Bridging Worlds

A Qualitative Study On Interdisciplinary Collaboration with Spiritual Care in Psychiatric Facilities in the Netherlands

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I hereby declare and assure, Lisette van de Burgwal, that this thesis has been drawn up independently by me, that no sources and tools other than those mentioned by me have been used and that the passages in the work whose verbatim content or meaning from other works – including electronic media – has been taken by citing the source are made known as borrowing.

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INTRODUCTION

Psychiatry has shown an increasing focus on the role of meaning, spirituality, and religion in the mental wellbeing of patients—a key focus in the professional practice of spiritual care. As such, spiritual care is highly relevant, albeit not often valued as such, within psychiatric care. Despite the legal basis of spiritual care in psychiatric hospitals, spiritual caregivers still need to show their value to other health care professionals in these facilities, in order to get more referrals, get the necessary support and make collaboration happen.

The relevance of spirituality and meaning in the psychiatric context has been studied elaborately in different disciplines: psychology, religious studies, and medical anthropology to name a few. Spiritual care and its (potential) role is rarely adopted in these studies. One reason for this could be that this profession varies widely between different countries, making it more difficult to publish and get funding for research on the specific and small context of spiritual care in the Netherlands. Nonetheless, this perspective can be beneficial.

The aim of this qualitative study is to gain insights in the experience of spiritual caregivers working in psychiatric facilities in the Netherlands regarding collaboration with other mental healthcare providers, specifically psychologists, psychiatrists and mental health nurses. Semi-structured interviews were conducted among seven spiritual care providers working in psychiatric facilities, to explore the factors that facilitate or form barriers to interdisciplinary collaboration, and how the spiritual caregivers experience the collaboration that takes place.

Laura R. Bronstein's model of interdisciplinary collaboration is used as a reference for this study (Bronstein, 2003). According to this model, there are five key characteristics of interdisciplinary collaboration in mental healthcare: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. Additionally, the model distinguishes four factors that aid or form barriers to interdisciplinary collaboration, which for the aim of this study, have been combined with four challenges described by spiritual care researcher Martin Walton (2011). The factors that are used in this thesis are: perception of spiritual care among other disciplines, structural characteristics, spiritual care as a "sanctuary", differences in professional role and language, and specific experiences and preferences. The qualitative data will be analyzed using these nine categories of Bronstein's model. The outcome of the collaboration is only touched upon to show the relevance of the collaboration and hence this study, but excluded in the scope of the research question.

Research questions

The main research question of this paper is:

> **How do spiritual caregivers experience collaboration with mental healthcare providers of other disciplines in in-patient psychiatric settings?**

Sub-questions are:

> What are ways in which spiritual caregivers collaborate with other mental healthcare providers?
>
> How do spiritual caregivers describe this collaboration in terms of interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process?
>
> What aids and what poses barriers in allowing interdisciplinary collaboration to take place, in terms of perception of spiritual care among other disciplines, structural characteristics, the pros and cons of spiritual care as a "sanctuary", differences in professional role and language, and personal characteristics and experiences?

The structure of this master thesis is as follows. The first chapter looks into the terminology and position of meaning, the main focus of spiritual care, in different disciplines within psychiatric care. This is already indicative of the base of support for spiritual care among these disciplines. The second chapter elaborates on the position of spiritual care in psychiatric facilities and in what way interactions with other disciplines take place, including its relevance. The third chapter introduces the model of interdisciplinary collaboration, entailing key components of interdisciplinary collaboration and factors that may aid or form barriers to interdisciplinary collaboration. Some hypotheses are shared about how this can play out for spiritual care providers. The fourth chapter introduces the qualitative research, including elaboration on procedures regarding the interviews. The fifth and last chapter provides an analysis of the qualitative data, using the model of interdisciplinary collaboration and the theory described in the previous chapters.

CHAPTER 1: MEANING IN PSYCHIATRIC CARE

In psychiatric facilities, care providers from different disciplines work alongside one another. For instance, there are psychiatrists, clinical psychologists, psychiatric nurses, social workers, creative therapists[1] and occupational therapists[2]. These disciplines work in multidisciplinary teams but have their own methods and practices. Just like in spiritual care, practitioners from these different disciplines speak their own language with regards to illness and treatment (Walton 2011). This can pose a challenge for interdisciplinary collaboration. Meaning and spirituality, as well as conscience, are at the core of spiritual care and distinguish it as a discipline (Van Eijk and Van Bijsterveld 2021). In order to assess collaboration between spiritual care and other disciplines, it is therefore useful to explore the function of meaning and spirituality in the other disciplines that are present in psychiatric in-patient facilities. In this chapter, we will focus on three key disciplines that are central in determining the direction of treatment for patients in psychiatric facilities: psychiatrists, clinical psychologists and mental health nurses.

In the context of this paper, meaning can be understood as an existential need to find purpose and value in life, to experience efficacy (control on the external environment) and self-worth (Baumeister and Wilson 1996). Psychologist Kenneth Pargament has defined religion as a search for significance in ways related to the sacred (Pargament 2003). Using this definition, religion can be regarded as a source of meaning. It has been found to serve as a source of a sense of identity, belonging and support, and to bring answers to existential questions (Ivtzan et al. 2013).

1.1 Meaning-making practices in contemporary Dutch society

Institutionalized religion, mainly Christianity, has been declining for decades in the Netherlands. Other forms of spirituality have become more prevalent as a source for meaning, as the need for meaning and significance are still prevalent. Examples of such forms of spirituality that have gained popularity are new age movements, individualized spiritual practices and ideas and movements focusing on wellbeing and self-improvement (Bernts and Berghuijs 2016, 149). Simultaneously, immigration has created an increasingly multicultural and therefore multi-religious society with particularly an increase of Muslim citizens (Ibid, 13). As will be argued further on in this chapter, this has also affected the organization of spiritual care in psychiatric care.

1.2 Integrating meaning in psychiatric practices

Psychiatry has developed into an evidence-based science and practice over the course of the last century. Positioned within the realm of medicine, psychiatry operates as a biomedical discipline, grounded in a secular worldview (Maier 2006). This perspective contrasts sharply

[1] Such as musical therapist and dance therapist. In Dutch: vaktherapeut.
[2] In Dutch: activiteitenbegeleider.

with the focus of spiritual care, a profession that prioritizes the exploration of meaning in the context of healing. Anthropologist Talal Asad has delineated the secularist narrative of biomedicine as a impersonal approach to investigate the functions and sensations of the living body. In contrast, he characterizes the religious perspective on healing as a deeply personal endeavor aimed at providing comfort and a sense of healing (Asad 2003, 48). The dichotomy between these approaches underscores the difference in priorities, with psychiatry primarily concerned with empirical evidence and biomedicine, and spiritual care placing a greater emphasis on the subjective and meaningful aspects of healing. The most recent developments in psychiatry, particularly biological psychiatry, have been criticized to increasingly reduce mental states to disordered brain states (Walter 2013). According to critics, this leaves too little room for external factors, such as culture and religion (Ibid).

Psychiatric practices have seen a recent shift towards acknowledging the importance of these external factors and a sense of meaning on one's well-being and recovery process (Aist 2012). This trend is visible in the professional standard of psychiatry in the Netherlands, where a growing emphasis has been placed on meaning in the diagnostic and treatment approach (Akwa 2023). The professional standard for 'meaning-making' in mental healthcare states that patients have voiced their need for more meaning-focused care. It describes the meaning patients attribute to their experience of mental illness as one of the core dimensions of their well-being and recovery (Ibid). The standard goes on to describe different aspects of meaning, including spirituality and existential matters and tools for mental healthcare providers in psychiatry to talk about these themes with their patients in both diagnosis and recovery.[3]

1.3 Meaning in clinical psychology

Similar to the academic discipline of psychiatry, clinical psychology has been dominated by evidence-based practices and a "mechanistic" perspective for a long time. In the last decades, new treatment practices have emerged that focus more on the client's relationship to their experiences instead of purely on their experiences (Hayes and Hofmann 2021). This allows for more room for existential matters, meaning and spirituality (Ibid). Third wave behavioral therapy methods, such as acceptance and commitment therapy and dialectical behavior therapy, have become more popular and emphasize a holistic recovery process. In these methods, there is room for personal values and spirituality (Third Wave Psychotherapy 2024).

1.4 Meaning in psychiatric nursing

Nursing as a professional practice is based on providing compassionate, sensitive care that aids the well-being of patients. Several scholars in nursing have described spiritual care provided by nurses as beneficial for both the therapeutic relationship and the patient's well-being (Veloza-Gómez et al. 2017). Despite the emphasis on meaning and spirituality in the nursing practice, studies have shown that nurses sometimes struggle to apply concepts of spirituality and meaning into their healthcare practice (Lalani 2020). These challenges can be attributed to a sense of insecurity and lack of expertise, a lack of time and the notion that providing spiritual care in nursing is a way to promote certain religious values (Clarke and Baume, 2019).

[3] More on this shift in focus in: Rijnbout et al., 2011.

As a profession present in psychiatric facilities, the professional standards in psychiatry also apply to psychiatric nurses. In other words, the tools for discussing meaning with patients are also written for them (Akwa 2023). This shows a growing effort in supporting nurses in the Netherlands to address spirituality and meaning in their practice.

1.5 Conclusions

The exploration of meaning within psychiatric care shows a complex interplay between disciplines, having their own perspectives and approaches. While spiritual care uniquely prioritizes meaning and existential significance, disciplines like psychiatry, clinical psychology, and mental health nursing follow an evidence-based approach which leaves less room for subjective experiences like meaning and spirituality. In Dutch post-secular society, where institutionalized religion wanes and diverse spiritual practices are on the rise, the integration of meaning in psychiatric practices is increasingly emphasized. Despite challenges, such as interdisciplinary language barriers and nurses' struggles with spiritual care implementation, there's a notable shift towards acknowledging the relevance of meaning in mental health treatment.

CHAPTER 2: SPIRITUAL CARE IN PSYCHIATRIC FACILITIES

Spiritual care has a wide spectrum of tasks in psychiatric facilities, in which it interacts with other disciplines as well. Compared to these other disciplines, however, its position is unique. This chapter will lay out how the profession of spiritual care is embedded in psychiatric care, and what this means for the presence of interactions with professionals from other disciplines.

