Teaching Spiritual Care in an Interfaith Context

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Abstract

This article discusses the possibilities of teaching spiritual care in an interfaith context, notably in the Netherlands. It first explores the background processes of deinstitutionalization and pluralization, resulting in a fragmented religious landscape. The change in nomenclature from pastoral care to spiritual care in part reflects these changes. The middle part of the article describes key features of spiritual care from different traditions. It starts with Christian views of spiritual care (historically the oldest in this context) and then discusses how secular/Humanist, Muslim, Buddhist, and Hindu perspectives not only add to the picture of spiritual care, but challenge its key notions. The final part discusses options of intrafaith and interfaith approaches of spiritual care and ends with a description of the curriculum the authors developed to accommodate students from a variety of denominational backgrounds in a rich interfaith learning environment.

Introduction: Changing Concepts of Spiritual Care in a (Post-)secular Society

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

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functionalist paradigm which is characterized by instrumental and economic rationality. This rationality shows up in evidence-based policies and efficiency structures. This challenges spiritual caregivers to define and present their contribution to the health care system in terms heretofore alien to the spiritual nature of the discipline. Moreover, the functionalist paradigm is characterized by a hermeneutical horizon that excludes religion and spirituality. Somewhat parallel processes can be observed in the other traditional institutional contexts of spiritual care (army, prison), especially when economic circumstances ask for austerity and result in budget cuts.

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

Two processes, then, seem particularly important when we sketch the changing face of religion in light of the developments in the field of spiritual care: deinstitutionalization and pluralization. Deinstitutionalization refers to the process in which the traditional religious (notably Christian) institutions lose control over the religious/spiritual domain in society (Heelas and Woodhead 2005; McGuire 2008; Streib 2007). They may have been the guardians, gatekeepers, and gracious providers of the spiritual repertoire (although even that image can easily be debunked as a backward projection), but in our days they are humble (or rather humbled) representatives of a wisdom of bygone days. Contemporary believers (if that is still the correct term) create their bricolage (HervieuLeger 2001), patchwork (Wuthnow 1988), or off-road-religion (Streib 1999). They may claim to belong to one, multiple or no religious tradition, and choose the degree and shape of their affiliation. It is less and less clear that they can or should be identified as groups based on a shared affiliation. Many of them adhere to religious or spiritual traditions that are not acknowledged socially and legally as formal traditions and that do not yield the recognition and privileges that older traditions have secured for themselves. All this implies that the religious institutions today have lost not only their authoritative position regarding religion but also their representative power (Ganzevoort 2011). Although traditional churches and similar institutions from the main worldview traditions (including Humanism) are still seen as the

formal counterparts of the government in matters of religion, like spiritual care their constituency becomes weaker.[2]

The second, related, process is pluralization. This refers to the increasing diversity of religious traditions and perspectives. The Netherlands has a long history of multidenominationalism, culminating in the pillarized society of the twentieth century. Protestants (subdivided in a wide array of denominations), Roman Catholics, and seculars (socialists and liberals) defined public debate and the structures of society. Education and health care institutions accommodated these three main perspectives. Through the centuries, immigrants from diverse religious traditions added to the plurality (for example the sixteenth- and seventeenth-century Jewish refugees from Spain and Portugal). The main shifts, however, date back to the past few decades. The Moluccan immigration in the fifties was mostly Protestant but also included some Muslims. In the sixties large groups of migrant workers were invited from Turkey and Morocco, eventually followed by their families. A significant number of Surinamese moved to the Netherlands when Surinam became independent in 1975, mostly Christians, Muslims, and Hindus. Likewise, one third of the (Christian) Dutch Antillean population now lives in the Netherlands. And finally, there is a wide variety of economic migrants and asylum seekers from especially Africa and the Middle East, bringing with them different shapes of Islam and (charismatic) Christianity (Stoffels and Jansen 2007). These two processes of deinstitutionalization and pluralization have resulted in a religious landscape that is increasingly difficult to define. There is a variety of denominations from all kinds of religious traditions, each with various degrees of affiliation and participation, crossovers and combinations, atheistic, agnostic, and spiritual secularism, and so on. This is not so much a problem for researchers who increasingly turn to concepts like 'lived religion' (Grözinger and Pfleiderer 2002; McGuire 2008) as it is for policy makers, for example regarding spiritual care. How can we accommodate this religious diversity if we cannot take as a starting point a limited number of clearly distinguished denominations?

