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Hilde Frøkedal

Existential Groups Led by Healthcare Chaplains

within Norwegian Specialist Mental Health Services:
Patient and Interdisciplinary Perspectives

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Hilde Frøkedal

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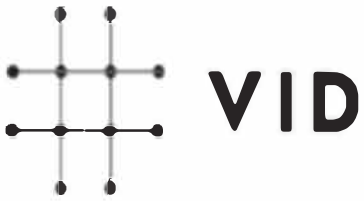

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In loving memory of my grandmother
Borghild Otelie Ulveraker Frøkedal (1912–2002)

Broken Narratives

Just as fragments of poetry can be written with no overarching narrative, or only the briefest strand hinted at, so can we articulate our suffering without appeal to elaborate stories of origins, motives, obstacles, and change. Instead, we may create metaphors that lack the larger temporal structure of narrative but are no less persistent and powerful. Such fragments of poetic thought may be the building blocks of narrative: moments of evocative and potential meaning that serve as turning points, narrative opportunities, irreducible feelings and intuitions that drive the story onward. (Laurence J. Kirmayer 2000, p. 155)

Meaning in Life

Meaning is imposed on the world in small bits and chunks, although gradually these are built up into large systems. Cultures offers broad systems of beliefs and values that tell people how to think. These systems (ideologies) offer broad frameworks that help people make sense of events and that provide the contexts within which lives find meaning. (Roy F. Baumeister (1991, p. 28)

Leading groups

When you lead groups [with patients suffering from severe mental illness], you must provide even more direct support. Examine the behaviour of the […] patients and find in it some positive aspect. Support the mute patient for staying the whole session; compliment the patient who leaves early for having stayed twenty minutes; support the member who arrives late for having shown up; support in active members for having paid attention throughout the meeting. If members try to give advice, even inappropriate advice, reward them for their intention to help. If statements are unintelligible or bizarre, nonetheless label them as attempt to communicate. (Yalom & Leszcz, 2005, p. 491)

What can you as a therapist do in the face of the inevitable? I think the answer lies in the verb to be. You do by being, by being there with the client. Presence is the hidden agent of help in all forms of therapy. Clients looking back on their therapy rarely remember a single interpretation you made, but they always remember your presence, that you were with them. It is asking a great deal of the therapist to join the group, yet it would be hypocrisy not to join. The group does not consist of you (the therapist), and they (the dying); it is we who are dying, we who are banding together in the face of our common condition. (Yalom & Leszcz, 2005, p. 106)

Two snares

If, for whatever reasons, counselors are tuned mainly to the wavelength of psychosocial aspects of human problems, they tend not to hear the profound spiritual longings often present .... On the other hand, lopsided attention to the religious dimension may diminish awareness of complex psycho-social factors that are always interwoven with spiritual issues. (Clinebell, 1984, p. 105).

He who has a why to live can bear with almost any how.
(Nietzsche, 1968)

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Acknowledgement

This thesis is a result of a long personal and academic journey, but I have not travelled alone. So many people have travelled together with me and supported me all along. First of all, I wish to thank Akershus University Hospital and Senter for kliniske fellesfunksjoner and the Director of the chaplaincy section, Hilde Halsteinli Unsvåg for giving me the opportunity to be a research fellow and making it possible for me to finish the research project. I could not have done it without you! Further I am grateful to VID Specialized University and Centre of Diaconia and Professional Practice (SDP), for acceptance of my project on the doctoral programme! I would like to thank my supervisors, Professor Hans Stifoss-Hanssen and Assistant Professor Torgeir Sørensen at VID for believing in me and the project, your supervision and being so generous with your time! It has been a bumpy road, but we made it through! I would also like to thank my two other supervisors, Professor Torleif Ruud, former Head of Research at Division of Mental Health Services, Akershus University Hospital and Professor Valerie DeMarinis, Uppsala University, Sweden for valuable guidance, insightful feedback and careful reading of the manuscripts during the Phd process. My thanks also go to Professor Marianne T. Gonzalez for time and effort put in the first article, Anja Visser for valuable help with the statistics in an early phase and Milada Cvancarova Småstuen for very important statistical help in the final phase of the whole project.

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Abstract

Background

In Norway, healthcare chaplains have a long history of leading existential groups (EGs) for patients in the Norwegian mental healthcare services. In EG practice, patients are invited to share stories about their life, reflect upon existential issues, talk about meaning in life or crisis of meaning, hope or hopelessness and share thoughts about faith. To the author's knowledge, no previous study has explored this particular group practice in the field of chaplaincy, and only a few studies have explored existential meaning making in group practice within the research field of existential health. The role of existential meaning making and the experience of meaningfulness within treatment settings have gained interest in recent years. The existential dimension of health is believed to be of vital importance for humans' well-being and mental health. A lack of meaning in life can be devastating and even lead to existential suffering and mental illness.

Aim

The overall aim of the present study was to explore the characteristics of the EG practice led by healthcare chaplains within Norwegian specialist mental health services in light of group psychotherapy; groups and clinical traditions integrating existential, religious and spiritual issues; the healthcare chaplain's role and professional practice; mental health professionals' viewpoints; and patients' existential meaning making.

Design

A nationwide cross-sectional design was chosen as a research strategy and both qualitative and quantitative methodologies were used in three sub-studies. A web-based survey was used in sub-studies 1 and 2, whereas printed questionnaires were used in sub-study 3 because information was assumed to be sensitive.

Materials and method

Data were gathered from Norwegian specialist mental healthcare services. A total of 101 mental healthcare professionals, including 21 healthcare chaplains, participated in sub-studies 1 and 2, while 157 patients within 44 EGs across Norway participated in sub-study 3. Data were collected via a web-based questionnaire (Questback) containing various scales developed for the purpose of exploring the EGs (sub-study 1) and the attitudes, practices, and perceptions of value among mental healthcare professionals when addressing the existential dimension (sub-study 2). Additional data were established from open-ended responses (sub-studies 1 and 2) to which the content analysis proposed by Graneheim and Lundman (2004)

was applied as an analytical strategy. Patients' participation and a list of 24 EG discussion topics grouped into four dimensions by an expert panel were examined (sub-study 3). Data were gathered using standardised, printed questionnaires examining psychological distress, crisis of meaning and meaningfulness. Univariate, and multivariate statistical data analyses were performed using the Statistical Package for the Social Sciences (SPSS) software.

Results

Sub-study 1 revealed EGs led by healthcare chaplains to be a well-established and integrated eclectic group practice within the Norwegian specialist mental health services. Five different EG approaches provided room for patients' existential meaning making during times of crisis, of which the psychodynamic approach was the most prominent. The narrative approach was the most distinctive. Sub-study 2 found that mental healthcare professionals' attitudes towards addressing the existential dimension in treatment settings were open and positive. Nevertheless, a small gap between positive attitudes and the actual practice of addressing the existential dimension was identified. Sub-study 3 found a significant inverse association between lengthier EG participation and lower levels of psychological distress. The-discussion topic of religious and spiritual issues was shown to have a significant positive association with the experience of meaningfulness.

Conclusion

These findings indicate that EG practice led by healthcare chaplains is a well-established and eclectic group practice integrated in the Norwegian specialist mental health services. Mental health professionals reported positive attitudes towards addressing the existential dimension in treatment settings. Nevertheless, a small gap between those attitudes and the actual practice of addressing that dimension was discovered. A significant association was found between lengthier EG participation and lower levels of psychological distress. EG discussion topic of religious and spiritual issues were found to be to be significantly associated with the experience of meaningfulness.

The findings may point clinicians and researchers towards the importance of creating spaces for existential meaning making, including space for discussion of spiritual and religious topics, and research in the same field.

Sammendrag

Bakgrunn

I Norge har sykehusprester lang erfaring med å tilby eksistensielle grupper, og har i mange år ledet slike grupper for pasienter i spesialisthelsetjenesten innenfor psykisk helsevern. Pasienter i de eksistensielle gruppene er invitert til å dele livsfortellinger, reflektere over eksistensielle temaer, snakke om både det som gir mening i livet og meningskriser, håp eller håpløshet og tanker rundt tro. Vi er ikke kjent med at det tidligere er gjort noen studie av denne type gruppepraksis innenfor sykehusprestens sitt arbeidsfelt. Noen få studier innenfor feltet eksistensiell helse, har imidlertid tatt for seg eksistensiell meningsdannelse i grupper. I de senere år har det derimot blitt mer interesse for hvilken rolle eksistensiell meningsdannelse og opplevelse av mening har innenfor behandlingen. Det er grunn til å tro at den eksistensielle dimensjonen har stor betydning for menneskets livskvalitet og psykiske helse. Tap av mening kan være nedbrytende, og kan føre til eksistensiell lidelse og psykisk sykdom

Mål

Det overordnede målet med denne avhandlingen var å utforske hva som kjennetegner den eksistensielle gruppe praksisen ledet av sykehusprester i norsk spesialisthelsetjeneste, sett i lys av gruppe psykoterapi, grupper og kliniske tradisjoner som integrerer eksistensielle, åndelige og religiøse temaer, sykehusprestens rolle og profesjonelle praksis, tverrfaglig helsepersonells synspunkter og pasienters meningsskapende prosesser innenfor EGs.

Design

Et nasjonalt tverrsnitt studiedesign ble valgt som forskningsstrategi. Studien brukte både kvalitativ og kvantitativ metode innenfor rammen av de tre delstudier. En nettbasert spørreundersøkelse ble brukt i delstudiene 1 og 2, og en skriftlig spørreundersøkelse ble brukt i delstudiet 3 på grunn av en antagelse om sensitivt materiale.

Materiale og metoder

Det ble samlet inn data fra norsk spesialisthelsetjeneste innenfor psykisk helsevern. Totalt deltok det 101 personer som jobbet som tverrfaglig helsepersonell i psykisk helsevern. Dette inkludert 21 sykehusprester som deltok i delstudiet 1 og 2, og 157 pasienter fra 44 eksistensielle grupper fra hele Norge deltok i delstudiet 3. Data ble samlet inn gjennom en nettbasert spørreundersøkelse (Questback) som inneholdt forskjellige vurderingsskalaer utarbeidet for å utforske de eksistensielle gruppene i delstudiet 1, og i delstudiet 2 holdninger, praksis og opplevde verdier hos tverrfaglig helsepersonell knyttet til å adressere den eksistensielle dimensjon (delstudiet 2). Det ble i tillegg samlet inn data fra åpne spørsmål i

spørreskjemaene (delstudiene 1 og 2), hvor innholdsanalyse utarbeidet av Graneheim og Lundman (2004) ble brukt som en analytisk strategi. Pasienters deltagelse og en liste på 24 diskusjonstemaer, gruppert inn i 4 dimensjoner av et ekspertpanel ble undersøkt (delstudiet 3). Datainnsamlingen i delstudiet 3 utgjorde standardiserte spørreskjema i papirformat som utforsket gruppedeltagerne sin psykiske og eksistensielle helse. Univariate og multivariate dataanalyser ble gjennomført ved å bruke dataprogrammet Statistical Package for Social Sciences (SPSS).

Resultat

Delstudiet 1 viste at eksistensielle grupper ledet av sykehusprester er en veletablert, integrert og eklektisk gruppepraksis innenfor spesialisthelsetjenesten i norsk psykisk helsevern. Det ble identifisert 5 ulike tilnærminger til de eksistensielle gruppene som viste seg å gi rom for eksistensiell meningsdannelse for pasienter i krisesituasjoner. Den psykodynamiske tilnærmingen viste seg å være den mest brukte og den narrative skilte seg ut på grunn av flest særtrekk. Delstudiet 2 rapporterte at helsepersonell sine holdninger til å adressere den eksistensielle dimensjonen i behandlingen i psykisk helsevern, var åpen og positiv. Allikevel ble det identifisert en avstand mellom positive holdninger og faktisk praksis når det gjelder å adressere den eksistensielle dimensjonen. Delstudiet 3 fant en signifikant sammenheng mellom lengre tids deltagelse i eksistensielle grupper og færre symptom på psykisk stress. Tematikk som omhandlet religiøse og åndelige behov ble også identifisert å ha en signifikant sammenheng med opplevelse av mening/meningsfullhet (delstudiet 3).

Konklusjon

Funnene antyder at de eksistensielle gruppene ledet av sykehusprester, er en veletablert og eklektisk gruppepraksis innenfor psykisk helsevern i Norge. Helsepersonell har rapportert å ha en positiv holdning når det gjelder å adressere den eksistensielle dimensjonen som en del av behandlingen. Det ble likevel indentifisert en liten avstand mellom disse holdningene og praksis i, når det gjelder å adressere denne dimensjonen. En signifikant sammenheng mellom lengre tids deltagelse i eksistensielle grupper og færre symptom på psykisk stress ble identifisert. Tematikk om åndelige og religiøse behov og opplevelse av mening/meningsfullhet, ble også identifisert å ha en signifikant sammenheng.

Funnene kan for klinikere og forskere peke på betydningen av å lage rom for eksistensiell meningsdannelse, som også inkluderer åndelige og eksistensielle behov, og behov for mer forskning på dette feltet.

Abbreviations

ASGW	The Association for Specialists in Group Work
CMHC	Community mental health centre
CPE	Clinical Pastoral Education
EGs	Existential groups
ENHCC	European Network of Healthcare Chaplaincy
FAPH	Committee of Norwegian healthcare chaplains
MIL	Meaning in life
NCPE	Norwegian Clinical Pastoral Education
NOU	Official Norwegian Reports
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

List of Papers

I. Frøkedal, H., Stifoss-Hanssen, H., Ruud, T., DeMarinis, V., & Gonzalez, M. T. (2017). Existential group practice run by mental healthcare chaplains in Norway: A nationwide cross-sectional study. Mental Health, Religion & Culture, 20(8), 713–727. doi:org/10.1080/13674676.2017.1400528

II. Frøkedal, H., Sørensen, T., Ruud, T., DeMarinis, V., & Stifoss-Hanssen, H. (2019). Addressing the existential dimension in treatment settings: Mental health professionals' and healthcare chaplains' attitudes, practices, understanding and perceptions of value. *Archive for the Psychology of Religion, 41*(3), 253–276. doi:https://doi.org/10.1177/0084672419883345

III. Frøkedal, H., Stifoss-Hanssen, H., Ruud, T., DeMarinis, V., Visser, A., & Sørensen,T. (Submitted, revised). Participation in existential groups led by Norwegian healthcare chaplains–relations to psychological distress, crisis of meaning and meaningfulness.

1 INTRODUCTION

The present study focuses on existential groups (EGs) led by healthcare chaplains in Norwegian specialist mental healthcare services, as well as patients' participation and existential meaning making within these groups. In Norwegian healthcare chaplaincy there is a longstanding tradition of inviting patients to share stories about their life, reflect upon existential issues, talk about meaning in life or crisis of meaning and hope or hopelessness and share thoughts about faith. However, to my knowledge, this is the first study to explore this kind of group practice in Norway. Telling and sharing stories, seen as psychosocial constructs, is believed to be of significance to human health as it allows people to integrate incongruent qualities in their life into a more unifying and purpose giving whole (McAdams, 2008). However, in contemporary postmodern societies in which multiple choices and contradictory social worlds exist, this is believed to be especially challenging, and there are no guidelines for how humans should live their life or what life means (Giddens, 1991). In light of this, it might be important to better understand the practice of EGs.

Humans have always used groups to heal their ills (Scheidlinger, 2004). Professionally guided "helping groups" originated in the US with Joseph Pratt who, in 1905, started to teach patients suffering from tuberculosis how to care for themselves at home (Scheidlinger, 2004). Psychiatrists like Cody Marsh, Edward Lazell and Trigant Burrow subsequently followed this type of practice in the US, while Alfred Adler and Jacob Moreno started to use patient groups in Europe (Scheidlinger, 2004). Group therapy saw major growth during World War II when an unexpectedly large number of soldiers in understaffed military hospital in both the US and the UK needed psychiatric treatment (Scheidlinger, 2004). Today, group psychotherapy is frequently used in Norwegian specialist mental healthcare services as a form of treatment for patients with various kinds of mental illnesses (Lorentzen & Ruud, 2014).

It is suggested that patients suffering from mental illness might sometimes consider themselves a burden and believe they could not make any difference in people's lives (Yalom & Leszcz, 2005). Building on these assumptions, EG practice is believed to give patients the experience of being valuable to others, as well providing a therapeutic safe place to explore ultimate existential concerns (Yalom & Josselson, 2011; Yalom & Leszcz, 2005).

1.1 Aim and research questions

The overall aim of the present study was to explore the characteristics of the EG practice led by healthcare chaplains within Norwegian specialist mental health services in light of group psychotherapy; groups and clinical traditions integrating existential, religious and spiritual issues; the healthcare chaplain's role and professional practice; mental health professionals' viewpoints; and patients' existential meaning making. Based on this aim, the following three specific aims and research questions were developed for the three sub-studies.

Sub-study 1

The aim of sub-study 1was to explore and describe the variety within the Norwegian existential group practice, and the following research questions were addressed:

- What theoretical perspectives, aims and scope, as well as therapeutic strategies, characterize healthcare chaplains' existential group practice?
- What are healthcare chaplains' and interdisciplinary staff's views on existential group practice?
- What characterizes healthcare chaplains' and interdisciplinary staff's professional educational backgrounds and clinical experience?

Sub-study 2

The aim of sub-study 2 was to examine the attitudes, practices, understanding and perceptions of mental health professionals, including healthcare chaplains, regarding the value of addressing the existential dimension in treatment programmes. The following research questions were addressed:

- To what extent and in what ways do mental health professionals characterize their attitudes and practices around addressing the existential dimension in treatment programmes?
- What are the differences in mental health professionals' attitudes and practices around addressing the existential dimension in treatment programmes?
- To what extent and in what ways do mental health professionals understand the existential dimension in mental health?
- What are mental health professionals' perceptions of the value of integrating the existential dimension into treatment programmes?

Sub-study 3

This study examined possible associations between patients' participation in EGs and the topics discussed and their experiences of psychological distress, crisis of meaning and meaningfulness.

- Firstly, it was hypothesized that there would be an inverse statistically significant association between lengthier EG participation and lower levels of psychological distress in the sample.
- Secondly, it was hypothesized that there would be a positive statistically significant association between the EG discussion topics: coping, existential concerns, meaning-giving activities and religious and spiritual issues, and the experience of meaningfulness.

1.2 Research design

To fulfil the study's aim and answer the research questions, a nationwide cross-sectional design was chosen (Creswell, 2014) (Table 1). Data from both open-ended and close-ended responses were obtained from web-based survey questions in stub-studies 1 and 2 (Foddy, 1994). In sub-study 3, printed questionnaires were used.

Table 1. Research design

Research design	A nationwide cross-sectional design		
	Sub-study 1	**Sub-study 2**	**Sub-study 3**
Details of design	•An explorative, descriptive nationwide cross-sectional web-based survey design •Quantitative material supported by qualitative material	•A nationwide cross-sectional web-based survey design •Influenced by a convergent, parallel, mixed-methods design	•A nationwide cross-sectional design
Data collection	•Data derived from survey completed by healthcare personnel including healthcare chaplains: •Close-ended responses on group characteristics and viewpoints of the EG practice •Educational backgrounds •Demographic data •Data derived from survey completed by healthcare chaplains: Open-ended responses on group descriptions	• Data derived from survey completed by healthcare personnel including healthcare chaplains: •Close-ended responses on attitudes, practices, understandings, and perceptions of value when addressing the existential dimension •Open-ended responses on attitudes, practices, understandings, and perceptions of value when addressing the existential dimension •Demographic data	• Data derived from questionnaires completed by patients. Measures: •Psychological distress •Crisis of meaning •Meaningfulness •EG discussion topics •EG participation •Group participants characterstics and demographic data
Participants	•101 mental health professionals, including 21 healthcare chaplains	•101 mental health professionals, including 21 healthcare chaplains	•157 patients from healthcare chaplains' EGs in Norway

1.3 Context of the study

Approximately 110 healthcare chaplains working both full time and part time are represented within all the Norwegian health trusts (Official Norwegian Reports, 2013:1). No coordinating instance for healthcare chaplains exists in Norway (Stifoss-Hanssen, Danbolt, & Frøkedal, 2019). However, every third year, five healthcare chaplains are elected by the members of the Norwegian Association of Clergy (2019; Norwegian term: *Presteforeningen*) to represent the organisation on a committee of Norwegian healthcare chaplains (FAPH) (2020). The committee's responsibilities include, among other things, working with healthcare chaplains' professional qualifications and best practices.

1.3.1 Healthcare system in Norway

The Norwegian healthcare system is free to all citizens. In 1997, the Norwegian Parliament introduced a development plan for the mental healthcare system aiming to strengthen user-friendliness and continuity of care in Norway (Ministry of Social Affairs and Health, 1996-97). The current system is divided into three administrative levels: *1) Primary healthcare services located in the municipalities are s*taffed by semi-specialised personnel and general practitioners. The local municipality services provide outpatient counselling as well as long-term residential care for severely mentally ill persons, in the form of sheltered homes. *2) Specialist healthcare located in local community mental health centres (CMHC)*, staffed with psychiatrists, clinical psychologists, and psychiatric nurses. The CMHCs include outpatient services, less specialised inpatient units, day care and mobile teams and many CMHCs have clinical units at more than one location (Holman, Ruud, & Grepperud, 2012). In addition to providing specialised psychiatric care locally, CMHCs coordinate all the other mental health services within a sector. *3) Specialist healthcare located in central psychiatric hospitals*, also staffed with psychiatrists, clinical psychologists and psychiatric nurses. The psychiatric hospitals contain acute units and other specialised inpatient units, like affective, psychosis, and forensic units, among others. The two levels of specialist healthcare are organised through 19 health trusts (national counties) (Ministry of Health and Care Services, 2018). There are 75 CMHCs in Norway, and the population in the average catchment area is 65,000 (A. Kolstad & Hjort, 2006).

1.3.2 Dominant discourses in mental healthcare

There is a profound relationship between clinical pastoral care and psychiatry (Sutherland, 2000). Anton Boisen (1951), the founder of clinical pastoral education (CPE), developed CPE from his own experience of mental distress. However, the field of mental health comprises

competing and mutually exclusive ideologies, and three different discourses have been identified (Sutherland, 2000, pp. 275-277):

First, *the psychological-social discourse* is concerned with the ideology of the mind, emphasising human life stories in which treatment of mental health disorders is viewed a as therapeutic process of reconstruction and reworking of an individual's emotional biography within a dynamic relationship between patient and therapist.

Second, *the psychiatric discourse* is engaged with the ideology of the brain in which a biological conception of brain illness is used to explain severe mental disturbance. Consequently, there is little interest in searching for the origin of the mental disturbance in each individual's psychosocial history, and pharmacological and behavioural treatments are considered most suitable to reduce symptoms.

Finally, *the spiritual-theological discourse* emphasises a holistic ideology of personhood with roots in the traditions of mystical theology and clinical pastoral care, both of which accentuate the negotiation with the deep parts of emotional life not reachable to rational consciousness involved in a deeper integration with God and the pursuit of health. Mental health disturbance is viewed as a process of discernment of an individual's life journey and experiences in which a trusting and containing relationship between an individual and clinical care practitioner become important.

1.3.3 Existential groups led by healthcare chaplains in mental healthcare

In Norway, all healthcare chaplains working in specialist healthcare are funded by hospitals (Stifoss-Hanssen, Danbolt, et al., 2019). In terms of educational background, Norwegian healthcare chaplains are closely tied to both the group psychotherapy tradition (Island, 1995; Lorentzen, Herlofsen, Karterud, & Ruud, 1995) and clinical pastoral education (Farsund, 1982; Høydal, 2000; Norwegian Clinical Pastoral Education, 2020).

The healthcare chaplains have the main responsibility for leading EGs that normally are co-led by healthcare staff members in a fixed, random or rotating arrangement. In general, the healthcare chaplains lead two or more EGs each during a week. EGs normally meet once a week for 45 minutes. Patients are assigned to a group depending on which unit they are hospitalised in. In general, no diagnosis is required to be included in an EG. Likewise, all patients are welcome to participate, independent of religious background. Nevertheless, when a group is offered in a psychosis unit, for instance, most participating patients have diagnoses tied to this spectrum. Core aims of the EGs are to improve reflection on life, to accept illness, to get to know oneself and to improve relationships.

The arrangement and composition of EGs can vary greatly depending on the type of unit where they are held. For instance, healthcare chaplains will have different approaches when leading an EG in an acute psychiatric care unit compared to an inpatient unit at a community mental health centre. In general, it could be argued that EGs provided in hospital units offer a more supportive approach from the healthcare chaplains while EGs provided at a lower care level, like outpatient units, may follow a more explorative phenomenological approach. EGs are managed and operated in accordance with healthcare chaplains' area of competence, also described as their expertise, which includes taking care of patients' existential needs (Berthelsen & Stifoss-Hanssen, 2014; Stifoss-Hanssen, Danbolt, et al., 2019).

1.3.4 Practical guidelines for leading existential groups in clinical settings

Management and operation of EGs normally includes preparing for the meeting, performing the meeting, debriefing and reporting back to the clinic after a session in cooperation with the co-leader. Although these practical guidelines have been validated by healthcare chaplains through a process known as member-checking (Harvey, 2015), they are only a sketchy proposal; however, they might be helpful for those readers who are not familiar with this specific group practice.

Preparing I:

If the EG is held in an inpatient unit, healthcare chaplains might participate in the interdisciplinary morning meeting in which patients' conditions and clinical treatment planning are discussed. The EG might also be discussed during the meeting and the healthcare chaplain will have the opportunity to ask about any particular precautions to be taken. The various professionals in the interdisciplinary team give their opinions on who should participate or not and the healthcare chaplains take this information into account.

Preparing II:

If the EG is held in an inpatient unit, healthcare chaplains might attend a morning meeting with the patients led by clinical staff presenting the agenda for the day. The healthcare chaplain has the opportunity to announce that there will be an EG that day and briefly explain what it entails. Clinical staff sometimes encourage those patients in the morning meeting whom they think would benefit from participation in an EG to participate.

Performing:

The room: The healthcare chaplain and the co-leader arrive at the regular EG meeting room five minutes before the group participants. Chairs are usually placed in a circle. Sometimes a table with lighted candles on it is placed in the middle of the circle.

The opening sequence: At the designated starting time, the healthcare chaplain opens the group session and welcomes everyone. If the EG is held in an inpatient unit, where new patients are commonly included every week, a presentation of the participants is appropriate, and everyone will then introduce themselves with their own name. Some group rules are likely to be presented in the beginning of a group session: for instance, every group participant decides for themselves what they want to share with the group. If the EG is provided in a hospital unit, the chaplain might mention that it also would be ok to be quiet for the whole session and listen to what others are sharing. Most commonly, the patients negotiate which topics are to be discussed within a group session. However, EGs provided in hospital units where patients are more likely to be suffering from severe mental illness require more active facilitation from the healthcare chaplains, including choosing appropriate discussion topics that resonate with the group participants.

The group process: Participants are invited to share thoughts, feelings, reflections, stories and also frustrations within the EG. Some group participants share important life stories while others are invited to respond. Some group participants do this by commenting and affirming what has been shared within the group, others do it by telling a story that may be related to what just has been shared. The healthcare chaplain facilitates this process within the EG, creating space for reflection and elevating the individual stories to a universal level. Usually the healthcare chaplain and co-leader collaborate in this work, making the group a safe place for sharing stories. If the healthcare chaplain and the co-leader have been cooperating on EG work for a long period of time, things presumably go more smoothly.

Topics discussed: How to find meaning in life despite illness, how to cope with everyday life, and mending broken relationships are topics commonly discussed. Participants also share thoughts and fears, including the fear of never being well again or the fear of not being able to have a good life. Reflections on personal identity and being in the world are commonly expressed with questions such as “What kind of space should I possess in the world?”, “How can I become who I am?” and “How can I become alive inside myself?” Feelings of loneliness, being an outsider and not belonging in society are also discussed, as are faith and spiritual issues.

Wrapping up: Towards the end of the group session, the healthcare chaplain sums up what has happened in the group session. He or she might invite the participants to comment, clarify something that was said or say something that had not yet has been said but needs to be said before ending the day's session. The session is then over, and the healthcare chaplain reminds the group participants of the next meeting time.

Debriefing:

The healthcare chaplain and co-leader sum up what went well and what could have been done differently.

Reporting back to the clinic:

After an EG session, the healthcare chaplains usually reports back to the clinic. This kind of report can be done in several different ways. Healthcare chaplains that have access to patient records may choose to chart about important observations made during the EG session. However, more commonly, co-leaders, who do have access to patient records, document important observations made during the EG session. In some cases, clinical staff keep a book wherein they record the names of participants, topics discussed and notable happenings during the group session to report back to the clinic. However, some healthcare chaplains do not seem to have co-leaders and have not established a tradition of reporting back to the clinic. Others do not report anything, citing professional confidentiality as an important premise of this type of group practice.

1.4 Main findings of the three sub-studies

The main findings of the three sub-studies are presented in Table 2.

Table 2 Outline of the three sub-studies with the main findings

Sub-study 1	Sub-study 2	Sub-study 3
•49 EGs identified within 11 of 19 Norwegian health trusts across service levels. •Five different EG approaches addressing patients' existential religious and spiritual issues were identified: psychodynamic, narrative, coping, systems-centred and thematic. The psychodynamic EG approach was the most frequently applied. The narrative EG approach was the most distinctive. •The healthcare chaplains reported using perspectives of existential and psychodynamic theories most frequently in their clinical practice. •A general eclectic group practice applying a variety of therapeutic strategies from various traditions was identified. •Most interdisciplinary staff regarded the EG practice as an established and integrated part of the treatment settings, while the healthcare chaplains were the most reluctant to accept this viewpoint. •The healthcare chaplains possessed various types of therapeutic competence.	•An open and positive attitude towards addressing the existential dimension in treatment settings. A small gap between attitude and practice was identified. •The existential dimension was described as a dynamic search for hope and meaning during a struggle with existential, religious and spiritual pain and issues in order to enhance coping. •An existential meaning-making process was identified to describe the relationship between the existential dimension and mental health. •Improved recovery, strengthening of other therapies, coping with illness and experiencing existential meaning were perceived as values by mental health professionals.	•An inverse significant association between lengthier EG participation and lower levels of psychological distress. •EG discussion topic of religious and spiritual issues showed to have a significant positive association with the experience of meaningfulness. •A significant positive association was shown between age and meaningfulness.

1.5 Theoretical positioning

The present study is situated within the paradigm of pragmatism (Cherryholmes, 1992; Rossman & Wilson, 1985). Pragmatism entails identifying practical solutions to problems independently of ideologies and methodologies (Patton, 2002). In the present study, which explores a group practice in interdisciplinary mental healthcare treatment settings, the problem is how to uncover and understand the differing ideologies and methodologies interwoven and situated in this group practice. The health professionals working in this context are anchored in different philosophy of science traditions and their views of knowledge according to their professional background (Borge, 2013; Sutherland, 2000). The pragmatism paradigm focusses on finding the best way to answer particular research questions (Morgan, 2007) and should therefore be a good choice of research paradigm.

The discipline of psychology of religion provides an overarching perspective for the present study, which is placed in the subarea of clinical psychology of religion (Van Uden & Pieper, 2003). Perspectives of culture, experience and meaning have also been taken into

account, suggesting that the present study applies a pragmatic cultural approach to the psychology of religion in accordance with James Cresswell (2014).

However, the present study is considered to belong to two different research fields. First and foremost, the study is situated within the recently developed research field of existential public health promotion in Scandinavia (Cetrez, 2011; DeMarinis, 2008; Haug, Danbolt, Kvigne, & DeMarinis, 2016; Lloyd, 2018; Melder, 2011). This research field builds upon knowledge from the field of public mental health, which has incorporated a health promotion perspective. Second, the study's focus extends to the research field of chaplaincy (Ford & Tartaglia, 2006; Swift, Handzo, & Cohen, 2012, 2016; Swinton, 2001, 2002).

1.7 Outline of the study

The present study consists of eight chapters and aims to clarify, contextualise and discuss the overall study, including the three sub-studies. Chapter two provides a short presentation of healthcare chaplains in Norway to situate EG practice. Chapter three outlines the theoretical and conceptual frameworks relevant for the examination of EG practice led by healthcare chaplains. The fourth chapter presents empirical studies to situate the study within the research literature. Chapter five presents the overall methodological research design and strategies employed to collect and analyse the data. Chapter six presents the findings within and across the three-sub-studies, which are discussed in chapter seven. Finally, chapter eight summarises the contribution of the present study and outlines possible implications for future research.

2 HEALTHCARE CHAPLAINS IN NORWAY

The profession of hospital chaplain is one of the oldest professions in Norwegian hospitals (Stendal, 2013). At Gaustad Hospital in Oslo, the tradition of chaplaincy can be traced back as far as 1855 (Farsund, 1980, 1982). At Oslo University Hospital (formerly Ullevål Hospital), the first hospital chaplain was hired on 1 September 1919 (Stendal, 2013). This chapter provides some examples of debates that have influenced Norwegian healthcare chaplains' role and professional practice and gives a short presentation of existing knowledge about the existential group practice led by healthcare chaplains in the Norwegian specialist mental health services. It also gives a short presentation of healthcare chaplains' educational and clinical traditions along with some key facts about Norwegian healthcare chaplains in the present day. I start by introducing some useful definitions and terminology.

2.1 Definitions and terminology

The present study will use the term "healthcare chaplain/chaplaincy" for chaplains that are currently working in the Norwegian healthcare system. This choice is based on a shift in terminology during the 1980s and the inclusion of healthcare chaplains in the government's draft healthcare law (The Health Personnel Act, 1999; Ministry of Social Affairs and Health, 1998-1999). A healthcare chaplain has been defined as a hired professional, working on spiritual and existential challenges in institutions such as hospitals (Stifoss-Hanssen, Danbolt, et al., 2019). The term "hospital chaplain" will primarily be applied in relation to the historical roots of Norwegian chaplaincy.