2.1 Positioning of spiritual care in psychiatric facilities

Professional spiritual care in psychiatric in-patient hospitals has a legal basis in the Netherlands. The profession's right to exist in healthcare in general is based in the constitutional freedom of religion (Van Eijk and Van Bijsterveld 2021). Prior to the depillarization in the 1960s[4], healthcare institutions were typically affiliated with one particular religious denomination and provided spiritual care (then more commonly referred to as chaplaincy) from that denomination. Nowadays, healthcare institutions are largely secular, and spiritual care has become more diverse (ibid). Even though current spiritual care providers are not always affiliated with a religious denomination, the right to spiritual care still exists and is secured in various healthcare laws, finding their ultimate basis in the freedom of religion. There are still spiritual care providers who have a religious mission, or who rely on a particular religious institution for their qualifications as a spiritual care provider. Non-religious institutions, such as The Dutch Humanist Association, can also provide such qualifications. Furthermore, the so-called 'general spiritual care providers', those that are not affiliated with a specific religious institution, can obtain their qualifications from professional institutions like RING-GV and SKGV (ibid).

Dutch juvenile law[5] states that minors are entitled to spiritual care if they reside in a psychiatric hospital for at least 24 hours ('Jeugdwet'). Adults are also entitled to spiritual care when they reside in a facility for over 24 hours. The legal basis for this can be found in the law for quality, complaints and disputes in healthcare ('Wet kwaliteit, klachten en geschillen zorg').[6] Spiritual care is also adopted in the professional standards of mental healthcare in the Netherlands.

[4] A process in which public institutions that were previously affiliated with a particular religious or political identity, became deconfessional and more accessible to the wider public, regardless of religious or political identity.
[5] Translated from the Dutch name 'Jeugdwet'.
[6] Translated from the Dutch name: 'Wet kwaliteit, klachten en geschillen zorg'.

2.2 Interactions with other disciplines

The main tasks of spiritual caregivers in psychiatric facilities are individual conversations with patients, group sessions, rituals (such as collective prayers and religious ceremonies), and moral counseling. Moral counseling is often done for and with colleagues from other disciplines, for example in the form of a moral case deliberation (Doolaard 2006, 323). Group sessions require space, time and organization, for which spiritual caregivers rely on other professionals in the organization, most often nurses. Spiritual caregivers also sometimes lead support groups for patients in psychiatric facilities in collaboration with other mental healthcare providers, such as psychiatric nurses and psychologists (Walton 2011).

The tasks and treatment goals of spiritual care providers partially overlap with those of other mental healthcare workers in the psychiatric setting (Ganzevoort and Visser 2018, 23). As described in the previous chapter, the core subject of spiritual care is meaning, which increases to receive attention among other disciplines. Furthermore, spiritual caregivers do not exclusively talk about existential matters and can thereby step into the role of other care providers. This overlap leads some scholars to believe that spiritual caregivers are in competition with other care providers and that spiritual caregivers can best distinguish themselves by using religion-based spiritual care. Others believe that they operate in completely different domains and work alongside each other, based on the notion that spiritual wellbeing is separate from mental wellbeing. A third view is that of cooperation, based on the notion that spiritual caregivers and other care providers share objectives and patients, but offer different perspectives, theoretical frameworks and methods to offer to the different aspects of mental healthcare (Ibid, 24).

In psychiatric facilities, spiritual care providers are often not part of the treatment team and operate independently from the other healthcare providers. That is not to say that there is no collaboration between them. Spiritual caregivers often rely on nurses, psychiatrists and other healthcare providers to get referrals, to set up group sessions and so forth. Furthermore, spiritual caregivers can be consulted by other staff members for advice on patients that struggle with existential questions or desire spiritual guidance (Walton 2006). There are tools available for staff of psychiatric facilities to raise topics such as meaning, spirituality and religion, which have been created by spiritual caregivers. This tool includes questions to ask in order to assess whether a patient may benefit from seeing a spiritual care provider (Akwa 2023) Staff can also ask advice on ethical questions in terms of the care they provide (Walton 2006).

2.3 Relevance of spiritual care in psychiatric facilities

As described in the previous chapter, meaning and spirituality has recently received more attention in psychiatric facilities. Research shows that hospitalized patients often have spiritual or religious needs (Ellis et al. 2013). This need for spiritual support shows a need for spiritual caregivers (Akwa 2023). The need for spiritual care can include processing the experience of loss of life before mental illness or before hospitalization, lack of a sense of meaning due to depression, and existential questions such as ‘why me?’ (Vandenberghe 2007). Furthermore, spiritual care can aid patients in trying to make sense of their experience of illness, give meaning to their experience of being hospitalized and incorporate this into their narrative and identity (Kirmayer 2007).

There are specific needs for patients depending on their diagnoses. For patients with depression or suicidality, a sense of meaning is often lacking. Patients with trauma and anxiety related diagnoses tend to avoid doing the things that can provide meaning (Vandenberghe 2007). For patients with schizophrenia, a loss of dreams and expectations and a feeling of emptiness are common. Additionally, visionary and auditory hallucinations can have a religious or spiritual character. Whereas these anomalous experiences are often perceived as a symptom of their diagnosis, especially when they have an intrusive nature, spiritual caregivers can create more space to evaluate them together and find a sense of meaning in these experiences as well (Muthert 2007).

Interdisciplinary collaboration is a way for spiritual care to reach patients and for all care providers involved to support patients adequately and in accordance with the facility's mission (Gilhuis 2007).

2.4 Conclusions

Spiritual care in psychiatric facilities in the Netherlands is made possible by a legal framework rooted in the freedom of religion. The position of spiritual care within the healthcare system reflects a transition from affiliation with specific denominations to a more inclusive and even secular approach. Spiritual care professionals operate independently while relying on collaborative efforts with nurses, psychiatrists, and other staff members to support patient care and address existential needs.

CHAPTER 3: MODEL OF INTERDISCIPLINARY COLLABORATION

In order to examine interdisciplinary collaboration in the context of social work, Laura R. Bronstein (2010) has come up with a model that analyzes different components of collaboration and factors that can aid or form barriers to interdisciplinary collaboration. Bronstein has found that this model can be applied in various settings where social workers are active, including psychiatric facilities. The model can be applied to other interdisciplinary teams as well. Additionally, spiritual care researcher, Martin Walton (2011), has described some key challenges spiritual care faces when collaborating with other disciplines (across different care settings). They will be incorporated into Bronstein's model to create a theoretical framework that is fitting to the context of this study.

In this thesis we will analyze interviews with spiritual caregivers using Bronstein's five key components of interdisciplinary collaboration: interdependence, newly created professional goals, flexibility, collective ownership of goals and reflection on process. Furthermore, the interview data will be analyzed using five factors that can either help or challenge interdisciplinary collaboration: perception of spiritual care among other disciplines, structural characteristics, spiritual care as a sanctuary, differences in professional role and language, and experiences and preferences specific to the care providers and/or the facility. This chapter elaborates on these five key components and the five factors that can aid or form barriers to collaboration.

3.1 *Five components of interdisciplinary collaboration*

The five key components of interdisciplinary collaboration that are described in the model, are necessary aspects that can also be described as criteria for collaboration to take place. These are: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process.

3.1.1 Interdependence

Interdependence is the first key component of interdisciplinary collaboration**.** Bronstein describes this as professionals from different disciplines relying on each another to accomplish certain goals and tasks. In order for professionals to be willing to rely on professionals of another discipline, it is important that they understand and value this other discipline, as well as the distinction between their own professional role and that of the other discipline (Bronstein 2003).

3.1.2 Newly created professional activities

Newly created professional activities, refer to all tasks, activities and programs that take place across different disciplines. These new initiatives and activities would not have taken place if the professionals would work independently rather than collaborative (Bronstein, 2003: 300). In the context of spiritual care, this can be seen when spiritual caregivers start and lead new talking groups for patients in collaboration with nurses, psychologists or other care providers

in the facility (Walton 2011). This allows for a more interdisciplinary objective and a multitude of professional insights that benefit the patients. Other examples of professional activities that spiritual caregivers create with other mental healthcare providers include meetings and clinical lectures intended to exchange knowledge, as well as an interdisciplinary workgroup about meaning in psychiatry with care providers from different psychiatric facilities. There are also examples of workgroups about specific topics, such as palliative care and euthanasia and ethics in mental healthcare, started by spiritual care providers and other care providers (Ibid).

3.1.3 Flexibility

Flexibility refers to the need to adapt and compromise when collaborating with professionals from other disciplines. Based on one's background and discipline, professionals will have different aims and considerations when working with patients at a psychiatric facility. Simultaneously, interdisciplinary collaboration may reveal overlap between the disciplines. In order to have successful collaboration, it is important that the collaborators remain flexible and open for their roles to blur with other professional's roles (Bronstein 2003). The role of spiritual care providers can easily overlap with the roles of other mental healthcare providers, such as psychologists and psychiatric nurses. They work with the same patients in the facility, all having conversations with the patients about their struggles and challenges. Spiritual care providers distinguish themselves by their expertise on meaning, religion and spirituality. But with a recent increased focus on meaning in psychology, this is still a domain in which their role can overlap with spiritual care providers (Ganzevoort and Visser 2018, 23). According to Bronstein's model, interdisciplinary collaboration would require the professionals to be secure in their role and the specific expertise of their own discipline, yet at the same time be flexible when the situation requires and not shy away from having their roles blur (Bronstein 2003).

3.1.4 Collective ownership of goals

Collective ownership of goals is described as a shared responsibility and a similar vision on the aim of the collaboration. This does not require agreement on every part of the process, but rather a sense of responsibility for each person's part in success or failure and the ability to have constructive discussions in the face of disagreements. Clearly defined and attainable goals are beneficial to successful collaboration (Bronstein 2003). Bronstein describes the example in mental healthcare of a commitment to client-centered care, which could also be an objective in the collaboration between spiritual caregivers and other mental health care providers. An underlying goal for collaboration can be aligned with the mission of the facility. In psychiatric facilities in the Netherlands, missions often focus on client-centered care, empowering the patient's ownership in their recovery process (e.g.: Altrecht 2023). As described in the previous chapter, meaning has also become a more important focus in the treatment in psychiatric facilities recently. Facility's missions and nation-wide professional standards can contribute to creating shared goals, which in turn facilitates interdisciplinary collaboration. A potential challenge for spiritual care in this regard, is that unlike most healthcare professions, spiritual care is typically not aimed at 'changing' or 'curing' the patient, or even measuring success of treatment (Muthert 2020). However, this does not mean that spiritual care has no goals or aims,

as described on webpages of the spiritual care team of psychiatric hospitals and in the professional standard for meaning in mental healthcare. Communicating these goals to professionals that have a different professional language and perspective is therefore key (ibid.).

3.1.5 Reflection on the process

Reflection on the process of interdisciplinary collaboration is a final component that is necessary for successful collaboration. It allows professionals to strengthen and improve their collaboration based on conversations and reflections about it (Bronstein, 2003: 302). Reflecting on their work and interactions with patients is an integral part of the profession of spiritual care. Through the professional association of spiritual care, the VGVZ, many spiritual caregivers are involved in peer reflection sessions, where they take turns bringing in specific cases from their workplace. Additionally, most spiritual care teams in facilities will have peer reflection sessions on a regular basis. The ability of having systematic peer reflection processes can be beneficial in the reflection on the interdisciplinary collaboration process with professionals from other disciplines. However, literature on if and how reflection on interdisciplinary interactions and collaborations take place, is lacking.