How can we provide care to individuals from a different tradition than our own (Schipani and Bueckert 2009)? Or to those who adhere to more than one tradition? Or to those who have no formal affiliation but live their own idiosyncratic configuration of religious beliefs, experiences, and behaviors? These questions play out differently in the various contexts in which spiritual care is organized. The Dutch army and justice systems have a centralized organization that until now only accepts spiritual caregivers that are duly recognized (ordained) by the institutions of their tradition. Hospitals and other health care institutions are decentralized and usually appoint spiritual caregivers from the main traditions represented among their patients. Increasingly, however, they also appoint unaffiliated spiritual caregivers.

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[2] Traditions with a younger history in the Netherlands are still in the process of developing an institutional framework that is acknowledged by the government; their influence on believers, however, also shows signs of deinstitutionalization.

The developments in the domain of religion and spirituality correlate with the transition in nomenclature from pastoral care to spiritual care. Historically, pastoral care was provided within the faith community by ordained clergy. This was extended into the realm of health care, which in the Middle Ages was primarily ecclesial. When modern hospitals developed as secular institutions, pastoral care was usually provided by local parish clergy visiting their own parishioners. The last four decades have shown a gradual integration of attention to existential/religious issues in the institutional health care system, which led to the usage of the broader name of spiritual care. It also led to a better cooperation between spiritual caregivers and other health care professionals and a professionalization of the discipline of spiritual care. More specifically, in several contexts spiritual caregivers participate in multidisciplinary teams alongside medical and psychosocial professionals. Clinical Pastoral Education and continuous education became central to the discipline. All this led to a long and profound debate about the relation between professional and confessional dimensions of spiritual care, including the question whether ordination in a recognized worldview tradition should be required for all spiritual caregivers. At stake is the core question how intrafaith and interfaith perspectives to spiritual care function in a contemporary pluralized society like the Netherlands.

This article reflects on these questions from the specific context of an interreligious theological faculty and spiritual care teaching program with students and lecturers from a variety of traditions (most explicitly Christian, secular, Islamic, Buddhist, and Hindu). Without expecting them to become religiously neutral, our integrated curriculum for spiritual care aims to introduce students to different concepts of interfaith spiritual care, because their future workplace in most cases will be interreligious. We start by describing some central elements in the various religious perspectives on spiritual care as this will allow us to see the overlapping consensus as well as the differences. In the closing parts of this article we will discuss interfaith and intrafaith approaches and present the curriculum we have developed together with its underlying principles.

Spiritual Care in Christian Perspective

The term commonly used in the Christian tradition, and typical for the Christian perspective, is pastoral work. This word evokes the nomadic life of trekking with livestock to find pastures where the animals can feed. The image of the shepherd originates in the Hebrew Bible, where it serves to illustrate the role of leadership among the Jewish people. In the book of Ezekiel (36:14), for example, it is used to accuse the kings of Israel ('Woe be to the shepherds of Israel that do feed themselves! Should not the shepherds feed the flocks?') and to reclaim leadership for God ('I will require my flock at their hand...I will both search my sheep, and seek them out...and will deliver them out of all places where they have been scattered in the cloudy and dark day...and will bring

them to their own land, and feed them upon the mountains of Israel by the rivers, and in all the inhabited places of the country')[3] In the book of Zechariah (13:7), the image of the shepherd is also used to accuse, but this time it involves the entire people: 'Awake, O sword, against my shepherd… Smite the shepherd, and the sheep shall be scattered: and I will turn my hand upon the little ones'. The words in the prophesy of Zechariah are quoted by Jesus (in Mt. 26:31 and Mk 14:27) on his way to Gethsemane, where he will be betrayed to the Jewish establishment who will demand his execution. To this quote Jesus adds, however, that he will go before the disciples to Galilee after he is raised up. Finally, Jesus is quoted as saying of himself: 'I am the good shepherd, and know my sheep, and am known of mine' (Jn 10:14). In biblical language, 'knowing' is not merely a matter of cognition but includes personal experience that equals love. Thus the primary biblical foundation of pastoral work is the metaphor of God as the shepherd looking after his people—followed by supplementary metaphors like the servant, the wisdom teacher, and the comforter. The metaphor of the shepherd reflects the dialogical structure of God's revelation by criticizing Israel's leadership and reclaiming leadership for God.

