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Existential group practice run by mental healthcare chaplains in Norway: a nationwide cross-sectional study

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ABSTRACT
Existential groups run by healthcare chaplains within mental healthcare have a long tradition in Norway. By using a national cross-sectional survey design, this study explored and described both quantitatively and qualitatively these groups’ characteristics. Quantitative data were analysed by descriptive statistics and content analysis inspired by Graneheim and Lundman was used to analyse the qualitative data. The current existential group practice was present in 11 of 25 Norwegian health authorities and across service levels. Five different group approaches, all addressing patients’ existential, spiritual and religious needs and issues, were identified and described. The existential groups were in general eclectic and applied a variety of therapeutic strategies representing group psychotherapy, existential therapy and clinical pastoral care. The findings suggest that this Norwegian existential group practice can be regarded as a well-established and integrated part of the Norwegian mental healthcare. Researchers are challenged to further qualitatively explore this Norwegian existential group practice.

Introduction
In Norway, we have had a long tradition of mental healthcare chaplains running existential groups within its mental healthcare system. Despite this, healthcare chaplaincy’ professional practice has been debated for decades in Norway. The practice has been described as a specialized form of religious ministry in an official Norwegian white paper (NOU, 2013, p. 1). This viewpoint has however been criticized for being too narrow in describing the chaplains’ role and practice, in particular concerning the chaplains existential competence (Berthelsen & Stifoss-Hanssen, 2014). Additionally, research on healthcare chaplains’ professional identity has been evolving the last years (Swift, 2016). This research has questioned whether healthcare chaplaincy is a form of religious ministry or a healthcare profession in healthcare settings (de Vries,
Berlinger, & Cadge, 2008). De Vries et al. (2008) have argued from a social science point of view, that the chaplains need to strengthen their professional status in order to clarify and establish agreed-upon standards of practice in healthcare.

At the Norwegian parliamentary level, the following has been stated: *Mental disorders touch fundamental existential needs. The patient’s needs must therefore be the starting point for all treatment and the core of all care, and this must affect the structure, practices and management of all health care* (St. prp. nr. 63). This resonates well with the World Psychiatric Association position concerning the importance of integrating religion and spirituality into clinical practice in mental healthcare (Moreira-Almeida, Sharma, van Rensburg, Verhagen, & Cook, 2016; Verhagen, 2017).

In the Norwegian existential group practice run by mental healthcare chaplains, patients suffering from a diversity of mental health challenges are invited to reflect upon and discuss existential issues, life experiences, religious and spiritual issues. Most often, interdisciplinary staff act as co-leaders. In these practices, religious, spiritual and existential issues are often used interchangeably in describing beliefs, values and ultimate meaning (Sinclair & Chochinov, 2012). Nevertheless, religious belief is more often associated with a formally structured religious institution, spirituality is more often associated within an open personal context (Hill et al., 2000) and existential views are more often associated with a humanistic and secular context (Hill et al., 2000; Sinclair & Chochinov, 2012). Addressing these issues in mental healthcare has great treatment potential and may contribute to the empowerment and resilience of patients in their recovery processes (Cornish & Wade, 2010).

To the authors’ knowledge, this Norwegian existential group practice run by mental healthcare chaplains, has yet not been in scope for research. Hence, this study aims to explore and describe this group practice across mental healthcare service in Norway, as a vital first research step.

**Background**

*Mental healthcare chaplains’ practice – educational and clinical traditions*

Healthcare chaplains have attended the Clinical Pastoral Education Program (CPE), offered both in Norway and in the US. This has been the core continuing education program for Norwegian healthcare chaplains (Eika, 2000; Høydal, 2000), influenced and inspired by the Anton Boisen tradition (Asquith, 1982; Boisen, 1951). Through this program, Norwegian healthcare chaplains have gained knowledge and understanding of the psychology of religion and diverse psychotherapeutic traditions (Høydal, 2000).