3.2 Factors that aid or form barriers to collaboration

Bronstein's model provides four factors that influence the success of interdisciplinary collaboration: professional role, structural characteristics, personal characteristics and history of collaboration. Walton has described four slightly different structural factors that can pose challenges to interdisciplinary collaboration for spiritual caregivers: 1) the way spiritual care is positioned in the organization and 2) challenges that are inherent to the dynamics of interdisciplinary teams, such as time restraints and power imbalances, and the communication factors of 3) speaking a different professional language and 4) the confidentiality of spiritual care providers. For the sake of this paper, these factors have been combined and altered slightly to the following:

1) perception of spiritual care among other disciplines
2) structural characteristics (including the positioning of spiritual care in facilities, power imbalances and time restraints)
3) spiritual care as a sanctuary (and challenges and benefits this brings)
4) difference in professional role and language
5) personal characteristics and experiences

3.2.1 Perception of spiritual care among other disciplines

One of the main challenges spiritual caregivers experience when attempting to collaborate with colleagues from other disciplines, is the perception these colleagues have of spiritual care as a profession (Walton 2011). This challenge also became apparent in a qualitative study on interdisciplinary collaboration of occupational therapists in psychiatric facilities (Fortune and Fitzgerald 2009). According to this study, lack of knowledge of and respect for occupational

therapy stood in the way of successful collaboration. For example, mental healthcare providers were less likely to refer patients to occupational therapists if they did not think it was an important part of their treatment goals (Fortune and Fitzgerald 2009). The position of occupational therapy in psychiatric care shows similarities to that of spiritual care, which can pose the same challenges for collaboration. Both disciplines do not rely on a medical diagnosis and stand outside of the core treatment team. Occupational therapists and spiritual caregivers rely on referrals and the ability to reach out to patients independently.[7] It is therefore particularly important that the mental healthcare providers who are in regular contact with the patients understand the value of these disciplines. Lack of this understanding and lack of appreciation for these disciplines inevitably results in more work for the occupational therapists and spiritual caregivers to reach patients and to provide their services to them (ibid.). For spiritual care this can be a challenge, as knowledge of spiritual care is often limited or outdated (De Boer 2006). Yet, as described in the previous chapter, one could argue that spiritual care has a lot to offer to mental healthcare in terms of meaning and spirituality. Simultaneously, spiritual care providers need other mental healthcare professionals to get referrals and in some cases to get information on the mental wellbeing of the patients they are seeing (Akwa GGZ).

Potential success of collaboration also depends on how particular colleagues view spiritual care and its professional role in the facility managers and care providers who value meaning and spirituality as part of the care provided in the facility, are an important factor in allowing interdisciplinary collaboration to take place and for it to be successful (Muthert, 2020).

Spiritual care still has an old-fashioned image in an increasingly secular society. It is often assumed that spiritual caregivers is only useful for religious patients. There is lack of knowledge about what spiritual care is and has to offer to different patient groups (Van den Bosch et al. 2021). This hinders the visibility and amount of referrals spiritual caregivers get from other care providers, and forms an obstacle to interdisciplinary collaboration.

[7] Occupational therapists are however better embedded in the treatment than spiritual care providers.

3.2.2 Structural characteristics

Favorable structural characteristics are indispensable for interdisciplinary collaboration, yet their absence can present challenges. Structural characteristics include the way in which spiritual care is positioned in the organizational structure, as well as resources such as time.

While spiritual care in psychiatric facilities is legally guaranteed, the extent of resources, including the employment of spiritual caregivers and the allocation of time, remains dependent upon the decisions made by the facility. Consequently, insufficient resources, particularly a manageable caseload for spiritual caregivers, hinder the ability to collaborate with other disciplines. Simultaneously, sufficient support for interdisciplinary cooperation from the facility, administrative support and professional autonomy allow for (successful) collaboration (Bronstein 2003). When applied to the context of spiritual care, collaborations such as group work with patients, interdisciplinary workgroups on specific topics and moral counseling sessions with colleagues from different disciplines all require time and space. In order to find the necessary resources, support from the facility as well as the participants in the collaboration are essential. With increasing budget-cuts in healthcare institutions such as psychiatric hospitals, spiritual care frequently suffers and needs to reinforce their own profession as a crucial one in the facility (Rebel 2006). In a study on interdisciplinary collaboration with spiritual caregivers in healthcare, lack of time and resources provided by the facility was often described as a challenge for interdisciplinary collaboration (Walton 2011).

3.2.3 Spiritual care as a sanctuary

Spiritual care serves as a refuge for patients seeking support, particularly within psychiatric facilities. Originating from the principles of freedom of religion, patients staying at psychiatric facilities for at least 24 hours are entitled to meet with spiritual caregivers. This right is protected and cannot be infringed upon by anyone else in the facility. In Dutch professional discourse, spiritual care is referred to as a sanctuary (*'vrijplaats'*), referring to its role as a haven for individuals' spiritual needs (VGVZ 2016). Historically, spiritual caregivers have occupied a unique position, positioned between religious institutions and governmental authorities, which are legally separated. This gives spiritual caregivers a kind of freedom that other care providers typically do not have: being able to choose how to fill in their role and which patients they do or do not pay a visit and not having to write notes in the patient files, allowing them to offer a higher level of confidentiality than other staff (Schilderman 2013).

This unique position of spiritual care providers in psychiatric hospitals can have implications for their ability to collaborate with colleagues from other disciplines. For example, a benefit can be that spiritual care providers are not tied to strict protocols and schedules that managers and the facility have assigned to them, allowing them to take on tasks, join initiatives and build relationships that are not intrinsically part of their role (Muthert 2020). The flipside of this freedom in their profession, is that it can sometimes be unclear for other disciplines what spiritual caregivers are there for. This lack of visibility can hinder getting referrals and being approached for collaboration (Schilderman 2013).

3.2.4 Differences in professional role and language

According to Bronstein's model, a clear perception of one's professional role and its values and ethics, impacts the success of interdisciplinary collaboration. Leaning too strongly on one's profession or department may hinder collaboration with other professions and departments. Relying too much on the interdisciplinary team and drifting away from the specifics of what one's own profession has to offer to this team, is also not beneficial for successful collaboration (Bronstein 2003). There are several roles that can be adopted in spiritual care, as have been described by Ganzevoort and Visser: witness (kerygmatic-sacramental or charismatic chaplaincy), helper (therapeutic or systemic chaplaincy), companion (humanitarian chaplaincy or presentation-based chaplaincy), translator/guide (hermeneutic chaplaincy) (Ganzevoort and Visser 2018). Some of these roles, such as that of a helper within the model of therapeutic chaplaincy, are more similar to that of other mental healthcare providers. According to Bronstein's model, this type of overlap can be beneficial for interdisciplinary collaboration to a certain extent. Overlap and similarities can improve communication and help other care providers see the value of spiritual caregivers. However, if the spiritual caregiver does not distinguish their role and domain from mental healthcare providers from other disciplines, this can pose a barrier to teamwork, as it makes it more challenging to see the added value spiritual care brings (Bronstein 2003).

As described in the first chapter of this paper, spiritual care has some inherently different perspectives with regards to illness, wellbeing and healing. As spiritual care researcher Hans Schilderman has noted, the notion of meaning-related problems is not generally considered as an evidence-informed criterion in healthcare settings (Schilderman 2015). Whereas other disciplines in psychiatric facilities are still primarily concerned with specific treatment goals and changing the health of the patient for the better; spiritual care providers focus on the 'slow questions', existential matters and topics that cannot be solved in the same way certain bodily or mental conditions can. Spiritual care as a profession is thus not focused on changing, but rather on exploring another layer of the experience with the patient (Muthert 2020). Additionally, spiritual care as a discipline has a particular domain consisting of themes such as existential matters, spirituality, conscience, religion, and meaning. This domain comes with a particular language and metaphors. Other healthcare providers are less likely to use this particular language. Similarly, unlike psychiatrists, psychologists, nurses and other healthcare providers in the facility, spiritual care providers are less likely to talk about patients using medical language and diagnoses when discussing patients (Walton 2011). The aforementioned shift in psychiatric care, putting more emphasis on meaning and recovery than before, may help spiritual care providers find common ground with other care providers (Rijnbout et al. 2011). However, spiritual care still operates in a different domain and can encounter challenges in collaborating with other care providers. As Bronstein's model has suggested, this requires finding a balance in adjusting to the language and perspective of other disciplines on the one hand, and staying true to the specifics of the domain of spiritual care on the other hand (Bronstein 2003).

3.2.5 Personal characteristics and experiences

Personal characteristics also affect interdisciplinary collaboration. Personal characteristics refer to how the collaborators view one another as people, and what this means for the extent to which they trust one another, deem one another capable and feel comfortable with their colleagues from other disciplines. According to Bronstein's model, this depends on the professional's personality. Bronstein cites surveys of characteristics that are considered important in this regard for social workers and for the professionals they collaborate with (Bronstein 2003). In the context of spiritual care, there are no specific studies on this topic. However, a study on interdisciplinary collaboration in spiritual care describes the necessity for spiritual caregivers to speak multiple languages, which is meant as a metaphor for the words and perspectives of different people with different roles. A relevant personal characteristic, is to be able to switch languages. Spiritual care uses different perspectives and theories than other healthcare providers. Therefore, spiritual caregivers need to adapt their language when talking to their colleagues from other disciplines. This requires particular communication skills. These skills are also essential in being able to describe the value of spiritual care to colleagues from other disciplines, which can aid interdisciplinary collaboration (Walton 2011).

These specific experiences and preferences are also influenced by previous experiences, which Bronstein calls 'history of collaboration' (Bronstein 2003). Spiritual care has a history of working alongside other disciplines, but this does not necessarily mean they collaborate in their work. Spiritual caregivers have often had experiences in collaboration, as described in the paragraph on newly created professional activities. The nature of these experiences, whether positive or negative, can influence any possible collaborations in the future.

3.3 Conclusions

In conclusion, this chapter has elucidated the key components and factors influencing interdisciplinary collaboration, particularly focusing on the model proposed by Laura R. Bronstein. By analyzing Bronstein's model alongside the insights of spiritual care researcher Martin Walton, this study has underscored the significance of interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on the process as fundamental components of successful interdisciplinary collaboration. Furthermore, it has described the main factors that can aid or form barriers to interdisciplinary collaboration: perception of spiritual care, structural characteristics, spiritual care as a sanctuary, differences in professional role and language, and personal characteristics and experiences has highlighted the complex dynamics that impact collaborative efforts.