The Bible does not only provide the foundation of pastoral work, it is also a source of pastoral models. However, the Bible does not provide a specific model for pastoral work. Nauer (2007) argues that pastoral work can and should take many different forms, depending on the actual needs, the structural conditions, the ecclesial directives, and the personal charisma of the pastoral worker. She mentions such forms as celebrating life, searching for traces of God's presence, comforting, accompanying, healing, defending in public, and materially supporting. Even if direct links cannot always be made between biblical models and contemporary practice, fundamental themes in the old text inspire pastoral interventions (Ballard and Holmes 2006). Thus the history of Christianity shows a variety of pastoral approaches as the classic study by Clebsch and Jaekle (1964) shows. Ganzevoort and Visser (2007) identify kerygmatic/ sacramental, therapeutic, and companionship models. Nauer (2007) distinguishes between spiritual-mystagogical, pastoral-psychological, and social-political or diaconal models. What these approaches have in common is the dialogical structure of God's revelation in the Bible, that is, pastoral work is done in the name of God who reveals himself in human experience. Both dimensions need to be taken into account in pastoral work, which implies a theological and a psychological moment (Van Deusen Hunsinger 1995). Whatever form it takes, pastoral work is committed to enable 'life abundant' (Bass and Dykstra 2008), in the midst of incompleteness, discontinuity, imperfection, uncertainty, brokenness, senselessness, loneliness, sickness, need, poverty, suffering, and mortality. In whatever way the functions of pastoral work are framed, they reflect that it is a concern of the community how its members stand up in difficult situations and give meaning to their lives.

Traditionally pastoral work involves practices like preaching, catechesis, diaconia, liturgy, evangelization, and governance of the community. Most of

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[3]   Bible quotes are taken from the King James Version.

these practices center on the Christian community. Diaconia and evangelization, however, extend beyond the community proper towards society at large. Both these practices deserve special attention in connection with spiritual care, precisely because spiritual care takes place outside the faith community—in institutions of health care, prisons, and the armed forces.

Diaconia involves, amongst others, visiting the sick and the imprisoned, comforting the dying, and promoting peace. In these cases the community reaches out to its members as well as others who are in need. Evangelization involves announcing the Gospel to society. In the history of Christianity, missionary work was almost always accompanied by diaconal activities, particularly health care. Thus, diaconia has often served to prepare the way for evangelization. This way of proceeding was seen to compromise diaconia by reducing it to a mere instrument for evangelization, which appeared to be the major purpose (Crijns 2004: 49). Understandably, when attending to the needs of the sick, the imprisoned, or the military is a guise for evangelization, pastoral workers are met with suspicion. On the other hand, serving the needs of people can never be completely separated from the biblical message that prompts Christians to engage in diaconia in the first place. This entanglement with evangelization is only one of the questions that Christian spiritual care shares with diaconia and that requires continuous reflection. Another structural question regards the efficiency of spiritual care and the relation between individual and society (Crijns 2004: 49). It is broadly accepted that pastoral workers can make a contribution in the various institutions in society where they are present by keeping these questions on the agenda. Less clear is how the efficacy and efficiency of pastoral work can be assessed in an institutional context that is dominated by instrumental and economic rationality. Interventions are evaluated in terms of cost and effectiveness, and professionalism is understood as problem-guided and solution-oriented evidence-based methodic working. In contrast, professionals in spiritual care, although they may work in a methodic way, are typically not problem-guided nor do they aim at solutions. Their mission is to face existential questions with the people they serve when solutions are not available. In this sense, spiritual care is seldom efficient. However, far from being a liability, inefficiency may be considered a strength. As Pauchant (1996: 15) observes, 'The crisis brings forth change because it leaves us empty-handed. It forces us, if we allow it, to forget our illusions for a moment and to communicate with the hard and real issues in life.' This quote demonstrates that 'reality' is not only found in measurable data, but also in inner experience. Holding out with people in their need may not bring any measurable result, but its effect is of immense value for those concerned. From a Christian perspective, life and leadership are not only concerned with achievement. As the metaphor of the shepherd shows, it is also concerned with conversion, that is, retracting from 'dead-end' ways to transformation and renewal. It is often testified that this can contribute to healing, but not in such a way that it could count as evidence-based.