In Norwegian clinical mental healthcare, group psychotherapy has developed since the 1950s through different theoretical traditions (Lorentzen, Wilberg, & Martinsen, 2015). Since 1984, important and comprehensive multi-professional education in group psychotherapy has been provided in Norway (Island, 1995; Lorentzen, Herlofsen, Karterud, & Ruud, 1995). Mental healthcare chaplains have taken part in this education from the beginning. They have also attended a variety of other psychotherapeutic educational programs.
Mental healthcare chaplains’ practice – theoretical perspectives and therapeutic strategies

The group psychotherapy tradition

Group psychotherapy is an eclectic therapeutic tradition anchored in psychodynamic theory (Karterud, 1999; Ward, 2006; Yalom & Leszcz, 2005). This includes integrating psychodynamic perspectives such as object relation theory (Klein, 1940; Winnicott, 1971), attachment theory (Bowlby, 1978) and self-psychology (Kohut, 2012; Pines, 1996). Theoretical perspectives such as systems-centred theory (Agazarian, 2004; Durkin, 1964) and phenomenological-existential perspectives (Cohn, 1993, 1996) are often also involved. The classical aims and scope of psychodynamic traditions are symptom reduction and improvement in intrapsychic balance and the ability to face the unacceptable (Cohn, 1996). Yet another tradition within group psychotherapy integrates spirituality and religion (S/R tradition). Group psychotherapy in the S/R tradition has not developed in the same way as has individual therapy that integrates S/R (Wade, Post, Cornish, Vogel, & Runyon-Weaver, 2014).

The existential therapy tradition

Existential therapy is represented by four schools anchored in different theoretical perspectives applying a range of therapeutic approaches (Cooper, 2003, 2012): First, Daseinsanalyse, with reference to Boss (1963) and Binswanger (1963), addresses openness towards the world. Second, meaning and logos therapies, with reference to Frankl (1986) and Wong (2010, 2012), address meaning and purpose in life through Socratic dialogue. Third, the British School of Existential Therapy, with reference to Van Deurzen (2012), Spinelli (2007) and Laing (1965), addresses lived experience and the spiritual dimension related to personal worldviews. Fourth, the existential-humanistic approach, with reference to May, Angel, and Ellenberger (1958), Schneider (2008) and Yalom (1980), addresses four ultimate concerns: the inevitability of death, existential loneliness, the meaning of existence and freedom. “Existential therapy” may be defined as psychological interventions that are informed, to a significant degree, by the readings of existential philosophers, most notably Heidegger, Sartre, Buber, Tillich, Kierkegaard, and Nietzsche (Cooper, 2012). Existential therapy may also be regarded as a way of thinking rather than a particular style of practicing group therapy, and it is thus relevant to a variety of groups (Corey, 2016). From this perspective, spirituality may be viewed as an existential scope or approach integrated in the theistic existential psychotherapy tradition (Bartz, 2009).

The CPE tradition

In the field of CPE, multiple theories, knowledge and insight from theology, psychology (Hemenway, 2005) and existential philosophy (Eliason, Hanley, & Leventis, 2001) are integrated, with self-reflection, emotional intelligence and pastoral skills being highlighted (Anderson, 2004; Jankowski, Vanderwerker, Murphy, Montonye, & Ross, 2008). The CPE has evolved from the Tavistock tradition, suggesting a strong psychodynamic approach (Hemenway, 2005), and also integrating action-reflection methodology. In later years, however, systems-centered theory has been part of the CPE (Agazarian, 2001; Hemenway, 2005). Another tradition that has influenced the healthcare chaplains’ clinical practice is narrative-based chaplaincy (Swinton, 2002), which highlights the therapeutic significance...
of illness and health narratives in encounters with patients and allows chaplains to be “bearer and sharer of stories” Swinton (2001, 2002), a forgotten dimension of healthcare.