CHAPTER 4: METHODS

Semi-structured interviews with seven spiritual caregivers in psychiatric in-patient facilities provide the data of our qualitative research. This chapter elaborates on the details of the ethical considerations, organizational context of the fieldwork and the demographics of the participants, and explains the underlying rationale of the choices for the participants and other methodological considerations.

4.1 Ethical considerations

As the data for this study were collected through fieldwork, some ethical considerations are necessary. The participants of this study are spiritual care providers, talking about their experiences in their work setting. The interviews focus on how spiritual caregivers view their own role in relationship to other professionals. As such, a review by the medical ethics committee is unnecessary. This study does not include patients and neither are they discussed in the interviews. However, there are still some ethical risks to consider. In the interviews the spiritual caregivers were asked to discuss their interactions and collaborations with colleagues from other disciplines. These included challenges and negative experiences. As this paper will be available online and the colleagues discussed in the data are able to read it, this could have implications for the professional relationships of the participants with their colleagues. Furthermore, it can impact the reputation of the psychiatric facilities where they are employed. For this reason, the interview transcripts have been anonymized and made unrecognizable. Additionally, the participants were all asked to give their informed consent. To this end, a consent form was shared with them, including the themes that would be discussed and information about the data management. All participants were thus informed about what was asked from them in participating in this study and the possible implications of their participation. At the start of the recording of the interview, the interviewer briefly repeated that this interview was being recorded and that the interviewee was allowed to ask to stop the recording at any time during the interview.

The interviews were conducted using Microsoft Teams, accessed with the author's account from Radboud University. This is a well secured account. The interviews were recorded in the MS Teams software, transcribed by the author and the transcripts were then anonymized before the coding and analysis. This included erasing all facts and information that could be traced to the participants. In case reference was made to patient types, the interviewees already made sure not to name individual patients. The anonymized transcripts were only saved in the secured cloud drive of Radboud University related to the author of this master thesis. Audio-recording will be deleted after defense of the master thesis, and anonymized written transcripts of the interviews only will be transferred to the supervisor of this thesis to be archived once the defense has taken place (and will be kept on the secured individual cloud drive only). The informed consent forms[8] did include the full names of the participants and signatures. They were therefore only made accessible to the supervisor, and are upon request

[88] See appendix B.

accessible for examinators of this work only.

These ethical considerations and data management are based on the guidelines of the Radboud University (as described on libguides.ru.nl).

4.2 Selection and overview of participants

The focus of this study lies on the experiences and perspectives of spiritual care providers. For this aim, seven spiritual caregivers have been interviewed. They were found through LinkedIn, websites of psychiatric facilities and through a previous internship of the author of this thesis. The aim was to attain a diverse group of participants, in terms of religious affiliation and location of the organization where they provide their services. This seemed particularly important, because the image care providers have of spiritual care can often be outdated and lead to challenges in making collaboration happen (Walton 2006). This image can vary based on the religious identity of the spiritual care providers and cause additional challenges. Even though the limited scope of this research makes it impossible to draw generic conclusions about the spiritual care provider's based on their particular religious affiliation, it can raise potential clues that can serve as recommendations for further research. Furthermore, existing research on spiritual care in the Netherlands is relatively homogenous. In many interview studies, a majority of participants - if not all- with some kind of Christian affiliation or with Christian socialization, seems to be the norm.[9] Spiritual care as a profession has diversified in recent decades and research is still catching up. And although the focus of this thesis lies on interdisciplinary rather than interreligious collaboration, the aim is to focus on how this interdisciplinarity is experienced by a diverse group of spiritual care providers, and thus attempting to reflect the increasingly diverse work setting of spiritual care.

Finding a diverse group of participants proved to be challenging, due to several logistical factors. The spiritual care providers were often busy and put forward a colleague in their team who had more availability. This limited the author's ability to fully choose the demographic of the participants. The participants ultimately consist of: 2 Roman-Catholic, 1 protestant, 1 Jewish, 2 Muslim and 1 Humanist spiritual care provider. They all work in psychiatric in-patient hospitals in different places in the Netherlands: bigger cities in the Randstad and locations in the provinces Noord-Holland, Groningen, Gelderland and Noord-Brabant. Some either had experience or were still working in a forensic psychiatric hospital and an addiction clinic, some had experience or were still working with an out-patient population, but all participants were (also) currently working at a general psychiatric in-patient facility. They work in different clinics of the psychiatric hospitals, namely: crisis units and long-term mental healthcare, including severe mental illness (SMI).

[9] This becomes apparent when browsing through the content of the Dutch journal of spiritual care, *Tijdschrift Geestelijke Verzorging*. Notably, while sporadic papers delve into religious and cultural contexts beyond Dutch Christianity, instances where a generalized concept of spiritual care is presented often exhibit a predominant participation and resourcing from Christian and/or Dutch individuals lacking a bicultural perspective.

The interviews have been anonymized to allow for all participants to speak more freely about the potential challenges they experience in collaborating with coworkers from other disciplines. One interviewee also explicitly asked for anonymity.

In the table below some additional characteristics of the interviewees are described.

Alias	**Pronouns**	**Religious affiliation**	**Work context**	**Interview date**	**Interview duration**
A	He/him	Jewish	Works as a freelancer for four hours a week throughout the entire organization, but mainly at the crisis unit.	2 February 2024	0:51
G	He/him	Protestant	Works at different departments at the in-patient clinic and for an addiction clinic	5 March 2024	1:19
H	She/her	Muslim	Works throughout the entire in-patient facility.	30 April 2024	0:54
K	He/him	Muslim	Works throughout the entire facility, including the forensic clinic.	21 February 2024	0:33
M	He/him	Catholic	Works for different departments of an in-patient clinic.	8 March 2024	1:17
P	He/him	Catholic	Works for long-term mental healthcare, for patients with severe mental illnesses. Is also active for out-patient care (patients who live at home).	14 February 2024	0:52
S	She/her	Humanist	Works at the department for ‘multi-complex’ care, serving patients who are hospitalized long-term and with complex diagnoses and needs.	21 February 2024	0:52

4.3 Procedures

The literature study reported upon in previous chapters helped to shape our interview questions.. The distinction between five components of interdisciplinary collaboration, and the five factors that aid or form barriers to collaboration also formed the basis of the analysis of the data. .

The interview protocol consisted of a list of questions which in practice were not followed strictly (appendix A). The questions started with some introductory questions about

their religious affiliation (if any), the location they worked at, with which patient group and how spiritual care is organized in their facility. Subsequently, the topic of interdisciplinary collaboration was introduced and the participants were asked about the different healthcare providers they encountered in their role. The interviews then moved on to discuss shared initiatives, the division of roles, interdependence and reflection on collaboration. Then, the interviewees were asked about any challenges they experienced when attempting to collaborate or when collaborating, first asked openly and then prompted by specific areas in which obstacles may be experienced (based on the factors described in the theoretical section of this thesis). The interviewees were also asked about what went well in their experience with colleagues and what benefits to the collaboration they experienced. Finally, they were asked how they would ideally want the collaboration to take place. Ultimately, the respondent decided what to elaborate on and what additional themes they felt relevant to discuss. On average, the interviews lasted an hour. They took place via video calls which were recorded, and transcribed afterwards. They were then analyzed using the software ATLAS.ti.

The interviews were coded based on the concepts of the model of interdisciplinary collaboration. To this end, the transcripts were read several times and notes were added to find the main themes that were discussed. This allowed us to add or adjust codes where necessary. The components and factors of the model turned out to be suitable for analyzing the interviews. When analyzing the data, the quotes were clustered based on any relevant code. Subsequently, all quotes that pertained to a particular theme were read multiple times and summarized. Quotes were chosen based on either a shared sentiment across the interviewees or a clear elaboration of a particular perspective.

CHAPTER 5: RESULTS

This thesis is aimed at answering the questions: how do spiritual caregivers collaborate with other mental healthcare providers; how do they describe this collaboration in terms of the key components; and what factors aid and pose barriers to collaboration? Seven caregivers in psychiatric settings were asked about their experiences with interdisciplinary collaboration. This chapter first describes how the participants experienced the key components of interdisciplinary collaboration. This answers both the first and second sub-question. Next, the factors that facilitate or hinder collaboration are discussed, answering the third sub-question.

5.1 Experiences of interdisciplinary collaboration

According to the model of interdisciplinary collaboration, the key components are interdependence, newly created professional initiatives, flexibility, collective ownership of goals, and reflection of the process.

5.1.1 Interdependence

Interdisciplinary collaboration requires a level of interdependence between colleagues from different disciplines. The spiritual care providers depend on their colleagues to be efficient in their work. Many of the participants described brief interactions with nurses and other care providers to let them know they were visiting the clinic and to ask if there were any patients who could use a conversation with them.[10] This seemed to be the most common form of collaboration, which shows a level of dependence on other care providers in order to reach patients, get referrals, and to know which patients need spiritual counseling. Spiritual caregivers usually visit multiple departments or locations, whereas nurses stay at the same clinic and are usually assigned to a single department. This implies that nurses spend considerable more time with the same patients. Nurses can therefore be helpful in informing spiritual caregivers on how patients are doing and who could benefit from spiritual care. One spiritual care provider described this as follows:

> [W]hen I visit a clinic, … the people who are the most manic or the most vocally strong receive the most attention. … And I know, for instance, that I preferably want to talk to people with anxiety and mood disorders- then I have the most impact. Because people who are psychotic… we can have beautiful conversations, but oftentimes they cannot really remember anything of what they have discussed with you. (M, 8 March 2024)[11]

Similarly, another participant said:

[10] See Appendix B, code 8.
[11] The interviews were conducted in Dutch and the quotes that were used in this paper were translated by the author.

> Many of the nurses know me and already refer patients to me. When possible, I drop by at the nurses' office and ask if they happen to know someone. Of course I do not have something for every patient, right? A patient needs to be able to talk a bit. And the problems need to be somewhat meaning-related, or contain an element of this. So people know me a bit by now, know where my strength lies. (A, 2 February 2024)

Besides depending on colleagues for referrals and suggestions on which patients to talk to, spiritual care providers often depend on nurses for practical assistance. When they want to bring patients on an outing outside the facility, for instance, these patients still need different types of care that spiritual caregivers cannot give. For example, a participant described that he and his spiritual care colleagues invited nurses to their visits to a monastery. The primary reason for this is that they can provide physical care for the patients who need it.