2.2 Influences on healthcare chaplains' role and professional practice

The role and professional practice of healthcare chaplaincy have been debated for many decades in Norway (Kolstad & Os, 2002). Traditionally, hospital chaplains' role within healthcare has been to preach the word of God by inviting people to worship in the hospital church, officiating baptisms and funerals, and offering pastoral care to patients and healthcare staff (Alterbok, 1920; Farsund, 1980, 1982). It is, however, suggested that their involvement in CPE from the 1960s onward influenced the negotiation of the healthcare chaplain's role within healthcare. Early on, Farsund (1980, 1982) argued that there had been a shift in the "role" of the hospital chaplain from official priest to clinical pastoral care provider. Farsund (1982) further argued that CPE gave these hospital chaplains an opportunity to become

integrated into the treatment settings, and from this experience, new issues related to the hospital chaplaincy's function became subject to discussion (e.g. the relationship between hospital chaplains and mental healthcare professionals).

Furthermore, Norwegian political debates have influenced how healthcare chaplains' role and professional practice have been challenged and negotiated in Norwegian society. For instance, healthcare chaplains' role and professional practice had to be negotiated when responsibility for hospital chaplains were transferred from the protection of the government to the county administration (K. Kolstad & Os, 2002; The Norwegian Association of Local and Regional Authorities, 1981), or when it was debated whether chaplains role and professional practice should be limited to a geographical area or tied to public health in general (Ministry of Social Affairs and Health, 1996-97; Official Norwegian Reports, 1995:14, p. 153). Furthermore, there was a debate over whether healthcare chaplains role and professional practice should be included in the government's draft healthcare law (The Health Personnel Act, 1999; Ministry of Social Affairs and Health, 1998-1999).

These are only few examples of political debates that have challenged the role and professional practice of healthcare chaplains within Norwegian society. However, to my knowledge, scarcely any research exists on healthcare chaplaincy in a Norwegian context. Two models of reasoning on the function of chaplaincy might provide a reader unfamiliar with these type of political debates with an understanding of two core assumptions (Stifoss-Hanssen, Danbolt, et al., 2019): (1) The "religious service model" views the chaplain as a "religious specialist worker" whose main tasks are to preach the word of God, officiate baptisms and funerals, and offer pastoral care to patients and staff members (Alterbok, 1920; Farsund, 1980, 1982). (2) The "existential care model" views chaplains as health professionals whose main task is securing and improving users' health and wellbeing and enhancing their capacity to cope with crisis, emphasising meaning in life, existential and spiritual support and comfort (Stifoss-Hanssen, Danbolt, et al., 2019).

2.3 Knowledge about healthcare chaplains' group practice

Healthcare chaplains working in the field of Norwegian specialist mental health services have been leading groups for patients for many decades. However, sparse knowledge exists concerning this particular group practice; I have identified just one article by Farsund (1982). The article describes the experiences of a healthcare chaplain leading several philosophy of life groups for patients at Gaustad Hospital in Oslo. There is also some unpublished work

describing hospital chaplains' group work written by Sigrid Helene Kjørven Haug (1991) and Anne Cathrine Holm Furuheim (2010). Another article written in Norwegian that describes hospital chaplains' professional practice is noteworthy, yet it only briefly mentions that the philosophy of life group practice is indeed offered at Gaustad Hospital (Farsund, 1980).

It is assumed that the Norwegian EG practice has evolved from the chaplain-led spirituality groups in the US, presumably in connection with Norwegian chaplains' participation in CPE program in the US from the 1960s onwards (Farsund, 1980, 1982; Høydal, 2000).

2.4 Healthcare chaplains' educational and clinical traditions

Clinical Pastoral Education (CPE) has been a central continuing education path for Norwegian healthcare chaplains (Eika, 2000; Farsund, 1982; Høydal, 2000). CPE was first initiated at Worcester State Hospital in Massachusetts in the 1920s when Rev. Anton Boisen was hired as a hospital chaplain (Boisen, 1951). Eduard Lindeman is, however, regarded as the first pioneer in adult education (Lindeman, 1945). Lindeman's adult education theories were further developed by Knowles (1975) and integrated into the CPE programme (Parker, 1978). The Association for Clinical Pastoral Education (ACPE) was established in 1967 (Snorton, 2006).

CPE is suggested to have a strong psychodynamic approach (Hemenway, 1996, 2005) in addition to integrating action–reflection methodology. More recently, CPE has been influenced by perspectives from systems-centred theory (Agazarian, 2001; Hemenway, 2005) and the philosophical tradition of existentialism (Eliason, Hanley, & Leventis, 2001). It has been argued that Anton Boisen wanted to strengthen clinical pastoral care's existential roots (Asquith, 1982; Boisen, 1951) and that his understanding of humans as "living human documents" might shed light on the relationship between the tradition of existentialism and clinical pastoral care (Miller-McLemore, 1993).

Norwegian healthcare chaplains have been influenced by the CPE tradition since the 1960s (Høydal, 2000), in particular by its use of an action reflection methodology in which group processing (Hemenway, 2005) and theological reflection are central elements (Norwegian Clinical Pastoral Education [NCPE], 2020, p. 36). A CPE programme is offered at some hospitals in Norway (NCPE, 2020, p. 10) integrating three levels in a continuing education master's degree in clinical pastoral care and counselling. Additionally, CPE supervisory training is offered and usually takes five years to complete.

Theological reflection is an integral part of the CPE programme as reflected in the literature list for CPE students (NCPE, 2020, p. 36) (For instance see Doehring, 2006; Graham & Walton, 2018; Thompson, 2014; Whitehead & Whitehead, 1995). According to Fagerli (2020), the head of the Norwegian CPE certification committee, this means that theological reflection is included in verbatim reviews, self-experience group work, guidance on preaching etc. Fagerli (2020) accentuates that CPE programmes commonly include teaching about theological reflection and how life in general and the lives of specific clients can be interpreted theologically. This integrated way of working with theological reflection and reflection on clinical material is described in the CPE Handbook in Norway:

> In pastoral care, the basic perspectives are our faith traditions and theology, but other relevant (e.g. social science) interpretations of human behaviour are also taken into account. The reflection, which will always comprise an investigative and critical element, will often seek to view the material within a larger context than what was possible in the actual situation described. In this way is reflection far more than just "feedback", and something quite different from the focus on right and wrong. It is a demanding task to learn how to reflect on clinical material in a group, and sometimes challenging for the individual participant to let the group into their own world of experience and practice. The formula of reflection is the conversation in the group (reflective team) - or with the supervisor in the individual supervision. Since our practice of pastoral care is on the agenda of learning, the reflection will also touch upon and explore the interpersonal dynamics that will materialise in the material in the individual supervision. It will highlight the pastoral care counsellor contribution and how - and with what background - the pastoral care counsellor makes his or her choices and influences the conversation. (Norwegian Clinical Pastoral Education, 2020, p. 5)

The Institute of Group Analysis has played a central role in providing important, comprehensive, multi-professional education in formal group psychotherapy in Norway (Island, 1995; Lorentzen et al., 1995). The group psychotherapy tradition developed in Norway in the 1950s and, according to Lorentzen, Wilberg, and Martinsen (2015), a formal training programme lasting a total of five years and comprising three levels of group psychotherapy was introduced in 1984. The training was provided in blocks and included small and large self-experience groups, theory, and group supervision. Healthcare chaplains took part in this education from the start in 1984. In recent years, mentalisation-based therapy has been included in this training (Bateman and Fonagy (2006), and a manualised group version of mentalisation-based therapy is implemented in Norway today (Karterud & Bateman, 2012). The aims and scope of almost all psychotherapy groups have been determined to be the improvement of interpersonal relationships, the reduction of symptomatic distress, and increased self-knowledge.

Existential therapy educational training is not offered in Norway, although the New School of Psychotherapy and Counselling in London offers such training. Likewise, the Existential–Humanistic Institute, located in San Francisco, California, provides in-depth training in existential–humanistic philosophy, practice, and inquiry (Corey, 2016).

Continuing education for healthcare chaplains in the public health sector (Norwegian term: *videreutdanningsmodul for prester i helsesektoren*) was developed by The Norwegian Association of Clergy in the 1990s. The continuing education was provided over the course of four semesters, and an additional course in emergency psychiatry was offered. Theories from CPE were included in the continuing education module in addition to other theories relevant to healthcare chaplains' professional practice. This particular continuing education module has been offered for Norwegian healthcare chaplains several times since the 1990s, although it has not been available within the last ten years. The tradition of CPE is an eclectic one, integrating theological and psychological insights from multiple theories (Hemenway, 2005) with self-reflection, emotional intelligence, and pastoral skills (R. G. Anderson, 2004; Jankowski, Vanderwerker, Murphy, Montonye, & Ross, 2008).

3 THEORETICAL FRAMEWORKS

This chapter discusses concepts and theories central to researching existential groups (EG) led by healthcare chaplains in specialist mental healthcare services. Research on existential groups led by healthcare chaplains, as well as on existential groups, is generally scarce; therefore, a broader field of group work and clinical traditions has been included in the theoretical framework, as well as in the research review in the next chapter. This has made it possible to spot some differences and similarities across different types of groups and clinical therapy traditions.

Research on the role and professional practice of Norwegian healthcare chaplains is limited. For this reason, I found it necessary to incorporate theories and research from a broader international context. Research on Norwegian mental health professionals' viewpoints on EGs is also limited, and I have thus turned to international research to inform my discussion of these views? These viewpoints will however be displayed in the research chapter and not be included in the present chapter.

The existential dimension, as well as existential meaning making, has been the core concept within the present study, so this chapter will begin with a presentation of existing theories relevant to these concepts. Research on the existential dimension relevant to the EGs will be presented in the next chapter along with existential meaning making.

3.1 The existential dimension

Scandinavia is recognised as one of the most secular regions in the world (Botvar & Schmidt, 2010; DeMarinis, 2006; la Cour, 2008; la Cour & Hvidt, 2010). Because of this, it is suggested that religious thinking, religious institutions and religious behavior have changed in the Scandinavian countries, creating a need for an existential framework that accommodates both existential, religious and spiritual issues. Therefore, in the present study, the existential dimension is viewed as an overarching concept, encompassing secular, religious and spiritual domains (DeMarinis, 2003, 2008; la Cour & Hvidt, 2010). The existential dimension is a broad concept that includes a worldview conception, a life approach and a decision-making structure, as well as a way of relating to and understanding rituals and other ways of making meaning (DeMarinis, 2003, 2006, 2008).

3.1.1 Distinctions between existential, religious and spiritual issues

Existential issues within the secular, religious and spiritual domains (DeMarinis, 2003, 2008; la Cour & Hvidt, 2010) have been used interchangeably to describe beliefs, values and ultimate meaning in human life (Sinclair & Chochinov, 2012). However, in the secular domain, existential issues might refer to ultimate concerns in life regarding death, loneliness, freedom and the search for meaning that are not related to religion or a transcendent reality/divine being (Yalom, 1980). In the spiritual domain, existential issues could be related to the search for the sacred in a personal context (Hill et al., 2000; Koslander, da Silva, & Roxberg, 2009; Zinnbauer & Pargament, 2005) while the search for the sacred that unfolds within traditional and organised sacred context could be understood as belonging to the religious domain (Hill et al., 2000; Koslander et al., 2009; Zinnbauer & Pargament, 2005).

3.1.2 Mental health and the existential dimension

Mental health comprises multiple social, psychological, and biological factors that determine an individual's level of mental health at any point in time (World Health Organisation [WHO], 2016). This view of mental health builds upon a bio-psycho-social model (Engel & George, 1980) that has been applied for the purpose of explaining the complexity of mental ill-health. The World Health Organization (2006) emphasises that the determinants of mental health are inseparable from public health and that good mental health is the basis for all health.

Scandinavian healthcare researchers have expanded the bio-psycho-social model presented below (Figure 1) to incorporate the existential dimension into a cultural context (DeMarinis, 2013; DeMarinis, Ulland, & Karlsen, 2011; Lloyd, 2018; Lloyd, af Klinteberg, & DeMarinis, 2015; Melder, 2011). These researchers suggest that this model provides a more complete and interesting understanding of the complexity of mental ill-health than does the previous model.

The present study is built upon the understanding that the existential dimension is an autonomous and central health dimension that influences other health dimensions (biological, sociological, psychological) (DeMarinis, 2003, 2008; Melder, 2011). This understanding is in accordance with Routledge, Roylance, and Abeyta (2017, p. 605), who argue that "perceptions of meaning may be one key to a long and fulfilling life. Existential health in the form of perceiving one's life as meaningful and full of purpose promotes overall psychological and physical health."

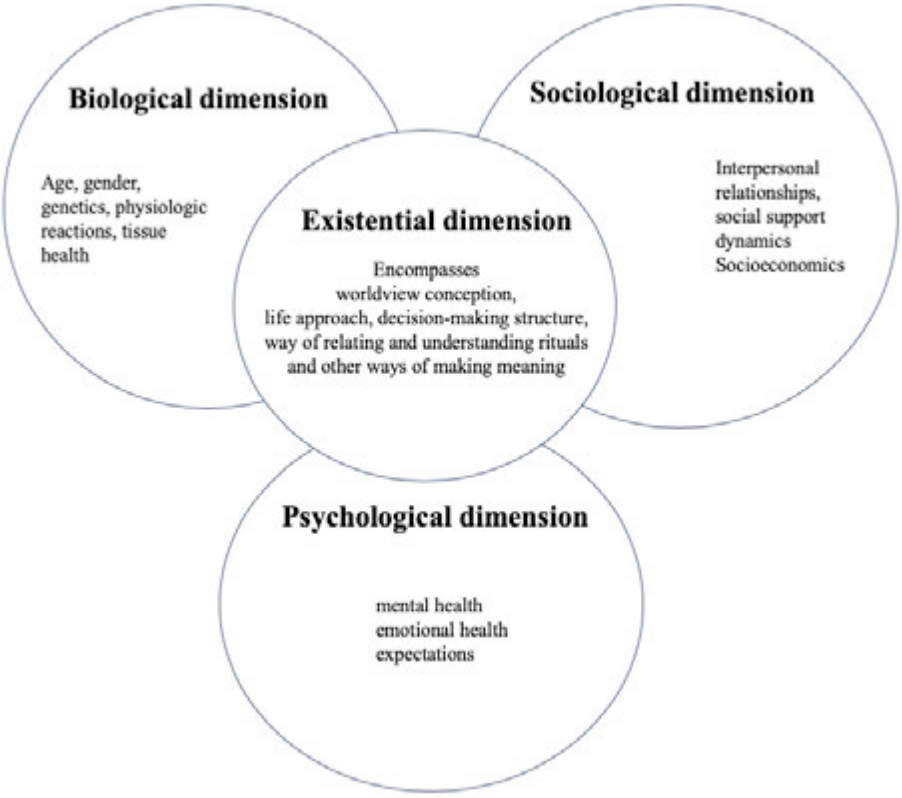


Figure 1. The concept of the existential dimension as a health dimension.

3.1.3 Cultural context and the existential dimension

A final understanding of the existential dimension is that it is based on one's understanding of the importance of a cultural context. This understanding has been influenced by the work of Kleinman (1988) and Marsella (2005). While the former researcher differentiated between illness and disease, the latter developed a cultural model that is defined as

> shared learned behaviour and meanings, socially transferred in various life-activity settings for purposes of individual and collective adjustment and adaptation. Cultures can be (1) transitory (i.e. situational even for a few minutes), (2) enduring (i.e., ethno cultural life styles), and in all instances are (3) dynamic (i.e., constantly subject to change and modification). Cultures are represented (4) internally (i.e., values, beliefs, attitudes, axioms, orientations, epistemologies, consciousness levels, perceptions, expectations, personhood), and (5) externally (i.e., artefacts, roles, institutions, social structures). Cultures (6) shape and construct our realities (i.e., they contribute to our worldviews, perceptions, orientations) and with this ideas, morals, and preferences. (Marsella, 2005, p. 567)

The model below (Figure 2) facilitates an understanding of the cultural dimension as an important condition for developing existential health, while the dynamic relationship between the external and internal dimensions of culture is significant for maintaining functional meaning making (DeMarinis, 2006, 2008).

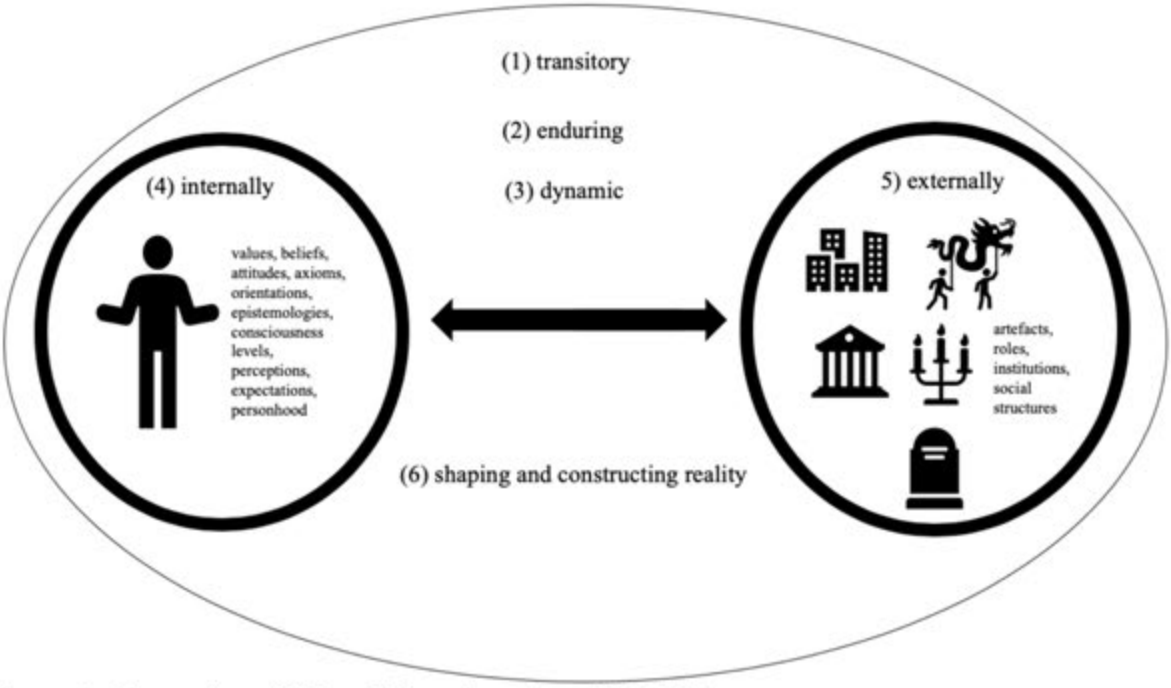


Figure 2. Illustration of Marsella's cultural model (2005)

3.1.4 Existential meaning making

The existential dimension has been operationalised and defined in the present study as existential meaning making that can be both functional and dysfunctional (DeMarinis, 2003; 2006). Existential meaning making refers to how people make meaning in or of their lives with the religious, spiritual and secular domains (Figure 3).

The Danish researchers Peter la Cour and Niles Christian Hvidt (2010) have systemised the literature on existential meaning making by developing a model that offers a broader understanding of meaning making and coping with regard to health in a secular context. The model combines the three existential domains (secular/spiritual/religious) with three core psychological dimensions of meaning making (cognition/practice/importance). la Cour and Hvidt (2010) suggest that the model can be useful when trying to comprehend the multidimensional complexity of meaning making related to illness in secular countries. They based the three existential domains on definitions from the literature and structured these definitions on a continuum ranging from subjective, constructivist viewpoints to a more transcendent reality. According to la Cour and Hvidt (2010), the secular domain defines existential concerns within a humanistic secular universe (e.g., Yalom (1980) Greenberg, Koole, and Pyszczynski (2004)). Further, the spiritual domain defines existential concerns as existing within more personal contexts (e.g., Doyle (1992) Wulff (1997) J. Levin (2001)). Finally, the religious domain has the longest tradition of addressing existential concerns,

which it does within a more formally organised religious context (e.g., Argyle and Beit-Hallahmi (1975) James (1987) Tillich (1963)).

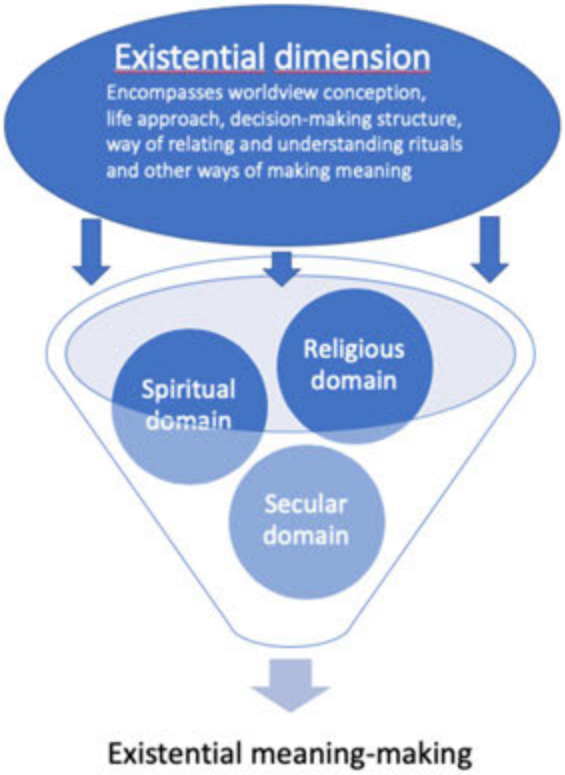


Figure 3. The existential dimension viewed as existential meaning making

3.1.5 Functional and dysfunctional existential meaning making

Functional existential meaning making includes an existential worldview suitable for meeting the existential needs in life, which helps people to function in both daily life and in situations of crisis and meaning. The core task of an existential worldview is to provide people with narratives, values and ritual behaviours that nurture and function as sources of meaning in times of both hope and crisis. Dysfunctional existential meaning-making could be understood to occur when members of a cultural context do not have access to the internal and external representations necessary for human development and identity. The situation might eventually lead to poor mental health, characterised by random or abrupt decision making, mental paralysis, or even identity problems (Bauman, 1998; DeMarinis, 2006, 2008). In this study, the existential dimension is understood as an overarching concept encompassing secular, spiritual and religious domains (DeMarinis, 2003, 2008; la Cour & Hvidt, 2010).

The dynamic relationship between the internal (values, belief, attitudes, axioms, expectations, personhood, amongst other) and external (artefacts, roles, institutions, social structures) dimensions of culture as defined by Marsella (2005, p. 567) (Figure 2) has been considered significant for maintaining functional meaning making (DeMarinis, 2006, 2008).

3.2 Group work and clinical traditions

The use of groups to heal human illness is believed to be as old as humankind (Scheidlinger, 2004). Group therapy experienced major growth during World War II when an unexpectedly large number of soldiers needed psychiatric treatment. The question that concerns me here, however, is, What does it mean to have an existential approach to group therapy within psychiatric treatment? Would this mean group psychotherapy that adds existential issues, or existential psychotherapy adjusted for groups? Or does it mean that spiritual and religious issues are integrated into group psychotherapy?

The Norwegian EG practice is believed to have evolved from chaplain-led spirituality groups in the US, presumably linked to Norwegian chaplains' participation in CPE programmes in the US from the 1960s onwards (Farsund, 1980, 1982; Høydal, 2000). Is it possible then that there are some similarities between these two traditions?

Existential groups led by healthcare chaplains can be seen in light of different group psychotherapy and pastoral care traditions, underscoring the "eclectic" nature of group psychotherapy and group work in general (Karterud, 2007; Ward, 2006b). For the purposes of this study "eclectic" is defined according the *Oxford Advanced Learner's Dictionary of Current English* as "not restricted to one source of ideas, etc, but choosing from or using a wide range" (Hornby & Cowie, 1993, p. 383).

The group traditions presumed to be most relevant in this context will be discussed in the following. Developed guidelines and key therapeutic factors will be emphasised tinform my discussion of these views. First, I provide some background on existential groups.

3.2.1 How to define an existential group?

Existential groups might be viewed in relation to existential therapy or existential psychotherapy (Correia, Cooper, & Berdondini, 2015). There have been several attempts to establish a coherent conceptual framework existential psychotherapy. These attempts represent four schools of thoughts anchored in different theoretical perspectives, applying a range of therapeutic approaches (Cooper, 2003, 2012): (1) Daseinsanalysis emphasises openness towards the world (Binswanger, 1963; Boss, 1963); (2) Meaning and Logos Therapies focuses on meaning and purpose in life through Socratic dialogue (Frankl, 1986; Wong, 2010, 2012); (3) the British School of Existential Therapy emphasises lived experience and the spiritual dimension tied to personal worldviews (Laing, 1965; Spinelli, 2007; Van Deurzen, 2012); and (4) the Existential–Humanistic Approach, addresses four ultimate

concerns: the inevitability of death, existential loneliness, the meaning of existence, and freedom (May, Angel, & Ellenberger, 1958; K. J. Schneider, 2008; Yalom, 1980).

The multiplicity of perspectives in existential therapy has been linked to core epistemological principles of existential philosophy due to struggles to recognise the ambiguity and uncertainty of existence (Spinelli, 2007). Against this background, it has been argued that existential therapists tend to be distrustful of and often oppose standardising theory or practice (Cooper, 2012). Existential therapy has been defined as "psychological interventions that are informed, to a significant degree, by the readings of existential philosophers, including – most notably –Heidegger, Sartre, Buber, Tillich, Kierkegaard, and Nietzsche" (Cooper, 2012; Vos, Craig, & Cooper, 2015, p. 115).

The present study, however, builds on a broader definition of existential therapy proposed by Yalom and Josselson (2011, p. 310), who define existential psychotherapy as "an attitude toward human suffering that has no manual. It asks deep questions about the nature of the human being and the nature of anxiety, despair, grief, loneliness, isolation, and anomie. It also deals centrally with the questions of meaning creativity and love". Based on this definition, the present study suggests that an EG led by healthcare chaplains might be viewed as a type of group that focusses on the existential dimension by making space for human stories. Additionally, core questions in life and existential meaning making encompassing existential, religious, spiritual issues are discussed, assisted by a variety of psychological and existential theories.

The Association for Specialists in Group Work (ASGW) has developed professional standards to train group workers (R. V. Thomas & Pender, 2008) to work in four types of group (Ward, 2006a): work-task groups, psychoeducation groups, group counselling groups, and psychotherapy groups. Ward (2006a) considers this typology, sanctioned by the ASGW, to be helpful, although the reality of group work is characterised by the experience of overlap and blending between the different group approaches. Moreover, it has been argued that the existential approach to groups is relevant among a wide variety of psychotherapy groups, counselling groups, and support groups (Corey, 2016).

3.2.2 What characterises therapy groups at inpatient, outpatient and day patient units?

In general, group therapy is used in many different clinical settings. Yalom and Leszcz (2005) describe some characteristics and challenges that seem to appear at different levels of care. Some of the same challenges are presumed to apply to the EG practice as well and will therefore be presented below.

Group therapy provided in outpatients units is often characterised by various types of negotiations, such as which topics to discuss. These groups tend to be freestanding and independent and meetings are usually held the local CMHC.

Group therapy provided in day units or inpatient units at CMHCs are usually more closely tied to a treatment programme at the CMHC. A distinct difference between outpatient and inpatient groups is that the latter are highly dependent on administrative backing. In other words, groups will be supported if managers are convinced that group therapy is an effective form of therapy; if not, support is unlikely (Yalom and Leszcz (2005). In the latter case, staff members will not be assigned to group leader positions, or group sessions will not be scheduled at a convenient time relative to the treatment programme in the unit.

According to Yalom and Leszcz (2005), therapy groups in acute inpatient units, in particular, are confronted with several factors that might influence the group work: (1) *Rapid patient turnover in the unit* – short hospitalization times, from approximately a few days to a few weeks, could affect the group process. (2) *A wide diagnostic spread among the patients* (for instance psychosis, borderline, substance disorder, eating disorder, affective disorders, post-traumatic stress disorder, situational reactions) – this could represent a challenge when conducting a group in that patients' capacity for group therapy might vary greatly and many patients might not be motivated to participate. (3) *Blurred group boundaries* – poor understanding of, or lack of respect for, confidentiality might lead patients to share important events from the group with other patients in the units or staff members to share information with one another during reports or staff meetings. (4) *The complex role of the group leader* – the group leader might have other roles in the treatment facility and be involved with the patients throughout the day. Additionally, the leader might have limited autonomy since each patient in the group usually has several therapists at the same time. Taking these factors into account, what might groups be able to accomplish?

3.2.2.1 Goals for group therapy in inpatient and outpatient units

As described in the previous section, inpatient units and outpatient units represent two completely different contexts when it comes to providing group therapy. Treatment goals in therapy groups in outpatient units are generally more ambitious because it is assumed that patients attending groups have their life outside the CMHC, live at home and often have a job. Goals for this type of group could be improving psychological functioning, reducing the pressure of illness symptoms or improving relationship patterns.

Treatment goals in therapy groups at inpatient units need to be more realistic due to all the challenges described in the previous section. Yalom and Leszcz (2005, pp. 485-487) have

enumerated six achievable goals that are of significance when conducting groups for patients in a vulnerable state in life, hospitalised in an acute/inpatient unit in a hospital/CMHC:

1. *Engaging the patient in the therapeutic process.* A primary goal of inpatient group therapy is to engage patients in a process that would be perceived as constructive and supportive. The hope is to be able to create a desire within patients to continue group therapy (and/or individual therapy) after discharge from hospital. It is believed that if the group therapy experience has been sufficiently positive and supportive, this will encourage the patient to attend group therapy after discharge.
2. *Demonstrating that talking helps.* It is important to help patients understand that talking about their problem is recognised as a significant goal. Further, patients could learn that there might be relief to be gained in sharing pain, and being heard, understood and accepted by others. Listening to other group members, patients may also realise that others suffer from the same time type of disabling distress. In this way, Yalom and Leszcz (2005, p. 485) argue, the group introduces group members to the therapeutic factors of *cohesiveness* and *universality.*
3. *Problem spotting.* Skills learned in the group can help patients identify problems which is an important goal of group work. In this way, patients are suggested to increase the efficiency of other therapies. Group therapy is thus argued to be an "ideal therapy arena in which to learn about maladaptive and interpersonal behaviour" (Yalom & Leszcz, 2005, p. 486).
4. *Decreasing isolation.* It is believed that the inpatient group therapy can help alleviate the feeling of isolation often experienced by group members. The group could thus be viewed as a "laboratory exercise" (p. 486) intending to improve communication skills. The better communication is, the less isolation group members experience, the reasoning goes. Thus, group therapy can help group members to share with one another permitting them to get feedback about how others might perceive them. Furthermore, it might allow them to learn about their blind spots. Having good communication skills will presumably help patients improve their relationships outside the hospital, too, in which case the inpatient group will have fulfilled a very important goal.
5. *Being helpful to others.* This goal has been described as the therapeutic factor *altruism.* It is believed that patients are helped not only by their peers, but also by the experience of being valuable to other patients. Patients often feel that they are a burden to other people and that they have nothing valuable to offer other people. The experience of being

valuable to other group members is believed to affirm patients' sense of self-worth and is thus suggested to be of great importance in their recovery.

6. *Alleviating hospital-related anxiety.* Finally, it is emphasised that being hospitalised in a psychiatric unit can intensify anxiety and be experienced as shameful. Some patients might even be afraid of being stigmatised, or perhaps afraid that the hospitalization might affect their work situation or even friendships at home. It is also believed that patients might become distressed by strange or frightening behaviour from other patients, but also if they pick up on any tension between the staff. Based on the assumption that these feelings of anxiety might progress, inpatient group therapy is thought to offer a space in which patients might address these issues. Patients who share these types of anxieties will presumably be reassured by the fact that other group members share their worries. They might not assume that other hostile or intend to reject them, but rather understand their behaviour as being preoccupied or fearful.

3.2.2.2 Therapeutic strategies for groups in inpatient and outpatient units

In an outpatient unit, the time frame for group therapy could be many weeks, several months or sometimes even years. Building cohesiveness can take years and requires a lot of patience from the group leader (Yalom and Leszcz (2005, p. 488). Group leaders in outpatient settings can often be more laid back and let issues build up over time before working through them. Outpatient groups might also allow group members to express forceful anger and provide space for them to examine it. Possible therapeutic strategies include mirroring, confrontation, criticism or in-depth exploration of interpersonal conflicts that might come to light during the group process.

In an inpatient setting, the situation might be quite different due to group composition, rapid turnover of patients and short group duration, sometimes only a single session. However, continuity from one session to the next is also possible. Some patients could function as culture bearers, being present in several consecutive meetings. In any case, offering something useful for as many participants as possible during a particular session is an important goal of inpatient group therapy. The question, then, is how it is possible to provide efficient therapy in the space of a single session with no time to develop or work slowly.

Yalom and Leszcz (2005, pp. 487- 496) have developed some techniques that presumably also might apply for EG practice and will therefore be presented in the following:

Support as a technique: It is important for the group leader to create an atmosphere within the group that the group members experience as safe, supportive, positive and constructive. Furthermore, it is suggested that group members need to learn to trust the group

and to experience it as a place where they will be understood and accepted. Confrontation is to be avoided to prevent making the group feel unsafe. Two types of support are proposed: *direct support*, characterised by personal engagement, empathic listening, understanding, accepting glances nods and gestures; and *indirect support*, which builds a cohesive group that can develop into a powerful mediator of support.

Acknowledgement, specifically "to acknowledge openly the members' efforts, intentions, strengths, positive contributions and risks" (p. 489) is another aspect of support. Likewise, to identify and reinforce the adaptive parts of group members presentations.

Emphasising the positive rather than the negative is another aspect of support suggested to be helpful when conducting these types of groups. Another way of providing support might be by helping members to obtain support from the group.

When *identifying fatiguing behaviour,* for instance a group member talking endlessly about their health issues, the group leader has to intervene quickly before dislike and rejection develop within the group. It is then possible *to translate this behaviour into a real message*, also seen as an aspect of being supportive. For instance, the group leader might say something like, "When listening to your story about your health situation I get a sense that you are saying that you also have needs but they might be overlooked and that it is difficult to ask for help." This kind of intervention might lead to new perspectives and insight.