**Relevant research**

Research in the general field of existential therapy within mental health treatment seems to be evolving (Correia, Cooper, & Berdondini, 2015). Existential approaches are reported to exist in various practices such as counselling for persons suffering from psychotic disorders and drug abuse (Mendelowitz & Schneider, 2008; Schneider, 2011). In a recent meta-analysis on existential therapies for somatically ill patients (Vos, Craig, & Cooper, 2015), 15 randomized controlled trials were identified. Four types of outcomes were categorized: effects on positive meaning in life and improvements in symptoms, self-efficacy and physical well-being. The authors concluded that there is evidence for incorporating the discussing of meaning in life into structured interventions. In a recent review of humanistic experimental psychotherapy including existential therapy (Elliott, Watson, Greenberg, Timulak, & Freire, 2013), positive effects are demonstrated showing improvement in depression, relationship quality, substance misuse, eating disorders, psychosis and anxiety.

Effects of inpatient group psychotherapy in general are reported for patients diagnosed with personality disorders, substance use disorders and psychotic disorders, as well as among patients with serious somatic illness (Leichsenring & Rabung, 2008; Orfanos, Banks, & Priebe, 2015). In a recent systematic review addressing group psychotherapy integrating S/R, Viftrup, Hvidt, and Buus (2013) reported that participation in S/R groups seemed to strengthening participants’ motivation to take part in psychotherapy. These S/R groups were, however, poorly conceptualized. Mental health improvements in cancer patients after S/R intervention have also been reported (Ross, Kennedy, & Macnab, 2015).

A Norwegian cross-sectional study by Lorentzen and Ruud (2014) exploring the Norwegian clinical field of general group psychotherapy identified nine categories of group psychotherapy: theme oriented, physical activity, psycho-educative, cognitive behavioural, psychodynamic, body consciousness, art/expressive, social skills/communication/coping and eclectic groups most frequently applying a psychodynamic approach. The general core aims and coverage of these approaches seems to be improving interpersonal relationships, reducing symptomatic distress and increasing self-knowledge.

International research on general clinical healthcare chaplaincy seems to be ongoing (Ford & Tartaglia, 2006). Due to clinical outcome studies (Fitchett, Nieuwsma, Bates, Rhodes, & Meador, 2014; Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014), such research has strengthened the position of healthcare chaplaincy in healthcare settings (Orton, 2008; Weaver, Flannelly, & Oppenheimer, 2003).

Research on mental healthcare chaplains’ professional practice and in particular on their group practice is, however, sparse thus far (Gubi & Smart, 2016). Only one study (Kidd, Maripolsky, & Smith, 2001) that made explicit use of biblical stories as a therapeutic approach has been identified. The researchers reported that the provision of a therapeutic possibility for exploring beliefs, cultures and values was experienced as beneficial. A Norwegian study has also reported that patients’ individual encounters with mental healthcare chaplains as part of their treatment has been experienced as important (Borge &
Rolfsnes, 2009). Research on mental healthcare chaplaincy in Norway is however scarce. Hence, this study aims to explore and describe this unique existential group practice of Norwegian mental healthcare chaplains.

**Aims**

To explore and describe the variety within the Norwegian existential group practice, the following research questions were developed:

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

**Methods**

**Design**

The study was designed as an explorative, descriptive cross-sectional web-based survey. This manuscript reports findings from this survey solely referring to the above research questions.

**Participants and sampling procedure**

Four participants groups were involved in the study: healthcare chaplains, co-therapists, clinicians and managers. The identification and sampling of participants was organized stepwise. First, 27 healthcare chaplains within mental healthcare were identified through the Norwegian Church Pastors’ union in autumn 2015. Of these, 21 healthcare chaplains within 11 of the 25 health authorities in Norway were eligible. Second, a coordinated application was sent to these 11 health authorities applying for access to the research field. Third, the respective healthcare chaplains of each unit provided an e-mail list of 208 available interdisciplinary staff (co-therapists, clinicians and managers).