This practical help is also needed for interdisciplinary initiatives within the facility. One participant described how she co-organized art exhibits with a patient's art, as part of the art committee of the facility. She said:

> Recently there was an exhibition on our terrain. No, if I would have to do that by myself or only with spiritual caregivers; who would then make sure that it would all be hung properly and that everyone knows about it? (S, 21 February 2024)

The dependence works both ways. Nurses and occupational therapists sometimes depend on spiritual care providers to gain more insight on the experience of patients, as patients can sometimes open up to spiritual care providers more readily than to other care providers. This was experienced by multiple participants. They ascribed this to spiritual care's position as a sanctuary, with full confidentiality and without the requirement to report in the patient files. Another reason that was given, was the themes of the conversations the spiritual care providers have, such as meaning and spirituality. However, as spiritual care providers promise full confidentiality to patients, they are not likely to share this information with other care providers. In group sessions, they sometimes invite nurses or occupational therapists to join, with consent of the participating patients. This way, the other care providers get to know the patients in a different way and gain new insights. This is described by the participant in the quote below.

> I also notice that nurses or occupational therapists that join, say that they got to know the patient better in this way as well, or understand how they perceive things. … Not a concrete example off the top of my head, but what I keep on hearing is: oh, I am surprised that someone experiences this in that way. Or that he is occupied with these questions. That is something that does not really come up in daily interactions. (P, 14 February 2024)

This dependence on spiritual care providers was also described to be true for medical doctors and psychiatrists. In some cases, the expertise of a spiritual caregiver is important in order to provide the best treatment for the patient. The following quote illustrates that.

> [Sometimes care providers call and say] this patient thinks he is affected by a jinn or believes voodoo was done to him. So he does not recognize himself in our diagnosis. Can you advise us from a different culture or religion? And then I do so. … The same happens with Ramadan. … Should a patient fast or not? Especially if it is not responsible for a patient to fast, because of their weight, but the patient insists on continuing to fast. So I have an advisory role in this. (H, 30 April 2024)

5.1.2 Collaborative professional activities

There were examples of professional activities that the spiritual care providers had started by themselves and in which they asked colleagues with other roles to contribute to. For example, many of the spiritual caregivers described inviting nurses, lived experience experts or occupational therapists to join a counseling group facilitated by spiritual caregivers sometimes.[12] One interviewee described starting a group around loss and grief in collaboration with a lived experience expert[13] with personal experience in dealing with grief. This is an example of a newly created professional activity as a collaborative effort.

Several participants have been involved in collaboration in the form of clinical lessons, training, or advisory roles. Sometimes this included a consulting function of spiritual caregivers, in which they were asked by other care providers to share their expertise. In other cases it was a professional activity they initiated together with colleagues from other disciplines. One participant described this as follows:

> I also teach medical doctors in training, together with <name psychiatrist>, and to some other providers. We work together. And then I tell them something from the perspective of my own, a theoretical part that I tell, from my own cultural and religious background, and something from the practice, how patients interact with me. And the providers tell something from their expertise, so to say. So that is always a pleasant collaboration, in my opinion. (H, 30 April 2024)

Another participant was part of an out-patient FACT-team (Flexible Assertive Active Community Treatment team), an intrinsically interdisciplinary method, aimed at recovery on different levels of the patient's wellbeing. This is described by a participant as follows:

[12] See: appendix B, code 11.
[13] In Dutch: ervaringsdeskundige.

> These FACT-teams … are interdisciplinary by definition. … So within the locations that I visit and these FACT-teams, I am one of many different disciplines. So I contribute my voice to that. (G, 5 March 2024)

One spiritual caregiver said she was part of an art committee, in which she collaborated with a creative therapist, a secretary, someone from the logistics department, and a volunteer to create expositions for a patient's art in one of the buildings of the facility. She said: "I really think that this [initiative] is only possible because there are people from different roles collaborating to make it happen." (S, 21 February 2024)

The same spiritual care provider described how she was involved in a workgroup to create a silence room in the facility. This is another example of a newly created professional activity. In this workgroup, the spiritual caregiver works together with a psychiatrist, nurses and other disciplines.

A last example of a newly created professional activity in collaboration with other colleagues, was the 'layman's sermon', in which spiritual care providers asked a colleague from a different discipline to tell a story in the church. In this initiative, spiritual care providers work closely together with their colleagues who share their stories in the ceremony, in order to prepare the sermon and ceremony.

5.1.3 Flexibility: specialized but adaptable

According to the participants, when collaborating with others, it is important to be aware of and assert their specific expertise as a spiritual caregiver. At the same time, they reiterated the importance of remaining flexible and allowing for overlap with other roles. This was described by one participant as follows:

> For us as spiritual caregivers, you have to show that you have knowledge of [the topic meaning], yet you should not fully claim it. Because then you are building a fence around it and that is not how it should be either. So you do not force it. You can spread it and it should be clear that it is our reason for existence, that our knowledge of this topic is above average. (G, 5 March 2024)

Several participants said that working with colleagues from other disciplines requires a level of open-mindedness and awareness of common goals.[14] And this is true for spiritual care providers as well as for their colleagues. For instance, some participants described cases in which their colleagues were flexible to focus on meaning, even if this was not a direct aspect of their role. This is described in the quote below:

[14] See Appendix B, code 3.

> Well, yesterday I had a meeting with a psychiatrist who is writing her research about silence rooms and about silence in the work of psychiatrists in general. Sometimes you also get involved in something like that. You know, the fact that you are invited for this meeting is because I know a bit more about that and then you work with each other for a bit, so to say. And in the past there was also a psychiatrist who was writing her research about meaning, about the need for meaning among patients and the willingness to look at meaning among providers. (S, 21 February 2024)

Another participant described flexibility as a necessity for joining initiatives of colleagues from other disciplines and vice versa. He said that when colleagues join a group session or a monastery visit, he expects them to actively participate and share something, just like the patients. This requires these colleagues to step out of their specific role of e.g. a nurse, and get closer to the role of a spiritual care provider or an equal conversation partner of the patients.

Another spiritual care provider described how she also had to be flexible in her role and adopt some aspects of the therapeutic role, when working with patients with complex diagnoses. She said she asked the personal companion[15] for advice on how to deal with her patient's specific mental illness. She said:

> For instance, I have two patients who have a pretty complex disorder and I discuss this with their personal companion sometimes. About what my role should be. And since I know more about this, I think I sometimes take on the role of a therapist. … This concerns someone who has dissociative identity disorder and whose identities show up in different parts. And since I know more about this, I know for instance that it is important that when I have had a conversation with another part and the 'I' returns, that I try to summarize it a bit. That I help him or her to restore the overview. That might be a bit of a therapeutic action, but I do think it is useful. (S, 21 February 2024)

Despite all the participant's opinion that flexibility is important in their interactions and collaborations with their colleagues; some also felt that this flexibility should have its limits. This is illustrated in the following quote.

> I once received a beautiful lesson from a doctor. Someone was dying and I was asked, because I had meant a lot for this lady. I arrived … and this lady became delirious. This is very unnerving when you are with a dying person like that. So I got in contact with her, but still very afraid. And then I said to the doctor: can you please give her some <name of medication, unintelligible>? And she said: I also don't tell you which Our Father prayer you should pray, right? I think this is so beautiful, because I thought, yes, you are right. I am in a domain that is not mine. (M, 8 March 2024)

[15] Translated from the Dutch function: "persoonlijk begeleider".

The participants describe some degree of flexibility as a necessary component of interdisciplinary collaboration.[16] The level of flexibility versus sticking to one's own expertise, is described as a possible facilitator or barrier to interdisciplinary collaboration. This will be elaborated upon in a later section of this chapter.

5.1.4 Increase of shared goals and visions

Ultimately, colleagues share the same goals of helping patients in their recovery. But there are differences in their roles and approaches. A shared vision of the goals is experienced as one of the more beautiful components of interdisciplinary collaboration by different participants. One spiritual care provider describes this as follows:

> I think the strength of collaboration between different disciplines is that … it becomes much more about the whole person and that we actually do not experience much competition, but rather ways to reinforce each other. (M, 8 March 2024)

Sharing the same goal is essential for any kind of collaboration and is what makes for positive interactions and collaborative efforts. One participant said:

> I never experienced having a conflict with a care provider. Or that things aren't going so well. Because we have one common goal and that is actually in the interest of the patient. (H, 30 April 2024)

Another participant shared a similarly positive experience in the interdisciplinary art committee. She describes how she and colleagues from other disciplines share goals to create positive experiences for patients within the context of being hospitalized. Sharing this positive goal for patients results in pleasant interactions with colleagues.

> I think it is a really nice way to collaborate. … Together we ensure that patients can really shine. … It has a really nice effect, when beautiful art pieces get to be displayed somewhere and family comes to visit, or providers visit and really get to see the patient from his healthy side. Simply that he makes beautiful things, so to say. (S, 21 February 2024)

According to several participants, there is more collective ownership of goals between spiritual care and other disciplines than in the past. The reason is a shift of focus in mental healthcare towards a greater emphasis on meaning-making and existential matters. As this is a key focus

[16] Similar to Bronstein's model as described in chapter 3 of this paper.

in spiritual care, the goal of assisting patients with this, has become a common one. This is described in the following quote about multi-disciplinary meetings:

> Especially in long-term care, you see the accent shifting from less emphasis on treatment and more focus on recovery. And about how people can have a more pleasant life within the setting they are in, with a future, what is important to them. Then you could almost say it is becoming more an experience-focused care. And then you just need one another to coordinate how we can ensure treatment that is suitable in this situation. How can we ensure that patients are represented and are not, so to speak, the object of policy or the rules of the department. (P, 14 February 2024)

5.1.5 Lack of formal interdisciplinary reflection

Spiritual care providers describe reflection of the process of interdisciplinary collaboration as something that does not take place formally.[17] This is related to the different barriers that spiritual caregivers describe to make collaboration happen, such as lack of time and lack of visibility due to their position as a sanctuary. One participant answered the question if reflection with colleagues from other disciplines on their collaboration takes place:

> No, not really. And that is partially because of that sanctuary position we have. Or at least I assume it is. Ultimately, we are only accountable to ourselves, formally speaking. And that sounds a little bit strange and it does not actually look like that, but if you ask, who evaluates your performance, well, no one. There is no formal moment of evaluation. (G, 5 March 2024)

In other words, lack of formal evaluation makes a moment of reflection a complementary activity. It is not mandatory as part of the rules and policies, because spiritual care operates as a sanctuary, outside of the treatment team. For this reason, spiritual care providers can choose if they want to evaluate together or not.

Some spiritual caregivers do describe informal interactions after collaborations, such as group sessions. This is not a formal meeting in which the care providers discuss how they experienced their collaboration and what could go better, but rather a brief informal conversation in which the colleagues share what they feel like sharing, what stood out to them. An example is of care providers who joined a group session of the spiritual caregiver and afterwards shares their surprise of something a patient shared during the session.