Spiritual Care in Secular Perspective

Whereas the Christian perspective to spiritual care evolved from the traditional practices of care within and by churches, secular Humanist spiritual care has a much shorter history (unless we would trace the story back to the caring advice offered by Greek philosophers). The emergence of a non-religious constituency in the nineteenth century resulted in a proactive Humanist movement in the Netherlands after WWII. The then established Humanistisch Verbond (Humanist Association) advocated the development of individual spiritual care in hospitals and other institutions. Rather than defining this as a practice of spiritual guidance, which would be at odds with fundamental Humanist principles such as individual autonomy and rejection of authoritative spiritual traditions, spiritual care was understood as a form of counseling. The central notion was respect for the 'reality that has taken shape in another human, remembering, especially in this situation, the words: take off thy shoes from thy feet, for the place upon which thou standest is holy ground' (van Praag 1948). The use of these words from Exodus 3 illustrates that, at least for some, spiritual references were compatible with a secular Humanist perspective, although they were interpreted in a metaphorical and human-centered way. Interestingly, Anderson (2003) offers a reverse (Christian) interpretation of all care-giving as essentially spiritual and even sacramental, illustrating the fluid boundaries between religious and secular care.

For some decades, Humanist spiritual care was primarily offered by volunteers; the first full-time Humanist spiritual caregiver in the army was appointed in 1964 and in hospitals in 1972. An interesting feature of Humanist spiritual care in the Netherlands is that it is organized analogous to the mainstream religious traditions. Caregivers are expected to receive a mandate from the Humanist Association, comparable to the mandate of ordained clergy. They are expected to complete a three-year MA, equaling the length of study for ordained clergy. And they comply with a code of ethics and a vow of confidentiality. In structure and role, Humanist spiritual care mimics Christian spiritual care, mainly because the easiest way to acquire recognition was to present it as just another denomination. There is fruitful collaboration rather than rivalry between Protestant, Roman Catholic, and Humanist spiritual caregivers in most institutions.[4]

Another shape of secular spiritual care is found in the movement of unaffiliated and/or generic spiritual care. A number of spiritual caregivers employed by hospitals do not self-identify as belonging to one particular worldview tradition. Others have a personal commitment to a tradition but do not incorporate this into their professional identity. They claim that one-sided affiliation, especially when expressed in the form of ordination, is a barrier in

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[4] There is more competition in Belgium between 'moral counselors'—as Humanist caregivers are called there—and Roman Catholic chaplains, probably because Belgium is more monolithically Roman Catholic.

building trusting relationships with many patients, especially those not belonging to a specific tradition. Instead of presenting themselves as representatives of a specific tradition, they define themselves as professionals offering care and support in existential questions, thus championing a 'depillarization' of spiritual care. If the patient makes reference to a religious or worldview tradition, the care- giver follows that reference rather than sharing his or her own convictions (H. Schouten 2006). Their perspective is often disputed by those who claim that spiritual care is by necessity tradition-specific and not generic. This dispute is still lively although organizational measures have been taken to accommodate the varying perspectives. The most important one is the impending merger between the two most important Dutch associations for spiritual caregivers with—until recently—opposing views on need for ordination.

Spiritual Care in Islamic Perspective

The arrival of large contingents of migrant workers from Islamic countries since the sixties has brought about a broadening of the profession of spiritual care. The legitimacy of spiritual care lies in the sacred sources of a religion (Ganzevoort and Visser 2007). It had its origin in pastoral care by religious communities on the basis of their mission to care for the needy, on the basis of evangelization, or a combination of the two. The main texts in the Islamic tradition which give the fundaments of spiritual care are: 'And feed with food the needy wretch, the orphan and the prisoner, for love of Him' (Qur'an: 76:8) and (from the prophets): 'The Prophet Muhammad said: "God will question a person on the Day of Resurrection (saying): 'O son of Adam, I was sick but you did not visit Me". The person will say: "O my Lord, how could I visit Thee when Thou art the Lord of the worlds?" Thereupon (God) will say: "Didn't you know that a servant of Mine was sick but you did not visit him, and were you not aware that if you had visited him, you would have found Me by him?"'[5] Traditionally, spiritual care is an activity of clergy. On behalf of the community the imam[6] pays attention to the prisoners, sick people, and those in the armed forces.