**Data collection**

A web-based questionnaire (Questback) inspired by Lorentzen and Ruud (2014) was developed and customized for each participant group. The questionnaire was developed and outlined as scales with different response alternatives. The factual information on the groups’ aims and scopes and theoretical perspectives was directed to the healthcare chaplains exclusively. In order to explore in depth the group practice, this section also included one sole open question “How would you describe the group you are running in terms of theoretical underpinning, aim, scope and therapeutic approach?” The final part of the questionnaire sought the educational and demographical information of the clinical participant groups.
Data analysis

Quantitative data were analysed using SPSS version 22.0 applying descriptive statistics. In some cases data were missing, and explains why the numbers not always add up in the tables. Qualitative data referring to the sole open question were analysed using qualitative content analysis as proposed by Graneheim and Lundman (2004). Qualitative data included literature references and descriptions of the group characteristics, therapeutic strategies, scope and aims, as well as applied therapeutic strategies in their group practice. Meaning units were identified, condensed, and coded by the first and last author independently. To obtain trustworthiness, the same authors discussed the data analysis until consensus was reached. The findings were also presented to the healthcare chaplains in order to validate the results.

Ethical considerations

The Regional Committee for Medical Research Ethics in Norway approved the study under registration number 565978. All the 11 health authorities provided formal access to the research field.

Results

Sample and response rate

Of the 208 invited participants, 101 responded, providing a 100% response rate (R/R) for healthcare chaplains, 38% for co-therapists, 36% for clinicians and 83% for managers. Demographical data are presented in Table 1. In total, 49 groups run by 21 healthcare chaplains were identified in 11 health authorities across Norway.

The 49 groups consisted of 28 (57%) from community mental health centres (CMHCs) and 21 (43%) from hospitals. The existential groups were most frequently provided at inpatient units.

| Table 1. Demographical variables illustrating gender and age across informant groups (N = 101). |
|---------------------------------|-----------------|----------------|----------------|----------------|----------------|
| **Gender**                     | **Age**         | 20–29 | 30–39 | 40–49 | 50–59 | 60–69 |
| Healthcare chaplains (n = 21) | Male / Female  | 9 / 12 | 8     | 8     | 5     |
| Co-therapists (n = 34)         | 4 / 29          | 1     | 9     | 8     | 9     | 5     |
| Clinicians (n = 27)            | 8 / 19          | 3     | 10    | 7     | 3     | 3     |
| Managers (n = 19)              | 3 / 16          | 3     | 3     | 8     | 5     |

The existential group practice: theoretical perspectives, aims, scope and therapeutic strategies

Regarding the quantitative question, “Which theoretical perspective is relevant for your practice as healthcare chaplain?”, all 21 healthcare chaplains responded that their practices were anchored in several theoretical perspectives, for example; existential (20); psychodynamic (17); attachment (16), emotional theory (13); cognitive (12); trauma (11); integrative (4); solutional (3); and behavioural (2). As elaborated, existential and
psychodynamic perspectives were those theoretical perspectives most frequently applied in the groups.

On the quantitative questions, “What is the overall aim for this group?” and “What is the most significance therapeutic strategy used in the group?”, the participants responded that the core aims of the existential groups were to improve life reflection, accept illness, get to know oneself and improve relationships, as illustrated in Table 2. Mirroring and feedback were common therapeutic strategies.