Other spiritual care providers take on the role of moderator when their colleagues have a meeting in which they reflect on their work as a team. In this case, the reflection is not about their collaboration with spiritual care providers, but of their own work. Spiritual caregivers are asked to assist and to create an environment where the care providers can share their experiences.

Another type of reflection can be found in moral deliberations. Here too, spiritual care

[17] See appendix B, code 6.

providers take on the role of a moderator or facilitator to this ethical reflection. This means that the reflection is not on the collaboration with spiritual caregivers per se, but on how the providers from different disciplines can best support a particular patient, for instance. Many of the participants have been involved in moral deliberations in this way.

In some cases, common reflection was seen as a risk to possible collaboration. Reflection on the work of other colleagues could be perceived as criticism and impair the relationship with colleagues from other disciplines. As one participant described:

> It is difficult to get a foot in the door and it is easy to be out. … If you're always only the sorehead that says: well, you don't have your things in order here and it's a mess and I wouldn't be seen dead here; then they will say, you know what? That guy, never mind. Then they just don't approach you and you keep on joining meetings, but you will be left to the side or ignored otherwise. So you really need to seek collaboration and see the potential. (G, 5 March 2024)

Even though reflection with other disciplines about their collaboration is rare and only occurs informally, spiritual care providers do frequently reflect on their work with other spiritual caregivers. One participant said: "A monthly team meeting, in which we discuss the shared policy among other things. And we bring in cases and discuss issues we encounter in our work." (P, 14 February 2024)

Another participant describes this kind of reflection as follows: "Within our team, we have our manager of course, when it comes to our annual plan and visions et cetera. Then [interdisciplinary collaboration] comes up. And also evaluated, in the form of self-evaluation. (K, 21 February 2024)

5.2 Factors that aid or form barriers to collaboration

Overall, the participants have different experiences of the collaboration. All of the spiritual care providers consider collaboration with other disciplines valuable and have had positive experiences with it.[18] Many of them, however, also experienced challenges. The main ones are a result of spiritual care's position as a sanctuary and how this negatively affects their visibility in the facility. Another challenge that recurred in the different interviews is a lack of time to make collaboration happen. In this section of the results, the experienced facilitators and barriers of collaboration, structured by the different factors that can aid or form barriers to collaboration as described in the previous chapter, are elaborated upon.

5.2.1 Restrictive perception of spiritual care

Spiritual caregivers see a shift with regards to the image that care providers have of their profession in recent years. Meaning seems to have gained importance among providers in psychiatric facilities, which has positively impacted the image of spiritual care. Simultaneously, the spiritual caregivers describe how their profession has changed and become

[18] See appendix B, code 24.

less denominational/confessional and more inclusive. However, an old image sometimes persists among care providers, which is sometimes experienced as a challenge for attempting to collaborate. Most notably, the participants describe an old image of spiritual care as a strictly religious profession, only meant for patients who are religious or have religious problems.

> Sometimes they say, the imam is there. Then I say, no, the spiritual caregiver is there. Or: there is the priest. No, that is a spiritual caregiver. That shows that people still have an old image of spiritual care, of the temple and the church and the mosque. It is immediately linked to religion, while that is not necessarily the case at all. And besides, when we talk about meaning, they just don't have a clue what we are talking about. (K, 21 February 2024)

This image of a spiritual caregiver as someone who is only there for religion-related problems, can negatively impact the referrals. Several participants describe not reaching patients who are not religious sometimes, because the caregivers assume that spiritual caregivers do not have anything to offer to them. The participants still experience that colleagues have a limited image of what and whom spiritual care is for.

However, all of the participants feel that there has been a shift in focus within psychiatric care, and that meaning has gained importance. This has been beneficial for spiritual care providers in their interactions and attempts of collaboration with other disciplines. One participant said:

> When I started as a spiritual caregiver, the question of 'is all that still necessary?' was still prevalent. They felt a bit like: a pastor or a reverend, that's something from the past, right? And now everyone says that meaning-making is important. So that is a big change. That has certainly been favorable for us. Being allowed the space to work and the opportunity to collaborate as well. However, old images are pretty persistent, so I haven't just lost them like that. But you can consequently provide clarity about what spiritual care is and what it is not. It's not a confessional position, so to speak. (P, 14 February 2024)

> This sentiment is felt by other participants as well. For instance, one participant said:

> I do see shifts. Particularly when I started working in mental healthcare about twenty years ago, the relationship between healthcare and spiritual care was much worse. At the time, the medical model was still very strong, like, you have the patient who is sick, you have to toss in a pill and shake a couple of times and then the disease is over and the patient goes home and is cured. And that was, very simply put, how the medical model worked. Over time they are beginning to realize that, especially for this group, the more severe psychiatric patients, that curing is not really an option. Not in that way. You use medication and someone with schizophrenia loses their delusions, but is not a

> healthy person. They can still not do very much. And what is left, is a domain in which you can mean a lot more as a spiritual caregiver. Then it is about grief, for example. Like, how do you go on in a life in which you can no longer accomplish what you hoped to accomplish. … And there is increasingly more attention for that nowadays, also among healthcare workers, they value that this can have for people, compared to in the past. (A, 2 February 2024)

Another participant mentioned the recently changed quality standard of the mental healthcare sector, in which a section of meaning was added: "We used this addition as an entry point to make this a topic for discussion." (K, 21 February 2024)

The way in which spiritual care is perceived by their colleagues, is also variable and dependent on the role of the colleagues or personal characteristics. According to one participant, collaboration is mostly possible when colleagues have a sensitivity towards the topic of meaning. He said:

> If an employee does not really understand what it is about, meaning, and doesn't quite understand that word or can retrieve it from how patients are behaving, then you cannot really expect a referral from them. (G, 5 March 2024)

As participants of different religious/philosophical denominations were interviewed for this study, it is also interesting to look at the potential differences between how they are perceived in the facility. The two Muslim and one Humanistic spiritual care providers, for example, feel that they are perceived differently than their Christian colleagues. This can both be positive and negative. A positive experience described by one of the Muslim spiritual caregivers, is having a clear expertise that other care providers know and understand. This allows her to get referrals and to be asked for advice in specific cases, where she believes she can really help and use her expertise. She said:

> People know how to find me, is what I notice. I get a lot of referrals and they are often pretty specific too. So there is a clear question. But this is not always the question that ends up being behind it. For example, someone says they want to learn how to pray. … So they know how to find me and I would say the image is OK. … So if you ask me personally, am I being recognized in my expertise, I would say yes. (H, 30 April 2024)

The other Muslim participant also describes getting specific referrals. As Muslim spiritual care providers, they both describe how they sometimes operate as a bridge-builder between Muslim patients and (non-Muslim) care providers. For instance, they both described Ramadan as an example when care providers ask them to talk to Muslim patients who want to fast and this is in some way incompatible with the treatment the providers have in mind for them. For instance, a patient does not want to take his medication because he believes he should not consume anything during Ramadan, including medication. In another case, a patient wants to fast, but

the providers think this is not healthy because of the patient's low weight. These specific referrals and the role of educating both patients and staff, is experienced positively by the two participants. Being a bridge-builder also comes with a risk, according to one of the participants. She said:

> As a spiritual caregiver I do have the experience of… how do I make sure I'm not being used. I don't mind thinking along, not to solve anything, but to think along and to connect different people. … But I do want to beware of: someone is not taking their medication, can you get them to take their medication again? … I typically ask a lot of questions to find out why someone disagrees with their diagnosis, for instance. Or why someone believes they are troubled by a jinn rather than psychosis, for instance. I personally believe that spiritual caregivers take more time in this. … To find out what is really the life's question of the person. Because that is what we are for. … I am not there to just solve things. (H, 30 April 2024)

As these quotes illustrate, having a specific religious background other than Christian as a spiritual caregiver, can make it more clear to care providers what sort of patients and problems they can refer to them or ask advice about. However, this is sometimes based on a limited understanding of spiritual care. The participants describe that they are there for much more than just problems related to religion. For the humanist spiritual caregiver that participated in this study, her denomination is perceived positively by many staff members, especially younger ones. She said that she often gets positive reactions, such as "oh, that's great that there is also someone for non-religious people, so to say." Or: "that's great that you have a wider range to offer now; that there are not only Christian ceremonies, but also other kinds of ceremonies." (S, 21 February 2024)

However, as a spiritual caregiver who has a particular denomination but is not religious, she also experiences challenges in terms of how she is perceived: "I can imagine that colleagues may think sometimes: then what are you still doing, if you're not here for religion? Are you a psychologist for meaning or something? Even more for me to explain."

One of the Muslim spiritual care providers also had some negative experiences with stereotypes of Muslims.

> It is never explicit and you always have to guess. But there have been enough moment in which I thought, my presence is not being appreciated. And then that was because of my identity as an Islamic spiritual caregiver. … This includes rudeness and the way people behave. … One time, someone misspoke and she was also called out for this by the team leader, who then apologized to me. … When patients, regardless of their religion, use drugs, they will take any moment they can to deal or to use. This always happens at moments when they come together, where different departments come together. And this happens in the Friday prayer. That happens in the church ceremonies.

> There was a time when drugs were coming into the clinic. … And there was a suspicion that dealing had happened during the Friday prayer. And this colleague said, 'that's weird that this always happens with you guys.' And I'm thinking, what do you mean, 'you guys'? Do you mean spiritual caregivers or 'you guys' me, or us as… And then she didn't know what to say and I already knew that she meant 'you Muslims'. (K, 21 February 2024)

Stereotyping can negatively impact the relationship with colleagues, and thus potential collaboration. This is also experienced by one of the Christian spiritual caregivers who was interviewed. He said:

> Especially when they know I am also a reverend, well, then all God questions are being projected on me. … They associate me with that and go, oh, that is a religious person or oh, that is the Bible, and then they make a joke about it. … I don't mind it so much. because it's also important to me to be able to do this from my background and my tradition. (G, 5 March 2024)

5.2.2 Challenges of structural nature

Spiritual caregivers experience practical challenges.[19] Most notably, this included a lack of time, but also a lack of a formal structure for collaboration and working at more than one location. Spiritual caregivers often work part-time in the facility and in multiple clinics or on multiple locations. The healthcare providers they wish to collaborate with are also busy and short-staffed. This makes collaboration particularly difficult. One spiritual caregiver said:

> Of course I only have, in my case, 24 hours. I get asked much more than I can deliver. So I need to make choices sometimes that I am not happy with. And sometimes there are expectations where someone says, isn't this exactly what you can do? And then I say, yes, that's true, but I do not have the time for it. (M, 8 March 2024)

In the limited amount of hours that spiritual caregivers get in their contracts, they need to prioritize. Many of the participants say that seeing patients always comes first and other activities, including interdisciplinary collaboration, comes later. In practice, this often means that there is very little collaboration.