One main characteristic of spiritual care is the focus of the caregiver on personal attention and orientation to individuality in a context of confidence (Heitink 1982). Imams offer this spiritual care in various ways. They support terminally ill people with recitation of the holy Qur'an and prayer (du'a). They

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[5] Muslim:1172, mentioned in http://www.answeringprophetofdoom.net/Islamic_Quotes.php.

[6] Professional female Muslim chaplaincy is (as far as we have been able to determine) a new phenomenon which has risen in Western contexts. Seven of fifty Muslim spiritual caregivers in the Dutch penitentiary institutions are female. There are also a few female Muslims caregivers in Dutch health institutions. In The Netherlands female and male Muslim spiritual caregivers are considered equal in their professional skills, though not in leading prayers for male clients, which can only be done by male spiritual caregivers. For a description of the British situation see Gilliat-Ray, Ali, and Pattison 2013.

perform ablution of the deceased body (ghusl). They direct the funeral and support the bereaved. They visit people to bless their marriage. They pray for a newborn child. They mediate (sulh) in a conflict between father and son or between husband and wife. They discuss confidential matters with people and give them advice about moral dilemmas.

As these examples show, spiritual care is not unknown in the Islamic tradition. In most Islamic countries, however, it is practiced as a sidebranch of imamate. That is to say it is not yet developed as a specialized branch with its own academic training, professional roles, and professional standards. As a specific profession, spiritual care in Islamic countries is usually not practiced in the three main areas of the public domain where it functions in Western countries: prisons, health institutions, and the military (Ajouaou 2010: 21). If spiritual care is offered, like in Egypt and Saudi Arabia, one speaks in terms of 'religious guidance', 'religious support', or 'missionary work'. These terms indicate a classical application of spiritual care in which one focuses on religious transmission, religious education, and, generally spoken, dawa in the sense of evangelization (Ajouaou and Bernts, forthcoming).

In Western democracies such as the Netherlands, Islamic spiritual care is finding ways to develop as a profession. Freedom to express one's religion in the public sphere and the equality between traditions created the space for the birth of Islamic spiritual care and enabled it to learn from the rich practices of the established Protestant, Roman Catholic, and Humanist spiritual care perspectives. Methods, models, training programs, and organizational structures were adopted and—where needed—adapted.

The main challenge for Islamic spiritual care in the Western context is to bridge the gap between traditional Islamic understandings and expectations on the one hand and Western institutional understandings and expectations on the other. Muslim spiritual caregivers need to explore the Islamic theological repertoire of spiritual care, rethinking and reinterpreting many religious concepts and doctrines to make them fit the lives of Muslims living in a multi-faith, secularized, and modern context. Muslim spiritual caregivers also need to redefine the tasks and purposes of spiritual care, which means distancing themselves from the classical shapes of a dominating dawa with its focus on religious instructions, liturgical functions, paternalistic attitudes, and the monopoly of the imam, one-way communication, and superficial pastoral relationships. In professional spiritual care, the focus shifts to reciprocal communication, equality and partnership in pastoral relations, depth in pastoral probing of questions and stories, and attention to personal problems and emotions of the care receiver. This is, however, not a matter of simply copying Christian or secular models. Recent research shows that the central background factor of secularization is less poignant for the Muslim constituency (Maliepaard and Gijsberts 2012) or at least assumes different forms (Ajouaou 2010). Religious leadership, religious knowledge, and religious rituals remain of central importance to the lives of many Muslims and to the Islamic spiritual care relationship. The development of modern Islamic spiritual care will serve not only Muslims living in Western countries; in our

globalized world the exchange of ideas and practices begins to change the perspective of spiritual care in Islamic countries as well.