Making certain that the group is safe is suggested to be another approach to support. Constantly foreseeing and avoiding conflict, for instance between two group members, is an important task for the group leader, as is quick intervention. Such intervention could take the form of *searching for a positive aspect of the conflict* or *redirecting a conflict,* for instance by asking individuals to discuss the various way in which they are similar to the person they disagree with. The use of *role switching* is also suggested to be an effective technique: because envy can be an integral part of interpersonal conflict, asking rivals to talk about the qualities that they appreciate in one another might be useful showing the group that taking an opposing position can be a sign of caring (Yalom and Leszcz (2005, p. 491).

Making the group safe for people that feel unsafe is also an important aspect of being supportive as a group leader. Group members who feel unsafe might be afraid of losing control or perhaps of saying something that they did not intend to share. Allowing group members to exercise control over their own participation is suggested to be an important intervention. Yalom and Leszcz (2005, p. 491) have suggested using questions such as, "Do you feel you're pushing you too hard?", "Is this too uncomfortable for you?", "Do you think

you have revealed too much of yourself today?", and "Have I been too intrusive by asking you such direct questions today?"

3.2.3 Group psychotherapy

Group psychotherapy is an eclectic, therapeutic tradition anchored in psychodynamic theory (Karterud, 2007; Ward, 2006b; Yalom & Leszcz, 2005). However, systems-centred theory is also suggested to be included in this tradition (Agazarian, 2004; Durkin, 1964). Psychodynamic perspectives, such as object relation theory (Klein, 1940; Winnicott, 1971), attachment theory (Bowlby, 1978), and self-psychology (Kohut, 2012; Pines, 1996) are included in the group psychotherapy tradition.

A "dynamic" approach to therapy is based on the assumption that every human being has a deep structure of personality in which forces exist at different levels of awareness, or even outside of conscious awareness, and that these forces might be in conflict with one another. A classic psychoanalytic approach considers that conflict exists between an individual's fundamental drives (primarily seen as sexual and aggressive drives) and an environment that frustrates satisfaction of those drives. Self-psychology, which has a slightly different view of "dynamic", emphasises the individual's attempts to hold on to a stable sense of self – for instance, the experience of disappointing self-object relationships – as fundamental and meaningful. The aims and scope of the classical psychodynamic traditions include symptom reduction, improvement in intrapsychic balance and the ability to face the unacceptable (Cohn, 1996).

Group therapy is considered to be the ultimate form of therapy "for understanding the complexity of human interaction" (Counselman, 2008, p. 271). Training to become a group psychotherapist should focus on several areas such as presence in the here-and-now, comfort with affect in the room, and attention to closeness and separateness. Additionally, fostering empathic connection, be sensitivity to shame, handling exploration of resistance, handle different ways of communicating and have an awareness of group dynamics are important areas to pay attention to.

3.2.3.1 Therapeutic factors in group psychotherapy

Yalom and Leszcz (2005, pp. 1-2) have described eleven central factors of group psychotherapy: (1) *Installation of hope* involves, for example, gaining knowledge that the group has been able to help other people with similar challenges. (2) *Universality* is about discovering that one is not alone in their experiences. (3) *Imparting information* can be described as psychoeducation about mental health and mental disorders, general teaching on

psychodynamic dynamics, and counselling. (4) *Altruism* is described as an experience to be able to help others to gain self-respect. (5) *The corrective recapitulation of the primary family group* deals with new perspectives what it was like growing up in one's own family. (6) *Development of socialising techniques* refers to improve social skills such as tolerance, boundaries, empathy, and conflict resolution. (7) *Imitative behaviour* is about identifying with others who are more comfortable in the group. (8) *Interpersonal learning* deals with becoming aware of, for example, how one affects others and is perceived by them. (9) *Group cohesiveness* can be described as belonging to and feeling secure in the group. (10) *Catharsis* is about being able to relieve pressure and be able to express one's feelings and put one's concerns into words. (11) *Existential factors* are related to the recognition that life is unfair, and that death and loneliness are very real in every person's life.

Yalom and Leszcz (2005, pp. 31-52) a theory of process-oriented group therapy in which the understanding of the group as a "social microcosm" is central. This means that a therapy group could be viewed as a small social world with interpersonal interactions that are enacted in an analogous way to interpersonal interactions outside the therapy group.

3.2.4 Existential approach to group psychotherapy

The existential factors mentioned above (Yalom and Leszcz (2005, p. 98) are considered central when applying an existential approach to therapy. They consist of five items: (1) recognising that life is at times unfair and unjust; (2) recognising that ultimately there is no escape from pain or from death; (3) recognising that no matter how close I get to other people, I must still face life alone; (4) facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities ; and (5) learning that I ultimately must take responsibility for the way I live my life no matter how much guidance and support I get from others.

These existential factors represent human "givens" in life, which might be considered ultimate concerns: death, freedom, existential isolation (loneliness), and meaninglessness (Yalom & Josselson, 2011, pp. 318-322; Yalom & Leszcz, 2005, pp. 101-102). These concerns express general human existential needs that could be activated when exposed to major emotional stress. The existential approach to therapy proposes that there is a dynamic conflict between humans and these givens instead of the more classic assumption of repressed instinctual drives or internal conflict with significant adults in early childhood. All four concerns give rise to anxieties.

Death

Death is assumed to be the obvious ultimate concern, which rumbles continuously under the surface of life (Yalom & Josselson, 2011). It is clear to all humans that death will come and that there is no escape. A core inner conflict is proposed between human awareness of inevitable death and the concurrent wish to keep on living. It is assumed that humans create denial-based defences against death awareness to be able to cope with this assumed terror. These defences are assumed to shape character structure, and if they are maladaptive this might result in clinical maladjustment. From an existential point of view, psychopathology could be the result of failed death transcendence. This means that symptoms and maladaptive character structure are believed to have their origin in the individual terror of death (Yalom & Josselson, 2011, p. 321).

Freedom

Within an existential framework, freedom refers to a human being's responsibility for authoring his or her own world – for his or her own choices and actions in life (Yalom & Josselson, 2011, pp. 318-319). It is assumed that individuals need to be confronted with the limits of their destiny because of it's terrifying implications. While it is believed that beneath human existence there is only nothingness and that this awareness creates an internal conflict with the confrontation with freedom: human consciousness of freedom and groundlessness on the one side and human deep need and wish for ground and structure on the other. Yalom and Josselson (2011, pp. 318-319) proposed that the ultimate concern of freedom includes many themes that have profound repercussions for psychotherapy, such as responsibility, willingness and action. From this point of view, willingness embodies the path from responsibility to action. Many individuals have difficulty expressing their wishes, and impulsivity and compulsivity can be understood as a disorder of wishing. It is suggested that before an individual fully experiences a wish, he or she is faced with a decision.

Existential isolation or loneliness

Yalom and Josselson (2011, pp. 312-313) refer to three types of isolation: (1) *Interpersonal isolation* refers to the gap between oneself and other people resulting from deficient social skills and psychopathology in the sphere of intimacy; (2) *Intrapersonal isola*tion (intra-psychic isolation) refers to an individual's isolation from parts of his or her self that are split off; and (3) *Existential isolation* refers to the unbridgeable gap between an individual human and the world. Every human enters the world alone and must depart from the world alone, creating in a fundamental loneliness. The conflict related to existential isolation is thus between the awareness of fundamental human isolation and the wish to be protected, to merge

and to be part of a larger whole. It is proposed that fear of existential isolation, and perhaps defences against this fair for instance, using another person to fill a function in one's life rather than relating to that person out of caring for his or her being – can cause interpersonal psychopathology,

Meaninglessness

The ultimate concern of meaningless builds on the other ultimate concerns, asking questions such as, "Must each person die?" and "Does each person constitutes his or her own world?" (Yalom & Josselson, 2011, p. 320). Furthermore, if each person is alone in an uncaring universe, then what possible meaning can life have? Another question could then be whether it is possible that a "self-created meaning" is substantial enough to withstand one's life. From an existential point of view, human beings need meaning in life. This builds on the assumption that human perceptual neurological organisation instantly creates patterns out of random stimuli (Yalom & Josselson, 2011, p. 320). It is believed that people face existential situations in the same way: In a chaotic world, individuals feel unsettled and search for patterns, for an explanation and meaning of existence. Additionally, humans need a sense of meaning in life to generate a hierarchy of values. From an existential point of view, it is argued that values provide humans with a design for life, helping us make sense of not only why we live but also how we are to live. The internal conflict related to meaninglessness suggests that humans are meaning-seeking beings who have been thrown into a world that has no meaning, leading to the following question: "How does a being who requires meaning find meaning in a universe that has no meaning?" (Yalom & Josselson, 2011, p. 320).

3.2.5 Religious and spiritual approach to group psychotherapy

Another branch of group psychotherapy integrates religious and spiritual (R/S) issues into group treatment (Cornish & Wade, 2010). These types of groups apply theories and therapeutic strategies from the tradition of group psychotherapy, for instance developmental theories (Viftrup, La Cour, Buus, & Hvidt, 2016) or psychoeducational, dynamic-interpersonal, cognitive interventions (M. J. Thomas, Moriarty, Davis, & Anderson, 2011) in encounters with patients' religious and spiritual issues. Addressing these issues is a core aim of this type of group psychotherapy (Viftrup et al., 2016). Guidelines for group psychotherapy have been provided by Wade, Post, Cornish, Vogel, and Runyon-Weaver (2014, p. 137). These guidelines include considerations about when to decide to incorporate discussion about R/S topics, dealing with conflict related to R/S issues and how to process R/S issues in a group setting. Guidelines for integrating R/S into group counseling including group

psychotherapy has also been offered by Cornish and Wade (2010, pp. 401–403). Sample of questions to facilitate discussions of R/S issues in groups are included in the guidelines.

3.2.6 Healthcare chaplains' approach to group work in the USA

Spirituality groups led by American healthcare chaplains in mental health treatment settings are closely tied to the provision of CPE programmes. These types of groups are thought to provide a non-judgmental setting in which patients can discover and experience three elements for recovery: acknowledgement, meaning, and coping skills (Gangi, 2014).

Central to this way of thinking about groups is the "recovery model", in which health care providers focus on the patient as a whole person with potential to live a rehabilitated life (Lukoff, 2007, pp. 642-643). This is in contrast to a "medical model" in which mental illness is seen as a set of symptoms that must be removed (Lukoff, 2007). Spirituality is viewed as one health dimension amongst others, including mental, physical and social dimensions (Gangi, 2014).

Guidelines for a group model that chaplains apply in mental healthcare have been developed by Gangi (2014, pp. appendix 9-10). This model draws on elements from 1) *a spirituality group outline* created by Suzanne Shady (chaplain with Unity Health Systems in Rochester NY, 2) *Clinical Pastoral Education residency training* at the University of Rochester Medical Centre in Rochester NY and (3) from the 12-step recovery model (Gangi (2014, pp. 7-8). The model is presented below:

Model for a spirituality group provided in an acute inpatient psychiatric unit

Before group begins: Leader greets each patient by name upon entrance allowing patients to choose their seats around a large table.

Opening: Leader introduces him or herself and welcomes all, explaining 1) the purpose of the group, 2) the differences between spirituality and religion, 3) that the setting is a non-judgmental, that everyone's beliefs will be respected, and that all are free to share or just participate silently.

Outline of group: The leader prepares the participants for what will happen in the group. It is suggested to have a written outline written displayed for the group. This could help to establish a structure and reassure participants about what is coming next. Gangi (2014, pp. appendix 9-10) has outlined the following possible structures: (A) introductions, centring exercise, story reading – "What's in a name?", discussion of story, musical meditation and closing moments of silence/prayer; or alternatively, (B) introductions, centring exercise,

question: “What does unconditional love mean to you?”, discussion/interaction around question, “stones of hope” practical exercise and closing moments of silence/prayer.

3.2.7 Narrative approach to therapy

Psychotherapy might be considered fundamentally a process of story repair, reformulation and restoration in which disturbed and incoherent life stories are believed to influence symptoms and trigger poor mental health. Narrative therapists might help clients to transform their narratives into new stories capable of acknowledging transgression and point the way to a changed and accepting life (McAdams, 2008). This viewpoint builds on the assumption that stories are integrative. McAdams (2001), for instance, has argued that narratives have the ability to bring together incongruent qualities and tendencies in a human life into a more or less unifying and purpose-giving whole.

No single theory or research paradigm is known to represent the examination of life narratives (McAdams, 2008). However, across the many different approaches to life narratives, McAdams (2008, pp. 243-248) identifies six common principles of common understanding. (1) *The self is storied*, meaning that the self is both the storyteller “I” and the stories told about “me”. (2) *Stories integrate lives*, meaning that the most important function a story has in a person’s life is the ability to integrate. It is believed that autobiographical reasoning is a practice in personal integration putting things together into a narrative pattern that affirms life meaning and purpose. However, this practice is considered especially difficult in contemporary postmodern societies in which multiple choices and contractionary social worlds exist without guidelines for how humans should live their life or what life means (Giddens, 1991). (3) *Stories are told in social relationships*, meaning that stories are social phenomena, presumably told in line with social expectations and norms, in which discursive and performative aspects of life storytelling play an important role. (4) *Stories change over time,* meaning that autobiographical memory is unstable, and therefore contributes to the life story’s changing over time. Most recognizably, people accumulate new experiences over time, some of which may prove to be so important as to make their way into narrative identity. (5) *Stories are cultural texts,* meaning that life stories mirror the culture to which a person belongs. It is assumed that stories eventually will die according to the norms, rules and tradition, dominant in a given society. Finally, (6) *Some stories are better than others,* meaning that a life story always implies a moral perspective. In other words, humans are “intentional moral agents”, whose actions can be understood from the standpoint of what is good and what is bad in a given society.

A narrative approach to therapy has also been understood to provide privileged access to the subjective experience of illness, offering the person experiencing illness the opportunity to express his or her changing sense of self and identity (Frank, 1995; Kleinman, 1988; Woods, 2011). Kirmayer (2000) has argued in favour of the importance of using metaphors when patients' stories are broken:

> Just as fragments of poetry can be written with no overarching narrative, or only the briefest strand hinted at, so can we articulate our suffering without appeal to elaborate stories of origins, motives, obstacles, and change. Instead, we may create metaphors that lack the larger temporal structure of narrative but are no less persistent and powerful. Such fragments of poetic thought may be the building blocks of narrative: moments of evocative and potential meaning that serve as turning points, narrative opportunities, irreducible feelings and intuitions that drive the story onward. (Kirmayer, 2000, p. 155)

Healthcare chaplains' clinical practice can be considered a narrative-based chaplaincy (Swinton, 2002). This tradition highlights the therapeutic significance of illness and health narratives in encounters with patients, thus allowing the chaplain be a "bearer and sharer of stories" (Swinton, 2001, 2002). Swinton (2001, 2002) furthermore suggests recognising the narrative practice as a forgotten dimension of healthcare.

3.3 Healthcare chaplains' role and professional practice

Healthcare chaplains' professional practice has been debated extensively within healthcare contexts in European countries and also at large in the US. One might ask what kind of professional work healthcare chaplains provide and whether they fulfil a "function" in the healthcare system, negotiating power and dominance. Or should they be seen as "virtuous agents" whose purpose and goals are informed by the critical sense of their tradition? Furthermore, should healthcare chaplains be considered healthcare professionals, religious workers, spiritual care providers, pastoral care providers or clinical pastoral care providers, existential care providers, or even practitioners in practical theology?

These questions concerning the role of healthcare chaplains have evolved from processes of professionalisation and de-professionalisation that have influenced western society in the last several decades (Brint, 1994; Griffiths, 1983; Hood, 1991; Pill & Hannigan, 2010). The professions strive for legitimation, and the demand for evidence-based practices is suggested to develop from these processes. The following quote illustrates this struggle for recognition from and within the healthcare system:

> But what about chaplains? Are we not healthcare professionals who indeed have the time and training needed to listen for stories? Are we not "professional listeners" who

> are as Tim Thurston some says 'interpreters' or human experience and 'reflectors' who enable meaning-making in the midst of suffering? Chaplains need not be so mute an invisible. Instead I think that we offer a most prophetic witness in healthcare environments that calls for greater expression. Chaplains know already by their own experience how to establish a report of attentive listening presence with their patients […]. Chaplains need to claim this experience and communicate it better to others. (Mundle, 2011, p. 179; Thorstenson, 2012)

In the following, a few theories concerning professional practice will be presented. Due to the complexity of the field of healthcare chaplains' role and professional practice, some main trends that seems to be in play in different healthcare contexts will be presented. See for instance Woodward and Pattison (2000) on this.

3.3.1 What is a professional practice?

According to researchers in the field of professional practice, no unified practice theory seems to exist (Corradi, Gherardi, & Verzelloni, 2008; Kemmis & Grootenboer, 2008). Rather, it has been argued that different disciplines have taken different approaches, and similarly, different theorists have focused on practice in different ways, resulting in multiple understandings and interpretations of the practice concept (Corradi et al., 2008; Kemmis & Grootenboer, 2008). Practice is defined by the *Oxford Advanced Learner's Dictionary of Current English* as "practicing one's profession" ((Hornby & Cowie, 1993, p. 971). Practice may also refer to an occupation, field of activity, or learning method for improving one's competence or skills (Aspfors, 2012; Corradi et al., 2008). Schatzki (2012) states that a practice is an "open-ended, spatially-temporally dispersed nexus of doings and sayings" (p. 14). It has been argued that practices are descriptive of fundamental phenomena in society, and through the history of man, practice has constituted the essence of existence (Aspfors, 2012; Corradi et al., 2008; Schatzki, 2002).

There are various views of what constitutes a profession, and Pill, Wainwright, McNamee, and Pattison (2004) outline two very different approaches to understanding professions. The first approach is grounded in social science and emphasises the organisational and structural aspects of understanding social evolution. The function of a profession, then, is perceived by institutions and described by Pill et al. (2004) to be concerned with issues such as power, dominance, socio-historical factors, and context.

The second approach evolves from the tradition of philosophy, which highlights the moral significance of professions and the goods they might seek (Pill et al., 2004). This approach particularly emphasises the character of an individual professional as a virtuous agent. Pill et al. (2004) further argue that MacIntyre (1981) would be a representative of this

approach based on his understanding of what practice is. MacIntyre (1981) describes practice as purposes, goals, or ends that constantly evolve and are informed by the critical sense of their tradition. He further argues that any meaningful account of a practice will take the form of a narrative and possess a sense of both continuity and evolution. Further, MacIntyre (1981) claims competition for the external goods of particular practices is always potentially corruptive and that, if society is motivated by such competition for external goods, internal virtues are likely to be absent. Finally, MacIntyre (1981) argues that the internally related goods of practice-oriented professionals should be seen as a counterweight to this potential corruption.

MacIntyre's (1981) approach has been deemed strongly normative (Pill et al., 2004). Nevertheless, Pill et al. (2004) suggests, that a real tension in both practice and theory can be seen in the modern phenomenon of whistle blowers. Pill et al. (2004) propose that whistle blowers are often virtuous practitioners who attempt to act outside and preserve the intrinsic goods of their professional practice at the expense of criticising an encroaching institution.

According to Julia Evetts (2003), professions essentially constitute the knowledge-based category of occupations that usually follow a period of tertiary education, vocational training, and expertise. Evetts (2003) argues that to be approached as a generic group of occupations, a profession must be based on knowledge that is both technical and tacit. Furthermore, she underlines that she does not attempt to draw a hard line between professions and other occupational groups; rather, she emphasises their shared characteristics and common processes. Evetts (2003) accentuates two important aspects of professions: first, the organisational aspect, which regulates access and autonomy, is politically constituted and authorised and has a contract with society and professional associations; second, the performative aspect comprises service production, client reliance, the solving of practical problems, changes in services, use of systematised knowledge, discernment, and services that are normatively regulated and involve uncertainty

3.3.2 Healthcare chaplains' professional practices and theology

Before considering healthcare chaplains' professional practice just, I will offer a short remark on the theological context. The relationship between theology and healthcare chaplains' professional practice has been debated extensively, for instance the direction of influence between the two kind of theologies (Woodward & Pattison, 2000) and whether the professional practice should be seen as pastoral care or practical theology. The present study, however, considered pastoral care and practical theology as equal agree with Woodward and Pattison (2000, pp. preface, xiii-xviii) assertion that "pastoral or practical theology can be

defined as the place where contemporary experience and the resources of the religious tradition meet in a critical dialogue that is mutually and practically informing".

3.3.3 What professional practices are healthcare chaplains providing?

The relationships between the concepts of *spiritual care*, *clinical pastoral care* and *pastoral care* are interwoven and the definitions of these concepts have changed over time. They are all related to healthcare chaplains' professional practice (Harding, Flannelly, Galek, & Tannenbaum, 2008; Schuhmann & Damen, 2018; Thorstenson, 2012), but the use of spiritual care appears to be increasing while the use of pastoral care is decreasing within the healthcare literature (Harding et al., 2008). Nevertheless, *pastoral care* has been referred to as "care offered within Christian and Jewish communities" (Doehring, 2006, p. 6). Over time, the term has expanded to include other religious contexts, including the Muslim, Buddhist, and Hindu traditions. *Spiritual care* is understood as "care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health, or sadness and can include the need for meaning, self -worth, to express oneself, for fair support, perhaps for rites, prayer or sacrament, or simply for the sensitive listener (Handzo, 2015, p. 66; NHS Education Scotland, 2009). *Clinical pastoral care,* also called *chaplaincy care* (Handzo, 2015, p. 66), overlaps with both pastoral care and spiritual care (Figure 4). *Clinical pastoral care* is provided by healthcare chaplains with high existential competence working in treatment settings (Berthelsen & Stifoss-Hanssen, 2014; Timmins et al., 2017). The healthcare chaplains have usually completed one or several CPE units. Clinical pastoral care could be understood as a hybrid therapy and of spirituality in that it "draws from psychodynamic, family systems and narrative theories, and they speak the language of attachment disorders and maladaptive behaviours as much as the language of spirituality" (Thorstenson, 2012, p. 5).

It has also been suggested that pastoral care and spiritual care form a continuum (Harding et al., 2008, p. 115; LaRocca-Pitts, 2006). Pastoral care then refers to the care provided by a faith leader within a community that shares the same set of beliefs, practices, and values (Harding et al., 2008, p. 115). Building on the work of LaRocca-Pitts (2006), Harding et al. (2008, p. 115) claims that the nature of the care "shifts from pastoral care toward spiritual care to the degree the faith leader allows the individual's spiritual quest to take precedence over the norms of their shared faith tradition". Harding et al. (2008, p. 115), again with reference to LaRocca-Pitts (2006), underscores that in secular healthcare institutions, chaplains commonly offer spiritual care and pastoral care first to those patients who invite it.

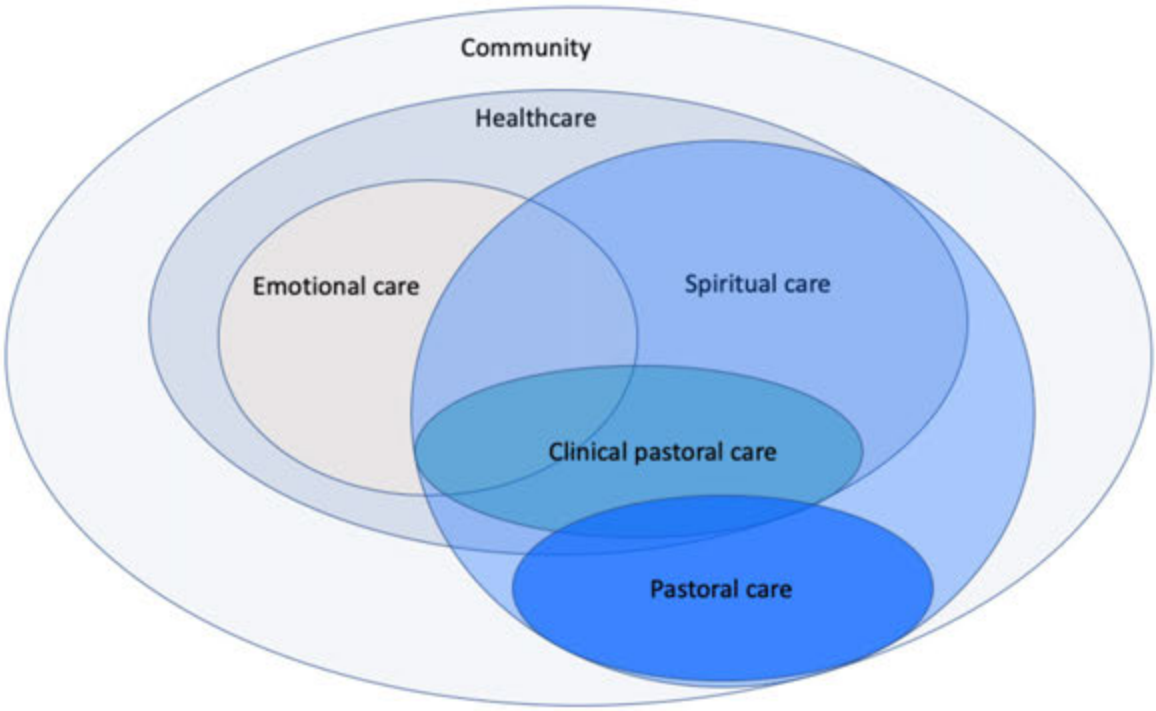


Figure 4 Illustration of the relationship between the concepts of spiritual care, clinical pastoral and pastoral care, building on a model developed by David Fleenor and George Handzo (Handzo (2015, p. 66).

4 RELEVANT RESEARCH

Several systematic searches were conducted during the preliminary phase to prepare for the research project, then again later on to prepare for each scientific article, and once again during the final phase for the present study overview. A university librarian informed the reviews, and Medical Subject Headings terms were included in the searches within the fields of group psychotherapy, healthcare chaplaincy, pastoral care, spiritual care, worldview conceptions, existential meaning-making, existential health, and mental health. However, this review emphasised research concerning healthcare chaplains' approach to groups, which is the most extensive in this context.

The following databases were included: EBSCO, ATLAS, SocIndex, CINAHL, eBook Collection, PsychINFO, PubMed, and Google Scholar. WHO and encyclopaedias in psychology of religion, pastoral care, and mental health and illness were applied to these searches when appropriate. During the search process, priority was given to empirical research within the last two decades; exclusively peer-reviewed English and Scandinavian publications were included. The research process consisted of four steps: first, the title and keywords were read; next, if relevant, the abstract was read; then, if the aim, methods, and/or results corresponded, the article was read; and finally, if the relevance was questionable, the article was read and included in the study's knowledge base if applicable.

4.1 The existential dimension

4.1.1 Existential meaning making

Addressing patients' existential, religious and spiritual issues has been demonstrated to be beneficial, as reported by a large number of research studies (Bonelli & Koenig, 2013; Gonçalves, Lucchetti, Menezes, & Vallada, 2015; Heffernan, Neil, & Weatherhead, 2014; Koenig, 2009; Koslander et al., 2009). Integrating and addressing the existential dimension in treatment settings has been proven to improve patients' mental health and reduce symptoms such as anxiety, depression, and substance abuse (Bonelli & Koenig, 2013; Gonçalves et al., 2015; Heffernan et al., 2014; Koslander et al., 2009). Spirituality has been explored among people with mental health difficulties in a qualitative systematic review (Milner, Crawford, Edgley, Hare-Duke, & Slade, 2020). The study identified six core themes characterising the spiritual experience: meaning-making, identity, service-provision, talk about it, interaction with symptoms and coping. It also found support for the importance of spirituality for people

experiencing mental health difficulties. These findings indicate the importance of mental health professionals being attentive and ready to support the spiritual dimension of people using mental health services.

In Scandinavia, research on the existential dimension and existential meaning making has been developing in clinical settings (Hanevik et al., 2017; Haug et al., 2016; Lloyd et al., 2015). In mental healthcare settings, previous research has focused on understanding ritualization and existential meaning making related to mental health function (DeMarinis, 2013) by dealing with existential information in mental health treatment settings (Ulland & DeMarinis, 2014). Religion has been identified to function as an existential resource or as a meaning making system that can influence people's mental health positively (Van Uden & Zondag, 2016). In a Norwegian study that examined the recovery processes of patients diagnosed with substance abuse disorder, informants reported that spirituality and religious activity contributed to existential meaning-making and recovery processes (Sørensen, Lien, Landheim, & Danbolt, 2015). A study conducted in Sweden found that the use of an existential framework was important for the recovery process in a group of devout Christians suffering from mental illnesses (Lilja, DeMarinis, Lehti, & Forssén, 2016).

Existential meaning making among clinical young women has also been explored (Lloyd, 2018; Lloyd et al., 2015). The findings suggest a general lack of an operating existential worldview supplemented by little or no reflection on existential worldview matters among the majority of those young women and their parents. Existential worldview function has been explored among young women on a waiting list at an outpatient psychotherapy clinic (Lloyd, af Klinteberg, & DeMarinis, 2017). It was reported that belonging and significant relationships are significantly associated with existential worldview, ontological security, self-concept and meaning in life.

In Danish secular society, a phenomenon known as "crisis faith" in which severe illness and crises seemed to intensify existential concerns and bring out spiritual and religious beliefs as sources for meaning making has been identified among people admitted to hospital (Ausker, Busch, Nabe-Nielsen, & Pedersen, 2008; la Cour, 2008). Further experimental studies have suggested that existential themes may play an important role in how people live their lives and respond to uncertain situations (Pyszczynski, Greenberg, & Koole, 2004).

4.1.2 Meaning in life, meaningfulness and crisis of meaning.

Previous research has identified "meaning in life" (MIL) as a significant factor of mental health and well-being in people's lives (DeMarinis, 2013; Heintzelman & King, 2014; Mascaro & Rosen, 2008; Schnell, 2009). MIL has been reported to help with prevention and

treatment of mental illness (Marco, Guillén, & Botella, 2017), as well as fostering adaptive coping processes in clinical settings (Lilja et al., 2016; Park, 2010). By contrast, the experience of crisis of meaning can be devastating to human life and is strongly associated with negative well-being, which may be related to depression and anxiety (Lilja et al., 2016; Schnell, 2009; Schnell, Gerstner, & Krampe, 2018).

In several studies with large population samples applying the SoMe questionnaire, explicit religiosity and spirituality were amongst those sources of meaning that were significantly associated with the experience of meaningfulness (Damásio, Koller, & Schnell, 2013; Pedersen et al., 2018; Schnell, 2009; Sørensen et al., 2019). In a Danish study employing SoMe, religious characteristics were also found to be more significantly associated with meaningfulness compared to socio-demographic variables (Pedersen et al., 2018).

Individual differences in motivation of meaning in life have also been found, suggesting that sources of meaning vary depending on people's views of life. For instance, people with a secular view of life, for example, atheists, have reported engaging more with self-actualization, such as individualism and achievement (Pedersen et al., 2018; Schnell & Keenan, 2011) while people who are more religious seem to be more motivated by self-transcendence (Pedersen et al., 2018)

4.1.3 General coping and religious and spiritual coping

Coping strategies have been widely explored in mental healthcare and can be divided into two groups: problem-focused strategies that focus on behavioural activities and emotion-focused strategies that focus on expressing emotions (Brougham, Zail, Mendoza, & Miller, 2009). It has been argued that MIL and positive well-being seem to be critical features of the coping process with regard to stressful life events (Folkman & Moskowitz, 2000; Park, 2010; Park & Folkman, 1997). Furthermore, hope is found to be essential for people who are coping with serious and persistent psychological stress; hope and coping have been suggested to have a dynamic and reciprocal relationship, each supporting and being supported by the other (Folkman, 2010).

Another branch of coping theory is religious and spiritual coping, also widely applied in clinical settings and research (Pargament, 2001, 2011; Pargament & Raiya, 2007; Park, 2005a, 2005b, 2010; Park & Folkman, 1997). Within this tradition, faith has been identified as an important resource for recovering from serious mental illness (Exline, Pargament, Grubbs, & Yali, 2014; Exline & Rose, 2014; Yangarber-Hicks, 2004). For instance, Exline et al. (2014) has identified six domains of R/S struggle: "*divine* (negative emotion centred on

beliefs about God or a perceived relationship with God), *demonic* (concern that the devil or evil spirits are attacking an individual or causing negative events), *interpersonal* (concern about negative experiences with religious people or institutions; interpersonal conflict around religious issues), *moral* (wrestling with attempts to follow moral principles; worry or guilt about perceived offenses by the self), *doubt* (feeling troubled by doubts or questions about one's r/s beliefs), and *ultimate meaning* (concern about not perceiving deep meaning in one's life)" (pp. 208-210). The study emphasised the importance of paying attention to religious and spiritual struggles, both as a source of support and also as a burden like not feeling forgiven.

Spiritual coping among patients suffering from schizophrenia has been explored by Hustoft et al. (2013). The study reported that the participants demonstrated many signs of spiritual struggle and transitional spiritual coping strategies that were seemingly linked to hallucinatory experiences. However, although the participants' spirituality met the criteria for religious delusions, the study found it was nevertheless of vital importance to the patients. In secular Scandinavia, nature has been found to be a sacred and available resource to which people turn to cope (Ahmadi, 2006).

4.2 Group work and clinical traditions

4.2.1 Group psychotherapy

Group psychotherapy is frequently applied in mental health treatment settings (Lorentzen & Ruud, 2014). The aim of group psychotherapy is to reduce patients' symptoms of mental illness and improve their intrapsychic balance (Karterud, 2007).

Systematic reviews and meta-analyses have documented the effects of group psychotherapy on inpatients diagnosed with personality, substance abuse and psychotic disorders (Leichsenring & Rabung, 2008; Orfanos, Banks, & Priebe, 2015). Previous research indicates that patients diagnosed with a personality disorder who participated in long-term dynamic group psychotherapies improved significantly on all outcome variables compared to their short-term counterparts (Kvarstein, Nordviste, Dragland, & Wilberg, 2017; Lorentzen, Ruud, Fjeldstad, & Høglend, 2015).