Table 2. Aims and therapeutic strategies of the various group approaches (N = 45).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Psychodynamic (n = 12)</th>
<th>Narrative (n = 10)</th>
<th>Coping (n = 9)</th>
<th>Systems-centred (n = 9)</th>
<th>Thematic (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflection over life</td>
<td>11(92)</td>
<td>10(100)</td>
<td>9(100)</td>
<td>8(89)</td>
<td>5(100)</td>
</tr>
<tr>
<td>Improve relationships</td>
<td>11(92)</td>
<td>6(60)</td>
<td>8(89)</td>
<td>5(56)</td>
<td></td>
</tr>
<tr>
<td>Accept illness</td>
<td>9(75)</td>
<td>3(30)</td>
<td>1(11)</td>
<td>3(33)</td>
<td>2(40)</td>
</tr>
<tr>
<td>Symptom reduction</td>
<td>8(67)</td>
<td>1(10)</td>
<td>-</td>
<td>2(22)</td>
<td></td>
</tr>
<tr>
<td>Get to know oneself</td>
<td>8(67)</td>
<td>7(70)</td>
<td>7(78)</td>
<td>6(67)</td>
<td></td>
</tr>
<tr>
<td>Behavior modification</td>
<td>5(42)</td>
<td>-</td>
<td>4(44)</td>
<td>4(44)</td>
<td></td>
</tr>
<tr>
<td>Daily coping</td>
<td>1(8)</td>
<td>2(20)</td>
<td>4(44)</td>
<td>2(22)</td>
<td></td>
</tr>
<tr>
<td>Therapeutic strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special problems</td>
<td>8(67)</td>
<td>6(60)</td>
<td>6(67)</td>
<td>3(33)</td>
<td>4(80)</td>
</tr>
<tr>
<td>Mirroring/feedback</td>
<td>4(33)</td>
<td>3(30)</td>
<td>6(67)</td>
<td>5(56)</td>
<td></td>
</tr>
<tr>
<td>Training skills</td>
<td>3(25)</td>
<td>1(10)</td>
<td>2(22)</td>
<td>2(22)</td>
<td></td>
</tr>
<tr>
<td>Specific advice</td>
<td>2(17)</td>
<td>2(20)</td>
<td>1(11)</td>
<td>1(11)</td>
<td>3(60)</td>
</tr>
</tbody>
</table>

Note: Several aims and therapeutic strategies could be listed.

Regarding the open questions referring to Table 3, “How would you describe the group you are running in terms of theoretical underpinning, aim, scope and therapeutic strategy?”, the data analysis refers to 45 of the 49 groups, as data were missing on four groups. The qualitative data provided in-depth insight into the quantitative findings presented above. Eclectic perspectives seemed to cover more or less all groups, including the groups characterized as psychodynamic groups. Working here and now and making use of narratives

Table 3. Group characteristics of the various group approaches (N = 45).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Psychodynamic (n = 12)</th>
<th>Narrative (n = 10)</th>
<th>Coping (n = 9)</th>
<th>Systems-centred (n = 9)</th>
<th>Thematic (n = 5)</th>
</tr>
</thead>
</table>
seemed to be the core therapeutic strategies. The narrative groups appeared to have the broadest scope, involving existential and spiritual issues as well as religious rituals.

The five group approaches – psychodynamic, narrative, coping, systems-centred and thematic, seemed to represent the healthcare chaplains’ existential group practice. The psychodynamic tradition was the one most frequently used, followed by the narrative tradition. All approaches were almost equally distributed across inpatient units as Table 4 illustrates. The existential groups were provided on units varying from acute to rehabilitation and across diagnoses. Looking at the findings more in detail, the approaches seemed to be adjusted to the target population, such as providing a coping perspective and motivational perspective for rehabilitation and substance abuse units. The findings revealed that the narrative approach was provided across units.

Table 4. Theoretical perspectives in the existential groups (N = 49) across service level and type of units.

<table>
<thead>
<tr>
<th>Theoretical perspective</th>
<th>Groups</th>
<th>Service level</th>
<th>Type of unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CMHC</td>
<td>Hospital</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>12</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Narrative</td>
<td>10</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Coping</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Systems-centered</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Thematic</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>No information</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>28</td>
<td>21</td>
</tr>
</tbody>
</table>

Views on the existential group practice within mental healthcare

As illustrated in Table 5, most interdisciplinary staff viewed the healthcare chaplains group practice as having a clear existential strategy, and they regarded the existential groups as an established and integrated part of the total treatment. Interestingly, the healthcare chaplains were the most reluctant to define their group practice as integrated into the total treatment.