Spiritual Care in Buddhist Perspective

Buddhist spiritual caregivers—or Buddhist chaplains as they are called in the USA—represent a relatively new phenomenon, connected with the rising popularity of Buddhism and Buddhist meditation practice in the West. Not only does the rise of the Buddhist chaplain add a new member to the family of spiritual care workers, it also has the potential to redefine the field as such. Within Buddhist circles, especially in North America, the notion of 'spiritual care' is increasingly connected with, or even reframed as, contemplative care. As Giles and Miller (2012: xvii) put it in their recent collection of essays *The Arts of Contemplative Care*:

> We understand spiritual care to refer to a wide swath of practitioners who provide emotional and spiritual support in a variety of contexts, both professional and informal. Contemplative care, on the other hand, refers to a kind of care that is informed by rigorous training in a meditative or contemplative tradition... [t]he art of providing spiritual, emotional, and pastoral support, in a way that is informed by a personal, consistent contemplative or meditation practice.

The focus of such Buddhist contemplative care can be summarized with the help of the Buddhist tradition: it is to help others to come to terms with the three marks of existence, i.e. dukkha (often translated as 'suffering', but more adequately rendered as the fundamentally unsatisfactory nature of existence), anicca (impermanence), and anatta (the illusory nature of any sense of self). With regard to the suffering of those in need, a Buddhist chaplain serves not so much as an intermediary or authority, but rather as a steady companion who has investigated suffering through his or her own life experiences and Buddhist practice. With regard to impermanence, a Buddhist chaplain can help others realize that there can be beauty and safety in change, by encouraging an open attitude of letting go and nonattachment. With regard to anatta, all interventions of a Buddhist chaplain can be seen as an aid to the realization that 'nothing whatsoever should be clung to as "me" or "mine"'. This practice of the Buddhist chaplain is fueled by the fundamental Buddhist virtue of boundless compassion, as epitomized in the Mahayana Buddhist bodhisattva vow: 'sentient beings are numberless; I vow to save them all'.[7] Related to these features of Buddhist chaplaincy is its particular contribution to the development of modern palliative and hospice care (see e.g., Watts and Tomatsu 2012).

Giles and Miller (2012: xviii-xix) take care to distinguish the difference between Buddhist chaplaincy workers (who provide spiritual, pastoral, and emotional

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[7] Buddhist notions of compassion can differ, however, from Western philosophical views on compassion. See van der Braak 2012.

care to patients, their families, and staff in the domains such as health care, prison, and army) and Buddhist ministers, or dharma teachers (who tend to the religious needs of a particular Buddhist community or sangha). Although both chaplaincy and ministry can be seen as practices of presence (listening, being attentive, and being sensitive to the spiritual needs of others), one can only become a Buddhist dharma teacher by receiving dharma transmission from a Buddhist teacher within a recognized lineage. However, Buddhist chaplains that work in hospitals or prisons may also be asked to set up meditation groups for patients or inmates. Does that make them meditation teachers?

Moreover, seeing Buddhist spiritual care as contemplative care implies that a Buddhist chaplain is also a practitioner of meditation, and preferably connected to a contemplative tradition or lineage. This provides an interesting conundrum for the academic training of Buddhist chaplains: What to do with candidates that show academic excellence, but who are not Buddhist practitioners? Should the academic curriculum also include meditation training? How could such meditation training possibly be graded? And should the academic staff also be connected to a Buddhist contemplative tradition or lineage? Questions and tensions like these are probably inevitable in this evolving field.[8] The increasing societal acceptance of the 'vocational Buddhist' calls for new identity markers and boundary policies. And the training of Buddhist chaplains, that has so far primarily taken place in the Buddhist sangha's themselves,[9] will also increasingly be taken up by academic institutions. The training of academic Buddhist bodhisattvas will, in all likelihood, not only change the field of spiritual care, but also have an impact on the practice and organization of Buddhism in the West.

Spiritual Care in Hindu Perspective

The last branch we discuss is Hindu spiritual care. Like the other traditions, the Hindu perspective to spiritual care had to be integrated into the Dutch institutional contexts of hospitals, prisons, and the army, where the professional practices of spiritual care were deeply rooted in Christian thinking and in Christian role models. Even if a Hindu practice of spiritual care will function similarly within the walls of these public institutions, traditional Hindu spiritual care is framed very differently from Christian pastoral care.