A Norwegian cross-sectional study conducted by Lorentzen and Ruud (2014) has explored and identified nine different categories within the Norwegian clinical field of general group psychotherapy: theme oriented, physical activity, psycho-educative, cognitive behavioural, psychodynamic, body consciousness, art/expressive, social skills/communication/coping, and eclectic. The psychodynamic approach is most frequently

applied. Lorentzen and Ruud (2014) determined that half of the group therapists within mental health services reported having received formal group therapy education. They also reported that although merely 16% had received one to five years of formal training in psychodynamic group therapy, as many as 35% had been trained in various other therapy traditions for a shorter duration. Lastly, general core aims in group psychotherapy were reported to be improved interpersonal relationships, reduced symptomatic distress and increased self-knowledge.

Therapeutic change in group psychotherapy has been described by Yalom and Leszcz (2005) as "an enormously complex process that occurs through an intricate interplay of human experiences which I will refer to as «therapeutic factors" (p. 1).

4.2.2 Existential approach to groups and existential therapy

In a study focusing on a group practice (Johnson, 1997), patients with a chronic mental illness reported relief when they were able to talk about their fears in life. Moreover, patients reported a renewed strength in battling their hopelessness during their group practice work.

Existential therapy is generally reported to be expanding in the field of mental healthcare, and can be found in various practices, such as counselling for persons suffering from psychotic disorders and drug abuse (Correia, Cooper, & Berdondini, 2016; Mendelowitz & Schneider, 2008; K. J. Schneider, 2011).

An international survey on the nature of existential psychotherapy was conducted among practitioners from 48 countries, asking them to identify the authors and texts that had most influenced their practice (Correia et al., 2015). The study found *Man's search for meaning* (Frankl, 9.4%), *Existential psychotherapy* (Yalom, 9.2%), *Practicing existential psychotherapy* (Spinelli, 3.5%), *The doctor and the soul* (Frankl, 3.5%), *Everyday mysteries* (van Deurzen, 3.4%), and *Existential counselling & psychotherapy in practice* (van Deurzen, 3.2%) to be the most influential texts among the practitioners.

In a meta-analysis of existential therapies for somatically ill patients (Vos et al., 2015), fifteen randomised controlled trials were identified, while the following four types of outcomes were categorised: effects on positive MIL, improvements in symptoms, self-efficacy, and physical well-being. The authors concluded that evidence exists for the successful incorporation of MIL-centred discussion into structured interventions. In a recent review of humanistic experimental psychotherapy (including existential therapy), reported positive effects include improvement of depression, relationship quality, substance abuse, eating disorders, psychosis, and anxiety (Elliott, Watson, Greenberg, Timulak, & Freire, 2013).

4.2.3 Religious and spiritual approaches to group psychotherapy

Research on group psychotherapy integrating R/S issues is less developed than research on individual therapy with a similar focus (Wade et al., 2014).

A systematic review of research on group psychotherapy that addresses R/S issues reported that participation in such groups strengthens participants' motivation to take part in psychotherapy (Viftrup, Hvidt, & Buus, 2013). These types of groups have, however, been reported to be poorly conceptualised (Viftrup et al., 2013).

R/S are reported to intersect with psychological functioning and addressing R/S issues in group psychotherapy is often difficult and uncomfortable (Wade et al., 2014). Facilitation of discussions by group therapists – who, for instance, carefully choose when to follow up with clients and present the subject, manage conflict and help clients process in group interactions that occur in response to discussions of R/S – is found to be important (Wade et al., 2014).

Chen, Thombs, and Costa (2003, p. 459) have noted the importance of diversity in group composition. They emphasised that cultural variables are powerful in shaping interpersonal interactions in the external world and should therefore be taken into account in group composition. Phenomena such as "avoidance of religion, acceptance of society's dominant religious group as the norm, or subgrouping and conflict related to religion" are likely to occur (Chen et al., 2003, p. 459).

Psychodynamic groups integrating R/S issues for patients within a psychiatric hospital have been examined by follow-up designs (Stålsett, Austad, Gude, & Martinsen, 2010; Stålsett, Gude, Rønnestad, & Monsen, 2012). The studies reported that participation significantly reduced patients' symptoms and improved their relational patterns

Effectiveness of a spirituality group compared with cognitive and emotional support groups has been examined among 122 women receiving inpatient eating disorder treatment (Richards, Berrett, Hardman, & Eggett, 2006). The study found that patients in the spirituality group tended to score significantly lower on psychological disturbance, eating disorder symptoms and higher on spiritual well-being compared to patients in the other groups (Richards et al., 2006).

Religions transformation among Danish Pentecostals attending religiously integrated groups has been explored (Viftrup et al., 2016). The study found that when the religion's meaning system was under pressure, the participants in the study constructed new religious meaning. The findings suggest that addressing religious transformation in group

psychotherapy can enhance mental health from the perspective of both meaning systems and religious development.

The effect of R/S group psychotherapy based on the so-called Happy Science doctrine was examined among 118 Japanese mental disorder outpatients (Chida, Schrempft, & Steptoe, 2016). The treatment group showed a significant reduction in depressive symptoms at 3-month follow-up compared to the control group.

Another study examining effects on outpatient group psychotherapy among patients with a Christian religious affiliation found significantly less attachment anxiety with God and less attachment avoidance with God, as well as more congruence between the emotional experience of God and theological beliefs about God (M. J. Thomas et al., 2011). Allegorical bibliotherapy and cognitive restructuring interventions were found to be most therapeutically effective.

4.2.4 Healthcare chaplains' approach to group work in the United States and Norway

Little literature and research exist on chaplains' group work in mental health in a US context (Gangi, 2014; Kidd, Maripolsky, & Smith, 2001; Popovsky, 2007). Several labels are used to describe these type of groups, including *spiritual growth group* (Clinebell, 1984), *chaplains' group* or *spirituality group* (Hirschmann, 2011), *spiritual issues discussion group* (Popovsky, 2007) and *spirituality matters group* (Revheim & Greenberg, 2007; Revheim, Greenberg, & Citrome, 2010) amongst others.

Spiritual growth groups are suggested to be similar to various other kinds of growth groups provided in congregations based on Biblical interpretations as well as acceptance of the author of biblical scripture (Clinebell, 1984). These groups focus primarily on participants' spiritual dimension. Psychological outcomes of the experience of group participation are considered only as supplementary to spiritual enhancement (Genia, 1990). For instance, the use of biblical stories as a therapeutic approach among patients with mental illness was explored by Kidd et al. (2001). They found that that patients experienced the provision of a therapeutic opportunity for exploring beliefs, cultures, and values was as helpful.

Religious-issues therapy groups in day-treatment programmes (Kehoe, 1998), also described as *therapy groups on spiritual issues* (Kehoe, 1999), have been suggested to have influenced chaplain led groups for patients with chronic mental illness in the United States (Gangi, 2014; Hirschmann, 2011; Popovsky, 2007). Nany C. Kehoe (2016, 2017), who has led these groups since the 1990s, accentuates that the goal for this type of group is to

> provide a therapeutic context for clients examinations off their religious beliefs their religious traditions and their families involvement in our religious tradition as well as to facilitate the exploration of some of the questions, problems and feelings clients have about their religious beliefs, their spirituals believes, or the absence of either in their lives. (1998, p. 47)

These groups also offer an opportunity to explore the ways in which religious or spiritual beliefs and values are or are not a part of clients lives; they are not, according to Kehoe (1999), considered prayer or Bible study groups. Hirschmann (2011) examined a *chaplaincy group* held in an inpatient psychiatric setting. Patients telling stories about their lives and reacting to others' life stories was found to be a core feature of the group. Furthermore, the group was found to give patients an opportunity to reflect on the experience of being in the group, a place where they could find points of communality with others in a similar situation, seek affirmation and fellowship and test out ways of interacting positively with others. The study by Hirschmann (2011, p. 973) found "the need to be authentically present and engaged", "the need to be the focus of others' attention", "the pleasure that comes from answering questions directed to us alone" and "the need to give voice to our longings" to be important considerations when providing group therapy.

Participation in a *spiritual issues group* for patients in a psychiatric day treatment programme suffering from mental illness was explored by O'Rourke (1996). The purpose of the study was to explore how group psychotherapy as a treatment modality can aid patients suffering from mental illness in resolving spiritual and religious crises, as well as to distinguish spiritual resources as agents in the process of recovery. The group gave patients a chance to scrutinise their spiritual beliefs, religious conflicts and doubts, as well as the positive dimension of their religious experience. Findings showed that the spiritual issues group acted as a transitional space for patients between communities of support. Participating in the group also provided patients with opportunities for corrective religious and emotional experiences (O'Rourke, 1996).

A description of a *spiritual issues discussion group* for psychiatric inpatients at New York Presbyterian Hospital with frequent turnover has been provided by Popovsky (2007). The group was open to people of all faiths, offering all patients space to explore the many relationships between their beliefs, past experiences, mental illness, and spiritual lives. The goal of the group was to give patients an opportunity to reflect on their own spiritual resources, which have been suggested to support them in their recovery from illness. Popovsky (2007, p. 128) noted that the spiritual issues discussion group "provides an

important opportunity for psychiatric in-patients to begin to integrate their spiritual journeys and their recovery processes form mental illness."

Another report explored a *spirituality matters group* for persons with persistent psychiatric disabilities; the group was described as highly structured (Revheim & Greenberg, 2007). The brief report discussed activities and themes from certain group sessions applying a recovery-oriented emotion-focused coping framework. The group was found to offer comfort and hope through structured and innovative exercises focusing on spiritual beliefs and coping. This is in line with recent studies on the recovery potential of spirituality as a factor improving recovery in therapeutic practices. Revheim and Greenberg (2007) support the view that group activities using spiritual themes permit persons with persistent psychiatric disabilities to explore positive emotion-focused coping.

A *spirituality-based therapeutic group* was examined among patients hospitalised with schizophrenia (Revheim et al., 2010). Potential associations between spirituality and coping among patients who either attended (n = 20) or did not attend (n = 20) the group were explored. Spirituality, self-efficacy, quality of life, hopefulness, and religious/personal demographic profiles were measured. Findings showed that for the total sample, spirituality status was significantly correlated with self-efficacy. Furthermore, significant differences were reported between group attendees and non-attendees for spirituality status, but not for self-efficacy or quality of life. For group attendees, spirituality status was significantly correlated with self-efficacy for positive symptoms, negative symptoms and social functioning. Group attendees were significantly more hopeful than non-attendees and hopefulness was significantly associated with degree of spirituality. The findings lend support for offering spirituality groups and positive coping throughout recovery from psychiatric disabilities (Revheim et al., 2010).

Patients were positive about their experiences of involvement in EGs led by Norwegian healthcare chaplains (Frøkedal & Austad, 2019). Enhanced self-reflection, new skills, strengthened self-confidence, and reduced loneliness were described as added values by the patients when participating in the EGs (Frøkedal & Austad, 2019). According to some of the patients, EGs provided spiritual/religious growth and enhanced existential reflection (Frøkedal & Austad, 2019).

4.2.5 Narrative approach

An increasing number of narratives interventions have been applied in clinical settings within the last few decades (Graaf, Sanders, & Hoeken, 2016; Woods, 2011). The literature on narrative and the self originates from psychology, philosophy, sociology, literary studies,

anthropology, psychiatry, and neuroscience, encompassing memory, identity, ethics, and emotions; this type of literature seems to be growing as a central concept in the medical humanities (Woods, 2011). Chaplains working in the field of mental health have been identified as using narrative as an approach in encounters with patients (Penner, 2006).

The usefulness of narratives in medical humanities is disputed (Strawson, 2004; Woods, 2011). Questions have been raised, for instance, about the truth contained in patients' stories of their experiences (Freeman, 2008), as well as about therapeutic and transformative aspects (Hunt, 2000; Peterkin & Prettyman, 2009).

4.3 Healthcare chaplains' role and professional practice

International research on general clinical healthcare chaplaincy has been developing (Ford & Tartaglia, 2006; Poncin, Brandt, Rouiller, Drouin, & Robert, 2019). In recent years, it has been argued that clinical outcome studies in chaplaincy care (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014) have strengthened the position of healthcare chaplaincy in healthcare settings (Orton, 2008; Weaver, Flannelly, & Liu, 2008; Weaver, Flannelly, & Oppenheimer, 2003).

Research on the healthcare chaplain's role and professional practice has been evolving (Handzo et al., 2008; Swift et al., 2012, 2016). For instance, in European countries, through the European healthcare chaplaincy network, topics such as being recognised as professional partners in changing healthcare institutions has been explored (Kofinas, 2006; Miller & Burton, 2014). Similar research projects on healthcare chaplain's professional practice and role have been conducted in the UK (Ballard, 2004, 2010; Handzo et al., 2014; Macritchie, 2001; Pattison, 2010; Swinton, 2003), in the US (Cramer, Tenzek, & Allen, 2013; Vries, Berlinger, & Cadge, 2008), in Canada (Mela et al., 2008) and in New Zealand (Carey & Del Medico, 2013).

In the US, Vries et al. (2008) explored whether healthcare chaplaincy is a form of religious ministry or a healthcare profession in healthcare settings. They argued that chaplains must strengthen their professional status in order to clarify and establish agreed-upon standards of practice in healthcare. Further, they suggested using the term "translator" to describe the healthcare chaplain's role in healthcare because healthcare chaplains often use the term themselves to describe their work. Vries et al. (2008) further suggest that healthcare chaplains provide a kind of translation when they listen to patients' deepest concerns and help them redefine their lives. Vries et al. (2008) point out that a patient, family member, nurse, or

physician may seek out the healthcare chaplain for assistance translating a situation with questions such as “Is the family in denial?”, “Is the team giving up?”, and “Is the patient ready to go home like she said, or is there something else we should pay attention to?”

Researchers in the UK have argued for healthcare chaplains’ full integration into interdisciplinary teams (Swift, 2009; Swift et al., 2012, 2016) and have further emphasised that healthcare chaplains are skilled brokers of spiritual care beyond the limits of their own faith formation (Swift et al., 2012, p. 188). Some researchers in the UK have reflected upon the dilemma tied to healthcare chaplains’ profession and have suggested that a vital part of the chaplaincy is at risk of being lost when chaplains are considered healthcare professionals; for instance, they may be considered catalysts for transformative healthcare practices (Ballard, 2010; Swinton, 2003). Others, meanwhile, have argued that the clergy are considered professional amateurs or court jesters in clinical settings (Ballard, 2004) and have described the healthcare chaplain’s professional identity as that of a translator (Macritchie, 2001).

Healthcare chaplains’ communication tasks were examined (Cramer et al., 2013) and described as offering presence, respecting diversity, listening to concerns, and providing support (Lyndes, Fitchett, Thomason, Berlinger, & Jacobs, 2008). However, Cramer et al. (2013) conclude that these communication tasks might not carry much weight in the medical world due to the difficulty associated with measuring spiritual care services. Cramer et al. (2013) further accentuate that healthcare chaplains encounter difficulty when translating the profession’s benefits in ways that resonate with patients, team members, and hospital administrators alike.

A systematic review of the biomedical literature regarding pastoral care providers in inpatient psychiatric units by Pennybaker, Hemming, Roy, Anton, and Chisolm (2016) found that multiple studies suggest that psychiatric inpatients have spiritual needs that are often unrecognised and/or unmet by the traditional care team (Galek, Flannelly, Koenig, & Fogg, 2007; Khan, 2006; Lawrence et al., 2007). The review suggest that these findings supports the need for incorporation of pastoral care providers into inpatient psychiatric care teams. Additionally, data from these studies indicated, the review accordingly, that these unrecognised or unmet spiritual needs was not restricted only to patients who were openly religious (Khan, 2006; Lucchetti, Braguetta, Vallada, & Vallada, 2013; McGee & Torosian, 2006). Nevertheless, the review found no support of any patient harm from pastoral care integration into care team, but “the opinion of experts in this field is that PaC (pastoral care) may be most effective when these providers are well integrated into the current care team with well- defined roles and are given specific training in working with psychiatric patients.

However, it must be added, there is no strong evidence to either support or refute this opinion" (Pennybaker et al., 2016, p. 380). The review identified multiple case reports of spiritual working groups from which patients reported benefiting to participate (Grossoehme, 2001; Jensen, Cozza, Flynn, & Karabin, 1998; Meyer, Royer, & Nighswonger, 1967; Pasewark, Hall, & Grice, 1969; Smith & Suto, 2014)

In an analytical review (Poncin et al., 2019) of healthcare chaplaincy publications on chaplains and theologians between 2000 and 2018, five areas of focus were identified: chaplains' practices, spirituality, research, impact, and healthcare professionals' spiritual care practices. They further assert that publications ought to strive for greater conceptual clarity to establish common research standards and apply more critical research designs. Poncin et al. (2019) also recommended that research projects focus on documenting and improving rather than justifying practices. However, the following concern related to the research field of healthcare chaplaincy was expressed: "…, until chaplains are fully accepted as essential members of multidisciplinary healthcare teams, the evolution toward a more mature, objective, and critical healthcare chaplaincy literature might prove difficult" (Poncin et al., 2019, p. 16).

4.4 Mental health professionals' viewpoints

How healthcare professionals meet patients' spiritual questions is suggested to be crucial for the patients' health condition (Sulmasy, 2006). It has been claimed that

> illness is a spiritual event. Illness scraps persons by the soul as well as by the body an disturbs both. Illness ineluctably raises troubling questions offer transcendent nature - question about meaning, value, a relationship. These questions are spiritual. How healthcare professionals answer these questions for themselves will affect the way they help their patients struggle with these questions. (Sulmasy, 2006, p. 17)

Sulmasy (2006) holds the viewpoint that spirituality is not only for religious people: "even an atheist has a spirituality because an atheist must search for a personal meaning and value in light of his or her rejection of the possibility of a transcendent source of personal meaning and value" (p. 14).

Previous international surveys from the 1970s and 1980s that explore mental health professionals from the US found that they were less committed to traditional values, beliefs, and religious affiliations than were non-clinical populations (Beit-Hallahmi, 1977; Bergin, 1980; Henry, Sims, & Spray, 1971). An US international survey in 1990 somewhat modified

these findings and identified a surprisingly significant level of unexpressed religiosity among mental health professionals (Bergin & Jensen, 1990).

More recently, several international studies from the US (Curlin et al., 2007), the UK (Lawrence et al., 2007), and Germany (E. Lee, Zahn, & Baumann, 2014) have explored mental health professionals' attitudes and behaviours towards religiosity and spirituality in clinical practice. All these studies report professionals' openness towards spiritual and religious matters, yet the researchers did not often encounter these issues being addressed in clinical practice. Barriers to integrating these matters include professional neutrality, lack of time, the perception that these matters fall outside one's area of professional responsibility, and insufficient knowledge (E. Lee et al., 2014).

Some studies have also included healthcare chaplains when exploring mental health professionals. For instance, Galek et al. (2007) found that mental health professionals (medical workers, social workers, nurses, and chaplains) referred patients to chaplains for issues related to loss, meaning, and death. In another study, more collaboration with communal clergy and mental health professionals was suggested to add value to mutual learning (Weaver, Flannelly, Flannelly, and Oppenheimer (2003). Healthcare chaplains were found to provide a significantly less positive assessment of psychiatrists' and psychotherapists' attitudes towards spiritual and religious concerns compared with the psychiatrists and psychotherapists (E. Lee, Zahn, & Baumann, 2015).

Research suggests that attitudes towards spiritual and religious issues in mental health practice vary across professions (Dein, Cook, Powell, & Eagger, 2010). Nurses have been reported to more frequently share their religious and spiritual backgrounds with patients than do psychiatrists (E. Lee et al., 2014), while psychiatrists tend to be less religious than their patients (Lukoff, Lu, & Turner, 1992) - although this condition may be changing (Curlin et al., 2007). A Norwegian study that examines the Norwegian education of psychology reported that existential, religious and spiritual concerns were neglected, thus resulting in insufficient training that did not meet E/R/S concerns in clinical practice (Reme, Berggraf, Anderssen, & Johnsen, 2009).

At a Norwegian hospital, Ulland and DeMarinis (2014) investigated therapists working with existential information in an adolescent psychiatric context, finding that therapists' backgrounds and existential orientations had a striking impact on their practice, goals, their values of care, and how existential information was applied in therapy practice.

Within a Norwegian mental healthcare context, Borge and Mæland (2017) explored mental health professionals' experiences with spirituality during encounters with patients,

reporting that spirituality was not often addressed in general clinical mental healthcare practice, but was rather considered taboo.

In regard of existential competence, no developed measurement was identified. Various scales of spiritual care competence was however identified (Burke et al., 1999; Dailey, Robertson, & Gill, 2015; Kelly, 2012; Robertson, 2010; Van Leeuwen, 2008; Van Leeuwen, Tiesinga, Middel, Post, & Jochemsen, 2009) even applied in a Norwegian context (Ross et al., 2016). Nevertheless, existential competence in Norway was not found to be operationalised in the form of an instrument measure.

5 DESIGN, MATERIALS AND METHODS

The present study explored an existential group practice led by healthcare chaplains in mental health treatment settings. The field of mental health contains "competing and mutually exclusive ideologies"; notably, three different discourses have been identified – the psychological-social discourse, the psychiatric discourse and the spiritual-theological discourse (Sutherland, 2000, pp. 275-277). Accordingly, a main aim of this study was to seek practical solutions to the problem of differing ideologies and methodologies interwoven and situated in the group practice explored herein. To this end, the paradigm of pragmatism was chosen applying multiple methods, various worldviews and assumptions, as well as different ways of collecting and establishing data and analyses (Creswell, 2014). Table 3 presents an overview of the research design including its theoretical positioning in relation to the philosophy of science (Krumsvik, 2016, pp. 109-112).

The chapter is divided into several parts: First, I present the research design of the study, followed by research field and discipline. Next, I explain the recruitment process and present the sample, strategies of inquiry, analytical strategies and analysis. Finally, I discuss my engagement in the study and ethical considerations.

5.1 Research design

Research design, which I refer to as the plan or proposal to conduct research, involves the intersection of philosophy, strategies of inquiry, and specific methods (Creswell, 2014). Table 3 give an overview of the research design for the three sub-studies in which the strategies of inquiry and specific methods are presented. A detailed description of strategies of inquiry is presented in section 5.5. To fulfil the study's aim and answer the research questions, a nationwide cross-sectional design was chosen (Table 3), which gives a snapshot of merely one particular point in time (Creswell, 2014). To strengthen the design, data from both open-ended and close-ended responses were obtained from the web-based survey questionnaire in stub-study 1 and 2 (Foddy, 1994). Due to the considerably sensitive information, printed questionnaires were applied in sub-study 3. The research design's theoretical positioning in relation to the philosophy of science will be presented in the following section.

Table 3. Overview of the research design for the three sub-studies including its theoretical positioning in relation to the philosophy of science

	Ontology *Nature of reality*	**Methodology** *Research design: A nationwide, cross-sectional design*	**Data collection** *Type of material*
Sub-study 1	•Paradigm of pragmatism •Truth is what works at the time •The world may either be constructed or exist independently of the mind •Social reality is multiple	•An explorative, descriptive nationwide cross-sectional web-based survey design •Quantitative material supported by qualitative material •Aim of research questions: Understanding "What"	Data derived from web-based survey completed by healthcare professionals including healthcare chaplains: •Close-ended responses •Open-ended responses •Demographical data •101 completed web-based surveys
Sub-study 2	•Paradigm of pragmatism •Truth is what works at the time •The world may either be constructed or exist independently of the mind •Social reality is multiple	•A nationwide, cross-sectional web-based survey design •Influenced by a convergent, parallel, mixed-methods design •Aim of research questions: Understanding "What" and "in what ways"	Data derived from web-based survey completed by healthcare professionals including healthcare chaplains: •Close-ended responses •Open-ended responses •Demographical data •101 completed web-based surveys
Sub-study 3	•Paradigm of pragmatism •Truth is what works at the time •The world may either be constructed or exist independently of the mind •There is concrete world "out there"	•A nationwide, cross-sectional design •Quantitative material •Aim of research questions: Statement of relationship between independent and dependent variables	Data derived from questionaries' completed by patients: •Statement of relationship between independent and dependent variables •Questions phrased in term s of hypothesis •Demographical data •157 completed questionnaires

	Epistemology *What can we know and who can know*	**Methods** *Methods best proper for understanding the research problem*	**Data analysis** *Type of analysis*
Sub-study 1	•Objectivistic and subjectivstic •Goal to understand multiple subjectivities. •No definitive subject-object split in knowledge-building (individuals and scientists are the experts)	•Quantitative and qualitative methods applied	• Descriptive statistics (SPSS version 22) •Content analysis •Abductive approach
Sub-study 2	•Objectivistic and subjectivstic •Goal to understand multiple subjectivities •No definitive subject-object split in knowledge-building (individuals and scientists are the experts)	•Mixed methods applied	•Qualitative and quantitative data were analysed separately •Qualitative material applied a content analysis •Quantitative material applied descriptive statistics, •Paired sample T-test •One-way between-groups analysis of variance •Tukey's post hoc tests •Side-by-side comparison of qualitative and quantitative material as part of the discussion • Abductive approach
Sub-study 3	•Objectivistic •Goal to ascertain "the truth" in order to predict and uncover "laws" of human behaviours through objective social inquiry (scientists are the expert)	•Quantitative method applied	•Descriptive statistics •Cronbach's alpha •Confirmatory factor analysis with Oblimin rotation •Multiple regression analysis •Deductive approach

5.2 Theoretical positioning

The current study is situated within the paradigm of pragmatism (Cherryholmes, 1992; Grbich, 2012; Rossman & Wilson, 1985). Pragmatism is a philosophical movement that gained prominence in the aftermath of the American Civil War, emphasising democracy, plurality and reconstruction, and represented by central thinkers like Charles Sanders Pierce, William James, and John Dewey (Neal, 2011). For pragmatists, who are not committed to any system of philosophy or reality, the world may either be constructed or exist independently of the mind (Cherryholmes, 1992). According to Cherryholmes (1992), questions regarding reality and the laws of nature are not a primary concern within the paradigm. Rather, the focus is on finding practical solutions to problems independently of ideologies and methodologies (Morgan, 2007; Patton, 2002). Working within this paradigm, researchers are free to choose methods, techniques, and procedures that optimally fit the study's purpose (Creswell, 2014).

Generating and comparing different sorts of data from various respondents' perspectives has its origins in the method of triangulation, which attempts to validate research findings on the topic under investigation (Denzin, 1989; Torrance, 2012). One such validation technique is respondent validation (Torrance, 2012), also called member checking (Birt, Scott, Cavers, Campbell, & Walter, 2016; Harvey, 2015)

The present study explored a group practice situated within interdisciplinary mental healthcare treatment settings. The health professionals who work in these settings are anchored in different traditions of philosophy of science and their views of knowledge vary depending on their professional background (Borge, 2013; Sutherland, 2000). The decision in the present study to combine different methodologies (mixed methods) influenced the choice of the analytical approach. Furthermore, to enhance trustworthiness (Birt et al., 2016), healthcare chaplains were invited to validate (check) synthesised analysed data (Harvey, 2015) in sub-study 1. The invitation to validate was based on a key assumption of pragmatism, namely that conclusions in inquiry should be "referred back to ordinary life experience" and make a difference to practitioners (Dewey, 1958, p. 7). From an epistemological point of view, the validation was performed in both a positivistic (checking results) and constructionistic (providing an opportunity to comment and supplement data) way (Birt et al., 2016).

The combination of different research methods in multidisciplinary health professions-based research is also considered desirable and adds value when each discipline can bring its own unique perspective to collaborative projects (Z. Schneider & Whitehead, 2013). The current study, which includes health professionals from a variety of backgrounds on the

research team (psychologists, psychiatrists, psychiatric nurses, and healthcare chaplains) was influenced by this perspective.

5.2.1 Research fields

The present study can be considered to belong to two different research fields. First and foremost, the study can be situated within the recently developed research field of existential public health promotion in Scandinavia (Cetrez, 2011; DeMarinis, 2008; Haug et al., 2016; Lloyd, 2018; Melder, 2011). This research field builds upon knowledge from the discipline of public mental health, which incorporates a health promotion perspective. Second, the study's focus extends to the research field of chaplaincy (Ford & Tartaglia, 2006; Swift et al., 2012, 2016; Swinton, 2001, 2002), which considers the professional practice tied to healthcare chaplains' work and competence in treatment settings (Berthelsen & Stifoss-Hanssen, 2014; Ford & Tartaglia, 2006; Swift et al., 2016; Timmins et al., 2017).

5.2.2 Discipline

The present study is situated within the discipline of psychology of religion and more specifically the subarea of clinical psychology of religion (Van Uden & Pieper, 2003). Perspectives of culture, experience and meaning have also been taken into account, in line with the pragmatic cultural approach to the psychology of religion described by Cresswell (2014). Despite being grounded in secular reasoning, pragmatism has also influenced theology and religion through a reconstructive spirit that regards pragmatic secularism as an aid to faith rather than a denial (V. Anderson, 1998). Pragmatism has also been incorporated into pastoral theology (Doehring, 2006, pp. 169-170), specifically through pragmatic historicism, which emphasises the "embodied, material, and political character of historical existence" Davaney (2000, p. x).

Clinical psychology of religion influenced the present study in four different ways. Firstly, it constituted a theoretical foundation for examining the characteristics of a group practice that gives patients room for existential meaning making in a clinical context (sub-study 1). Secondly, it provided a framework for exploring healthcare chaplains' and healthcare professionals' attitudes, practices, understandings, and perceptions of value regarding their addressing of the existential dimension in mental health (sub-study 2). Thirdly, it provided a framework for exploring patients' various ways of meaning making in the EGs (sub-study 3). Finally, it made it possible to link the study to the growing body of research within the field of clinical psychology of religion in Scandinavia, which is interwoven with

the research field of existential public health promotion in Scandinavia (Cetrez, 2011; DeMarinis, 2008; Haug et al., 2016; Lloyd, 2018; Melder, 2011).

The discipline of psychology of religion employ different psychological theories and methods for studying faith and worldviews as experiences, behaviours, and functions. Exploring individuals' meaning-making processes centrally contributes to understanding how faith and worldviews may support or burden the human experience of crisis and illness (Belzen, 1997; Danbolt, 2014).

5.3 Recruitment and sampling

A research protocol was developed as required as part of planning a study (see section 5.5.1) in accordance with the Health Research Act (2008 §6).

The informants (healthcare chaplains, mental health professionals, and patients) were recruited from the Norwegian specialist mental health services. A stepwise recruitment process was applied. In order to identify all the EGs led by healthcare chaplains across the Norwegian health trusts, the healthcare chaplains were recruited from within all 19 trusts (cf. The Ministry of Health and Care Services, 2018, Norwegian Government web-based overview of health trusts).

5.3.1 Step 1: Recruitment of healthcare chaplains

Based on information from the Norwegian Association of Clergy (*Presteforeningen*) dated June 2015, 91 hospital chaplains and 2 deacons working for the Norwegian health trusts were identified. In order to locate all the EGs run by healthcare chaplains across the Norwegian health trusts, all 19 trusts were contacted by phone and asked if the healthcare chaplains were running EGs for patients. To ensure all healthcare chaplains were included, they were systematically asked if they knew someone else conducting an EG within the same health trust.

Starting with a list (dated June 2015) of 91 potential healthcare chaplains and 2 deacons, a total of 27 healthcare chaplains were identified as having experience leading groups. However, of these, only 21 were leading a group at the time they were contacted and were thus considered possible informants for the study. Only healthcare chaplains leading EGs in mental healthcare were of interest in this study. In total, the 21 healthcare chaplains identified ran 49 EGs.

5.3.2 Step 2: Recruitment of Norwegian health trusts

After the healthcare chaplains leading EGs were identified and expressed willingness to participate in the study, an application was sent to their respective health trusts to gain access to the clinical setting. The information contained a brief overview of the project, a list of current EGs within the health trusts (established by the research project), a recommendation letter from the Regional Committee for Medical Research Ethics in Norway (REK), the study's aim and research design, a brief presentation of data-collecting methods; trusts were asked to reply to the application within fourteen days. The main task during this process was to coordinate applications and approvals between the clinical department, the research department, data protection officers, and healthcare chaplains.

Some applications were sent to department heads (level furthest from the clinical setting), while others were sent directly to Department managers (level closest to the clinical setting). Upon receiving approval from the health trust, a request was sent to each research department asking what kind of documentation they would need in order to conduct clinical research. All applications were sent in cooperation with the local healthcare chaplain of each health trust. Upon approval, a meeting was scheduled between the researcher and the healthcare chaplain at the chaplain's clinic to discuss practical guidelines for and information about the project.

5.3.3 Step 3: Recruitment of patients

After conferring with the healthcare chaplains, it was decided to have a meeting in each health trust to provide information about the study and review practical guidelines. The information included a cover letter, consent forms, reply envelopes, a questionnaire, and a memory list.

All patients participating in the EGs who were able to give their consent were invited to participate in the study by the healthcare chaplains and co-leaders in each unit. Due to patients' vulnerable situation, recruitment was carried out over a period of three months. Completed consent forms and questionnaires were returned in an individual sealed envelope and handed over to the clinical staff, including healthcare chaplains, on each unit. The questionnaires were collected by the researcher.

5.3.4 Step 4: Recruitment of mental health professionals

In the final recruitment step, the 21 healthcare chaplains identified co-leaders of the EGs, therapists of patients participating in the EGs, and the manager of the unit that offering an EG. This resulted in a list of 187 mental health professionals in addition to the 21 healthcare chaplains.

5.3.5 Step 5: Distribution of a web-based questionnaire

All 187 mental health professionals and 21 healthcare chaplains received an e-mail inviting them to participate in a study concerning the EG practice led by healthcare chaplains. The e-mail contained a link to the web-based questionnaire tailored to each informant group.