Table 5. Informants’ (N = 101) views in percentage of the chaplains’ existential group practice.

<table>
<thead>
<tr>
<th>Addressed statement</th>
<th>Healthcare Chaplains (n = 21)</th>
<th>Co-therapists (n = 34)</th>
<th>Clinicians (n = 27)</th>
<th>Managers (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The chaplain’s group has a existential therapeutic strategy</em></td>
<td>95</td>
<td>74</td>
<td>78</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>11</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td><em>The chaplain’s group is an integrated and established part of the total treatment</em></td>
<td>62</td>
<td>86</td>
<td>74</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>9</td>
<td>15</td>
<td>5</td>
</tr>
</tbody>
</table>

Professional educational background and clinical experience

The healthcare chaplains had continuing education and were well educated both in CPE, in psychodynamic therapy and in various other therapies (Table 6). Among the co-therapists, a majority were nurses, followed by social workers, milieu staff and mental health staff. Some of the nurses had group therapy education. Among the co-therapists various other professional backgrounds (22%) were represented (e.g., social educator, child welfare officer,
psych-motoric physiotherapist, occupational therapist and psychologist). Psychiatrists and psychologists were the most frequent clinicians, followed by psychiatric nurses. Concerning clinical experience, the mean number of years healthcare chaplains had worked in psychiatry was 13 years (range from 0 to 36), starting between 1980 and 2016. For co-therapists, it was 16 years (range from 2 to 44 years), starting between 1972 and 2014; and for clinicians it was 12 years (range from 0 to 36 years), starting between 1980 and 2016.

### Discussion

Existential groups were identified across 11 Norwegian health authorities. The groups were in general regarded as an established and integrated part of mental health treatment.

**The Norwegian existential group practice: variety across the group approaches**

The psychodynamic existential group approach aimed to reduce symptoms and in particular to address the phenomenon of shame. It had an inside/outside scope and used narratives in combination with group analytic principles. This group approach has similarities with the phenomenological-existential group represented by Cohn (1993, 1996), anchored in the Van Deurzen (2012) existential tradition. The psychodynamic groups also seemed to be strongly influenced by the existential-humanistic school (May et al., 1958; Schneider, 2008; Yalom, 1980). The use of a narrative therapeutic strategy in these groups seemed, however, to be distinct to this existential psychodynamic group approach.

The narrative existential group approach aimed to reach existential and spiritual needs in line with the S/R tradition (Viftrup et al., 2013; Wade et al., 2014), however, addressing a broader scope than the S/R tradition. The therapeutic strategies of these groups were using philosophical themes, making narratives and making use of religious rituals, which deviates from the S/R tradition (Viftrup et al., 2013; Wade et al., 2014). For that reason, narrative existential groups are perhaps better mirrored with the school of meaning and logos therapies (Frankl, 1986), which aim at addressing meaning and purpose in life and the use of Socratic dialogue as a therapeutic strategy. Likewise, according to Wong (2010, 2012), such therapy would also resonate well with the narrative approach. Further, the influence of literature from a variety of perspectives, such as Buber, Yalom, and the Christian mystical tradition was reported regarding this group approach (Table 3).

---

**Table 6. Healthcare chaplains (N = 21) professional educational background and continuing education.**

<table>
<thead>
<tr>
<th>Type of education</th>
<th>N  = 21 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master in theology</td>
<td>21 (100)</td>
</tr>
<tr>
<td>Clinical Pastoral Education: 1 Unit</td>
<td>11 (52)</td>
</tr>
<tr>
<td>Clinical Pastoral Education: 2–4 Units/ Trained supervisor</td>
<td>10 (48)</td>
</tr>
<tr>
<td>Group analytic education/Psychodynamic therapy: 3–5 years/ Trained supervisor</td>
<td>8 (38)</td>
</tr>
<tr>
<td>Various psychotherapeutic educations</td>
<td>5 (24)</td>
</tr>
<tr>
<td>PhD or Master: Health and theology/ Psychology of religion/ Pastoral care</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Healthcare chaplains education: Specialist programme</td>
<td>10 (33)</td>
</tr>
<tr>
<td>Various other continuing educations</td>
<td>11 (24)</td>
</tr>
</tbody>
</table>

