Meaningful Conversations: Reciprocity in Power Dynamics between Humanist Chaplains and Patients in Dutch Hospitals

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Abstract: There is a reluctance within humanist chaplaincy to critically reflect on power dynamics during conversations. This reluctance stems from the idea that every person is capable of finding meaning in equal contacts and that chaplains do not have aims or direct the conversation. A study was conducted to gain insight into power dynamics in conversations between chaplains and patients, and how these power dynamics influence the co-creation of meaning. Power in a conversation is dynamic because of changing positions of power between conversation partners and depends on their initiative and response in a conversation. Based on feminist relational theories, power is conceptualized as both dominating and transformative, and within transformative power a distinction is made between agential and receptive forms of power. A secondary analysis was performed on qualitative interview data of six humanist chaplains. Dominating strategies taken from the Initiative-Response theory and verbal responses from chaplaincy literature have been used to map the power dynamics between chaplain and client. The results showed that both chaplain and patient use dominating strategies, and that transformative power is necessary to foster the co-creation of meaning. This transformative power can take both agential forms, such as direct leading by questions and focusing, and receptive forms, e.g., listening and affirming. The receptive forms were still the dominant strategies used by chaplains, but the results made clear that agential forms have taken ground within humanist chaplaincy, although some strategies may need to be developed further in training, such as focusing and self-disclosure by the chaplain.

Keywords: power dynamics; humanist chaplaincy; co-creation

1. Introduction

Humanist thought and ethics are deeply rooted in Dutch society, from the sixteenth and seventeenth century onwards (Van Praag 1946; Cliteur and van Houten 1993; Derkx 2015). In 1946, the Humanist League was founded to support the growing number of people who are non-religious. Soon after that, humanism became officially recognized as an organized (non-religious) worldview, aiming at human emancipation and social justice. From 1960 onwards, training programs started for humanist chaplains in the army and broadened to other sectors, such as prisons and healthcare institutions. Nowadays, humanist chaplains are educated in an academic master course in humanistic studies at the University of Humanistic Studies. This academic degree is a requirement for working as a Humanist chaplain and the Dutch Humanist League watches over the worldview competency of graduates. Chaplaincy is a legal right in the Netherlands for persons staying within an institution for more than 24 h; and recently Dutch government has started an experiment with the funding of chaplaincy ‘at home’ to provide spiritual care to older people and people in a palliative phase within their home situation. Humanist chaplains do not hold their own professional association, but can become a member of the Dutch Association of Spiritual Caregivers (www.vgvz.nl, accessed on 23 November 2021) for chaplains of all denominations and working areas (healthcare, police force, the army, prisons). Currently, there are over 230 registered humanist chaplains with the Dutch...
Humanist League. The latter organization has developed a professional standard for Humanist Chaplaincy, in addition to the standard of the Dutch Association of Spiritual Caregivers.

1.1. Humanist Chaplaincy

Humanist chaplaincy has its roots in humanist thought and ethics, as well as in humanist psychology and counselling (Carl Rogers, Abraham Maslow), focusing on self-actualization, meaning in life, human growth and creativity. Although in later years humanism has been criticized for being too centered on modern, Western-European, male- and individualized perspectives, thereby ignoring the violence that accompanies this worldview too (e.g., Kunneman 2007), there is still a reluctance within humanist chaplaincy to critically reflect on power dynamics. This reluctance stems from the humanist idea that chaplaincy takes place in an equal meeting between persons, in which the other person is capable of giving meaning themselves (Jorna 2008). Humanist chaplaincy puts emphasis on the horizontal relationship between chaplain and client, in contrast to Christian chaplains where there is also a vertical relationship with God. Equal contacts in this view represent autonomy and self-determination as fundamental client rights (Van Praag 1953). The role of the chaplain is basically to tune into the client in order to help them to find their own answers which makes the practice of chaplaincy client-centered: ‘the visions of the good of the client are the primary focus of attention, not those of the pastoral caregiver’ (Schumann and Damen 2018, pp. 413–14). However, it is increasingly recognized that humanist chaplains do take an active role in supporting persons in their search for meaning. Their own ‘visions of the good’ may not be central in the conversation and not provide answers for the client, but the chaplain does impact upon the conversation and the accompanying meaning processes.