5.4 Sample

5.4.1 Sample of sub-studies 1 and 2

A total of 101 respondents (healthcare chaplains and mental health professionals) completed the questionnaire for an overall response rate of 49%. The response rate was 100% for healthcare chaplains (21 of 21), 38% for co-leaders (34 of 89), 36% for therapists (27 of 75), and 83% for managers (19 of 23) (Table 4).

Table 4. Participants in sub-studies 1 and 2 (N=101)

	Gender	**Age**				
	Male / Female	20–29	30–39	40–49	50–59	60–69
Healthcare chaplains (n=21)	9 / 12			8	8	5
Co-leaders (n=34)	4 / 29	1	9	8	9	5
Therapists (n=27)	8 / 19	3	10	7	3	3
Managers (n=19)	3 / 16		3	3	8	5

5.4.2 Sample of sub-study 3

In total, 157 patients completed the questionnaire (Table 5). The response rate could not be determined because the healthcare chaplains did not register how many patients they had invited to participate, and the patients who did not want to participate in the study were not registered. The healthcare chaplains did, however, report the average number of patients participating weekly across the 49 EGs, namely 252 (see Table 5). Based on this estimate, the response rate was calculated to be 62%. The informants represented 44 existential groups from 11 Norwegian health trusts.

Table 5. Characteristics of the study participants in sub-study 3 (N=157), clinical unit and diagnostics group, EG participation, EG discussion topics, experience with group therapy and estimated number of participants in each EG (N=49)

Gender	**n (%)**		**Motivation**	**n (%)**
Male	73 (48)		A Need to talk about my life	31 (20)
Female	80 (52)		The group seemed interesting	72 (46)
Age-group			Other reasons	21 (14)
Below 30 years	36 (23)		No specific motivation	32 (21)
30-39 years	34 (22)		**EG* participation**	
40-49 years	40 (26)		1-3x	76 (50)
50-59 years	27 (18)		4-7x	33 (21)
Above 60 years	17 (11)		8-11x	16 (10)
Work situation			12x or more	30 (20)
Employed	25 (17)		**EG* discussion topics***	
Retired	12 (8)		Religious and spiritual issues	59 (38)
Temporary social support	67 (46)		Existential concerns	137 (88)
Disability benefit	43 (29)		Meaning giving activities	98 (63)
Education			Coping	139 (89)
Up to 12 years	93(60)		**Experience with group therapy**	
Over 12 years	61(40)		Never participated in other therapy groups	75 (49)
Care level			EG do not differs from other therapy groups	25 (16)
Hospital	52 (34)		EG differs from other therapy groups	54 (35)
CMHC*	100 (66)		**Estimated number of participants in each EG**	
Clinical unit and diagnostics groups			3 participants	9 (18)
Inpatient	59 (38)		4 participants	10 (20)
Psychiatric geriatric patients	10 (7)		5 participants	14 (29)
Substance abuse patients	35 (23)		6 participants	6 (12)
Day patients	21 (14)		7 participants	5 (10)
Psychosis patients	10 (8)		8 participants	2 (4)
Affective	16 (10)		9 participants	2 (4)
Other	4 (3)		10 participants	1 (2)

*Note: EG: Existential group; CMHC: Community Mental Health Centre; EG discussion topics comprise 24 topics grouped in four different dimensions.

5.5 Strategy of inquiry

5.5.1 Sub-study 1

An explorative, descriptive nationwide, cross-sectional, web-based survey design, inspired by Lorentzen and Ruud (2014) was chosen as a strategy of inquiry. The web-based survey was tailored to each participant group (healthcare chaplains, co-leaders, therapists and mangers); it was developed in three stages (see Appendix 1).

Stage 1. Literature review

A literature review was performed of studies on Norwegian healthcare chaplains' group practice. No previous research was identified.

Stage 2. Development of the web-based survey

Since this was the first study of its kind, several items evolved from clinical experiences. The survey contained three parts, encompassing factual information about the group practice, mental healthcare professionals' views on the group practice and demographic, educational, and clinical information about the various participants (Appendix 1). The items were reviewed and discussed in an expert panel until consensus was reached regarding understanding and formulation of the items.

Stage 3. Testing the web-based survey

The survey was subsequently tested in each participant group. Cognitive interviews were conducted with 16 key informants who received an e-mail with a link to the web-based survey. Their replies were sent back to the researcher. In accordance with Beatty and Willis (2007, p. 287), cognitive interviewing is understood as "the administration of draft survey questions while collecting additional verbal information about the survey responses, which is used to evaluate the quality of the response or the help determine whether the question is generating the information that its author intends." The cognitive interviews included techniques such as "thinking out loud" and "verbal probing" (Ryan, Gannon-Slater, & Culbertson, 2012). An expert panel further discussed the responses until consensus was reached on how the items should be interpreted and presented.

To explore factual information in the first part of the web-based survey, questions related to groups' aims, scope, and theoretical perspectives were developed, building upon the questionnaire produced by Lorentzen and Ruud (2014). One extra item covering "reflection on life" was added to the list of overall aims of EG practice. The theoretical perspectives were developed as a list of relevant items with multiple-choice responses: The responses were: Medicine oriented, Biological oriented, Psychodynamic oriented, Cognitive oriented, Integrative oriented, Solutions-oriented, Behaviouristic oriented, Emotional oriented, Trauma oriented and Attachment oriented. Additionally, the existential-oriented perspective was added. Another item was established as an open-ended response to explore the group practice in more depth and develop new categories as described in the literature (Reja, Manfreda, Hlebec, & Vehovar, 2003; Ruel, Wagner, & Gillespie, 2016). The open-ended question – "How would you describe the group you are running in terms of theoretical underpinning,

aim, scope, and therapeutic approach?" – was directed solely to the healthcare chaplains. The second part of the web-based survey sought mental healthcare professionals' views on the group practice. Two items were developed: (1) "The chaplain's group has an existential therapeutic strategy" and (2) "The chaplain's group is an integrated and established part of the total treatment". The items were outlined as a five-point Likert scale, wherein the participants were asked to indicate their agreement or disagreement with a statement. In sub-study 1, the scale ranged from 1 (not true at all) to 5 (completely true). Ruel et al. (2016) refer to a Likert scale as being particularly helpful when measuring participants' attitudes or viewpoints concerning a specific topic. The two items were later reorganised on a three-point scale – "true", "neutral", and "not true" – to simplify the analysis. The Likert-type items were introduced as follows, in accordance with recommended guidelines (Ruel et al., 2016):

> The questions below are formulated as claims concerning the existential groups' position within the treatment. We are interested in your assessment of how existential needs are taken care of as part of a holistic approach within the treatment. Use the scale below to identify to what extent these claims tend to be true or not.

The final and third part of the questionnaire contained demographic, educational, and clinical information about the various participants.

5.5.2 Sub-study 2

A nationwide, cross-sectional, web-based survey, influenced by a convergent, parallel, mixed-methods design (Creswell, 2014), was chosen as a strategy of inquiry. Both qualitative (open-ended responses) and quantitative (scales) data were collected concurrently from the same sample following Creswell's (2014, pp. 219-223) design. The web-based survey was developed in three stages (see Appendix 1).

Stage 1. Literature review

Key knowledge gaps were identified, including limited understanding of the existential dimension in relation to mental health, limited knowledge of treatment settings cooperating with healthcare chaplains and limited knowledge of relevant existential topics applied in the treatment settings. A knowledge gap regarding measurement of existential competence was also identified.

Stage 2. Development of the web-based survey

A structured survey was developed based on the findings of the literature review (Appendix 1). Both close-ended and open-ended responses were used in a corresponding way making it possible to gather different types of information that is suggested to be preferably in an early research phase (Reja et al., 2003; Ruel et al., 2016). Additionally, open-responses is suggested

to provide a richness to the data (Schaefer & Dillman, 1998). The items were reviewed and discussed in the expert panel until consensus was reached regarding understanding and formulation of the items.

Stage 3. Testing the web-based survey

To explore mental health professionals' in-depth understanding of the existential dimension, two open-ended questions were devised: (1) "What existential issues are of relevance in your general practice?" and (2) "How do you experience the meaning of the existential dimension in relation to mental health?" The second open-ended question was presented as follows, in accordance with the guidelines recommended by Ruel et al. (2016):

> The existential dimension, e.g., death, meaning and loneliness, might be seen as common to the human condition. In your own words, answer the following question in accordance with your experience:

To measure attitudes, practices, understandings, perceptions of value, and cooperation with healthcare chaplains, as assessed by the mental health professionals, six Likert-type items were developed and scored on a five-point scale ranging from 1 (not true at all) to 5 (completely true). Later on, these items were recoded and scored on a three-point scale: "true", "neutral", and "not true", to simplify the analysis. The following Likert-type items were part of the scale applied in sub-study 1 and introduced as abovementioned (see previous section 5.5.1, Stage 3): (1) "It is important to address patients' existential needs in the treatment of your unit", (2) "I consider that existential topics are addressed in treatment", (3) "I consider myself as having sufficient competence to address patients' existential needs in clinical practice", (4) "I cooperate with healthcare chaplains in treatment", (5) "It is important to address patients' existential needs with regard to coping with illness", and (6) "It is important to address patients' existential needs with regard to experiencing existential meaning".

When measuring the EG topics discussed, 24 categorical variables were developed, representing existential religious and spiritual issues, issues related to sources of meaning, and resources for life and for coping. The 24 items were introduced as follows in accordance with the recommended guidelines by Ruel et al. (2016): "Below you will find a list of topics that might be relevant for this group practice. Tick the topics that correspond with your experience". The 24 items required a dichotomous response of "yes" (1) or "no" (2), which is a common response format in surveys described in the related literature (Ruel et al., 2016). The EG leaders (healthcare chaplains) and co-leaders (mostly nurses) were asked to detail their group practice experiences, while the therapists and managers were asked to detail their

experiences with topics that would be important for patients to discuss. See previous section 5.5.1 for the full procedure.

5.5.3 Sub-study 3

A printed questionnaire was used for informants participating in the EGs because this information was assumed to be sensitive (see Appendix 2). The process of developing the questionnaire for sub-study 3 included four stages.

Stage 1. Developing items

Items on EG participation, EG discussion topics, demographic information and characteristics of the study participants were developed. Concerning the EG discussion topics, the items developed were based on topics previously applied in pastoral care sessions in a Swedish context (DeMarinis, 2003) and in two pastoral care studies in a Norwegian context (Grung, Danbolt, & Stifoss-Hanssen, 2016; Stifoss-Hanssen, Grung, Austad, & Danbolt, 2019). The EG discussion topics were meant to cover a broad spectrum of patients' existential meaning making, encompassing existential, religious and spiritual issues (DeMarinis, 2003, 2006, 2008).

Stage 2. Expert panel

Possible items were presented to an expert panel including a psychiatrist, a psychologist, and a theologian with knowledge of group psychotherapy, psychiatry, psychology, clinical psychology of religion and clinical pastoral care, in accordance with guidelines for item development and construct assessment (Presser & Blair, 1994). Expert panels are considered useful for identifying problems with questions or response options in a survey (Presser & Blair, 1994) and for evaluating how the developed items represent the construct intended to be measured (Jansen & Hak, 2005).

Stage 3. Testing

The selected items were tested among 16 key informants in a web-based survey. The first author performed individual cognitive interviews with each of these 16 informants (Sub-studies 1 and 2). See previous section 5.5.1, Stage 3. Testing the web-based survey, for the full procedure.

Stage 4. Revising

Information from these cognitive interviews was brought back to the expert panel and the items and topics were revised and new topics added by the expert panel. Discussion continued until agreement was reached on how the items should be presented. Through this process,

several errors in the questionnaire were discovered and corrected. Finally, a list of 24 possible discussion topics was included in sub-study 3, presented in the following:

Measures

The following measures were applied:

EG discussion topics were measured using a list of 24 topics: loneliness; hopelessness; losses; meaninglessness; relationships; death and dying; grief; worldviews and religions; religion/images of god; faith in different worldviews and religions; faith and doubt; traditions and holidays; hope; values; coping with difficulties; meaning; choices; coping with illness and crisis; being in crisis; creativity; inspirational activities; culture/music/literature; nature; and life-strengthening activity. The topics were grouped into four dimensions based on the expert panel's assessment of relevant topics, the cognitive interview, theoretical grounds and previous research literature. Patients were asked to indicate whether the topic had been discussed in their EG or not with a "yes" or "no" response. For each dimension, scale scores were created by summing up item scores:

1) *Religious and spiritual issues* (five items) (Cronbach's alpha 0.76) was included due to its relevance in meaning-making frameworks in times of crisis (Lilja et al., 2016; Pargament, 2001; Park, 2005b). Based on the viewpoints that religion and spirituality may be considered overlapping constructs (Streib & Hood, 2016) and that nature in secular Scandinavia is a sacred and available resource (Ahmadi, 2006) the topics of worldviews and religions, religion/images of god, faith in different worldviews and religions, faith and doubt and nature were included in the dimension.
2) *Existential concerns* (eight items) (Cronbach's alpha 0.78) was based on the four ultimate concerns by Yalom (1980) and included the topics of death and dying, loneliness, meaninglessness, meaning, choices, losses, grief and relationships.
3) *Meaning-giving activities* (five items) (Cronbach's alpha 0.73) was based on a secular understanding, namely that a broad spectrum of meaning-giving activities should be included in human meaning-making processes (Stifoss-Hanssen, 1999; Van der Lans, 1987). The topics included inspirational activities, culture music and literature, creativity, values and holidays and traditions.
4) *Coping* (six items) (Cronbach's alpha 0.70) included the topics of coping with difficulties, coping with illness and crises, hope, hopelessness, being in crisis and life strengthening activity. The dimension was based on stress and coping theory and the assumption that hope and coping have a dynamic and reciprocal relationship (Folkman, 2010).

EG participation was measured by the number of times an EG session was attended (1–3 times, 4–7 times, 8–11 times and 12 or more times).

Meaningfulness (five items) and *Crisis of meaning* (five items) were measured by two scales from the *Sources of Meaning and Meaning in Life* Questionnaire (SoMe) (Schnell, 2009; Schnell & Becker, 2006). *Meaningfulness* measures the degree of subjectively experienced meaningfulness. *Crisis of meaning* measures the degree of emptiness and a frustrated will to meaning. The items were rated on a six-point scale of agreement (0 = totally disagree, 5 = totally agree). The SoMe questionnaire has recently been validated in Norway (Sørensen et al., 2019). In the present study, the reliability of the sub-scales was $\alpha = 0.88$ for Meaningfulness and $\alpha = 0.92$ for Crisis of Meaning.

Psychological distress was assessed by the Clinical Outcome in Routine Evaluation (CORE-10) system. The CORE-10 measures symptoms of distress, anxiety and depression, as well as social functioning and risk to self (Connell et al., 2007). The items are scored on a five-point scale of agreement, measuring from "Not at all" (0) to "Most of the time" (4). Higher scores indicate severe mental illness and a lower scores indicate a healthier psychological condition. CORE-10 has been validated within an adolescent population in Norway (Solem & Moen, 2015). The reliability of this scale within the current study was $\alpha = 0.86$.

Demographic variables comprised gender, age-groups**,** education and work situation (See Table 5 for further information).

Variables concerning *characteristics of the study participants* comprised care level, motivation, experience with group therapy, clinical unit and diagnostics group and estimated number of participants in each EG (see Table 5 for further information).

5.6 Analysis

5.6.1 Sub-study 1

In sub-study 1, it was necessary to explore the empirical material related to the field of group work and what type of group was described (Ward, 2006a). The qualitative data were derived from the open-ended responses and analysed by applying a qualitative content analysis (Graneheim & Lundman, 2004). The text from the open-ended responses included literature references, group characteristics, therapeutic strategies, scope, and aims, as well as therapeutic strategies applied in healthcare chaplains' group practice. Meaning units were

identified, condensed, and coded by the author in accordance with an abductive approach (Reichertz, 2004) that included both inductive and deductive procedures for developing and elaborating upon theory. From this process five different EG approaches were identified: psychodynamic, narrative, coping, systems-centred and thematic. To obtain trustworthiness, the same authors discussed the data analysis until a consensus was reached.

Quantitative data were analysed using SPSS version 22.0 and by applying a univariate statistical analysis. Frequencies were derived from the categorical variables, and some were presented in cross-tables (binary analysis). Measures of central tendency were calculated from the continuous variables, and missing data were not replaced; as such, the numbers in the tables did not always add up. Based on the information from the group leaders (healthcare chaplains) five new dichotomous variables were computed, each containing one of the five EG approaches (psychodynamic, narrative, coping, systems-centred and thematic). In order to enhance trustworthiness, member checking was included in the research process (Birt et al., 2016). Member checking is understood as "[giving] participants an opportunity to consider whether any of the experiences or perceptions of others also applied to them" (Harvey, 2015, p. 30). All the healthcare chaplains were therefore invited to a group meeting in which the synthesised analysed data were presented and discussed. The healthcare chaplains recognised and confirmed the five different approaches discovered through data interpretation.

5.6.2 Sub-study 2

The qualitative data in sub-study 2 were obtained from two open-ended responses that were combined and viewed as one text. The material was characterised by shorter and longer compact texts from the informants that contained various themes. As such, a qualitative content analysis with an inductive approach (Graneheim & Lundman, 2004) was chosen to guide the data analysis. First, the material was read through repeatedly to get a sense of the whole. Second, meaning units in the text were identified, such as descriptions of "meaninglessness" and issues related to "death", "loneliness", and "shame" (Table 6). Third, similar codes were organised and grouped into sub-categories. For instance, similarly coded items were placed into the sub-category of "Experience of existential pain and struggles in life" (Table 6). Fourth, the related subcategories were organised and structured into main categories, which were presented as findings in paper I; for instance, one category was labelled "Understanding of the existential dimension discussed in treatment settings" (Table 6). Finally, at the fifth stage, a theme was determined, thus giving a voice to the text's latent content (Graneheim & Lundman, 2004). In sub-study 2, the theme was "An open and enthusiastic attitude towards the existential dimension in treatment settings", and the coding

was completed independently. However, to ensure trustworthiness, the authors had multiple discussions concerning the various themes in the data until a consensus was reached.

Table 6. Example of the analysis process in sub-study 2

Theme	Categories	Sub-categories	Meaning units
An open and enthusiastic attitude towards the existential dimension in treatment settings	Understanding of the existential dimension discussed in treatment settings	Experience of existential pain and struggles in life	Description of 'meaningless', issues related to 'death', 'loneliness', and 'shame' as sources of pain and struggle

Quantitative data were analysed using SPSS and by applying descriptive statistics. To examine differences in mean score between two self-reported items measured on a five-point Likert scale ranging from (1), not true at all to (5), completely true, a paired sample T-test was conducted (Field, 2009). A one-way between-groups analysis of variance (Field, 2009) was applied to examine the impact of profession, measuring the six self-report items concerning various aspects of the existential dimension in treatment settings. The categorical independent variable *profession* was separated into four groups, *healthcare chaplain*, *co-leader*, *therapist* and *manager*. The six self-reported items were the dependent variables measured on a five-point Likert scale ranging from (1), not true at all to (5), completely true. To identify statistically significant differences between the professions Tukey post hoc tests (Field, 2009) were used. To present frequencies of the six items self-reported by the professionals (see previous section. 5.5.2), the answers on the five-point Likert scale were recoded into three categories: "true", "neutral" and "not true". The category "true" included answers (1) and (2) on the five-point Likert scale, "neutral" included answer (3) and "not true" included answers (4) and (5).

The qualitative and quantitative materials were analysed separately, which is consistent with a convergent parallel mixed-methods design (Creswell, 2014). The overall theme and categories that emerged from the qualitative analysis formed the structure of the quantitative analysis. To compare and validate the findings, the separate materials were subsequently merged into a side-by-side comparison as part of the discussion.

5.6.3 Sub-study 3

Continuous variables were described with mean and standard deviation (SD), categorical variables with counts and percentages.

To assess the external validity of the proposed questionnaire, a confirmatory factor analysis using principal component analysis and Oblimin rotation (Harrington, 2009) was performed. The four proposed domains explained 50.3% of the variation in the original data. All the items loaded most on one domain, confirming that all the items cover one underlying construct. Thus, the domain of *Coping* was confirmed with our factor analysis with all the included items having the highest loadings on this domain. As the EG discussion topics were divided into four domains based on an extensive theoretical framework, we also investigated the second largest loadings:

- Domain of *Existential concerns*: three items loaded on domain *Religious and spiritual issues* but four on domain of *Existential concerns* and two on domain *Meaning giving activities*
- Domain of *Meaning giving activity*: three factors loaded on domain *Meaning giving activities* but two on domain *Existential concerns*
- Domain of *Religious and spiritual issues*: all factors loaded on this domain.

To summarise, the factor analyses confirmed that the four proposed domains explained more than half of the variation in the original data. The domains of *Coping* and *Religious and spiritual issues* were fully confirmed while some items from *Existential concerns* and *Meaning giving activity* also loaded on other domains.

In sub-study 3, three multivariate regression analyses were performed. Regression analysis can be described as the process of making a model that fits with the data and is applied to statistically "predict" values of the dependent variables from those of the independent variables (Field, 2009). A blockwise regression analysis was applied to assess possible associations between patients' EG participation, EG discussion topics and the experience of psychological distress, crisis of meaning and meaningfulness, adjusted for selected demographic variables. This analysis was chosen due to its ability to display how much additional variance can be explained by the variables of interest. In block 1, EG participation and the EG discussion topics of religious and spiritual issues, existential concerns, meaning giving activities, and coping were analysed. In block 2, age groups, gender, level of education and work status were added to adjust for possible confounders.

Assumptions of linear regression analysis regarding normality, linearity, and homoscedasticity were adequately met. Missing data were replaced by the respondents' mean score on the scale unless the person was missing more than 25% of the data on the respective questionnaire (Ruel et al., 2016). For instance, on the Core-10 scale, three cases were removed, and one single case replaced by the mean. On the meaningfulness scale, two cases

were removed, and one single case was replaced by the mean. All analyses were performed using SPSS version 25.0. The criterion function for acceptable reliability was set to $\alpha \geq 0.05$ (Field, 2009).

5.7 My engagement in the study

When I started my PhD study to research existential groups led by healthcare chaplains I was already in a position of knowing. First, I am a healthcare chaplain working in the Norwegian specialist mental health services. As part of this work, I led inpatient EGs at hospitals and community mental health centres (CMHCs) three times a week. Second, I am a trained psychodynamic psychotherapist, and that has also influenced my interest in exploring healthcare chaplains' therapeutic competence within healthcare settings. Third, during my last few years working as a healthcare chaplain, I have observed an increasing focus on evidenced-based practice within the healthcare system. In this environment, healthcare chaplains have faced cuts because our profession has not focussed on researching its own practice. Facing this situation, I felt an urge to start documenting healthcare chaplains' professional practice.

Reflecting upon my own research on EG practice, one challenge I encountered was relationship I had to those I was researching. As a healthcare chaplain with experience leading EGs, I might be characterised as having a research position somewhere in the middle between insider and outsider (Breen, 2007). Although I chose to study a group of professionals to whom I belong, suggesting an insider position, I was not part of the of the group under study and I did not work as a healthcare chaplain or lead EGs during this period of time, positioning me as an outsider (Breen, 2007). Nevertheless, being an insider in a research field might be a limitation. For instance, it can cause a researcher to lose their sense of distance to the field, which might lead to erroneous assumptions based on prior knowledge and/or experience (Hewitt-Taylor, 2002). Also, having the same profession as one's informants can create the "illusion of sameness" (Pitman, 2002, p. 285), although a great internal diversity of identities will always exist. In my case, being a healthcare chaplain myself and having a similar experience of leading EGs does not necessarily make me an appropriate match to do research on this particular group practice. Perhaps a researcher with another profession would be in a better position to conduct fruitful research on such a population, not being an insider. However, being an insider might also be considered a strength, for instance providing

superior knowledge of the group culture and the ability to interact naturally with the group being studied (Bonner & Tolhurst, 2002).

According to Malterud (2017), researchers' prejudices are unavoidably brought into the research process and are related to, for instance, their views of knowledge, particular knowledge interests, hypotheses, motives, and personal experiences. To be able to consider the validity of the findings, the frame of reference and interests upon which the research findings rest must be clarified. It has therefore been of great importance to be transparent about my own prejudices. To prevent erroneous assumptions and conclusions, I presented my results and my perspective to my research colleagues on my team alongside the research process (Kvale & Brinkmann, 2009). This process helped me distance myself from the material. The use of theory has also provided important distance from both the collected and established data. Additionally, all the healthcare chaplains were invited to check synthesised analysed data (Harvey, 2015). This is considered to have reduced the risk of wrong assumptions with the aim of enhancing the trustworthiness of the present study (Birt et al., 2016).

5.8 Ethical considerations

The overall purpose of the Health Research Act (2008§1) is to "promote good and ethically sound medical and health research". In the preparatory work for the Act, respect for human dignity and human rights is cited as the basis of ethically sound research. Such respect entails that people be willing to participate in research projects; this includes people with mental illnesses despite their vulnerability. However, vulnerability does not necessarily equate to impaired competence, and patients are not devoid of preferences or values even if they are vulnerable or regarded as belonging to a vulnerable group (Hem, Heggen, & Ruyter, 2007); on the other hand, participating in research does not make patients less vulnerable. (Storosum, van Zwieten, & de Haan, 2002).

As far as the patients were concerned, it may be argued that participation in the project might have contributed to their self-reflection and perhaps raised awareness of their own life situations and existential needs. It is possible that for these patients, participation brought about consciousness of their own sources of meaning in life (MIL), which in turn might have enhanced their ability to cope with an illness. However, various topics in the questionnaire might have touched on participants' shameful and/or painful life experiences related to loss and/or grief, which might have activated unknown and unprocessed grief or pain. Immediate

counteractions were prepared in the event of such a reaction: support and care would be initiated by clinical staff, and adequate treatment would be provided in the patient's unit. Based on a comprehensive consideration of the risks and benefits associated with participating in this study, it was concluded that the risk was minimal compared to the benefit of acquiring new knowledge of the EG practice. In conclusion, it seemed ethically acceptable to conduct this study.

Regarding mental health professionals (co-leaders, therapists, and managers), it could be argued that their participation in the project might have activated interests of conscience and competence in relation to the challenges that address the existential dimension in treatment settings.

5.8.1 Prior approval

According to the Health Research Act (2008§9), prior approval from the Regional Committees for Medical Research Ethics (REK) in Norway must be obtained for all medical research involving human beings. Because the current study was conducted within Norwegian mental health specialist services, prior REK approval was needed (2008§6). The risks associated with participation were considered minimal, and the study was approved under registration number 565978 (see Appendix 4 and 5).

5.8.2 Informed consent

Informed consent was obtained from all participants, and the participants were able to withdraw from the study at any time. The Health Research Act (2008§13) also specifies that consent must be informed, voluntary, expressed, documented, and related to a specific research project. Concerning the healthcare chaplains and mental health professionals (sub-study 1 and 2), informed consent was given at the time of inclusion in the web-based survey. However, the requested information was not considered sensitive, as the questions were primarily related to the EG characteristics and viewpoints concerning the practice of addressing the existential dimension in treatment settings.

Concerning patients (sub-study 3), only those who were able to give their informed consent were invited to participate in the study. When a patient's ability to provide informed consent was uncertain, the therapist (psychologist/psychiatrist) responsible for that patient was conferred with. In these instances, the therapists made decisions on behalf of their patients as to whether or not their participation was appropriate.

The principle of autonomy was respected throughout the entire research process. It was reasoned that the healthcare chaplains and mental health professionals working in the

various units with the responsibility of making qualified decisions regarding whether or not an EG patient should participate in the study could be trusted. In light of these procedures, the recruitment process was considered ethically acceptable and built upon the professionals' expertise in creating trustful relationships despite the accompanying challenges that were faced (Hem, Heggen, & Ruyter, 2008).

In sub-study 3, patients were given both verbal and written information (see Appendix 3) containing facts about the organisation and research team responsible for the study, the study's aim, the implications associated with participating, a description of the associated risks and benefits, a notification of their ability to withdraw, and the right for their data to be erased upon request. An informed consent form (see Appendix 3) was attached to the information letter and each participant was required to sign it. Completed informed consent forms and questionnaires enclosed in sealed envelopes were returned to respective healthcare chaplains or other healthcare professionals in each unit. These were later collected by the researcher.

5.8.3 Use of health data

The data in the present study was treated with confidentiality, and privacy and anonymisation were assured in accordance with the Health Research Act (2008). De-identifying data material with a key code attached to each questionnaire safeguarded the confidentiality. The key codes were kept in a locker in proximity to the researcher, and all patients' identity information was stored in a locker within the research department at VID Specialized University. Data material that contained personally identifiable information was not stored on a personal computer, and data from the open-ended responses were stored on the VID server and protected by a personal password.

6 MAIN FINDINGS

In the following sections, the main findings and review of sub-studies 1–3 are presented. The three sub-studies represent research on the existential dimension in treatment settings: sub-study 1 explores and describes the variety in EG practice led by Norwegian healthcare chaplains; sub-study 2 explores and examines mental health professionals' attitudes, practices, understandings, and perceptions of value when addressing the existential dimension in treatment settings; and sub-study 3 examine possible associations between patients' participation and topics discussed within EG practice and their experiences of psychological distress, crises of meaning and meaningfulness. At the end of the chapter, a summary of the findings is presented.

6.1 Sub-study 1

Background and aim of the study

The EG practice led by healthcare chaplains within Norwegian specialist mental health services has a longstanding tradition of inviting patients to talk about their life stories and experiences through faith, hope, and rituals. Research on healthcare chaplains' professional practice is fairly well developed, whereas research on healthcare chaplains' group practice is sparse. This study is assumed to be the first to explore this kind of group practice. Therefore, the aim of sub-study 1 was to explore and describe the variety within Norwegian existential group practice.

Design and methods

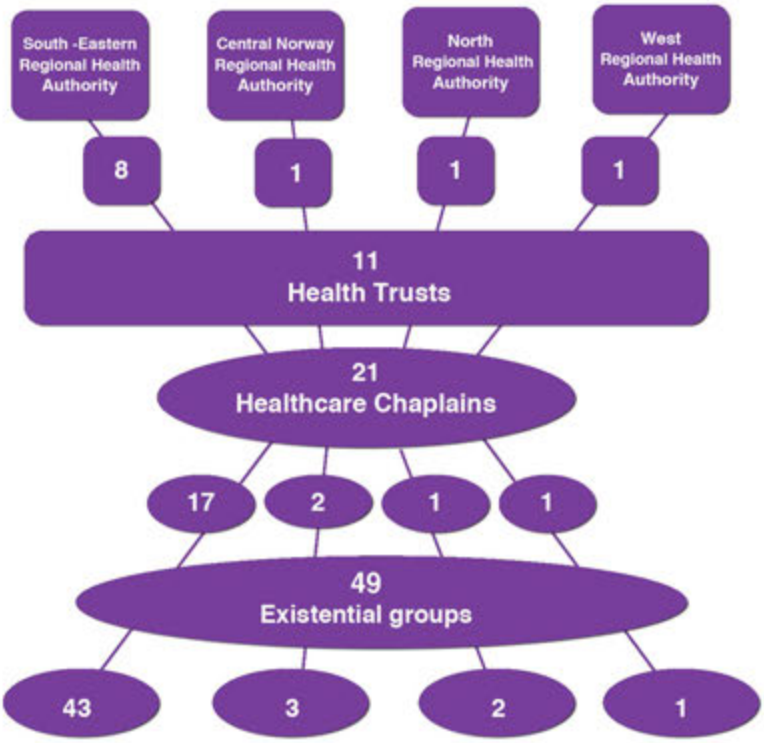
An explorative, descriptive nationwide cross-sectional web-based survey design was applied with both quantitative and qualitative methods to explore and describe these groups' characteristics. Eighty mental healthcare professionals and twenty-one healthcare chaplains recruited from Norwegian specialist mental health services participated in the study. Quantitative data were analysed using descriptive statistics, while a content analysis inspired by Graneheim and Lundman (2004) was performed to analyse the qualitative data.

Main Findings

The study identified 49 EGs in 11 of 19 Norwegian health trusts across different service levels (Figure 5). Five different EG approaches that addressed patients' existential, spiritual and religious issues were identified: psychodynamic, narrative, coping, systematic, and thematic. The psychodynamic EG approach was the most frequently applied. The narrative EG approach was the most distinctive, integrating discussions of spiritual and religious issues.

The healthcare chaplains reported using perspectives from existential and psychodynamic theories most frequently in their clinical practice. The EGs were generally eclectic and applied a variety of therapeutic strategies that represented the traditions of group psychotherapy, existential therapy, and clinical pastoral care. Most interdisciplinary staff regarded the EG practice as an established and integrated part of the treatment settings, while the healthcare chaplains were the most reluctant to accept this viewpoint. The healthcare chaplains possessed various types of therapeutic competence.

Figure 5. Distribution of the existential groups across Norwegian health trusts



Conclusion

The findings suggest that the EG practice led by healthcare chaplains is an eclectic practice that can be regarded as a well-established and integrated aspect of the total treatment within Norwegian specialist mental health service. The EG practice addresses patients' existential, spiritual and religious issues through a diversity of therapeutic strategies in which the psychodynamic EG approach was the most frequently applied and the narrative EG approach was most distinctive. The healthcare chaplains are well educated, clinically experienced, and possess therapeutic competence implying that their clinical practice goes beyond a specialised form of religious ministry.

6.2 Sub-study 2

Background and aim of the study

Previous research has revealed that addressing and integrating the existential dimension into treatment settings reduce symptoms such as anxiety, depression, and substance abuse; healthcare chaplains are considered key personnel in this practice. This study is one of the first of its kind to explore a group practice led by healthcare chaplains in cooperation with mental health professionals within treatment settings. With this background, the aim of sub-study 2 was to examine the attitudes, practices, understanding and perceptions of mental health professionals, including healthcare chaplains, regarding the value of addressing the existential dimension in treatment programmes.