First of all, most Hindus are very much like most Christians who wish a good daily life for themselves and others including security, material prosperity, physical and mental health, offspring, and divine blessing. Beyond that, however, Hindu notions of 'spirituality' are quite different. 'From a Hindu point of view, "spirituality" is everything that broadens the mind beyond the realm of

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[8] The thematic issue of Buddhist-Christian Studies 33 (2013) on 'contemplative pedagogies' explores the important issue of contemplative training within an academic context.
[9] E.g., the International Spiritual Care Program of the Rigpa community: www.spcare.org (accessed 8 October 2013).

this-worldly affairs, everything leading to an expansion of self-consciousness' (Minnema 2013: 109). Daily emotions, feelings, and thoughts are taken seriously but ultimately, they represent states of mind that have to be purified and transformed into a pure, focused, and peaceful state of mind, a radically higher state of consciousness that is aware of its transcendent origin and nature. Likewise, the acquisition of academic knowledge and insights in the realm of Hindu theology, philosophy, and religious studies is enriching and helpful but ultimately, it should only serve the radically higher goal of attaining liberation from the chains of ignorance on a deeper level of reality, of attaining spiritual knowledge and Self-Realization. This Self-Awareness can also take the form of a devotional focus (bhakti) on personal surrender to one god embodying that Ultimate Reality, such as Krishna. What this theistic form of worship has in common with the monistic focus on the identification of one's deepest Self (ātman) with Absolute Reality (Brahman) is a process of de-individualization. Ultimately, the microcosmic soul or Self dissolves into the macrocosmic realm of Krishna's love or Pure Consciousness respectively, leaving the individual traits of one's person behind in the mortal realm of time, change, and reincarnation. Secondly, whereas Christian pastoral care draws from religious role models and professions (pastor, priest, and minister) that tend to combine spiritual counseling with theological teaching, priestly ritual performance, and diaconal care of the poor and needy, this combination is not known in traditional Hinduism. Ritual performance is the specialism of brahmins and pundits. Brahminic priests may engage in teaching but their sacred knowledge serves their ritual performance in public temples and in the private homes of client families to whom they offer their service on special occasions such as weddings, initiations, and funerals (the jajmāni system). Theological and philosophical teaching is the rather secular responsibility of professors (acharya and shastri). Spiritual counseling is traditionally a personal affair between individual disciples and their ascetic masters (guru, swami, baba, sant, and yogi) whose social position and mental focus are disengaged from society. Spiritual leadership, however, is community focused and similar to that of a Christian pastor who is expected to be a shepherd to his sheep. Institutional care for the socio-economically poor and needy within and outside of one's own community is too Christian a concept to have its immediate parallel in traditional Hinduism where mutual support and volunteer service (sevā) are natural duties of a community to its own members only, without being institutionalized in a specific role and remaining interpersonal rather than becoming project focused. As younger generations of Hindus are more individualistic, their concerns and questions are similar to those of modern young people in many parts of the world.

In the Dutch context of publicly recruited spiritual care professionals, a context in which pastoral care-giving and spiritual counseling are combined with ritual tasks, theological knowledge, and local leadership, it is problematic even to find a proper Hindu word for the new kind of role envisaged. The Dutch pandits have their cultural roots primarily in Surinam, not in India. This historical background has had a considerable impact on their role perception because in Surinam, their authority was more based on their Brahmin caste origin than on

the Indian religious infrastructure they had left behind (Bakker 2005; Van der Burg 2005; J.P. Schouten 2005). In the Hindu diaspora context of Surinam and the Netherlands, the distinctions between pandit, guru, shastri, and pujari gradually blurred and the Dutch use of the term pandit now covers several of these functions. Whether the currently already practicing pandits feel the urge to extend their role and include other functions remains to be seen. It seems more likely that a new professional role of spiritual caregiver will develop in addition to that of the traditional pandit.