1.2. Myths in Humanist Chaplaincy

According to Mooren (1999), a Dutch lecturer in psychology and humanist chaplaincy, autonomy and self-determination are strong values in humanist chaplaincy that have led to three assumptions that nowadays still form a dominant discourse in humanist chaplaincy. He has called them the three myths: ‘the undetermined content of the work’, ‘the aimlessness of humanist chaplaincy’ and ‘the total openness of chaplaincy’ (pp. 16–18). The myths reflect the views that humanist chaplains ‘do not steer, they are no determining factor for the direction of the client’ and ‘they do not impose a structure on the client’s life story in favor of interpretation of that story’ (Mooren 1999, p. 18). By demythologizing humanist chaplaincy, he wants to contribute to its professionalization. Therefore, he encourages to gain insight into substantive perspectives and principles from which humanist chaplains work—their worldviews and concomitant beliefs—and thus steer and influence conversations. Although Mooren pinpoints towards developing visions from which humanist chaplain’s work, he does not regard this active role in terms of power dynamics. Unlike (blinded for review)—based on feminist theories of counselling—stresses the absence of critical reflection regarding power in humanist chaplaincy and the need to develop more insight into this area. Also Doehring (2015), based on a process theology viewpoint, states that chaplains—and other caregivers—are responsible for reflecting on power dynamics. In this view, relationships are an interchange of influence involving both agential and receptive power: “Agential power influences, guides, and shapes, while receptive power receives and takes in”. (Doehring 2015, p. 45). These power dynamics can shift between ‘life-giving’ and ‘life-limiting’ forces (Doehring 2015, p. 45), for example when the other person is objectified or in racial prejudice.

1.3. Aim and Research Question

Humanist chaplaincy takes place in meetings, mostly conversations, between chaplains and clients. Its aim is to help clients in difficult circumstances to find or rediscover meaning in their lives. The myths of humanist chaplaincy however, pretend that it has no
goals and that the chaplain is not influencing the conversation other than in a receptive mode. This would imply that dominating or agential power is absent within this profession, and that the chaplain does only contribute indirectly to the patient’s process of finding meaning in difficult life situations. Since chaplaincy is a professional relationship between human beings, our assumption is that power dynamics will be present, like in all other relationships, and that they can take different forms: dominating and transformative, the latter including both agential as well as receptive acts. So far, these power dynamics are insufficiently studied and theorized.

The aim of this explorative research is to gain insight into the power dynamics within verbal communicative acts between chaplain and patient while having a conversation, especially directed at the contribution of chaplains to processes of finding meaning in life. Our focus is on the hospital setting in which chaplains have conversations with clients in difficult situations, such as having received a bad prognosis, insecurity or fear about the future and identity loss in the face of chronic disease. Our research questions are: How are power dynamics expressed within verbal communicative acts within a professional relationship between chaplains and patients in a hospital context? And how do these dynamics support or hinder the patients’ process of finding meaning in life?

In the next section, we will outline the relationship between power dynamics and meaning in life, as the two central concepts of this contribution. We will then outline our narrative research method and present the main findings, followed by a conclusion and discussion of its implications for humanist chaplaincy and future research.

2. Theoretical Framework

Generally, power is considered as undesirable because it is associated with power over and asymmetry in helping relationships (e.g., Brown 2019; Dominelli 2002). This power is well-known as oppressive power or positional power (Levi 2017) and is expressed by forcing and manipulating the other (Roselle et al. 2014). However, this view has been criticized as representing only one form of power and ignoring the productive and connective forces it may have.

2.1. Dominating and Transformative Power

Relational feminist theorists state that the view of power as power-over, domination, or control is implicitly masculinist and individualist. Based on women’s unique experiences as mothers and caregivers, they have argued for a reconceptualization of power as a relational capacity or ability, specifically, the capacity to empower or transform oneself and others, also called transformative power (Held 1993; Baker Miller 1992). For example, Jean Baker Miller defines power as “the capacity to produce a change—that is, to move anything from point A or state A to point B or state B” (Baker Miller 1992, p. 241). According to Held, “the power of a mothering person to empower others, to foster transformative growth, is a different sort of power from that of a stronger sword or a dominant will” (Held 1993, p. 209). It is a relational power that comes ‘from within’ and in which one person is influencing the other and vice versa, however with the aim to appeal to the strength and sources and to foster the growth of the other. In later years, Miller and other scholars from the Stone Center in Boston, have stressed even more the fundamental relatedness in growth-enhancing relationships, leading to feeling recognized, valued and connected; to relational agency; and to an increase of zest or meaning in life (Jordan et al. 2004, p. 56).