Design and methods

A nationwide, cross-sectional, web-based survey design influenced by a convergent, parallel, mixed-methods design was applied due to its ability to gather different types of information during an early research phase. 80 mental healthcare professionals and 21 healthcare chaplains recruited from Norwegian specialist mental health services participated in the study. The qualitative and quantitative data materials were concurrently collected from the same sample also used in sub-study 1 and were analysed separately. The quantitative data containing close-ended responses were analysed using SPSS by applying descriptive statistics, a paired sample T-test, a one-way between-groups analysis of variance and Tukey's post hoc tests. A content analysis (Graneheim & Lundman, 2004) coupled with an abductive approach (Reichertz, 2004), guided the analysis of the qualitative data containing open-ended responses. The overall theme and categories that emerged from the qualitative analysis formed the structure of the quantitative analysis. To compare and validate the findings, the separate materials were subsequently merged into a side-by-side comparison as part of the discussion.

Main findings

The findings from both the qualitative and quantitative data report that the mental health professionals held open and highly positive attitudes towards addressing the existential dimension in treatment settings. A small gap between attitude and practice of addressing existential, religious and spiritual issues in treatment settings was identified. The existential dimension was described as a dynamic search for hope and meaning during a struggle with existential, religious and spiritual pain and issues in order to enhance coping. An existential meaning-making process was identified to describe the relationship between the existential dimension and mental health. Improved recovery, strengthening of other therapies, coping

with illness and experiencing existential meaning were considered perceived values among mental health professionals

Conclusion

Mental health professionals had open and positive attitudes towards addressing the existential dimension in treatment settings despite a small gap between attitude and practice that was discovered here. The relationship between the existential dimension and mental health was explained by an existential meaning-making process dominated by the crisis of meaning. However, the search for hope and meaningfulness also seemed important. Improved recovery, the reinforcement of other therapies, improved coping with illness and the experience of existential meaning emerged were perceived by mental health professionals as benefits of integrating the existential dimension into treatment. Further research could investigate co-leaders' competence in addressing existential, religious and spiritual issues and possible associations to the EG practice.

6.3 Sub-study 3

Background and aim of the study

Spirituality groups led or co-led by healthcare chaplains, aiming at psychospiritual growth have shown to have significance in patients' recovery processes at various psychiatric units in the US. In Norway, existential groups (EG) led by healthcare chaplains have been identified at various psychiatric units within specialist mental health services. However, patients' participation and topics discussed in these groups have not yet been examined. Thus, the aim of the study was to examine possible associations between patients' participation and topics discussed in EG practice and patients' experiences of psychological distress, crisis of meaning and meaningfulness.

Design and methods

A nationwide, cross-sectional design was applied to examine patients' participation and topics discussed among a clinical group of patients (N=157) attending EGs led by healthcare chaplains. A list of 24 EG discussion topics were provided and grouped into four dimensions based on an expert panel's assessment of relevant topics, cognitive interviews, theoretical grounds and previous research literature: (1) Religious and spiritual topics, (2) Existential concerns, (3) Meaning giving activities and (4) Coping. A confirmatory factor analysis was applied confirming the underlying structure of the four dimensions. Multivariate regression analyses were used to assess the strength of possible associations between patients' EG

participation, EG discussion topics and the experience of psychological distress, crisis of meaning and meaningfulness, also adjusted for selected demographic variables.

Main findings

An inverse statistically significant association was identified between lengthier EG participation and lower levels of psychological distress. The EG discussion topic of religious and spiritual issues was found to be significantly associated to the experience of meaningfulness. A positive statistically significant association was found between age and meaningfulness.

Conclusion

The findings suggested a significant association between lengthier EG participation and lower levels of psychological distress. The EG discussion topic of religious and spiritual issues was significantly related to the experience of meaningfulness. Further research could investigate functional and dysfunctional meaning-making processes within EGs and how such processes might contribute to the experience of mental and existential health.

6.4 Main findings and sub-findings

The main findings conclude that EG practice led by healthcare chaplains is a well-established and integrated part of the comprehensive treatment within Norwegian specialist mental health services and provides room within treatment settings for patients' existential meaning making during times of crisis (sub-studies 1–3). EG practice was characterised as eclectic, applying a variety of therapeutic strategies representing the traditions of group psychotherapy, existential therapy, and clinical pastoral care (sub-study 1), while a small gap between positive attitudes and the actual practice of addressing the existential dimension was identified (sub-study 2). The findings indicate that lengthier EG participation is significantly associated with lower levels of psychological distress. Furthermore, the EG discussion topic of religious and spiritual issues was significantly associated with the experience of meaningfulness (sub-study 3).

7 DISCUSSION

The findings generated several themes for discussion: characteristics of the EG practice in light of group traditions, healthcare chaplains' role and professional practice, mental health professionals' viewpoints and patients' existential meaning making. Consideration of what knowledge the present study generates, an attention must be afforded to implications for further research and clinical practice. A discussion of the methods, reliability of the findings, and limitations is also presented.

7.1 Characteristics of EG practice in light of other group traditions

The present study represents the first of its kind to investigate the EG practice led by healthcare chaplains. The study identified 49 EGs led by 21 healthcare chaplains across 11 of 19 Norwegian health trusts (sub-study 1, Figure 5). These groups were viewed by mental health professionals as a well-established and integrated part of the comprehensive treatment process (sub-study 1). Sub-study 1 found that EGs were provided at both care levels: 28 EGs at community mental health centres (CMHC) and 21 EGs at hospitals. By comparison, Lorentzen and Ruud (2014) reported that a majority of the 426 identified psychotherapy groups were offered at CMHC.

The difference in the distribution of EGs and group psychotherapy might be explained by group cohesiveness, which is suggested to take years to build, and rapid patient turnover in hospital, which could make it challenging to provide group psychotherapy (Yalom & Leszcz, 2005). The question in the present study is whether these differences in distribution related to care level might be explained by healthcare chaplains' daily work in acute psychiatric units. Maybe healthcare chaplains noticed that patients' existential needs were being met by starting up groups in these units Another explanation is that healthcare chaplains might use the goals developed by Yalom and Leszcz (2005, pp. 485-487), making it possible to conduct groups in units with rapid turnover by adjusting group techniques embracing a supportive leadership style.

Group psychotherapy used extensively within mental health treatment settings (Lorentzen & Ruud, 2014). However, group psychotherapy that integrates existential, religious and spiritual issues appears to be less frequently applied in mental healthcare (Elliott, Watson, Greenberg, Timulak, & Freire, 2013). Nonetheless, research on existential approaches to therapy is growing in the field of mental healthcare, and these approaches are used in various practices, including counselling for persons suffering from psychotic disorders

and/or drug abuse (Correia et al., 2016; Mendelowitz & Schneider, 2008; K. J. Schneider, 2011). When it comes to EG practice, it could be argued that the existence of 49 groups across 11 of 19 Norwegian health trusts does not make this practice prevalent within Norwegian mental healthcare, at least compared to group psychotherapy, with 426 groups across the Norwegian health trusts (Lorentzen & Ruud, 2014).

7.1.1 EGs: an eclectic practice?

Sub-study 1 found the EG practice to be eclectic, applying a variety of therapeutic strategies from various traditions. How can these findings be understood in light of other group psychotherapy traditions integrating existential, religious and spiritual issues? It should be recognised that the tradition of group psychotherapy has been understood as an eclectic therapeutic tradition anchored in psychodynamic theory (Karterud, 2007; Ward, 2006b; Yalom & Leszcz, 2005). This is also true for the existential therapy tradition (Vos et al., 2015) that is represented by four different schools anchored in different theoretical perspectives that apply a range of therapeutic approaches (Cooper, 2003, 2012). Although little literature and research exists on chaplains' group work in mental health (Gangi, 2014; Kidd et al., 2001; Popovsky, 2007), guidelines for these types of groups show them to be eclectic. For instance, the guidelines for chaplains' groups developed by Gangi (2014) emphasise different focuses, such as acknowledgement, meaning, coping skills and theory of recovery, showing an eclectic attitude (see section 3.2.6).

It might also be possible to understand the eclectic nature of EG practice in light of the tradition of CPE. The CPE tradition is also considered an eclectic tradition that integrates insights from multiple theories derived from theology, psychology (Hemenway, 2005), and the philosophical tradition of existentialism (Eliason et al., 2001). A strong psychodynamic approach has influenced CPE (Hemenway, 2005). However, more recently, perspectives from systems-centred theory have influenced the CPE tradition (Agazarian, 2001; Hemenway, 2005).

Based on this it might be argued that this group practice's eclectic nature is not unique, but rather a common phenomenon. Eclectic group practice is supported by the ASGW, which suggests that a mix of different group types best describes the genuineness of group work (Ward, 2006b).

7.1.2 The goals, aims, scope and therapeutic strategies of EG practice

The EG practice was characterised by five different approaches, addressing patients' existential religious and spiritual issues and concerns (sub-study 1): psychodynamic,

narrative, coping, systems-centred and thematic. The core goals of the EG practice included improving life reflection, accepting illness, getting to know oneself, and improving relationships (sub-study 1). The psychodynamic approach was the one most frequently applied (sub-study 1), while the narrative approach stood out as the only one to explicitly discuss spiritual/religious concerns (sub-study 1). Furthermore, the use of narratives as a therapeutic strategy was identified as a prominent finding (sub-studies 1 and 2). The question is how these findings compare with what has been observed about group psychotherapy or group and clinical traditions integrating existential, religious and spiritual issues.

The findings show that EG practice and the group psychotherapy tradition have similar aims in which symptom reduction and improvement in intrapsychic balance are core aims within this tradition (Karterud, 2007; Kvarstein et al., 2017; Lorentzen & Ruud, 2014). The five approaches identified in sub-study 1 resemble the nine different categories identified by Lorentzen and Ruud (2014) in the Norwegian field of group psychotherapy: theme oriented, physical activity, psycho-educative, cognitive behavioural, psychodynamic, body consciousness, art/expressive, social skills/communication/coping, and eclectic. In both studies, the psychodynamic approach was the one most frequently used.

However, this comparison raises several methodological considerations. On the one hand, had the current study used a more inductive explorative approach, the findings might have been more distinct from those concerning the group psychotherapy tradition. Sub-study 1 had a deductive approach (Reichertz, 2004), building on the survey questionnaire used to identify the practice of the group psychotherapy and represent the deductive approach (Lorentzen & Ruud, 2014). This choice was considered reasonable due to the fact that healthcare chaplains and professionals providing group psychotherapy receive a similar therapeutic education (Island, 1995; Lorentzen et al., 1995). However, it could also be argued that the uniqueness of the EG practice might be in danger of being lost by taking such a deductive approach.

On the other hand, the five different approaches were discovered by using abductive analytical approach (Reichertz, 2004), which involves switching back and forth between inductive and deductive approaches. The inductive analytical approach was based on open responses from all the healthcare chaplains describing their EG practice (sub-study1). The deductive approach was based on general theories on group work (Corey, 2016; Ward, 2006a), group psychotherapy (Karterud, 2007; Yalom & Leszcz, 2005), existential therapy traditions (Cooper, 2003, 2012), relevant clinical traditions to chaplaincy (Agazarian, 2001; Hemenway, 2005; Swinton, 2002). A possible critique of this methodology is that the

information collected was less rich and nuanced than if it had been obtained in focus groups or individual interviews. However, these approaches were validated through response validation, (Torrance, 2012), also called member checking (Birt et al., 2016). As a result, the five different approaches were recognised and validated by the respondents (sub-study1).

Perhaps the five different approaches make more sense if they are viewed in light of therapeutic strategies used in other group traditions integrating existential, religious and spiritual issues. A psychodynamic approach to EG practice then, might be recognised as being influenced by Yalom and his integration of existential factors into group psychotherapy (Yalom & Leszcz, 2005), as well as the by the tradition of existential psychotherapy (Yalom & Josselson, 2011). The therapeutic factors of *Interpersonal learning* or *Development of socialising techniques*, for instance, as well as *Existential factors* (Yalom & Leszcz, 2005) may then resonate with EG practice with its combination of psychological goals mixed with existential ultimate concerns (sub-study 1, 2 and 3).

Another option might be to view EG practice as characterised by the five different approaches against the background of spirituality groups in the US (Hirschmann, 2011; Jensen et al., 1998; Kehoe, 1998; Revheim et al., 2010). These types of groups commonly combine elements from group psychotherapy, the recovery movement, emotion-focused coping and religious coping (Gangi, 2014; O'Rourke, 1996; Revheim & Greenberg, 2007) that correspond to EG practice (sub-studies 1 and 2). We might look, for instance, at the guidelines for spirituality groups provided by Gangi (2014, pp. appendix 9-10), emphasising coping and the recovery tradition acknowledging human as a whole person (Lukoff, 2007, pp. 642-643), spiritual discussion topics and telling and sharing stories. Based on the findings in sub-study 1 and 2 and the guidelines presented in the present study, these characteristics can also be used to describe EG practice (Section 1.3.4). However, there are also differences between these spirituality groups and the EG practice. For instance, it seems like most spirituality groups include ritualization of various kinds: use of question cards, writing hopes and putting them into a "box of hope", silent reflection, prayer, meditation, musical meditation, use of stones, and reading biblical stories (Gangi, 2014; Hirschmann, 2011; Kidd et al., 2001; Popovsky, 2007; Revheim & Greenberg, 2007; Revheim et al., 2010), to mention a few. The use of these kinds of rituals was not prominent in the different approaches to EG practice, although art expression was reportedly used in the coping approach and religious rituals in the narrative approach (sub-study 1).

Another difference might be the primary focus on the spirituality dimension in the spirituality groups in the US (Gangi, 2014; Hirschmann, 2011; Kidd et al., 2001; Popovsky,

2007; Revheim & Greenberg, 2007; Revheim et al., 2010). The primary focus seems not to be so specific in the EG practice. The focus in the EGs seem broader, adjusted in line with what was significant in the patients' recovery situation (sub-studies 1, 2 and 3) and that religious and spiritual issues were not necessarily discussed if the patients did not choose these topics (sub-studies 1-3). This being said, the narrative approach stood out as the only one to explicitly discuss religious and spiritual issues (including ritualization; sub-study 1), as well as using narratives and personal stories as therapeutic strategies (sub-studies 1 and 2). Consequently, the narrative EG approach appears to most closely resemble the spirituality groups in the US, in which the use of narratives is reported to be dominant (Gangi, 2014; Hirschmann, 2011; Kidd et al., 2001; Popovsky, 2007; Revheim & Greenberg, 2007; Revheim et al., 2010). One exception to this similarity is the use of biblical stories as a therapeutic strategy in spirituality groups (Kidd et al., 2001). This particular strategy was not identified in the EG practice.

Sub-study 2 identified the use of personal stories in both a broad and a narrow sense. Stories used in a broad sense concerned everyday living, including themes such as finding meaning in illnesses, coping with everyday life, repairing broken relationships, and sharing fears of never being well again or not being able to have a good life. Stories used in a more narrow sense touched on lived experience and gave patients an opportunity to reflect upon their identities and their being in the world, for instance by exploring questions like "What kind of space should I possess in the world?", "How can I become who I am?", and "How can I become alive inside myself?" (cf. sub-study 1 and 2 and guidelines section 1.4.3). Similar types of stories also appear to be discussed in spirituality groups in a US context in both a broad sense, focusing on acknowledgement, meaning in life, and coping skills (Gangi, 2014), and a more narrow sense, highlighting philosophical questions in life (Hirschmann, 2011). However, the main difference between the two types of group appears to be that the spirituality groups have a clearer spiritual framework than EGs, which seem to have incorporated an existential framework (sub-study 1,2, and 3).

Nevertheless, the use of stories might also correspond to the hypothesis that healthcare chaplains are influenced by a narrative-based chaplaincy that highlights the therapeutic significance of illness and health narratives during encounters with patients (Swinton, 2001, 2002). Healthcare chaplains' extensive use of narratives may also be related to the narrative's role in medicine, which is suggested to have expanded a great deal in recent years (Graaf et al., 2016; Woods, 2011). McAdams (2001), for instance, claims that narratives have the ability to bring incongruent qualities and tendencies in a human life together into a more or

less unifying and purpose-giving whole. This possibility inherent in narrative is considered an important part of constructing an identity of the self (see section 3.2.7). It could then be reasoned that the expansion of the narrative's role in medicine in general (Graaf et al., 2016; Woods, 2011) and the importance of narratives in therapy related to identity of the self and psychological growth (McAdams, 2001, 2008) might have influenced the EG practice. However, this would only be a speculation. However, the difficulty of using narrative to integrate incongruent parts of a human life in contemporary postmodern societies in which multiple choices and contractionary social worlds exists simultaneously and no guidelines are suggested offered on how humans should live their life and what life means has been emphasised (Giddens, 1991). Perhaps this make the EG practice even more relevant by offering patients a place for sharing and telling stories in a complex postmodern society were multiple realities exist?

It might also be interesting to view EG practice against the background of the branch of group psychotherapy that integrates religious and spiritual issues (Cornish & Wade, 2010). These types of groups apply theories and therapeutic strategies from the tradition of group psychotherapy (Viftrup et al., 2016) or psychoeducational, dynamic-interpersonal, cognitive interventions (M. J. Thomas et al., 2011). The main goal of this type of therapy is address patients' religious and spiritual issues. As we have seen, EG practice seems to be broader in that all patients, not only the religious ones, are welcome to participate (see for instance guidelines of the EG practice in section 1.4.3). It could perhaps be argued that this branch of group psychotherapy integrating religious and spiritual issues has more in common with spirituality groups in the US, whereas the EG practice shares more similarities with the group psychotherapy tradition developed by Yalom and its existential approach. However, further research is needed to confirm this hypothesis.

7.2 Healthcare chaplains' role and professional practice

The EGs led by healthcare chaplains were reported to focus on the existential dimension by making space for human stories, core questions in life and existential meaning making encompassing religious and spiritual issues, assisted by a variety of psychological and existential theories (sub-studies 1–3). The EG practice was reported to be established and integrated into the treatment programme (sub-study 1). Furthermore, the healthcare chaplains reported possessing various kinds of clinical therapeutic, pastoral, and theological education (sub-study 1). One question might be whether this activity of providing and facilitating EGs is considered a professional practice of addressing the existential dimension. Based on the

definition of practice described as "practicing one's profession" (Hornby & Cowie, 1993, p. 971) it could be argued that healthcare chaplains are practising their profession of being healthcare chaplains by offering EGs, which could be regarded as a method of improving their skills and competence in group work (Aspfors, 2012; Corradi et al., 2008). This claim might however not be so interesting to debate. A more interesting question – and perhaps the key question – might be whether healthcare chaplains' role and professional practice should fill a "function" in the healthcare system, negotiating power and dominance (Evetts, 2003). Or should healthcare chaplains be seen as "virtuous agents" whose purpose and goals are informed by a critical sense of their tradition (MacIntyre, 1981)? These questions display a built-in dilemma in healthcare chaplains' role and professional practice and how we answer them will guide our responses to subsequent questions. For instance, should healthcare chaplains' professional practice be viewed as a specialised form of religious ministry or as healthcare (Vries et al., 2008)? What kind of professional care do healthcare chaplains provide? Is it considered spiritual care, religious care or existential care, all of which are related to healthcare chaplains professional practice (Harding et al., 2008; Schuhmann & Damen, 2018; Thorstenson, 2012)? So what does this mean? How might these questions be interconnected?

One way to look at this is that if healthcare chaplains are meant to "fill a function" (Evetts, 2003) within the healthcare system, then a struggle for recognition will immediately start in competition with other professionals (Pill et al., 2004). Following this path, it will become natural to consider healthcare chaplains as healthcare professionals. A large body of research seems to point in this direction, namely that healthcare chaplains seem to be developing their profession (Ford & Tartaglia, 2006; Poncin et al., 2019; Swift et al., 2012, 2016). The importance of outcome studies has been accentuated (Fitchett et al., 2014; Handzo et al., 2014) and the position of healthcare chaplaincy within healthcare is stronger than before(Orton, 2008; Weaver et al., 2008; Weaver, Flannelly, & Oppenheimer, 2003). Despite this, a struggle for legitimation among healthcare chaplains has been reported in healthcare contexts in Europe (Kofinas, 2005, 2006), the UK (Ballard, 2004, 2010; Handzo et al., 2014; Macritchie, 2001; Pattison, 2010; Swinton, 2003), the US (Cramer et al., 2013; Vries et al., 2008) and Canada (Mela et al., 2008), as well as in New Zealand (Carey & Del Medico, 2013). This way of thinking about healthcare chaplains' role and professional practice has been called the "existential care model" (Stifoss-Hanssen, Danbolt, et al., 2019). According to this model, healthcare chaplains' main task would be to secure and improve users' health and

wellbeing and enhance their capacity to cope with crisis, emphasising meaning in life, existential and spiritual support and comfort.

If, however, healthcare chaplains are seen as "virtuous agents" (MacIntyre, 1981), it is important to nourish what is unique about this particular profession. Providing religious service according to patients' requests is usually integrated in the practice of chaplaincy worldwide. This is commonly based on human rights described in Article 18 of the United Nations Declaration of Human Rights (Draft Committee, 1948) that mandates "Everyone shall have the right to freedom of thought, conscience and religion". This right covers the freedom to change one's religion or faith and the freedom to, by oneself or together with others, publicly or privately express one's religion or faith through teaching, practice, worship, or ritualization. The freedom of religion is also incorporated into the Norwegian Constitution, § 2: "All residences of the kingdom have the freedom of religious practice". This way of thinking about healthcare chaplains' role and professional practice has been called the "religious service model" (Stifoss-Hanssen, Danbolt, et al., 2019). According to this model, healthcare chaplains would mainly be viewed as a "religious specialist workers", preaching the word of God, officiating baptisms and funerals, and offering pastoral care to patients and healthcare staff (Alterbok, 1920; Farsund, 1980, 1982).

Holding EG practice up against the two models of care, it seems reasonable to understand it as a professional practice of existential care. Nevertheless, it could be argued that existential care in a Scandinavian context would correspond to *spiritual care* in a UK context, described as "care which recognizes and responds to the needs of the human spirit when faced with trauma, ill health, or sadness and can include the need for meaning, self - worth, to express oneself, for fair support, perhaps for rites, prayer or sacrament, or simply for the sensitive listener (Handzo, 2015, p. 66; NHS Education Scotland, 2009). Based on the findings, especially concerning the narrative EG approach (sub-study 1), this description seems to reflect the practice's emphasis on both existential and religious care. The same might be said about the professional practice of providing *clinical pastoral care*, described as a hybrid of therapy and of spirituality in that it "draws from psychodynamic, family systems and narrative theories, and they speak the language of attachment disorders and maladaptive behaviors as much as the language of spirituality" (Thorstenson, 2012, p. 5).

In the UK, researchers have critically reflected upon the dilemma tied to healthcare chaplains' professional identity; for instance, a vital part of the chaplaincy is seen to be at risk in the event that these chaplains identify as true healthcare professionals (Swinton, 2003). Furthermore, their identity as catalysts for transformative healthcare practices may be lost if

chaplains are exclusively considered healthcare professionals (Ballard, 2010; Swinton, 2003). Researchers in the UK have thus argued for the full integration of healthcare chaplains into interdisciplinary teams of healthcare personnel (Swift, 2009; Swift et al., 2012, 2016), as well as emphasising that healthcare chaplains are skilled brokers of spiritual care (Swift et al., 2012, p. 188). It has also been suggested that the clergy be considered professional amateurs or court jesters in clinical settings (Ballard, 2004), while healthcare chaplains are often considered professional translators (Macritchie, 2001). Researchers in the US (Vries et al., 2008), meanwhile, have argued that healthcare chaplains must strengthen their professional status and establish agreed-upon standards for professional practice (Cramer et al., 2013; Vries et al., 2008). As such, a strong position of healthcare chaplaincy should be established in healthcare such that a professional practice may develop (Orton, 2008; Weaver et al., 2008; Weaver, Flannelly, & Oppenheimer, 2003). Lee (2002) disputes this viewpoint and suggests that healthcare chaplains have become secularised in their professional practice.

The mental health professionals surveyed in this study described healthcare chaplains' professional practice as addressing the existential dimension in EGs (sub-study 1 and 2), and lengthier EG participation was found to be significantly associated with lower levels of psychological distress. Furthermore, religious and spiritual discussion topics and the experience of meaningfulness were significantly associated (sub-study 3). Based on these findings, and in light of previous research documenting healthcare chaplains' professional practice, EG practice might be considered a professional practice – specifically one that aligns with the function of an existential worldview (Bauman, 1998; DeMarinis, 2006, 2008), including providing people with narratives, values and ritual behaviours that nurture and provided sources of meaning in time of both hope and crisis. In light of these findings, and inspired by researchers in the UK (Swift et al., 2012, p. 188), healthcare chaplains might be considered skilled brokers of existential care, and their role and professional practice could thus be seen as existential healthcare providers in treatment settings. This aligns with what has been suggested elsewhere related to healthcare chaplains' existential competence and professional practice (Berthelsen & Stifoss-Hanssen, 2014; Ford & Tartaglia, 2006; Timmins et al., 2017).

7.3 Mental health professionals' viewpoints

In both the qualitative and quantitative data, the mental health professionals showed openness and positive attitudes towards addressing the existential dimension in treatment settings (sub-

study 2). How should this be interpreted? The sample might be a cause for concern, which was recruited based on their connection to EG practice across the Norwegian healthcare. The healthcare professionals were either co-leaders, therapists of patients participating in EGs, or managers in units providing an EG. For instance, did managers just assume, or hope, that certain things were being done in the groups, thus expressing their trust in those who run them? Could this also be the case of for the therapists? When it comes to insights into EG practice, mangers and therapists were considered to have only indirect information from the patients, whereas healthcare chaplains and co-leaders were the only ones who knew what was going on in EG practice in the unit.

Would the findings be more nuanced if mental health professionals not tied to the EG practice were included in the sample? Only one therapist in the study was critical, suggesting that existential, religious and spiritual issues should not be part of a treatment programme but rather be addressed outside treatment settings. It could be argued that if several mental health professionals without ties to the units providing EGs had been included, more similarly critical viewpoints would perhaps have been represented. The critical viewpoint might however reflect the dominant biomedical discourse in mental healthcare (Sutherland, 2000), accused of portraying treatment as one-sided, thus resulting in neglecting the existential dimension (DeMarinis et al., 2011; Koslander et al., 2009; Swinton, 2001). Additionally, psychotherapists have been found to be less committed to traditional values, beliefs, and religious affiliations compared to non-clinical populations (Beit-Hallahmi, 1977; Bergin, 1980; Henry et al., 1971), although this finding has been disputed (Bergin & Jensen, 1990) and may be out of date (Curlin et al., 2007; Lawrence et al., 2007)

However, it is interesting that healthcare chaplaincy was identified as the one profession most reluctant to recognise that the existential dimension is in fact being addressed in treatment settings (sub-study 2). The finding might even be viewed as surprising when viewed alongside the finding that mental health professionals considered the EG practice to be an established and integrated part of the treatment programme (sub-study 1). Why, then, are healthcare chaplains so critical? Interestingly, similar findings were also reported in a German study in which healthcare chaplains provided a significantly less positive assessment of psychiatrists' and psychotherapists' attitudes towards spiritual and religious concerns compared with what those professionals reported themselves (E. Lee et al., 2015). Could this be understood alongside the processes of professionalisation and de-professionalisation that are suggested to have influenced Western society and the subsequent demand for evidence-based practices (Brint, 1994; Griffiths, 1983; Hood, 1991; Pill & Hannigan, 2010)? These

processes have led to a struggle for professional legitimation for healthcare chaplains, who have sought to have their competence recognised within the healthcare system in various countries (Kofinas, 2006; Miller & Burton, 2014). Healthcare chaplains' communication tasks have been examined (Cramer et al., 2013) and described as offering presence, respecting diversity, listening to concerns, and providing support (Lyndes et al., 2008). However, Cramer et al. (2013) conclude that these communication tasks might not carry much weight in the medical world due to the difficulty associated with measuring spiritual care services. Cramer et al. (2013) further accentuate that healthcare chaplains often find it difficult to translate the profession's benefits in ways that resonate with patients, team members, and hospital administrators alike.

Research has shown that healthcare chaplains are considered to have existential competence (Berthelsen & Stifoss-Hanssen, 2014; Ford & Tartaglia, 2006; Timmins et al., 2017), therapeutic competence (Harding et al., 2008; Schuhmann & Damen, 2018; Thorstenson, 2012) and communications competence (Cramer et al., 2013; Lyndes et al., 2008). It thus could be argued that healthcare chaplains might possess expertise in addressing existential, religious and spiritual issues in clinical settings, which would make them particularly aware that patients' existential, religious and spiritual needs are not met properly in clinical settings, as research has shown (Galek et al., 2007; Khan, 2006; Lawrence et al., 2007), and also that these unrecognised or unmet spiritual needs are not restricted to patients who are openly religious (Khan, 2006; Lucchetti et al., 2013; McGee & Torosian, 2006). This might explain why the healthcare chaplains in this study were the most reluctant to recognise that the existential dimension was addressed in treatment settings. Spirituality has even been considered a taboo in Norwegian mental healthcare (Borge & Mæland, 2017). Furthermore, patients experienced meetings with healthcare chaplains as significant during their psychiatric treatment since these meetings created room for addressing existential and spiritual issues that were not dealt with during their therapy sessions (Borge & Rolfsnes, 2009).

With that said, research also suggests that attitudes towards spiritual and religious issues in mental health practice vary across professions (Dein et al., 2010). For instance, nurses are reported to more frequently share their religious and spiritual backgrounds with patients than are psychiatrists (E. Lee et al., 2014). Psychiatrists have been identified as less religious than their patients (Lukoff et al., 1992), although this situation is suggested to be changing (Curlin et al., 2007). A Norwegian study that explored Norwegian psychology education reported that existential, religious and spiritual issues were neglected leading to inadequate training of clinical staff (Reme et al., 2009).

However, what about in practice? Several international studies have explored mental health professionals' attitudes and behaviours towards religious and spiritual issues in clinical practice (Curlin et al., 2007; Lawrence et al., 2007; E. Lee et al., 2014), all of which reported a gap between positive attitudes towards such concerns and actual practice. In light of this information, I was interested to see if there was a similar gap in EG practice. In the present study, a small gap between attitudes towards and practices of addressing existential, religious and spiritual issues in treatment settings was identified (sub-study 2). While the gap appeared to be smaller compared to the other studies, it is difficult to compare due to differences in design and sample. The present study also found that co-leaders scored higher on existential competence (sub-study 2) compared with the international study of Lee et al. (2014). However, no conclusion can be drawn from this due to dissimilarities in research design and statistical analysis applied. Moreover, the sample in this study is not considered representative because only mental health professionals tied to EG practice were invited to participate in the study. Further research could investigate co-leaders' competence in addressing existential, religious and spiritual issues and possible associations to EG practice.

Although the present study did not explore mental health professionals' religious backgrounds, the gap between their attitudes and practice (sub-study 2) might also reflect the finding that therapists' backgrounds and existential orientations had an impact on their practice, goals, and values of care, as well as on how existential information was applied in therapy practice (Ulland and DeMarinis (2014). However, whether this also applies for the co-leaders involved in EG practice needs to be investigated further.

7.4 Patients' existential meaning making

Lengthier EG participation was significantly associated with lower levels of psychological distress (sub-study 3). This finding might, however, be challenging to interpret as it resembles findings regarding spirituality groups in the US whose aim is psychospiritual growth (Gangi, 2014; Genia, 1990; Hirschmann, 2011; Jensen et al., 1998; Kehoe, 1998, 1999; Popovsky, 2007; Revheim & Greenberg, 2007). Significantly higher spirituality status and hopefulness were found among patients attending spirituality groups compared to those not attending (Revheim et al., 2010). However, no differences were found related to self-efficacy and quality of life (Revheim et al., 2010). The study by Revheim et al. (2010) also examined only patients diagnosed with schizophrenia. The current study included patients from various kind of psychiatric units (sub-study 3), making it difficult to compare the findings. That being said,

a sample of 40 patients, as was the case in the study by Revheim et al. (2010), might also be too small to draw any certain conclusion.

The Norwegian EG practice is believed to have evolved from chaplain-led spirituality groups in the US, presumably linked to Norwegian chaplains' participation in CPE programmes in the US from the 1960s onwards (Farsund, 1980, 1982; Høydal, 2000). The findings of Revheim et al. (2010) are thus interesting and maybe also point to a difference between spirituality groups in the US and EG practice in Norway, namely that the latter emphasises psychological growth as a goal in itself (sub-studies 1, 2 and 3). The close connection between Norwegian healthcare chaplains and the group psychotherapy tradition in Norway might explain this psychological focus (Frøkedal & Austad, 2019; Island, 1995; Lorentzen et al., 1995). It could also be due to the secular Scandinavian culture (DeMarinis, 2006; la Cour, 2008; la Cour & Hvidt, 2010). This should be investigated further.

Another possibility might be to view the present findings against the background of group psychotherapy integrating existential, religious and spiritual issues (Cornish & Wade, 2010; Cornish, Wade, Tucker, & Post, 2014; Viftrup et al., 2016; Wade et al., 2014). For instance, participation in these type of groups has been shown to strengthen motivation for therapy (Viftrup et al., 2013), provide renewed strength in life (Johnson, 1997), reduce symptoms and improve patients' relational patterns (Stålsett et al., 2010; Stålsett et al., 2012). For comparison, patients participating in EGs have reported increased self-reflection, new skills, increased self-confidence, and decreased loneliness (Frøkedal & Austad, 2019). Additionally, healthcare professionals tied to units offering EGs in Norway have reported improved recovery, reinforcement of other therapies and improved coping with illness (sub-study 2). It is, however, difficult to compare these findings with findings on group psychotherapy integrating religious and spiritual issues owing to the differences in research design and outcome variables applied in the various studies.