Note: Several educations could be listed.
The **coping existential group approach** aimed to improve daily coping and to modify behaviour addressing lived experience as its core topical scope with values and choices as core existential issues. The motivational therapeutic strategy and the use of expression through art were distinct to this group. These aims and scopes may be mirrored against the British school of existential therapy (Laing, 1965; Spinelli, 2007; Van Deurzen, 2012) aiming to explore lived experiences and apply a descriptive phenomenological strategy. The therapeutic strategy of using a motivational approach and art expression seems to be distinctive of the coping existential group approach.

The **systems-centred existential group approach** uniquely applied language system theory and cognitive theory as theoretical perspectives. The core aim was behaviour modification, and the therapeutic strategy was exploring language in a reflective process in the here and now. This group approach is however, difficult to mirror with any of the existential schools elaborated by Cooper (2012). Thus, according to Karterud (1999), the systems-centred perspective is a core theoretical perspective in group psychotherapy.

The **thematic existential group approach** did not seem to have applied a specific theoretical perspective, as was also the case for the thematic groups in general group psychotherapy in Norway (Lorentzen & Ruud, 2014). Concerning scope, existential issues such as identity, human values, shame and guilt were addressed, applying an open, reflective and dialogic “here and now” therapeutic strategy. The thematic approach also involved addressing special problems and offering advice. Both the scope and the therapeutic strategy might be mirrored against the British school of existential therapy (Laing, 1965; Spinelli, 2007; Van Deurzen, 2012).

Summing up, the above discussion illustrates how the existential group practice run by mental healthcare chaplains in Norway is eclectic in its use of theory, aims and scope. This resonates well with what Ward (2006) underlines as the reality of group work in general. This is also in line with clinical Norwegian group psychotherapy as reported by Lorentzen and Ruud (2014) and with existential therapy tradition as reported by Vos et al. (2015). The various group approaches identified in this study share aims and scopes with ordinary group psychotherapy and they are mainly anchored in existential and psychodynamic theory. They do not, however, use classical therapeutic strategies in lines with the psychodynamic tradition. The use of a narrative therapeutic strategy seemed to be distinct for this existential group practice.

Looking at the qualitative and quantitative findings together, the theoretical perspectives were existential, psychodynamic and eclectic, and the core aims were improving life reflection, gaining acceptance regarding illness, getting to know oneself and improving relationships. The narrative therapeutic strategy was the most representative, and a variety of existential, spiritual and religious issues and scopes were covered. The existential groups had commonalities with Norwegian general group psychotherapy regarding their aims to improve relationships and increase self-knowledge, and by applying therapeutic strategies such as addressing special problems, using mirroring and providing personal feedback.

**The Norwegian existential group practice mirrored against the CPE tradition**

The Norwegian existential and eclectic group practice has commonalities with the CPE tradition, which also is eclectic in its use of psychodynamic, systems-centred and
existential theories (Agazarian, 2001, 2004; Eliason et al., 2001; Hemenway, 2005). The aims, scopes and therapeutic strategies of these existential groups also resonate with the aims and scopes of CPE, as self-reflection is a core strategy in developing skill to address patients’ existential, spiritual and religious needs and issues. It is reasonable that strategies within this clinical education tradition have influenced the healthcare chaplains in their clinical practice.

However, the distinct characteristic of therapeutic strategies within the existential group practice, such as the use of narratives, might share some similarities with the use of biblical stories as a therapeutic strategy (Kidd et al., 2001), or is perhaps better mirrored against “narrative-based chaplaincy” described by Swinton (2002). In this chaplaincy practice, stories of health and illness are core therapeutic strategies in patient encounters. This is not, however, a field of practice in group therapy, but a general practice of chaplaincy.