> We have a chronic shortage of time. There is much more work than we can actually do. And in fact, the way in which psychiatry is now being delivered, we cannot expect to get more hours. That is the reality. There is hardly any money for whatever. There is much more to be done. And in the multitude of what we do right now, we try to have as much contact with the patients as possible. And any contacts besides that are

[19] See appendix B, code 17.

> secondary. … That is the problem. I cannot even offer much more. I would like to have more hours and then closer collaboration. (A, 2 February 2024)

Another structural barrier to collaboration that the participants experience, is lack of a formal structure for collaboration. Although this can be ascribed to their position in the organization (and spiritual care being a sanctuary), it does not have to be. Other reasons include working at many different locations and not formally being part of the treatment team. Spiritual care providers often have their own separate office and visit the clinics from there. This means that they are less often at the clinics than the other care providers. One participant describes:

> Because the collaboration is not embedded at all, it is my experience that you have to put in a lot of effort for it. As a spiritual caregiver you often have multiple departments and then it is already a whole job to make yourself known a bit. Because oftentimes, there are 50, 60 people working there. And by the time they even know who you are and understand a bit of what you're doing and what your role is, well yes, that takes a lot of time and energy too. (S, 21 February 2024)

Another structural challenge is the many healthcare providers, particularly in the clinic, such as the nurses. The staff works in shifts and there are many flex-workers in addition to the regular staff. A participant describes that this makes it difficult to build relationships and to be visible and known among these care providers. She said:

> It is a lot easier to just wave at the nurses and maybe shout: 'hey, I have an appointment with so and so', and then you just go there and have a good conversation, the patient is happy, and you leave. But if you really want to coordinate with the nurses what you have to offer in that clinic, so that they can also help you to meet the patients who have a need for spiritual care, then you have to do that every single time, because the nurses present changes constantly. Or you need to attend their team meeting regularly. … That just takes a lot of time and energy to keep on doing that. Also because there are constantly different managers and different providers and different staff members. (S, 21 February 2024)

Oftentimes, spiritual care providers visit different clinics, just as the previous quote illustrates. Working at multiple locations is experienced as a challenge for collaboration as well. One participant said:

> The obstacles are mainly practical in my experience. … Because we work at all kinds of locations, we come and go. And if you want to join a shared meeting, for instance, you can only do so in one place at the most. If you work in multiple places and would try to join the meetings at multiple locations, you'd not get to anything else anymore.

> … We are a relatively small team. We work at many different locations. So yes, this makes collaboration hard sometimes. (P, 14 February 2024)

Spiritual care providers often experience the fewest interactions with psychiatrists, because of their lack of time. One participant describes this as follows:

> I often say, I have the best job and I think a psychiatrist is one of the most annoying jobs. You get 15 minutes to talk to a patient sometime and that's it. There is a big shortage of psychiatrists. (A, 2 February 2024)

The lack of time of some of the other care providers, also creates opportunities for collaboration in the form of referrals, according to some of the spiritual care providers. Especially when the referral includes a spiritual or existential element, the care providers seem more likely to ask spiritual caregivers to help. Even though spiritual caregivers say they are busy and experience a lack of time, they also acknowledge they have a certain amount of freedom to fill in their time as they wish, and to talk to a patient longer than other care providers. One participant said:

> Sometimes I get an email from a psychiatrist or a nurse or a specialist who says, this man or woman deserves to be listened to, but I simply do not have the time for that. … People who tell me they don't want to take medication, because they have a more spiritual outlook on life. And then they think about me sometimes. Can you check if there are openings. … And then I will sometimes have a conversation with the patient. (M, 8 March 2024)

5.2.3 Pros and cons of spiritual care as a sanctuary

As described in the previous chapters, spiritual care has a unique position of what in Dutch is called a sanctuary. This means that patients are entitled to see them regardless of their situation, that spiritual caregivers do not have to justify or report on what they do to other care providers and that their conversations with patients are confidential. This position has pros and cons. A benefit that participants describe, is that patients often feel more comfortable sharing personal thoughts and feelings, as the spiritual caregivers are not part of the treatment team and do not report to their colleagues who are. However, when it comes to opportunities to collaborate with other disciplines, their position can pose some obvious barriers. Not being part of the team, not writing and sharing notes of their interactions with patients, results in a lack of visibility and clarity among their colleagues of their role. One participant described this risk as follows:

> This [sanctuary] requires us to handle it responsibly. So you should guard it properly too, … you need to show them, so they see that, OK, they bring in quality. Because

> otherwise they'll say, what are those weirdos even doing, right? So then it becomes… eventually they can start nibbling at us. (G, 5 March 2024)

Visibility is an often mentioned barrier or challenge to interdisciplinary collaboration.[20] Many of the participants feel like they are not approached for collaborative efforts by colleagues from other disciplines, unless they show their faces frequently and make sure they are known in the different departments. The initiative often has to come from the spiritual caregivers. Even the fact that spiritual caregivers do not write any notes in the patient files, make them less visible among their colleagues. They are responsible to tell them what they do and why this is important themselves. One participant describes this responsibility as follows:

> People are very reluctant. Why this is, I can't tell you. People don't know what spiritual care is. … And this says something about us as well, that we need to be more visible and get more to the forefront, or educate about the work that we do. So this is just a task that is reserved for us. (K, 21 February 2024)

The position of a sanctuary also brings advantages in terms of visibility. Several participants described that this allows them to fill in their position as they please, including showing up when and where they want to. If they are willing and prioritize building relationships with colleagues from different disciplines, they can put in the work and will find many opportunities:

> We can show up anywhere we want to within the teams. It is actually kind of a luxury, and you need to do it. Because if they don't see you, then they'll have forgotten about us just as easily. Because they see each other every day. And we come there, I am able to come in one of those teams for an hour once every two weeks, when there is a FACT-team meeting. (G, 5 March 2024)

This sanctuary position is described as one of the reasons for a lack of a structure for collaboration by several participants. Having the freedom to build relationships or to only focus on seeing patients, means that a lot depends on the person and what they find important. According to one participant, this freedom can get a bit too comfortable sometimes, which stands in the way of collaboration.

> It is really pleasant to work on your own island. It is a luxury that you have this island as a spiritual caregiver. And that you don't have to answer to anyone. That is very different from my colleagues. And again, that is the sanctuary position. We don't have a quota or targets, or you have to see the patient a certain amount of times a day. Or writing notes, patient files. We don't have any of that. And that is very pleasant. And I

[20] See appendix B, code 18-a.

> think that that is one of the reasons why the blueprint [for collaboration] isn't there. You can feel at home on that island very quickly. (K, 21 February 2024)

Another participant shared a similar experience. According to her, spiritual care's unique position as a sanctuary also means that they do not get invited for multi-disciplinary meetings with nurses or providers. This means that formal collaboration is rare and that most of the collaboration that takes place, is informal interactions with staff at the clinics.

5.2.4 Overcoming differences in professional role and language

Spiritual caregivers describe that ideally, there is a balance between showing your expertise and being willing to adapt and take on other roles when collaborating with colleagues. One participant said: "Ideally, we would have a multi-disciplinary approach, meaning we would take the entire person." (M, 8 March 2024)

Like any profession, spiritual care providers speak a different professional language when discussing patients, their afflictions, and treatment methods. This is felt by the participants of this study as well. In order to make collaboration happen and to build strong relationships with other care providers, the participants said they need to be able to change their language and adapt to the other disciplines. This 'code-switching' as a benefit to collaboration is described by one participant as follows:

> Especially in the [crisis clinic], where the diagnosis still needs to be determined, I am able to talk along about it, simply because of experience. … [For instance,] when you're talking about trauma. Abuse. You don't say, 'this patient was raped by the father', but 'there has been abuse'. And of course you keep in the abstract this way. This is important though. … It is also a conversation domain in which you enter in the role of a nurse and psychiatrist. And especially when it comes to these topics, it is appreciated. Because it is often difficult for others to name the cause of, well, strange behavior, in that way. (A, 2 February 2024)

According to the participants, there is more overlap between certain disciplines and spiritual care than others. This makes it easier to adapt and collaborate, both for the spiritual care providers and for the caregivers they collaborate with. This includes lived experience experts, psychologists and some of the coaches.

While participants acknowledged the need to adapt and be flexible; they also said it is important to not fully conform:

> You need to find collaboration with the employees, so they know what I can add. At the same time, you shouldn't conform completely, like saying: you guys tell me what I should do. (G, 5 March 2024)

According to participants, it is important to know where you stand as part of the care the patients receive. One participant described this as: “you are necessary, but not indispensable” (G, 5 March 2024). In his opinion, it is important to remain flexible and open-minded when considering not only the importance of spiritual care, but also of other disciplines. He said:

> You have to be as open-minded towards your colleagues as you are to your patients, because otherwise you become an advocate. And that also has its right, but I don’t think it is the position of a spiritual care provider because they want the whole to function better. (G, 5 march 2024)

5.2.5 Personalities best equipped for the challenge

Besides the more general challenges that spiritual caregivers experience when attempting to collaborate, there are also some personal factors that play a role in the success of collaboration. This includes some personal character traits and behaviors that are seen as beneficial or not by the participants. A shared notion was the ability to connect with nurses and other caregivers on a personal level. One participant described how he invests in his informal relationships with nurses, by asking to be included in the mailing list, by making small talk and by expressing appreciation for their work. He said:

> I think that because I have an enormous appreciation for the work of the nurses and express that frequently as well, I am also being perceived as a welcome contribution to the range of services for the clients or patients. … That is also partially because I invest in my colleagues. Because I ask: oh, I heard you have to go to the hospital, or I heard that you were sick for a few weeks. (M, 8 March 2024)

Another theme that was discussed in several interviews was being able to assert yourself as a spiritual care provider. Because of sometimes outdated images of what the profession entails and lack of visibility of spiritual care providers in the facility, being able to explain who you are and what you have to offer is key for spiritual caregivers. Some spiritual caregivers are better at this than others. One participant said:

> I think that as spiritual caregivers we are experts in a certain field. And I don’t want to let go of that. So I don’t make myself smaller than a physician or a… Because I believe we stand next to them and not so much behind them. So as a spiritual caregiver I have enough experience to say… And I also think that if you enter a department, it is a bit about your demeanor. Once you make yourself a bit smaller, something happens in the collaboration as well, I think. (H, 30 April 2024)

A formal structure for collaboration between disciplines seems to be absent for spiritual care providers. This is why any successful interactions and collaboration is largely dependent on

the effort spiritual caregivers put into it, which in turn depends on their personality. One participant described this as a challenge for her:

> I think it really helps if you are assertive and a bit outgoing. I literally feel as though I am walking into a birthday I wasn't invited for, whenever I walk into a nursing office. There are people sitting there who know each other, work together daily. And then you come in and half of them know you and the other half doesn't. And you're asking for time that they don't seem to have. So in a way, you need to be able to handle that to take up space like that and at the same time to kindly explain what you've come to do and what you need. … It helps if you enjoy doing that. If you enjoy having lunch with colleagues from a department sometimes or to initiate informal contact. So for this reason I believe that it strongly depends on the personality of the spiritual caregiver. It is not formally embedded, so you have to ensure that collaboration comes about yourself. And it helps a lot if you are a bit more extroverted, I believe. (S, 21 February 2024)

5.3 Conclusions

In this chapter the experiences of spiritual care providers with regards to interdisciplinary collaboration have been described. Interdependence emerged as a central theme, with spiritual care providers depending on other care providers for referrals and practical assistance, and colleagues depending on spiritual care providers for insights in the spiritual wellbeing of patients. Flexibility also came out as a crucial aspect to collaboration, showing that spiritual caregivers are required to adapt to other roles, while also asserting one's expertise and not fully conforming. Despite recognizing the value of interdisciplinary collaboration, participants faced barriers such as an outdated and confessional image of spiritual care and time constraints. Flexibility in professional roles and communication styles are essential, alongside assertiveness and interpersonal skills, to overcome these challenges and enhance collaboration, ultimately improving patient care outcomes in psychiatric settings.