The findings might also reflect the fact that the patients received other treatment that led them to experience lower levels of distress. Nonetheless, the finding is suggested to be relevant also because of the similarities identified between EG practice and other therapeutic traditions (sub-study 1). Interestingly, the present study identified that almost half of the patients had never participated in group therapy before (see Table 1). In light of this, EGs might be seen as opening doors to other types of group therapy for some of the patients. It might then correspond to a primary goal for groups provided at inpatient psychiatric units according to Yalom and Leszcz (2005, pp. 485-487). The important goal has been described to engage the patient in the therapeutic process by creating an inherent wish for the patients to

continue with group therapy (and /or individual therapy) after the hospital discharge. This is believed to might happen if the group experience has been sufficiently positive and supportive. So maybe this could be the case with EG practice? In any case, it merits further examination.

Another challenge in interpreting this finding is that half of the patients participated in EG practice only one to three times (sub-study 3). Is it possible that participation of such a short duration could be of significance? The therapeutic techniques for these kind of groups have been described by Yalom and Leszcz (2005, p. 491) as follows:

> When you lead groups [with patients suffering from severe mental illness], you must provide even more direct support. Examine the behaviour of the […] patients and find in it some positive aspect. Support the mute patient for staying the whole session; compliment the patient who leaves early for having stayed twenty minutes; support the member who arrives late for having shown up; support in active members for having paid attention throughout the meeting. If members try to give advice, even inappropriate advice, reward them for their intention to help. If statements are unintelligible or bizarre, nonetheless label them as attempt to communicate.

Accordingly, effective group work appears to still be possible with rapid patient turnover, wide diagnostic spread among participating patients, blurred group boundaries and a complex role for the group leader (Yalom & Leszcz, 2005, pp. 487- 496). In light of this, even a single EG session might be useful for patients (Yalom & Leszcz, 2005, p. 488). However, this needs to be examined further.

EG discussion topic of religious and spiritual issues was found to be significantly related to the experience of meaningfulness (sub-study 3). In the study, it was also hypothesised that all the discussion topics, which covered a broad spectrum of patients existential meaning-making, were significantly associated with meaningfulness. This hypothesis was based on previous research that identified EGs as providing space for patients' existential meaning-making using a diversity of therapeutic strategies and including religious and spiritual issues (sub-studies 1 and 2). How might this finding be understood or explained?

This finding might correspond to similar findings about spirituality groups in the US. These type of groups commonly combine elements from group psychotherapy, the recovery movement, emotion-focused coping and religious coping, and attendance has been shown to play a significant role in patients' recovery processes (Gangi, 2014; Jensen et al., 1998; Kehoe, 1999; Kidd et al., 2001; Popovsky, 2007; Revheim & Greenberg, 2007; Revheim et al., 2010). Higher levels of hopefulness have also been identified among patients diagnosed with schizophrenia participating in a spirituality group compared to patients who did not participate (Revheim et al., 2010).

This was also identified in sub-study 2, in which the existential dimension was described as a dynamic search for hope and meaning during a struggle with existential, religious and spiritual pain and issues in order to enhance coping. It could, however, be argued that this finding is based on misjudgement because the study design did not allow for exploration of a process described as a dynamic search. Nevertheless, the informants of sub-study 2, namely mental health professionals and healthcare chaplains, understood the following key points related to the existential dimension: *The experience of loneliness* and *isolation* were associated with great pain and struggle and were triggers for illness and despair in patients' life. *Identity, mental illness, sexual abuse* and *exposure to violence* were also underscored as topics that caused existential pain. The *experience of not belonging* was also emphasised by several informants as being devastating and causing suffering that was manifested in feelings of alienation. Several of the mental health professionals also mentioned *faith* as a topic that patients struggled with, including the problem of evil, ontological questions concerning God's existence and personal spiritual experiences of questioning God's love. *Inspiring hope* was described by many of the informants as significant while it was believed to be coupled up with *coping*, suggesting that both hope and coping are tied to their understanding of the existential dimension. *Finding meaning in life* – from finding meaning in everyday living to having an all-encompassing sense of meaning in one's life – was also underscored by many informants as the most important life experience. The significance of finding meaning in illness and health was also emphasised. (See qualitative findings in article 2 for a full description).

So why this lengthy description of mental health professionals' and healthcare chaplains' understanding of the existential dimension? It could be argued that these descriptions say something important about patients' struggles related to the existential dimension during their hospitalization. Even though the study could be critiqued for not being designed to identify an understanding of the existential dimension as a dynamic process comprising hope and coping, the findings correspond with other findings that suggest a dynamic and reciprocal relationship between hope and coping (Folkman, 2010). Another possible critique of the findings in this study is that they do not include first-hand information from patients themselves; however, they do include the impressions of mental health professionals with many years of clinical experience (sub-studies 1 and 2).

In any case, from both mental health professionals' perspectives (sub-study 2) and patients' perspectives (sub-study 3) the concept of religious coping appeared to be central. The findings are in line with other studies reporting the importance of religious coping,

especially in times of crisis (DeMarinis, 2013; DeMarinis et al., 2011; Emmons, 2005; Lilja et al., 2016; Pargament, 2001, 2011; Pargament & Raiya, 2007; Sørensen et al., 2015).

For instance, previous research has found that religious coping empowers recovery for patients diagnosed with substance use disorder (Sørensen et al., 2015), patients diagnosed with first-episode psychosis (Hanevik et al., 2017), patients suffering from schizophrenia (Hustoft, Hestad, Lien, Møller, & Danbolt, 2013), devout Christians suffering from mental illnesses (Lilja et al., 2016), and young women at an outpatient psychotherapy clinic (Lloyd et al., 2017). The struggles reported by patients resemble the struggles identified by Exline et al. (2014), such as divine, moral, doubt and ultimate meaning.

Perhaps some of what the mental health professionals described resembles "crisis faith" (Ausker et al., 2008; la Cour, 2008), a phenomenon in which severe illness and crises seem to intensify existential concerns and the use of spiritual and religious beliefs as sources for meaning making (Ausker et al., 2008; la Cour, 2008). Nevertheless, experimental studies have also suggested that existential themes may play an important role in how people live their lives and respond to uncertain situations (Pyszczynski et al., 2004).

Also, when comparing the findings from sub-study 3 with studies applying the meaningfulness and crisis of meaning questionnaires (Schnell, 2009; Schnell & Becker, 2006) there is resonance. In these studies, a significant relationship between explicit religiosity and spirituality and the experience of meaningfulness was reported, the second most important relationship after generativity (Damásio et al., 2013; Schnell, 2009; Sørensen et al., 2019). However, important differences in motivation in life have also been found (Pedersen et al., 2018; Schnell & Keenan, 2011). For instance, people who have secular views of life, for example, atheists, have reported more engagement in self-actualization, such as individualism and achievement (Pedersen et al., 2018; Schnell & Keenan, 2011), while people who are more religiously oriented seem to be more motivated by self-transcendence (Pedersen et al., 2018). These differences might also be reflected in the findings of sub-study 3. However, this is only speculation.

It might also be argued that the mental health professionals' understanding of the existential dimension identified in sub-study 2 might reflect the description of the existential dimension developed by DeMarinis (2003, 2006, 2008), which includes a worldview conception, life approach, decision-making structure, and a way of relating and understanding rituals and other ways of making meaning. Furthermore, it might also correspond to the idea that existential dimension is an active process of making existential meaning (DeMarinis, 2003, 2013; la Cour & Hvidt, 2010; Schnell, 2003, 2009). The findings might also be

understood in light of dysfunctional existential meaning making, which is thought to occur when people do not have access to a culture's internal (e.g. values, beliefs, attitudes, expectations, and consciousness) and/or external representations (e.g. symbols, structures, and institutions of a society), a situation that is claimed to be harmful to human mental health (Bauman, 1998; DeMarinis, 2006, 2008). This viewpoint is supported by a study that identifies the absence of belonging, ontological security and meaning in life as risk factors for mental illness (Lloyd et al., 2017). This should, however, be further examined in a Norwegian clinical context to develop more knowledge of how to foster functional existential meaning making both when psychological distress is high and when there is a crisis of meaning.

It would perhaps also be interesting to view the findings in sub-studies 1, 2 an 3 with regard to existential meaning-making against the model developed by la Cour and Hvidt (2010). This model offers a broader understanding of existential meaning making and coping related to health in secular countries. The model consists of three existential domains (secular, spiritual, religious) in combination with three core psychological dimensions of meaning making (cognition, practice, importance). When viewing the findings of this study in light of this model, the secular domain seems most dominant in the healthcare chaplains' EG practice. This claim is based on the fact that only 10 of 49 groups reported the using the narrative EG approach, the only group approach that explicitly addressed religious and spiritual issues. Religious and spiritual issues were the least frequently discussed topics in the EGs (sub-studies 1–3), which might perhaps indicate that the EGs led by healthcare chaplains are more strongly characterised by the secular domain than by the religious/spiritual domain. This claim aligns with the description of Scandinavia as secular (la Cour & Hvidt, 2010), which includes Norway (Botvar & Schmidt, 2010). Healthcare chaplains being characterised by the secular domain would perhaps also reflect the claim that the healthcare chaplaincy is a newly secularised professional field (S. J. C. Lee, 2002). Nevertheless, all three sub-studies reported that religion and spirituality were relevant topics of discussion among patients participating in the EG practice, thus indicating that the religious/spiritual domain has remained relevant in Norwegian mental health treatment settings.

Lastly, the grouping of the EG discussion topics might also be questioned (see section 5.5.3). Would the findings have been different if the dimensions of groups had been constructed differently? In sub-study 3, a list of 24 possible EG discussion topics was included. Based on an expert panel's assessment of relevant topics, cognitive interviews, theoretical grounds and previous research literature, the 24 topics were grouped into four dimensions by the expert panel. The four dimensions were: (1) religious and spiritual issues,

(2) existential concerns, (3) meaning-giving activities and (4) coping. The dimensions most surely contain overlaps, and some of the topics could be included in more than one dimension. For instance, the discussion topic of nature could be included in both the dimension of coping and the dimension of religious and spiritual issues. However, based on the secular Scandinavian view of nature as a sacred and available resource for humans (Ahmadi, 2006), this topic was included in the dimension of religious and spiritual issues. Due to this situation that the dimensions most surely contain overlaps and the possibility of errors in the interpretation of the grouping, a confirmatory factor analysis (CFA) was therefore performed, confirming the underlying structure of the dimensions. Based on this analysis, these topics appear to make sense. However, relevant discussion topics in the EGs should be further examined, and more topics will presumably be added to the list.

7.5 Methodological considerations

Survey design is appropriate when a study's overall aim is to explore, describe, and map out characteristics of one or several phenomena (Creswell, 2014). Nevertheless, survey studies have several weaknesses, such as errors of coverage, sampling errors, and nonresponse related to sampling procedures. In the following sections, these limitations of survey design will be discussed.

7.5.1 Design

The overall design of the present study is a nationwide cross-sectional survey, which, according to Ruel et al. (2016), is a cost-effective way of distributing and collecting data – assuming it positively contributes to the response rate; on the other hand, a nationwide, cross-sectional design gives a snapshot of merely one particular point in time (Creswell, 2014). A survey design was chosen based on the study's overall aim of mapping out the characteristics of the existential group therapy practice run by Norwegian healthcare chaplains (sub-studies 1–3).

It should also be mentioned that the design in sub-study 1 might be considered only partly explorative due to the small number of open response questions included. However, the methodology was the same as that used by Lorentzen and Ruud (2014) (combining close-ended and a few open-ended responses) in their cross-sectional study of group psychotherapy in Norway, which they described as both descriptive and explorative because of the aim of "mapping" the group practice.

The cross-sectional design does pose limitations, such as its inability to examine changes over time and its inability to provide causal directions between variables (K. A. Levin, 2006). For instance, a significant association between longer EG participation and lower levels of psychological distress was found (sub-study 3). However, it is not known whether participation in EGs leads to lower levels of psychological distress, or whether patients with lower levels of psychological distress are more likely to attend EGs. The same can be said for the reported significant relationship between religious and spiritual issues and meaningfulness as well as the relationship between age and meaningfulness (sub-study 3).

To strengthen the survey design, quantitative and qualitative data obtained from close-ended and open-ended responses were included (Foddy, 1994). A limitation of the overall study design might be that it did not include qualitative interviews, which could have strengthened it.

7.5.2 Recruitment

Questions about generalisation or external validity relate to the transferability of findings from one setting to other populations (Taylor & Asmundson, 2008), which became relevant when discussing recruitment in the present study. A common challenge in survey research is the possibility that coverage errors may occur when the sampling frame has not considered all elements of the target population (Draugalis & Plaza, 2009). In a case such as this, potential coverage errors would be a risk because the opportunity to participate would be unequally dispersed among the target population. Coverage errors might eventually lead to sampling errors, which are described as discrepancies caused by random sampling between the true value of the population parameter and the sample estimate of that parameter (Draugalis & Plaza, 2009). This challenge was considered in the current study, and therefore, to the author's best knowledge, no informant groups relevant to the study were hindered from participating and were all equally afforded the opportunity to be selected. Probability sampling was challenging because the exact population size of the informant groups was unknown.

All informants were recruited from the Norwegian specialist mental health services across 19 health trusts. The informants all had a connection to EG practice, either as a group leader (healthcare chaplain), a co-leader (healthcare professionals, like psychiatric nurses), a therapist to patients participating in an EG (psychologist/psychiatrist) or a manager in a unit providing this type of group. The choice of informants was based on a desire to include a broad range of viewpoints from different professional backgrounds. Regarding the managers, there was some concern as to whether they should have the right to have an opinion on group

content, for instance. However, because managers are the ones who approve EG groups and have the power to end EG programmes that do not meet quality standards, it was assumed they would know what kind of topics were discussed in these groups. Moreover, as healthcare chaplains are included in interdisciplinary meetings in which the day's groups are discussed, it was assumed that managers would be aware of current information regarding the EGs.

Informants were identified and recruited using a stepwise process. The various informant groups that met the inclusion criteria were invited to participate in the study by e-mail with a web link to the questionnaire on Questback (www.questback.com). To increase the response rate, an e-mail reminder with the attached web-based link was sent to all non-responding participants on two occasions following the first round of invitations.

Of the 27 healthcare chaplains with experience of leading an EG who were identified, 6 did not meet the inclusion criteria because they were not leading an EG at the time the data was being collected. All healthcare chaplains that were leading an EG at the time of the study (21) were invited, and all ended up participating in the study, thus providing a 100% response rate. It is therefore possible to argue that the target population and population size are nearly identical to the sample size (21), thus indicating that the sample of the healthcare chaplains is representative and thus satisfactory. This condition is also desirable in small sample sizes (Krejcie & Morgan, 1970).

Managers were recruited based on an e-mail list of 23 managers provided by the healthcare chaplains following the identification of the 49 groups (sub-study 1). Some managers were in charge of several different units that provided EGs, which explains why the number of number of mangers was less than the number of groups. The participation rate among managers was 83%, (19 out of 23), which was considered quite high. (Krejcie & Morgan, 1970) recommend a 100% response rate when studying a small population; nevertheless, 83% was considered satisfactory for this study.

Recruitment of co-leaders and therapists was performed using purposive sampling (non-random sampling), which is described as a kind of convenience sample wherein the informants are chosen based on their specialised knowledge of the subject area under study (Kalton, 1983). This method was chosen because it facilitated the exploration of a practice based on expert knowledge, thus aligning with the study aim. One limitation concerning the inclusion of co-leaders here might be the different arrangements of co-leadership that exist in the various EGs; in addition, some co-leaders are experienced in co-leading while others are not. This discrepancy might have contributed to an uneven distribution of existential competence among the co-leaders (Table 6). However, the recruitment process was

challenging, and merely 38% and 37% of the invited co-leaders and therapists respectively participated in the study. Several reasons may be attributed to this low participation rate, including the technical reasons discussed below. The low response rate might also pose a threat to the study's external validity. Due to this situation, great caution should be taken when attempting to generalise and no certain conclusions can be drawn for this sample.

Group participants were recruited using convenience sampling (non-random sampling), also called availability sampling (Kalton, 1983). This sampling process has several weaknesses, and extreme caution should be exercised when attempting to generalise (Ruel et al., 2016). For instance, the response rate of the study could not be accurately determined because the healthcare chaplains did not register how many patients they had invited to participate, and the informants who did not want to participate in the study were not registered. Thus, we were not able to identify how many patients did not want to participate or dropped out. However, we need to bear in mind the vulnerable position of the target population in the study, being hospitalised and suffering from mental illness. In sub-study 3, one third of the sample (50 patients) were hospitalised at the highest care level (Table 5), indicating that they were suffering from severe mental illness. To accommodate for the lack of an accurate portrait of the target population, healthcare chaplains estimated that 252 patients participated weekly across all the EGs (Table 5). Based on this estimation, we consider it reasonable to assume that 157 patients participated in the study for a response rate of 62%, which was considered satisfactory.

It is also possible that the questionnaire was too demanding for patients in a vulnerable state. When the questionnaires were collected, one healthcare chaplain reported that on one occasion, two patients in the same group needed support from clinical staff after completing the questionnaire: the patients felt that there were too many questions and that the questions touched upon their vulnerability. However, other healthcare chaplains did not report similar reactions from participants. The effort the 157 participants put into completing the questionnaires was also taken into account and the sample was considered satisfactory.

There might be a selection bias tied to the fact that patients were invited to participate by healthcare chaplains and co-leaders who were also involved in receiving the completed forms and questionnaires. This may have influenced the patients' responses, making them more positive towards participating and responding. It might also explain the absence of critical voices in the sample. Nevertheless, all the patients were invited to participate. Questionnaires were filled out individually, and the completed forms and questionnaires were returned in sealed envelopes.

7.5.3 Data collection method and measures

An important question regarding construct validity is whether or not the measurements applied in the study are appropriate and related to the study's aim (Ruel et al., 2016). In sub-studies 1 and 2, most questions were developed for the purpose of exploring the EG practice, including a five-point Likert scale that sought the interdisciplinary viewpoints of the group practice and an open-ended question for healthcare chaplains concerning each group they were leading. In Norway, existential competence has not yet been operationalised in the form of a measurement instrument; therefore, a self-reported item was developed based on a five-point Likert scale to address the study's purpose in sub-study 2. Sub-study 1 is the first of its kind to examine the Norwegian EG practice, and there was thus no pre-existing questionnaire, which might be considered a limitation. However, the questionnaires in both sub-studies 1 and 2 were based on another questionnaire that had been developed in a previous cross-sectional survey of group psychotherapy (Lorentzen & Ruud, 2014) that also included an open-ended question concerning group descriptions. However, no claims can be made when it comes to the study's construct validity nothing can be claimed because we were not able to measure it.

Nonetheless, the web-based survey in sub-studies 1 and 2 was tailored to each participant group and was tested on each informant group beforehand (healthcare chaplains, co-leaders, therapists, and managers). Cognitive interviews were conducted with the test persons and notes from these interviews were brought back to the expert panel for further discussion until consensus was reached on how the items should be interpreted and presented. With this approach, several errors in the construct measurement are believed to have been discovered and corrected. However, this was not measured, so it is not possible to say whether this process enhanced the construct validity.

In sub-study 3, the construct validity was tied to the development of printed questionnaires. Most construct measurements had been psychometrically tested, including *meaningfulness* and *crisis of meaning* (Schnell, 2009; Schnell & Becker, 2006), as well as validated in Norway (Sørensen et al., 2019). In sub-study 3, the reliability was $\alpha = 0.88$ for *meaningfulness* and $\alpha = 0.92$ for *crisis of meaning.*

Psychological distress was assessed by the CORE-10*,* validated in an adolescent population in Norway (Solem & Moen, 2015). The reliability of this scale in the sub-study 3 was $\alpha = 0.86$.

A limitation of sub-study 3 could be that the 24 EG discussion topics were not validated. However, the topics were chosen based on an expert panel's assessment of relevant

topics, the cognitive interviews, theoretical grounds and previous research literature. Lastly, the 24 EG discussion topics were grouped into four dimensions by the expert panel (See section 5.5.3). To assess external validity of the proposed questionnaire, a confirmatory factor analysis using principal component analysis and Oblimin rotation was performed (Harrington, 2009). The proposed four domains explained 50.3% of the variation in the original data. All the items loaded most on one domain, confirming that all the items cover one underlying construct. Further, a majority of the items loaded highly on the anticipated domains thus confirming the underlying structure. This is common, and the literature confirms that the driving force when constructing the domains of a questionnaire is most often the theoretical framework (Harrington, 2009).

As mentioned previously, the researcher scheduled meetings at the various clinics with all the healthcare chaplains included in the study to safeguard the recruitment process of the EG participants. The participating healthcare chaplains were given boxes containing cover letters, consent forms, reply envelopes, questionnaires, and a memory list. In each meeting, the researcher provided the same orientation and practical guidelines to optimise a common understanding as efficiently as possible. In this way, these scheduled meetings might have enhanced the study's validity.

7.5.4 Missing data

The questionnaires developed for survey research plays a very important role in terms of the level of success a web-based survey may achieve, as well as influencing the data quality (e.g., non-responsiveness) (Manfreda & Vehovar, 2002). If questionnaire items are poorly worded or exhibit a poor visual design, non-responsiveness may quickly increase (Manfreda & Vehovar, 2002). To most effectively minimise this kind of design flaw in both the web-based and printed questionnaires, both were tested beforehand on group participants across the various professions on a voluntary basis.

There are several possible explanations for missing data from both questionnaires. Concerning web-based questionnaires, Draugalis and Plaza (2009) claim that participants might encounter technological issues, for instance when the survey equipment is not compatible with the software. These kinds of problems might be worse when multimedia technology is applied, and such difficulties may cause frustration among respondents and force them to abandon the questionnaire prematurely (Comley, 2000; Manfreda & Vehovar, 2002). Although multimedia technology was not applied in the current study, some technical problems were nevertheless detected. Several informants contacted the researcher and reported technical problems regarding their participation, and thus the researcher allowed

informants to use other personal computers. This strategy worked in some cases; in the few cases where it did not work, there was missing data. We can assume that such issues happened in more cases, which might perhaps explain the low response rate in the group of co-leaders and therapists (see discussion above). Nevertheless, the strategy for handling missing data in sub-studies 1 and 2 involved omitting missing data from the analysis to ensure that the data included in the analysis were accurate and not manipulated.

Missing data in the printed questionnaire posed some challenges. To safeguard this process as efficiently as possible, the researcher held individual meetings with the healthcare chaplains to collect the questionnaires following the completion of the data collection period. In these meetings, the healthcare chaplains reported verbally on how the questionnaire was received by the group participants. This allowed the researcher to understand the recruitment process from the perspectives of those participating in the study, which proved valuable; for instance, the researcher received similar feedback from several healthcare chaplains regarding two questions that were not properly understood, and this issue was reflected in the data analysis. As such, the researcher was able to form a broader understanding of the missing data. However, in sub-study 3, the missing data were replaced using the mean imputation method described by Jamshidian and Yuan (2013) when missing one answer (three cases) and removed when missing more (seven cases). Mean imputation is considered the simplest imputation method to perform (Jamshidian & Yuan, 2013), although it can also lead to biased estimates. In sub-study 3, only a few estimates were missing and were replaced by means.

7.5.5 Choice of data analysis

Questions regarding the appropriate use of statistics – called statistical conclusion validity – will arise when performing a study (Cook, Campbell, & Shadish, 2002). As previously mentioned, to strengthen the nationwide explorative cross-sectional survey design, both qualitative and quantitative data were obtained from close-ended and open-ended responses (Foddy, 1994).

Open-ended and close-ended questions contrast in several ways (Reja et al., 2003), particularly in terms of the role respondents play when answering each type of question. It has been argued that close-ended questions offer respondents limited alternatives for answering a question, while open-ended responses provide them the opportunity to express an opinion without being affected by the researcher (Foddy, 1994). Building on Reja et al. (2003), it may be argued that the advantages of open-ended responses are the possibility to identify spontaneous responses, which may avoid the bias that often occurs from suggesting responses in close-ended questions, and the richness that such responses can provide (Schaefer &

Dillman, 1998). However, this viewpoint has been disputed. According to Knapp and Heidingsfelder (2001) dropout rates are higher with open-ended questions and responses to these questions require extensive coding–a considerable disadvantage.

Few studies have investigated the differences between open- and close-ended questions in web-based surveys (Reja et al., 2003). Reja et al. (2003) have suggested that open-ended questions should be worded more explicitly. Decades ago, Lazarsfeld (1944) identified two different functions of such questions: first, during the initial stages of the questionnaire design, they uncover adequate answer categories for close-ended questions; and second, during the later stages, they can be used to explore deviant responses to their close-ended counterparts.

The current study has built on the two different functions of the open-ended responses described by Lazarsfeld (1944). In sub-study 1, an open-ended question was applied to identify adequate categories of methodological descriptions for the various groups; it would not have been possible to obtain this information using a close-ended question. Additionally, the response rate for the open-ended question in sub-study 1 was high: of 49 groups, only 4 provided insufficient information, and a lager item non-response could not be detected. Nevertheless, extensive coding was necessary, and a qualitative content analysis, as proposed by Graneheim and Lundman (2004), was applied to assess the richness that was detected in the open responses.

In sub-study 2, open-ended responses were applied to explore differences between the two types of questions (Lazarsfeld, 1944). In sub-study 2, the open-responses were characterised by richness and analysed using qualitative content analysis in accordance with Graneheim and Lundman (2004). The overall theme and categories that emerged from the qualitative analysis formed the structure of the quantitative analysis. To compare and validate the findings, the separate materials were subsequently merged into a side-by-side comparison as part of the discussion, following the recommendation of Creswell (2014). The data's quality became clear when the differences between the open- and close-ended responses were compared, and the qualitative data provided more nuanced insights compared to the close-ended questions (Reja et al., 2003). However, the response rate in the present study was higher than the one achieved by Reja et al. (2003). The mean response rate for the two open-ended responses (which were put together and viewed as one text) was quite high among the various informants, and the mean responses for these two questions was 79 (78%). The mean response rate of the healthcare chaplains was 90% (19 of 21), co-leaders 65% (22 of 34), therapists 74% (20 of 27), and managers 95% (18 of 19). Both the quality of the material

obtained from the open-ended responses and the high response rate to the open-ended questions were the reasons why this method was applied for the analysis.

Another limitation to the study was that the five-point Likert scale format was recoded into three categories (see section 5.6.2). The main idea was to make a Likert scale that is considered helpful when measuring, for instance participants' attitudes or viewpoints concerning a specific topic (Ruel et al., 2016), thus a five-point Likert scale was chosen. However, in the analytic phase it became clear that it was easier to only have three categories. It is however considered that this decision of only using three categories did not harm the data noteworthy.

A final limitation of the study might be the fact that I belong to the group of professionals I chose to study. This affiliation might put me at risk of losing my distance to the field, creating what has been called an "illusion of sameness" (Pitman, 2002, p. 285), which might in turn lead to erroneous assumptions based on my prior knowledge and/or experience (Hewitt-Taylor, 2002). This was a risk during the research process for all three sub-studies due to my professional background as a healthcare chaplain with clinical knowledge of EG practice, and it might have influenced the results of the data analysis. For instance, I may have experienced the illusion of sameness when identifying the five different approaches of the EG practice (sub-study 1). To prevent erroneous assumptions and conclusions, I presented my results and my perspective to my research colleagues on my team throughout the research process (Kvale & Brinkmann, 2009). This process helped me distance myself from the material. The use of theory also provided an important distance from both the collected and the established data. Additionally, all the healthcare chaplains involved in the research project as informants were invited to a meeting in November 2016 to check synthesised analysed data (Harvey, 2015). This was done to minimise the risk of making wrong assumptions and with the intention of enhancing the study's trustworthiness (Birt et al., 2016). In this case, the healthcare chaplains were clear in their feedback: they recognised the their own EG practice in the five different approaches.

8 CONCLUSIONS

The present study includes three sub-studies, all of which present analyses of EG practice from different perspectives. The overall aim of the study was to explore what characterises EG practice led by healthcare chaplains in Norwegian specialist mental health services in light of group psychotherapy, group and clinical traditions integrating existential, religious and spiritual issues, the healthcare chaplain's role and professional practice, mental health professionals' viewpoints, and patients' meaning making. First, this aim was pursued through selected open- and close-ended variables that were relevant for exploring the characteristics of EG practice from the perspectives of healthcare chaplains, mental health professionals, and patients. Second, the existential dimension was explored from a descriptive perspective (sub-study 1) as well as from a performative perspective related to attitudes, practices, understandings, and perceptions of value when the existential dimension was addressed in treatment settings (sub-study 2). Third, the existential dimension was investigated as existential meaning making from a patient's point of view (sub-study 3). Finally, the totality was presented through a cross-sectional survey design, and a breadth of multivariate methodological approaches was applied. Together, these many elements combined to build a comprehensive picture of the EG practice led by Norwegian healthcare chaplains.

The overall conclusion of the present study is that EGs led by healthcare chaplains represent a well-established, integrated, and eclectic group practice in the Norwegian specialist mental health services. Leading EGs may be perceived as a professional practice that creates room for patients' existential meaning making processes in times of crisis. The healthcare chaplains who lead these EGs could be considered skilled brokers of existential spiritual care or they could be seen as existential healthcare providers in treatment settings. Mental health professionals reported positive attitudes towards addressing the existential dimension of health in treatment settings. Nevertheless, a small gap between their attitudes and their actual practice of addressing the existential dimension was discovered, although this gap was smaller than that discovered in other related studies. A significant association was found between lengthier EG participation and lower levels of psychological distress. Lastly, the EG discussion topic of religious and spiritual issues was shown to be significantly associated with the experience of meaningfulness.

8.1 Implications for clinical practice and future research

Based on the present study's findings, it could be argued that EG practice in Norwegian specialist mental health services should continue making space for existential, religious and spiritual issues. It could also be argued that the unique and specific EG practice of Norwegian healthcare chaplains has transferable value related to existential questions and issues in healthcare treatment settings in general. In light of this implication, we would suggest that the EG practice be expanded with a goal of offering EGs in all Norwegian health trusts. This full implementation would offer more patients a safe space to share stories about their life, reflect upon existential issues, talk about meaning in life or crisis of meaning and hope or hopelessness and share thoughts about faith. This practice includes patients' existential, religious and spiritual issues and questions as important resources during the recovery process. Furthermore, exploring how EG practice may be tailored to the different care levels across the Norwegian health trusts may also be worthwhile. We also recommend that the development of EG practice be continued through the creation of new knowledge from both theory and practice. Specifically, further exploration of EG practice from patients' perspectives will prove important.

The present study of patients' existential meaning making was based on the assumption that meaning making is potentially a valuable tool to strengthen mental health and to prevent mental distress. The present findings support that assumption to some extent. EG practice seems to have the potential to play a role in this meaning making, and discussion of spiritual and religious issues in these groups also seems to be useful. This might be supported by research on the spirituality groups in USA (Gangi, 2014; Jensen et al., 1998; Kehoe, 1999; Kidd et al., 2001; Popovsky, 2007; Revheim et al., 2010). And indirectly, such findings support the analyses of DeMarinis and other researchers (Bauman, 1998; DeMarinis, 2006, 2008; Lilja et al., 2016; Lloyd et al., 2017), to the effect that the deterioration of common cultural and existential thoughts and practices may put people at risk for experiencing mental distress, especially when they are exposed to crises.

We therefore encourage researchers in the field of chaplaincy, existential health and public mental health to further explore patients' participation in spirituality groups in the US and EG practice in a Norwegian context. A next research step would be to apply longitudinal design, which would make it possible to identify causal relationships. This might provide clearer conclusions and enhance knowledge of both functional and dysfunctional meaning-making processes, as well as of how EGs might positively influence mental and existential health.

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Appendix 1

WEB-BASERT SPØRREUNDERSØKELSE FOR SYKEHUSPRESTER OG HELSEPERSONELL OM EKSISTENSIELLE SAMTALEGRUPPER I NORSK PSYKISK HELSEVERN 2016 *

***** Dette er en fremstilling av det web-baserte spørreskjema (QUESTBACK) som ble utviklet til studien: *'Existential groups led by healthcare chaplains within Norwegian specialist mental health services: Patient and interdisciplinary perspectives'. Web-lenken som ble anvendt fra Questback er ikke lenger tilgjengelig, men fremstillingen gjengir spørsmålene med svaralternativ som ble utviklet til studien. Spørsmålene anvendt i delstudiet 1 og 2 er oppgitt.*

Spørreskjemaet ble tilpasset de ulike informantgruppene.

Hvilken informantgruppe spørsmålet er rettet til er angitt etter spørsmålet på denne måten: SYKEHUSPREST (S); MEDLEDER (M); BEHANDLER (B); AVDELINGSLEDER (A).

Når ikke noe er angitt svarer alle informantgrupper på spørsmålet.

Av praktiske årsaker følger fremstillingen i spørreskjema oppbyggingen av det web-baserte spørreskjema anvendt i delstudiet 1

A) FAKTA OM GRUPPEPRAKSISEN
Factual information of the group practice

1. Hvor mange samtalegrupper for pasienter driver du i psykisk helsevern? (S)

2. Hva kalles samtalegruppen du driver i psykisk helsevern for voksne? (S/M)

3. I hvilken sammenheng driver du denne samtalegruppen? (Sett flere kryss hvis aktuelt) (S/M)

Del av et tilbud ved Poliklinikk
Del av et dagtilbud ved dagavdeling
Del av et tilbud ved DPS døgnavdeling
Del av et tilbud i rusomsorgen
Del av et tilbud ved alderspsykiatrisk avdeling
Del av et tilbud ved akuttpsykiatrisk avdeling
Del av et tilbud ved psykosebehandling avdeling
Del av et tilbud ved Behandling av stemningslidelser
Del av et tilbud ved Rehabiliteringspost
Annet

4. Vurderer du denne samtalegruppen som et fast etablert tilbud på avdelingen?

- **Ja**
- **Nei**
- **Vet ikke**

5. Denne samtalegruppen har vært drevet siden? (S/M)

År: 1960 – 2016
Vet ikke

8. Hvor ofte er det gruppemøter i denne samtalegruppen? (S/M)

- **En gang i måneden**
- **To ganger i måneden**
- **En gang i uken**
- **To ganger i uken**
- **Tre ganger i uken**
- **Annet**

9. Hvor lenge varer gruppemøtene i denne samtalegruppen? (S/M)

- **30 min**
- **45 min**
- **1 time**
- **1 time og 30 min**
- **2 timer**
- **Annet**

13. Hvor mange pasienter er det nå for tiden i denne samtalegruppen? (S/M)

- **3 deltakere**
- **4 deltakere**
- **5 deltakere**
- **6 deltakere**
- **7 deltakere**
- **8 deltakere**
- **9 deltakere**
- **10 deltakere**
- **11 deltakere**
- **12 deltakere**
- **Annet**

16. Hva er den overordnede målsetting med denne samtalegruppen? (S/M)

Nedenfor er det listet opp noen overordnede målsettinger på ulike former for grupper. Er det noen målsettinger som du tenker også kan gjelde denne samtalegruppen? Sett gjerne flere kryss hvis det er relevant.

