteworthy. This is surprising for one of the most secular countries. This could be explained by the majority of chaplains being Christian. Yet, it seems in contrast with the developments of pluralization and secularization. Therefore, further research is needed to find out how this role of “spiritual guide” is understood and how it is connected to religious interventions.

Positioning

The expectation that chaplains were increasingly collaborating and more involved in charting is not confirmed. First, the distribution of work hours over tasks remained largely the same concerning chaplaincy as a whole, although a little increase in charting and desk work can be observed, indicating that chaplains spend a little more time on accounting for their work without becoming dominated by bureaucratic tasks (Evetts, 2011). Second, a decrease was observed in structural participation of chaplains in multidisciplinary consultations. This might be explained by the diminishing chaplaincy teams in many organizations and the merger of care organizations as a consequence of budget cuts, which could result in a stronger focus on accompanying clients. Another explanation might be the contexts of prison chaplaincy and military chaplaincy that were included in 2017, in which participation in multidisciplinary consultations is unusual.

Other observations

During the analysis, we observed that there were major differences in charting behavior between the various working fields. In nursing homes and hospitals, almost ninety percent were charting, while in prison and military chaplaincy none of the chaplains charted. If chaplaincy developed in relation to the changes in healthcare, this raises the question of whether professionalization outside healthcare contexts takes different shapes. Chaplains in these institutions report that charting in these total institutions (Goffman, 1961) affects the reliability of chaplains (cf. De Witte, 2015). Additional research is needed to study the way chaplains are embedded in non-healthcare institutions.

Strengths and limitations

The current study contributes to the literature on the professionalization of chaplaincy through its empirical focus on the level of individual chaplains, rather than on the level of the association. Further, using a multilayered concept of professionalism prevents us from studying professionalism in a one-sided manner. Next, the present study is relevant to other Western countries that are pluralized and secularized, although there may be differences in the positioning of chaplaincy, and organization of health care delivery. Comparing one of the first empirical studies on Dutch chaplaincy to a contemporary survey provides insight into an important era for chaplaincy. However, the present study is limited in several ways. First, while we have made a comparison between many items, the surveys were not identical, and therefore, it was not feasible to compare the survey on all the items. Based on our data, we were not able to assess whether chaplains were charting more often in 2017 compared to 1997, since there was no electronic charting in 1997. Further, the data provided insight into the self-reported methods, goals, and interventions, although how they were actually applied in the accompaniment remains unanswered. Further research should be done to gain insight into the application of methods and interventions using qualitative or observational methods, which could contribute to a more detailed articulation of chaplaincy's interventions. Finally, this study was conducted in the Netherlands, and as a consequence, the theories and models mentioned are primarily Dutch and seem to stem more from a hermeneutical tradition, rather than having a focus on assessment, as in the United States. It will be interesting to conduct this study in other countries to determine whether other theories are used in other contexts.

Conclusion

Chaplaincy has been professionalized in the last decades in response to both changes in healthcare and the changes in the religious landscape. This study shows how Dutch chaplaincy's expertise has developed through a growing body of knowledge. Whereas we expected that chaplaincy's expertise would be more clearly distinguished from other disciplines, the body of knowledge is highly diverse. This diversity could be an indication of the range of chaplains' expertise; however, it could also be a danger for the profession when other disciplines cannot recognize what chaplains do and what their

specific contribution is. Current research projects that explore chaplaincy's practice, such as the Dutch Case Studies Project (Kruizinga et al., 2020; Walton & Körver, 2017)³ or projects on spiritual care in primary care settings, will presumably reinforce a distinctive expertise in the coming years. Further, a pluralization of chaplains' worldviews, including non-affiliated ones, can be observed, and we expect the pluralization to continue. Regarding the positioning of chaplains, no major changes were observed except for the decrease in participation in consultations. An interesting observation is that the charting behavior of chaplains is influenced to a great extent by their working field. Additional research on the articulation of chaplaincy's domain and interventions is needed to understand these findings.

Notes

1. Since 2015, chaplains that are not endorsed by a world view institution (e.g., the Protestant Church in the Netherlands, the Dutch Humanist Association) are admitted to the Dutch Professional Association of Chaplains (VGZV). They have to take an assessment by the Council for Non-Denominational Chaplains.
2. This could be biased, since the first two options were mentioned as example for answering the question.
3. In the Dutch Case Studies Project in Chaplaincy Care, more than hundred case studies of chaplaincy care were produced. For the currently published case studies, see: <https://ucgv.nl/case-studies-project/publications-csp/?lang=en>

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