CONCLUSIONS

This study has explored how spiritual caregivers experience interdisciplinary collaboration in psychiatric in-patient facilities in the Netherlands. There has been an increasing focus on the relevance of meaning and spirituality in psychiatric care. As these themes are part of the professional domain of spiritual care, it can be expected that spiritual care providers are able to play a crucial role in shaping this current vision of psychiatric care. Interdisciplinary collaboration is highly valuable to get spiritual care more involved in the treatment and contribute to this aim. However, collaboration is still limited and spiritual care providers experience challenges in this regard. This study has explored in what way spiritual care providers interact and collaborate with other disciplines, how they experience this collaboration and what challenges and facilitators they experience.

Interdisciplinary collaboration among spiritual care providers and colleagues from other disciplines is characterized by a significant level of interdependence. Spiritual caregivers rely on colleagues for referrals, practical assistance, and insights into patient experiences. Similarly, nurses and therapists often depend on spiritual care providers to gain insights into patients' spiritual and existential needs. Collaboration typically occurs informally through referrals, brief interactions, and occasionally professional activities initiated by spiritual care providers, such as group sessions or art exhibits.

The collaboration experiences of spiritual care providers vary, with most finding collaboration valuable but facing challenges due to outdated perceptions of their profession and time constraints. A crucial finding was that spiritual care's unique position in the organization, having a legal basis yet not being part of the core treatment team and not reporting in patient files, seems to play out as a double-edged sword when it comes to collaboration. Spiritual care providers describe that professionals from other disciplines often do not know exactly who they are and what they do. Despite a positive shift towards recognizing the importance of meaning in psychiatric care, some still view spiritual care as strictly religious, particularly Christian, hindering referrals.

Due to this lack of knowledge of spiritual care and their position outside of the treatment team, the spiritual care providers are not automatically included in collaborative efforts. This requires them to reach out and make collaboration happen themselves. To this end, being able to assert oneself and explain what their role entails is key.

With the responsibility lying for a large part with the spiritual care providers, time constraints are experienced as one of the main hindrances. Building relationships and creating a support base for spiritual care, takes time. Furthermore, it requires the spiritual caregivers to be willing and able to initiate these informal interactions and continue to assert themselves among colleagues from other disciplines.

There are opportunities for spiritual care providers as well. Their free position allows them to use their time however they want. This enables them to prioritize building relationships with colleagues and initiating collaborative activities. Furthermore, spiritual caregivers are well-equipped to act as bridge-builders between the experience of the patient and the care providers. The higher level of confidentiality spiritual caregivers can offer their patients, as

well as their expertise of experiences of meaning, spirituality and the 'slower questions' of life, often allows them to get closer to patients and understand their deeper experiences.

As this study has shown, spiritual caregivers play a crucial role in bridging the gap between patients' spiritual needs and clinical care, yet also face challenges in gaining visibility and recognition within the treatment team. Despite these barriers, there are opportunities for more and better collaboration through proactive engagement, assertiveness, and leveraging the unique position of spiritual care providers as bridge-builders. By addressing these challenges and adopting these strengths, spiritual caregivers can contribute significantly to shaping a more holistic and patient-centered approach to psychiatric care.

Limitations and directions for further research

An obvious limitation of this study is its small size, due to which generic conclusions cannot be drawn. This research wants to give insights and find themes that play a role in collaboration between spiritual care and other disciplines. Selecting a diverse group of spiritual caregivers for the qualitative study makes the scope a bit broader. But again, the results are not conclusive for all spiritual caregivers, neither for those of the religious affiliations that were represented. It can raise questions and themes that are worth exploring in further research.

Further research on how spiritual caregivers of particular religious affiliations experience collaboration with colleagues from other disciplines would be a valuable addition to existing research. The present study has indicated that there are some specific challenges, as well as benefits, Muslim and Humanistic spiritual caregivers experience based on how they are perceived due to their denomination. It could be interesting to explore it further though.

Another aspect of successful collaboration between spiritual care and other disciplines, would be the experience of colleagues from other disciplines. To better understand the aims, expectations and barriers of collaboration, further research could focus on the experience of professionals who collaborate with spiritual caregivers.

Finally, more insights on what is needed in terms of successful collaboration could be gained by interviewing patients about their experiences participating in particular interdisciplinary initiatives, such as group sessions.

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APPENDIX A - INTERVIEW PROTOCOL

<Toestemming vragen vóór het aanzetten van de opnameapparatuur middels een formulier.>

Introductie:

Dit interview wordt opgenomen voor mijn scriptie-onderzoek. Laat het mij alsjeblieft weten als je dit niet wilt. Je kunt mij op elk moment tijdens het interview nog vragen de opname te stoppen.

In dit gesprek wil ik je(/u) graag een aantal vragen stellen over interdisciplinaire samenwerking binnen de ggz-instelling waar je werkzaam bent. (Evt. uitleggen: daarmee bedoel ik de samenwerking met andere zorgverleners in de instelling, zoals psychologen, psychiaters, psychiatrisch verpleegkundigen en maatschappelijk werkers.)

Ik wil je graag eerst kort wat vragen over je functie stellen.

Binnen welke afdeling(en) werk je?

Werk je vanuit een religieuze zending? Zo ja, welke? Zo nee, hoe zou je jouw levensbeschouwelijke identiteit beschrijven?

Nu wil ik je graag wat vragen stellen over de interdisciplinaire samenwerking.

Hoe zie jij het onderscheid tussen de functie van geestelijke verzorging en andere disciplines binnen de instelling?

Met welke zorgverleners krijg je te maken bij je werk binnen de instelling?

Op welke manier krijg je met hen te maken?

Hoe ziet eventuele samenwerking met andere zorgverleners eruit?
Doorvragen: Kun je iets vertellen over…

- *…gezamenlijke initiatieven/werkgroepen en dergelijke?*
- *…de taak-/rolverdeling onderling, verdeling van verantwoordelijkheden?*
- *…de mate van wederzijdse afhankelijkheid dan wel onafhankelijkheid, de flexibiliteit*
- *…de manier waarop eventuele reflectie/evaluatie van de samenwerking, apart of samen, plaatsvindt? Specifiek voorbeeld van samenwerking: hebben jullie het daar achteraf nog samen over?*

Welke obstakels ondervind je bij het proberen aan te gaan van samenwerking, indien deze er zijn? (*barriers*)
Doorvragen: In hoeverre speelt je religieuze identiteit(/zending) een rol bij eventuele obstakels?

Wat helpt je bij het proberen aan te gaan van samenwerking? (*facilitators)*

Evt. doorvragen "op het gebied van …": professionele rol en rolverdeling; praktische zaken, zoals faciliteiten, tijdsplanning, taakverdeling etc. (structurele kenmerken); persoonlijke eigenschappen; eerdere ervaringen (geschiedenis van samenwerking)

Je gaf aan dat je samenwerkt op … manier. Wat levert deze samenwerking volgens jou op? (*benefits*)

Welke uitdagingen ervaar je hierbij eventueel? (*challenges*)
Doorvragen: o.b.v. dezelfde punten: professionele rol; praktische zaken, zoals faciliteiten, tijdsplanning, taakverdeling etc. (structurele kenmerken); persoonlijke eigenschappen; eerdere ervaringen (geschiedenis van samenwerking)

Doorvragen: In hoeverre speelt je religieuze identiteit(/zending) een rol bij eventuele obstakels?

Hoe zie je samenwerking met andere zorgverleners in de instelling voor je? (Hoe zou jij willen dat het ging?)

Zie je verschillen in de ervaring van interdisciplinaire samenwerking tussen geestelijk verzorgers met andere levensbeschouwelijke identiteit?

APPENDIX B – CODING OVERVIEW

In this appendix, all codes attributed to quotes in the seven interview transcripts in Atlas ti are presented in the order of the analysis. The number in parentheses signifies the amount of times this code was attributed to a quote in one or more of the interviews.

Components of interdisciplinary collaboration

1. Interdependence (16)
2. Collaborative initiatives (22)
3. Flexibility (11)
4. Division of roles (14)
5. Shared goals (9)
6. Reflecting/evaluating together (9)

Other codes in this category:

7. Referrals (26)
8. Informal interactions (23)
9. Meetings (22)
10. Clinical lessons (6)
11. Disciplines spiritual caregivers collaborate with (6)
12. Providing ethical assistance/moral support (5)
13. Practical collaborations (3)
14. Interreligious collaboration (2)
15. Providing or receiving feedback (2)

Factors that aid or form barriers to collaboration

16. Reputation of spiritual care (30)
17. Structural/practical obstacles (16)
18. Spiritual care as a sanctuary (68)
    a. Visibility of the profession (38)
    b. Confidentiality (15)
    c. Access to patient files (5)
    d. Freedom of not tracking hours (2)
19. Professional differences/differences in professional language (17)
20. Personal characteristics (15)
21. Previous experience with collaboration (7)
22. Role of religious affiliation (/mission) in obstacles to collaboration (5)

Other codes

23. Domain of spiritual care (26)
24. Benefits to collaboration (22)
25. Additions (/contributions) to treatment by spiritual caregivers (13)
26. Position of spiritual care in psychiatric care (13)
27. Wishes in terms of interdisciplinary collaboration (9)