- **Bli kjent med seg selv**
- **Redusere/bli kvitt symptomer eller plager**
- **Bedre mellommenneskelige relasjoner**
- **Forandre uhensiktsmessig atferd**
- **Hjelp til å klare dagliglivets oppgaver**
- **Få kontroll over misbruk (alkohol/stoff/medikament)**
- **Få hjelp til å reflektere over livet**
- **Få hjelp til å akseptere den sykdom/lidelse en har**
- **Annet**

17. Hva er de viktigste intervensjonene som brukes i denne samtalegruppen? (S)

Nedenfor er det listet opp ulike intervensjoner som brukes i ulike former for grupper. Er det noen av disse intervensjonene som du gjør nytte av i denne samtalegruppen? Sett gjerne flere kryss hvis det er relevant.

- **Tilbakemelding / konfrontasjon på væremåte**
- **Tolkning av ubevisste konflikter / holdninger**
- **Formidling av informasjon om sykdommen**
- **Fokusering på spesielle tema eller problemer**
- **Rådgiving overfor konkrete dagligdagse problem**
- **Hjemmelekse, oppgaver/trening mellom møtene**
- **Trening i sosiale eller praktiske ferdigheter**
- **Rollespill, psykodrama, gestalt**
- **Annet**

18. Hvilken type samtalegruppe er dette? (S)

Hvordan vil du beskrive gruppen som du driver med hensyn til faglig orientering/forståelsesramme, fokus og terapeutiske intervensjoner?

19. Har du medleder med deg i denne samtalegruppen? (S)

Her ønsker vi å få vite hvilken ordning som finnes i denne samtalegruppen vedrørende medleder og hvordan denne ordningen eventuelt fungerer. Nedenfor er det listet opp ulike måter å organisere medledere på. Sett et kryss.

- **Ja, en fast medleder er med i gruppen hver gang**
- **Ja, flere medledere er med i gruppen hver gang**
- **Ja, flere medledere som rullerer i turnus**
- **Ja, ulike medledere fra gang til gang**
- **Nei, det er ikke medleder med**

26. Tema som det blir reflektert over i denne samtalegruppen

Under finner du en liste med tema som kan være aktuelle for denne samtalegruppen. Sett kryss ved de temaene som samsvarer med din erfaring som gruppeleder.

- **Om å ha håp**
- **Om å erfare håpløshet**
- **Om mening i livet**
- **Om ulike kilder til mening**
- **Om å erfare meningsløshet**
- **Om å være i krise**
- **Om sentrale verdier i livet**
- **Om å ta viktige valg**
- **Om forskjellige tap**
- **Om sorg**
- **Om ulike tema knyttet til død**
- **Om livssyn og religioner**
- **Om trosspørsmål i forskjellige livssyn**
- **Om tro og tvil**
- **Om gudsforhold og gudsbilder**
- **Om erfaringer i forhold til høytider og tradisjoner**
- **Om å mestre vanskelige ting i livet**
- **Om ulike ting som gir kraft og stryke**
- **Om ensomhet**
- **Om å mestre sykdom og kriser**
- **Om forholdet til naturen**
- **Om forholdet til kreativitet**
- **Om forholdet til kultur, musikk og litteratur**
- **Om nære relasjoner**
- **Annet**

27. Beskriv

28. Opplever du å kunne påvirke hvilke temaer som tas opp i denne samtalegruppen? (S/M)

- **Ofte**
- **Av og til**
- **Sjelden**
- **Aldri**
- **Vet ikke**

29. Hvem bestemmer hvilke temaer som skal tas opp i samtalegruppen? (S/M)

- **Gruppedeltakerne**
- **Gruppeleder**
- **Gruppemedleder**
- **Alle bestemmer like mye**
- **Fast tema som rullerer gjennom året**
- **Fast tema som blir bestemt fra gang til gang**
- **Annet**

32. Hvilke eksistensielle tema erfarer du er sentrale i din praksis (S/M/B/A)

Skriv her

B) SYNSPUNKTER PÅ GRUPPEPRAKSIS OG DEN EKSISTENSIELLE DIMENSJON (Mental healthcare professionals' views on the group practice and the existential dimension)

Spørsmålene nedenfor er formulert som påstander og omhandler denne samtalegruppens plass i behandlingen. Her er vi interessert i å høre om din vurdering av ivaretakelsen av de eksistensielle og livssynsmessige forhold, som del av en helhetlig tilnærming i behandlingen. Bruk skalaen under utsagnene for å vise i hvilken grad utsagnene stemmer eller ikke stemmer.

1= Stemmer ikke i det hele tatt og 5= Stemmer helt.

36. Denne samtalegruppen er et eksistensielt samtaletilbud.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

37. Denne samtalegruppen er en integrert og etablert del av behandlingstilbudet.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

45. Jeg erfarer å nyttiggjøre meg sykehusprestens eksistensielle samtalekompetanse i behandlingen.

1 Stemmer ikke i det hele tatt

2
3
4
5 Stemmer helt

46. Det er viktig å ha fokus på pasientenes eksistensielle behov i behandlingen på avdelingen.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

47. Det er viktig å ha fokus på pasientenes eksistensielle behov i forhold til mestring av sykdom.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

48. Det er viktig å ha fokus på pasientenes behov for å erfare eksistensiell mening.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

50. Jeg vurderer å ha tilstrekkelig kompetanse om de eksistensielle og livssynsmessige forhold i møte med pasientene.

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

55. Jeg vurderer at de eksistensielle temaene blir jobbet med i behandlingen

1 Stemmer ikke i det hele tatt
2
3
4
5 Stemmer helt

57. Hvordan erfarer du den eksistensielle dimensjonens betydning for psykisk helse?

Den eksistensielle dimensjonen omhandler temaer om forhold til døden, mening og ensomhet som kan sees på som våre felles grunnvilkår i livet. Svar på spørsmålet med dine egne ord, i tråd med din egen erfaring.

C) DEMOGRAFI, UTDANNINGSBAKGRUNN OG KLINISK INFORMASJON (Demographical, educational, and clinical information)

58. Hvilke teoretiske perspektiv er relevant for din praksis som Sykehusprest/Medleder/Behandler

Nedenfor er det listet opp ulike teoretiske tilnærminger eller perspektiv som vektlegges ulikt i forskjellige typer behandling. Er det noen av disse teoretiske perspektiv som du tenker også er relevant for din praksis som sykehusprest? Sett gjerne flere kryss hvis det er relevant.

Medisinsk
Biologisk
Psykodynamisk
Kognitivt
Eksistensielt
Integrativt
Løsningsorientert
Adferdsfokusert
Emosjonsfokusert
Traumefokusert
Tilknytningsfokusert
Annet

59. Du jobber som: (S)

Sykehusprest ved psykiatriske avdelinger
Sykehusprest ved somatiske avdelinger
Sykehusprest ved både psykiatriske og somatiske avdelinger

61. Kjønn

Mann
Kvinne

62. Aldersgruppe

20-29 år
30-39 år
40-49 år
50-59 år
60-69 år
Over 70 år

63. Utdanningsbakgrunn

Sykehusprest	Medleder	Behandler	Avdelingsleder
Embetsstudie i teologi	Miljøpersonale	Psykolog	Avdelingsleder
Master i sjelesorg	Sykepleier	Psykologspesialist	Assisterende avdelingsleder
Master i diakoni	Vernepleier	Psykiater	Post leder
Pastoralklinisk utdanning (PKU) 1 kurs	Ergoterapeut	Overlege	Seksjonsleder
Pastoralklinisk utdanning (PKU) 2 kurs	Fysioterapeut	Lege i spesialisering	Enhetsleder
Pastoralklinisk utdanning (PKU) 3 kurs	Psykomotorisk fysioterapi	Turnuslege	Annet
Pastoralklinisk utdanning (PKU) 4 kurs og mer	Barnevernspedagog	Annet	
PKU - Veilederutdanning	Sosionom		
Psykodynamisk gruppeterapi, 3 årig	Klinisk sosionom		
Psykodynamisk gruppeterapi, 5 årig	Videreutdanning i psykisk helsearbeid		
Psykodynamisk gruppeterapi, veilederutdanning	Annet		
Psykoterapiutdanning, dynamisk retning			
Kognitiv terapi, videreutdanning			
Helseprest utdanning			
Spesialist utdanning i regi av presteforeningen			
Gestaltterapi			
Psykodrama			
Master i religionspsykologi			
Familieterapiutdanning			
Master i Familieterapi			
Annet			

64. Når begynte du å jobbe innenfor psykisk helsevern?

År: 1960-2016

65. Når startet du med å drive gruppe innenfor psykisk helsevern? (S/M)

År: 1960-2016

66. Er det andre du kjenner som driver lignende samtalegrupper som deg andre steder? (S)

Her spør vi deg om du kjenner til andre i ditt nærområde, prester, psykiatriske sykepleiere, sosionomer osv. f.eks. i kommunehelsetjenesten som driver lignende samtalegruppe/er som deg. Dette er for å få en bredere oversikt over feltet.

Nei
Ja
Vet ikke

67. Beskriv (S)

Appendix 2

Spørreundersøkelse for voksne i psykisk helsevern 2016

Gruppedeltakere i samtalegrupper ledet av sykehusprest

Spørsmål om samtalegruppen, livssyn, mening, og helse

Diakonhjemmet Høgskole

VID

VID Vitenskapelige Høgskole, Diakonhjemmet
Senter for diakoni og profesjonell praksis
Po Box 184, Vinderen. 0319 Oslo

Spørreundersøkelse for voksne i psykisk helsevern 2016

Deltagelse i denne undersøkelsen innebærer å:

1. **Lese informasjonen i «Forespørsel om deltakelse i Forskningsprosjektet»**
2. **Undertegne samtykkeerklæringen**
3. **Levere den signerte samtykkeerklæringen til sykehuspresten**
4. **Fylle ut spørreskjemaet**
5. **Svare på alle spørsmålene**
6. **Legge det ferdigutfylte spørreskjemaet i lukket konvolutt**
7. **Levere den lukkede konvolutten til sykehuspresten**

Dette skjer videre:

8. **Sykehuspresten sender alle lukkede konvolutter med spørreskjema samlet til forsker**

Vi vil sette stor pris på om du vil være med i denne undersøkelsen.

Med vennlig hilsen
Prosjektleder, Professor Hans Stifoss-Hanssen og PhD-Stipendiat Hilde Frøkedal

VID Vitenskapelige Høgskole, Diakonhjemmet

ATT: Hilde Frøkedal

Senter for diakoni og profesjonell praksis

Po Box 184, Vinderen

0319 Oslo

Tlf: (+47) 920 89 284

Spørreundersøkelse for voksne i psykisk helsevern som deltar i samtalegrupper ledet av sykehusprest i 2016.

Denne undersøkelsen handler om sykehusprestens samtalegruppe, livssyn, mening og helse. Studiens mål og hensikt er å få økt innsikt og forståelse av denne form for samtalegruppe.

Fylles ut av gruppedeltakere

A. Spørsmål om samtalegruppen

A1. Hvor lenge har du deltatt i denne samtalegruppen?

1.	❑	1 – 3 ganger
2.	❑	4 – 7 ganger
3.	❑	8 – 11 ganger
4.	❑	12 eller mer

A3. Hva var det som motiverte deg til å være med i denne samtalegruppen?

1.	❑	Hadde behov for å snakke om noe i livet mitt
2.	❑	Syntes denne samtalegruppen virket interessant
3.	❑	Informasjonsskrivet som jeg leste om samtalegruppen
4.	❑	Ingen bestemt motivasjon. Det var tilfeldig jeg ble med.
5.	❑	Annet (beskriv):

A5. Er denne samtalegruppen annerledes enn andre samtalegrupper du har vært med i / er med i?

1.	❑	Har ikke vært med i andre samtalegrupper
2.	❑	Den er ikke forskjellig fra ande samtalegrupper
3.	❑	Den er forskjellig fra andre samtalegrupper. Under kan du beskrive den viktigste forskjellen slik du erfarer denne samtalegruppen er i forhold til andre grupper du kjenner til.

B. Temaer i samtalegruppen

Tema i samtalegruppen. Under finner du en liste med tema som kan være aktuelle for denne samtalegruppen. Sett kryss ved de temaene som du har erfart at man snakker om i din samtalegruppe.

1.	❑	Om å ha håp
2.	❑	Om å erfare håpløshet
3.	❑	Om mening i livet
4.	❑	Om ulike kilder til mening
5.	❑	Om å erfare meningsløshet
6.	❑	Om å være i krise
7.	❑	Om sentrale verdier i livet
8.	❑	Om å ta viktige valg
9.	❑	Om forskjellige tap
10.	❑	Om sorg
11.	❑	Om ulike tema knyttet til død
12.	❑	Om livssyn og religioner
13.	❑	Om trosspørsmål i forskjellige livssyn
14.	❑	Om tro og tvil
15.	❑	Om gudsforhold og gudsbilder
16.	❑	Om erfaringer i forhold til høytider og tradisjoner
17.	❑	Om å mestre vanskelige ting i livet
18.	❑	Om ulike ting som gir kraft og stryke
19.	❑	Om ensomhet
20.	❑	Om å mestre sykdom og kriser
21.	❑	Om forholdet til naturen
22.	❑	Om forholdet til kreativitet
23.	❑	Om forholdet til kultur, musikk og litteratur
24.	❑	Om nære relasjoner

25	❑	Annet (beskriv):

D. Kilder til mening

Spørreskjemaet nedenfor berører mange forskjellige områder av livet. Det er emner som du ikke snakker om eller tenker på hver dag. Ta deg derfor god tid til å svare på dem og svar så ærlig som mulig. Det finnes ingen riktige eller gale svar.
Det er bare din personlige mening og din erfaring som teller. Bruk skalaen over svaralternativene for å vise i hvilken grad utsagnene stemmer eller ikke stemmer. Vær snill å ikke hoppe over noen av spørsmålene. Når det er vanskelig å velge et svar, kryss av i boksen som passer best.

		Stemmer ikke i det hele tatt					Stemmer helt
		0	**1**	**2**	**3**	**4**	**5**
1.	Jeg lever et rikt liv.	❑	❑	❑	❑	❑	❑
2.	Jeg synes at det jeg gjør er viktig.	❑	❑	❑	❑	❑	❑
3.	Jeg har en oppgave i livet.	❑	❑	❑	❑	❑	❑
4.	Jeg føler meg som en del av en større helhet.	❑	❑	❑	❑	❑	❑
5.	Jeg tror livet mitt har en dypere mening.	❑	❑	❑	❑	❑	❑
6.	Jeg lider under at jeg ikke finner noen mening med livet.	❑	❑	❑	❑	❑	❑
7.	Jeg opplever at livet mitt er tomt.	❑	❑	❑	❑	❑	❑
8.	Jeg synes at livet mitt er meningsløst.	❑	❑	❑	❑	❑	❑
9.	Når jeg tenker på livet mitt, virker det helt tomt.	❑	❑	❑	❑	❑	❑
10.	Jeg sitter fast i en meningskrise.	❑	❑	❑	❑	❑	❑

F. Hvordan har du hatt det i løpet av den siste uken?

Dette skjemaet inneholder 10 utsagn om hvordan du har hatt det I LØPET AV DEN SISTE UKEN. Les hvert utsagn og tenk over hvor ofte du har følt deg slik den siste uken. Kryss så av i ruten for det svaret som ligger nærmest hvordan du har følt deg.
I LØPET AV DEN SISTE UKEN:

		Aldri	Sjelden	Av og til	Ofte	Nesten hele tiden
		1	2	3	4	5
1.	Har jeg følt meg anspent, engstelig eller nervøs	❑	❑	❑	❑	❑
2.	Har jeg følt at jeg hadde noen å støtte meg til når jeg trengte det	❑	❑	❑	❑	❑
3.	Har jeg følt meg i stand til å takle det når noe har gått galt	❑	❑	❑	❑	❑
4.	Har det å snakke med folk vært for mye for meg	❑	❑	❑	❑	❑
5.	Har jeg følt redsel eller panikk	❑	❑	❑	❑	❑
6.	Har jeg lagt planer for å gjøre slutt på livet mitt	❑	❑	❑	❑	❑
7.	Har jeg hatt problemer med å sovne eller har våknet fort igjen	❑	❑	❑	❑	❑
8.	Har jeg følt meg fortvilet eller uten håp	❑	❑	❑	❑	❑
9.	Har jeg følt meg ulykkelig	❑	❑	❑	❑	❑
10.	Har uønskede bilder eller minner plaget meg	❑	❑	❑	❑	❑

J. Litt informasjon om deg

J1. Kjønn

1.	❑	Mann
2.	❑	Kvinne

J2. Aldersgruppe

1.	❑	Under 20 år
2.	❑	20 - 29 år
3.	❑	30 – 39 år
4.	❑	40 – 49 år
5.	❑	50 – 59 år
6.	❑	60 – 69 år
7.	❑	Over 70 år

J3. Utdanningsbakgrunn

1.	❑	Ungdomsskole / Folkeskole / Realskole
2.	❑	Videregående skole (allmenn, studieforberedende) / Gymnas
3.	❑	Yrkesfag (fagbrev og yrkesfag)
4.	❑	Fagskole
5.	❑	Høyskole- / universitetsutdanning lavere grad
6.	❑	Høyskole- / universitetsutdanning høyere grad

J7. Arbeidssituasjon		
1.	❑	Fast arbeid
2.	❑	Midlertidig arbeid
3.	❑	Arbeidssøkende
4.	❑	Arbeidsavklaringspenger
5.	❑	Sykemeldt
6.	❑	Uføretrygdet
7.	❑	Pensjonist
8.	❑	Annet (beskriv):

Tusen takk for at du deltok i denne undersøkelsen.

Diakonhjemmet Høgskole

VID

Forespørsel om deltakelse i forskningsprosjektet for gruppedeltakere i samtalegrupper ledet av sykehusprest.

Sykehusprestens samtalegruppe som eksistensielt samtaletilbud.

Bakgrunn og hensikt

Du er blitt spurt om å delta i dette forskingsprosjektet fordi du har vært deltaker i sykehusprestens samtalegruppe en eller flere ganger. Studiens mål og hensikt er å få økt innsikt og forståelse av denne form for samtalegruppe og hva det vil si å være deltaker i en slik gruppe. Vi ønsker å spørre deg om hvordan du erfarer å være med i denne samtalegruppen og om livssynet ditt kan hjelpe deg i din bedringsprosess.
Vi ønsker også spørre deg om kilder til mening i livet ditt, tro på egen mestring og noen spørsmål om din helse.
Professor Hans Stifoss-Hanssen er prosjektleder og ansvarlig for studien. Han har lang erfaring med forskning på livssyn og helse. Undertegnede er stipendiat og forsker og vil være den som administrerer dette forskningsprosjektet.

Hva innebærer studien?

Det vil ta deg ca. 20 minutter å gjennomføre spørreundersøkelsen.
Noen av spørsmålene er knyttet til personlige ting i livet og kan være utfordrende å svare på. Jeg håper likevel du vil være med å bidra med din viktige erfaring.

Mulige fordeler og ulemper

Denne studien ønsker å bidra med økt kunnskap og innsikt på et område som til nå er lite undersøkt i Norge. Hovedmålet er å kunne bidra til et bedre grunnlag for god helhetlig behandling og ivaretagelse av pasienters eksistensielle behov når man er bruker av tjenester i psykisk helsevern.

Hva skjer med informasjonen om deg

Alle spørreskjema deles ut, og samles inn av sykehusprest. Sammen med spørreskjema får du utdelt en svarkonvolutt. Når du har fullført spørreundersøkelsen legger du spørreskjemaet oppi konvolutten og levere den lukkede konvolutten til sykehuspresten på avdelingen. Sykehuspresten vil returnere alle utfylte spørreskjema samlet til forsker. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien.

Rett til innsyn og sletting av opplysninger om deg
Dersom du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du ønsker å trekke deg fra studien, kan du kreve å få slettet innsamlede opplysninger.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst trekke ditt samtykke til å delta i studien. Du trenger ikke begrunne hvorfor du trekker deg. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på denne side og leverer den til sykehuspresten på avdelingen. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du ringe undertegnede på telefonnummer nedenfor.

Hilsen

Hilde Frøkedal
PhD-Stipendiat
VID Vitenskapelige Høgskole, Diakonhjemmet
Senter for diakoni og profesjonell praksis
Po Box 184, Vinderen
0319 Oslo
Tlf +47 920 89 284 /22963732

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

_____

(Dato - Signert navn av deltaker)

Jeg bekrefter å ha gitt informasjon om studien

_____

(Dato- Signert, navn av sykehusprest)

Diakonhjemmet Høgskole

VID

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Jakob Elster	22845530	01.06.2015	2015/718 REK sør-øst B
			Deres dato:	**Deres referanse:**
			24.03.2015	

Vår referanse må oppgis ved alle henvendelser

Hilde Frøkedal
Diakonhjemmet Høgskole

2015/718 Livssynsgruppen som eksistensielt samtaletilbud innen psykisk helsevern

Forskningsansvarlig: Diakonhjemmet Høgskole
Prosjektleder: Hilde Frøkedal

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst) i møtet 06.05.2015. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektleders prosjektomtale
"Denne studien ønsker å utvikle ny kunnskap om betydningen av livssynsgrupper som et eksistensielt samtaletilbud innen psykisk helsevern. Samtaletilbudet er et godt etablert gruppetilbud om eksistensielle tema for pasienter tilknyttet psykisk helsevern i Norge. Hovedmål med studien er å utforske erfaringer med livssynsgruppen sett fra ulike perspektiv innen psykisk helsevern. Delmål 1: Undersøke hva som kjennetegner livssynsgruppene og deltakerne som benytter seg av dette tilbudet(Spørreskjema)Delmål 2: Undersøke hvordan pasienter, med-ledere og sykehusprester erfarer å være med i livssynsgruppene som pasienter/leder/ med-leder i lys av eksistensielle forhold og bedrings- og mestringsprosesser? (Fokusgruppe-intervju). Delmål 3: Undersøke hvordan de ulike informantene (pasienter, sykehusprester, med-ledere) erfarer deltakelse i at livssynsgruppen kan bidra til å styrke egen livssynskompetanse. (Fokusgruppe-intervju) Studien vil gjøre bruk av både kvantitativ og kvalitativ metode."

Komiteens vurdering
Prosjektet innebærer til dels en kvantitativ undersøkelse som innebærer bruk av spørreskjemaer, og til dels en kvalitativ undersøkelse med fokusgruppeintervjuer.

I den kvantitative delen skal man rekruttere til sammen ca 400 deltakere: ca 200 pasienter i psykisk helsevern som deltar i en livssynsgruppe i spesialisthelsetjenesten innen psykisk helsevern; til sammen ca 80 sykehusprester som leder livssynsguppene og med-ledere (ansatte i spesialisthelsetjenesten innen psykisk helsevern); og til sammen ca 120 behandlere til deltakerne i livssynsgruppene og avdelingsledere i spesialisthelsetjenesten innen psykisk helsevern. Man vil rekruttere informanter fra alle de 19 norske helseforetakene. Man vil først henvende seg til aktuell leder og så vil alle sykehusprester kontaktes med informasjon om prosjektet. Den enkelte sykehusprest vil bli forespurt om å rekruttere med-ledere, pasienter og ansatte.

I den kvantitative delen skal man rekruttere til sammen 48 deltakere: 16 pasienter i psykisk helsevern som deltar i en livssynsgruppe i spesialisthelsetjenesten innen psykisk helsevern; 16 sykehusprester i spesialisthelsetjenesten innen psykisk helsevern; og 16 med-ledere (ansatte i spesialisthelsetjenesten innen

Besøksadresse: Gullhaugveien 1-3, 0484 Oslo
Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

psykisk helsevern). Sykehusprestene inviteres til deltakelse per e-post, og med-ledere rekrutteres av sykehusprestene. Pasienter rekrutteres av den lokale sykehuspresten, sammen med helsepersonell, som vil rekruttere pasienter de tenker er egnet til å delta i studien. Gruppedeltakerne til kvalitative intervjuer er ikke de samme som også deltar i den kvantitative studien.

Prosjektet skal bare rekruttere samtykkekompetente informanter. Ved tvil om samtykkekompetanse, vil behandlingsansvarlig psykiater/psykolog for pasienten på aktuell avdeling avgjøre dette. Prosjektleder skriver at dersom det i intervjusituasjonen skulle komme frem opplysninger som tilsier at pasienten/informanten har behov for behandling, støtte, samtaler eller omsorg, vil forsker i samarbeid med informanten bidra til at informanten får adekvat behandling, støtte og omsorg i helsevesenet.

Komiteen anser at både rekrutteringsformen og beredskapen hvis det skulle oppstå behov for oppfølging, er godt beskrevet, og deltakernes velferd virker godt ivaretatt. Komiteen har dermed ingen forskningsetiske innvendinger til at prosjektet gjennomføres.

Informasjons- og samtykkeskriv

Komiteen har imidlertid enkelte merknader til det vedlagte informasjons- og samtykkeskrivene. Det er lagt ved fire informasjons- og samtykkeskriv:

1. Forespørsel om deltakelse i forskningsprosjektet for gruppeledere
2. Forespørsel om deltakelse i forskningsprosjektet for med-ledere
3. Forespørsel om deltakelse i forskningsprosjektet for gruppedeltakere i kvalitativ studie
4. Forespørsel om deltakelse i forskningsprosjektet for gruppedeltakere i kvantitativ studie

I informasjonsskrivene til gruppeledere og med-ledere omtales bare fokusintervju og ikke bruk av spørreskjema. Det må enten utarbeides egne informasjonsskriv til med-ledere og gruppeledere som skal fylle ut spørreskjema, eller, hvis det til dels er de samme deltakerne som skal delta i fokusgruppeintervjuer og fylle ut spørreskjemaer, må informasjonsskrivene til gruppeledere og med-ledere omtale både fokusgruppeintervju og spørreskjemaundersøkelsen. I begge disse informasjonsskrivene står det videre, under overskriften «Frivillig deltakelse», at hvis man trekker seg fra deltakelse, vil dette ikke få noen konsekvenser for vedkommendes behandling. Denne setningen er ikke relevant for gruppeledere og med-ledere, og komiteen ber om at dette rettes.

I forespørselen om deltakelse i forskningsprosjektet for gruppedeltakere i kvantitativ studie omtales også fokusgruppeintervjuet. Dette bør endres, da intervjuet ikke er relevant for disse deltakerne.

Prosjektlederansvar

Prosjektet er et doktorgradsprosjekt, og i søknadsskjemaet er phd-stipendiaten Hilde Frøkedal oppført som prosjektleder. I informasjonsskrivene står det imidlertid at hennes hovedveileder, Hans Stifoss-Hansen, er prosjektleder. Komiteen ber om en avklaring av hvem som er prosjektleder for prosjektet.

Ut fra dette setter komiteen følgende vilkår for prosjektet:

- Informasjons- og samtykkeskrivene revideres i tråd med ovenstående merknader. Reviderte informasjonsskriv sendes komiteen til orientering.

- Det må avklares hvem som er prosjektleder, og komiteen må få beskjed om dette . Hvis Hans Stifoss-Hansen skal være prosjektleder, må dette meldes REK som en endringsmelding og hans CV sendes til komiteen.

Vedtak
Komiteen godkjenner prosjektet i henhold til helseforskningsloven § 9 og § 33 under forutsetning av at ovennevnte vilkår oppfylles.

I tillegg til ovennevnte vilkår, er godkjenningen gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden.

Tillatelsen gjelder til 01.06.2018. Av dokumentasjonshensyn skal opplysningene likevel bevares inntil 01.06.2023. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder "*Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren*".

Sluttmelding og søknad om prosjektendring
Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden, må prosjektleder sende endringsmelding til REK. Prosjektet skal sende sluttmelding på eget skjema, se helseforskningsloven § 12, senest et halvt år etter prosjektslutt.

Klageadgang
Komiteens vedtak kan påklages, jf. forvaltningslovens § 28 flg. Klagen sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Komiteens avgjørelse var enstemmig.

Med vennlig hilsen

Grete Dyb
førsteamanuensis dr. med.
leder REK sør-øst B

Jakob Elster
Seniorrådgiver

Kopi til:
- *Rektor Ingunn Moser, Diakonhjemmet Høgskole*
- *Diakonhjemmet Høgskole ved øverste administrative ledelse*

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Ingrid Dønåsen	22845523	10.05.2019	2015/718 REK sør-øst B
			Deres dato:	**Deres referanse:**
			08.04.2019	

Vår referanse må oppgis ved alle henvendelser

Hilde Frøkedal
VID vitenskapelige høgskole

2015/718 Livssynsgruppen som eksistensielt samtaletilbud innen psykisk helsevern

Forskningsansvarlig: VID vitenskapelige høgskole
Prosjektleder: Hilde Frøkedal

Vi viser til søknad om prosjektendring datert 08.04.2019 for ovennevnte forskningsprosjekt. Søknaden er behandlet av sekretariatet i REK sør-øst på delegert fullmakt fra REK sør-øst B, med hjemmel i helseforskningsloven § 11.

Endringene innebærer:
- Utsettelse av prosjektslutt fra 01.06.2018 til 01.06.2022, grunnet forsinkelse i prosjektet.
- Publisering av ytterligere to artikler basert på allerede innsamlet materiale. Prosjektleder oppgir i skjema for prosjektendring at:
"*En artikkel er allerede publisert og en artikkel er sent inn og er til referee-vurdering. Den tredje artikkelen må enda bearbeides noe. I tillegg trenger jeg mer tid til å ferdigstille kappe.*"
og at:
"*Kvaliteten på datamaterialet er rikt og jeg ønsker derfor å benytte det allerede innsamlede datamateriale til å publisere ytterligere 2 artikler. Datamaterialet omhandler åpne responser i spørreskjemaet til gruppedeltakerne (pasientene) som etterspør deres erfaringer knyttet til gruppedeltagelse og tverrfaglig personal sin vurdering av gruppe praksisen. Denne gruppepraksisen i psykisk helsevern har ikke forskningsmessig tidligere vært undersøkt. Det er av stor betydning at denne gruppepraksisen kan bli belyst på en bredest mulig måte for å kunne vurdere betydningen av den i en helhetlig tilnærming i pasientbehandlingen i psykisk helsevern.*"

Prosjektleder bekreftet på telefon 10.05.2019 at de to artiklene innebærer ikke annet, mht. analyser osv., enn det som er beskrevet i tidligere godkjent forskningsprotokoll.

Vurdering
Sekretariatet i REK har vurdert de omsøkte endringene, og har ingen forskningsetiske innvendinger til endringene slik de er beskrevet.

Vedtak
REK har vurdert endringssøknaden og godkjenner prosjektet slik det nå foreligger, jf. helseforskningsloven § 11.

Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknad, endringssøknad, oppdatert protokoll og de bestemmelser som følger av helseforskningsloven med forskrifter.

Tillatelsen gjelder til 01.06.2022. Av dokumentasjonshensyn skal opplysningene likevel bevares inntil 01.06.2027. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel- og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Vi gjør samtidig oppmerksom på at etter ny personopplysningslov må det også foreligge et behandlingsgrunnlag etter personvernforordningen. Det må forankres i egen institusjon.

Klageadgang
REKs vedtak kan påklages, jf. forvaltningslovens § 28 flg. Eventuell klage sendes til REK sør-øst B. Klagefristen er tre uker fra mottak av dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering, jf. forskningsetikkloven § 10 og helseforskningsloven § 10.

Vi ber om at alle henvendelser sendes inn på korrekt skjema via vår saksportal: http://helseforskning.etikkom.no. Dersom det ikke finnes passende skjema kan henvendelsen rettes på e-post til: post@helseforskning.etikkom.no.

Vennligst oppgi vårt referansenummer i korrespondansen.

Med vennlig hilsen

Knut Ruyter
Avdelingsdirektør
REK sør-øst sekretariatet

Ingrid Dønåsen
Rådgiver

Kopi til: *ingunn.moser@diakonhjemmet.no*
VID vitenskapelige høgskole ved øverste administrative ledelse: post@vid.no

Paper I

Frøkedal, H., Stifoss-Hanssen, H., Ruud, T., DeMarinis, V., & Gonzalez, M. T. (2017). Existential group practice run by mental healthcare chaplains in Norway: A nationwide cross-sectional study. Mental Health, Religion & Culture, 20(8), 713–727. doi:org/10.1080/13674676.2017.1400528

Paper II

Frøkedal, H., Sørensen, T., Ruud, T., DeMarinis, V., & Stifoss-Hanssen, H. (2019). Addressing the existential dimension in treatment settings: Mental health professionals' and healthcare chaplains' attitudes, practices, understanding and perceptions of value. *Archive for the Psychology of Religion, 41*(3), 253–276. doi:https://doi.org/10.1177/0084672419883345

Paper III

Frøkedal, H., Stifoss-Hanssen, H., Ruud, T., DeMarinis, V., Visser, A., & Sørensen,T. (Submitted, revised). Participation in existential groups led by Norwegian healthcare chaplains–relations to psychological distress, crisis of meaning and meaningfulness.

Article manuscript under review.


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