Intra-faith and Interfaith Approaches

This overview of perspectives to spiritual care in the multifaith context of the Netherlands immediately brings to light the complex and hybrid identity of spiritual care. As a caring profession it is governed by the dominant cultural and institutional expectations, including the appropriation of professional standards, evidence-based care, and moral and spiritual neutrality. As a religious or worldview praxis it entails all kinds of meanings and practices that do not fall easily within those expectations. Spiritual caregivers constantly negotiate these two quintessential yet paradoxically related dimensions of their profession.

The variety of worldview traditions that are represented in contemporary spiritual care makes it even more complex. As described in this article, the various religions are not exchangeable or comparable, which also means that it is difficult to identify a common denominator for all denominational strands of spiritual care. There is a serious risk in taking the Christian perspective as the starting point to interpret other traditions (Vroom 2006). The Roman Catholic priest, Protestant minister, Humanist counselor, Imam, Buddhist teacher, and Pandit are not simply subspecies of the overall genus 'clergy'. Even when they all perform important aspects of their tradition, the specific role and spiritual reference differs. Certain aspects of those roles fit well in a paradigm of professional care, but other aspects are alien to it.

As the discipline of spiritual care increasingly follows the paradigm of professional care with its professional standards, codes of conduct, and evidence based caring methods, caregivers from various traditions are expected to work together.activities, then, focus mostly on pastoral conversation, individual counseling, and moral support. They may include some tradition-specific rituals but are usually limited to more generally accessible inclusive rituals, like burning candles or saying prayers. Swain (2011), for example, describes how spiritual caregivers from a variety of traditions shared the burden of providing spiritual care at Ground Zero, each contributing to a ministry of presence and prayers for the deceased. Clearly professional care in this example is not devoid of a specific religious or worldview identity, but this identity is not foregrounded. Schipani and Bueckert (2009) present the dilemmas for caregivers in providing interfaith

care, balancing the personal religious identity of the spiritual caregiver with the need to minister to people from other faiths.

In other cases, it seems unfeasible and undesirable to aspire to such an interfaith practice of spiritual care. Muslim caregivers perform ablutions of the dead bodies of the deceased and offer dietary advice during Ramadan. Buddhist caregivers teach meditation and mindfulness. Hindu caregivers offer purification rituals. Protestant caregivers read the bible to people. Roman Catholic caregivers take confession and may provide the reserved sacraments to people (dependent on their ecclesial position). It is hard to see how any of these tradition-specific elements could be offered with integrity by a caregiver from another tradition. That is to say: to the degree that the discipline of spiritual care is determined by religious and worldview traditions, it will inevitably become a more intrafaith praxis.

Many factors contribute to this balancing of interfaith and intrafaith practices. The specific context may allow for one or the other. If, for example, only one spiritual caregiver is available to a whole military unit, the care provided will be more interfaith. The personal convictions and experiences of the caregivers will also tend towards more interfaith or intrafaith practices. And finally the various traditions take a different stance. Generally speaking liberal currents will encourage interfaith spiritual care whereas more orthodox currents will advocate intrafaith spiritual care. There is, however, also a lack of synchronicity. Traditions with a shorter history in Western society may still be building their identity and specific contributions and therefore show less willingness to engage in interfaith practices.

Building a Curriculum

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

The Center for Islamic Theology was established in 2005. Since then several dozens of Islamic chaplains appointed by correctional institutions, the armed forces, and health care institutions received an academic degree. The training program consists of a Bachelor (or pre-Master) in Islamic Studies and a Masters in Islamic spiritual care. Since 2012 pre-masters Buddhist and Hindu studies

are offered (gleaning insights from the Oxford Centre for Hindu Studies and others), and in 2013 the newly developed integrative Masters programme in spiritual care was launched.

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

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

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

Conclusion

The developments within the discipline of spiritual care in modern secular societies present an intriguing case for studying interreligious relations. The discipline is in a sense secularized but at least pluralized. Rather than taking one shape of spiritual care—usually the Christian one—as the yardstick to measure all others, each tradition's perspective on spiritual care challenges the

taken-for-granted assumptions of the discipline. It seems unlikely that this will lead to one common denominator for the whole discipline, but our explorations show that it is possible to map the various configurations of intrafaith and interfaith spiritual care. Moreover, it is possible to build a curriculum that accounts for this divergent and volatile field.

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