**Views on the existential group practice**

Healthcare chaplains and interdisciplinary staff viewed the existential group practice as an integrated part of mental health treatment even though healthcare chaplains had the most reluctant view. The chaplains’ reluctance might be linked to the debate that for decades has been ongoing in Norway and internationally concerning whether the profession is a religious ministry or is a healthcare profession (NOU, 2013, p. 1). Our findings revealed that the healthcare chaplains run a clinical group practice underpinned by multiple theories applying a variety of therapeutic strategies in addressing patients’ existential, spiritual and religious needs. The findings also revealed that they possess therapeutic competence and are reflective concerning their practice. From these findings, we argue that the healthcare chaplain’s possess a broader competence than that of religious ministry only. This is in line with the arguments of Berthelsen and Stifoss-Hanssen (2014), and research reported by Swift (2016).

The interdisciplinary staff’s positive views on the existential groups correspond with findings reported by Cornish and Wade (2010) that addressing spiritual and existential issues in mental healthcare holds a great potential in treatment. The findings also resonate well with the viewpoints presented in the Norwegian parliamentary report on existential issues in Norwegian mental healthcare (St. prp. nr. 63, 1997–1998), and the World Psychiatric Association position (Moreira-Almeida et al., 2016; Verhagen, 2017).

**Professional, educational background and clinical experience**

The findings illustrated that the healthcare chaplains were well educated in both CPE and various psychotherapy traditions, dominated by the psychodynamic tradition. This reflects their continuing education both in group psychotherapy and in CPE, as well as in other psychodynamic psychotherapy educations. Regarding the co-therapists, the largest group among them were nurses, and a few reported having group psychotherapy education. The fact that nurses most often act as co-therapists in these existential groups, is interesting because human existential perspectives are core perspectives in general and psychiatric nursing (Travelbee, 1971).
Strengths and limitations

The first, and obvious, strength of this study is that it is a national cross-sectional study and has covered almost all mental healthcare chaplains’ existential group practice in Norway. The response rate differed among the respondent groups, but was considered satisfactory. It might have limited the study’s validity that the healthcare chaplains and co-therapists were all highly involved in the existential group practice they were asked to describe. This might explain the absence of critical voices.

Conclusion

The healthcare chaplains’ existential group practice within mental healthcare in Norway seemed to be eclectic in its use of theoretical perspectives. The psychodynamic and the existential traditions were the perspectives most frequently used. The existential groups address patients’ existential, spiritual and religious needs and issues through a diversity of therapeutic strategies. The narrative existential group approach stood out as the most distinctive existential group practice. The narrative group integrates a variety and complexity in theoretical perspectives, aims and scopes, as well as therapeutic strategies, and was anchored both in classical therapeutic traditions and in clinical pastoral care traditions.

The existential group practice can be regarded as a well-established and integrated practice provided across service levels and units in Norwegian mental healthcare.

The Norwegian mental healthcare chaplains are well educated, clinically experienced, and possess therapeutic competence implying that their clinical practice goes beyond a specialized form of religious ministry.

Researchers in the field of chaplaincy, and in in the field of mental healthcare in general, are challenged to further explore in depth this distinct existential group practice that integrates existential, spiritual and religious issues. This would inform a broader audience of clinicians and multi-disciplinary professions of the qualities in this practice. In addition, it is recommended to further explore how interdisciplinary staff through their roles as co-therapists integrate existential issues into their mental healthcare practice. We also recommend to further explore and identify barriers and success factors contributing to the effectiveness of the chaplains’ clinical work within the mental healthcare team.

The patients’ experiences of participating in the existential groups are also of vital importance in order to obtain a full picture of the therapeutic benefits experienced. In particular, it is important to explore and assess the patients’ religious, spiritual and existential issues and needs as an integrated part of mental health treatment and recovery, to which chaplaincy should be seen as an important contribution.

Disclosure statement

No potential conflict of interest was reported by the authors.

References