2.2. Initiative-Response Theory of Power

Language and communication scientist Linell (1990) shares this relational perspective in his initiative-response theory. In this theory, power occurs in relationships and power positions can be dynamic, meaning that power positions change between interlocutors while having a conversation depending on their initiative and response. Interlocutors may use different strategies as initiative or response, such as excessive talking or interrupting the other. The shift of power makes interaction dynamic and a process of reciprocal influ-
ence. Linell acknowledges the existence of dominant forms of power as characterizing all relationships. He discerns four types of dominance, including: interactional dominance; semantic dominance; amount of talk and strategic moves (see Table 1). During an interaction, different strategies can be used to dominate a conversation (interactional dominance). Linell puts emphasis on three strategies to obtain dominance: steering, controlling and inhibiting the other person’s utterances (see Table 1).

**Table 1. Dimensions of Dominance according to Linell (1990).**

| Type of Dominance      | Definition                                                                 | Strategies                                                                                   |
|------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Interactional dominance| The dominant party takes the most initiatives and makes the strongest moves. The subservient allows to be steered, controlled and inhibited by the interlocutor. | Direct: compel the other to respond under certain circumstances Control: evaluate, judge and disqualify the contribution of the other person Inhibit: hinder the other to participate in the conversation |
| Semantic dominance     | When one party mainly introduces and manages topics.                       |                                                                                             |
| Amount of talk         | The dominant party speaks mostly in the conversation. The other party gains less space to talk. |                                                                                             |
| Strategic moves        | Things interlocutors say to influence the conversation and result. An interlocutor may make a big impact with little talk. |                                                                                             |

How is power related to meaning in life within chaplaincy conversations? We will now turn towards a framework that will help to understand this relationship.

2.3. Meaning in Life

From a relational and narrative perspective, meaning is not a cognitive and individual process, but it emerges in dialogue and is therefore always an interactional and narrative process between persons (Hermans and Hermans-Konopka 2010). Mutual engagement is a necessary precondition for this to happen, which manifests itself in empathy, reliability, commitment, a shared purpose and determination to honor and respect each other (Jordan 2004, p. 35).

‘The other person has to be able to engage with the matter at hand, to enter into the movement of thoughts and feelings. If one person has more power in a relationship, it is more difficult for the less powerful person to bring about such engagement’ (Baker Miller and Pierce Stiver 1997, p. 39).

Meaning then is co-created by using ‘power with’ (transformative power or ‘life-giving’ power dynamics) unlike ‘power over’ (oppressive power or ‘life-limiting’ power). The willingness and capacity to be open to show feelings and receive feelings of others are important in the co-creation of meaning (Surrey 1991): ‘Feeling together and moving together also involve thinking together and being open to new perceptions and ideas that arise in this affective, relational joining’ (Surrey 1991, p. 172).

Chaplains use a narrative-relational approach to support patients in finding meaning in life in often disruptive life circumstances. Mooren (1999) describes a couple of responses that chaplains use to aim conversations at finding or creating meaning, using ideas and concepts from McLeod (1997) and Brammer (1974) (Table 2). Based on a relational perspective, we will call them strategies for co-creation of meaning.
| Table 2. Strategies: Chaplain Responses according to Mooren (1999). |
|---------------------------------------------------------------|
| **Response** | **Definition** |
| Confirming | Nodding, confirm that you understand what the client says or his or her point of view, approval of emotional response. Confirmation serves to give the client emotional support and confirm his or her response. |
| Informing | To inform about the content of chaplaincy to structure a conversation (defining the boundaries and aims). Or to give information about procedures of the institution, responses of other humans on situations, et cetera. |
| Leading directly | Direct advise or suggestions on the progress of the conversations or conduct outside the conversations to structure the process of storytelling. |
| Leading indirectly | Questions and suggestions of general character to stimulate the client’s process of storytelling in such a way that the client is going to feel responsible for the relationship. |
| Focussing | To focus the conversation on something that needs extra care (client response or aspect of the story) according to the chaplain. |
| Asking closed questions | Questions used to gain specific information. |
| Asking open questions | Questions to get a clear picture what is told or to get a better understanding of elements of a narrative. |
| Reflection | To focus on one aspect of meaning of the story: Feelings and intentions. Experiences. The content: by paraphrasing or mirroring: to tell with other words what the client has told. |
| Interpreting | A response from the chaplain’s point of view to initiate the client to tell the story in a different way to deepen the story or change the meaning. |
| Confronting | Without judgement or explanation pinpoint discrepancies between words and conduct. Confrontation supports to resolve conflict or incongruity. |
| Summarize | To appoint the essence of the conversation to make sure interlocutors understand each other. |
| Self-disclosure | Sharing of feelings and experiences that help the client to identify her or his own responses or to enhance and support the experience of the client. |

The dominating strategies put forward by Linell (1990) and the strategies outlined by Mooren (1999) are combined to investigate what power strategies chaplains use that give direction to the conversation, thereby fostering or inhibiting meaning creation. Mooren’s framework of strategies can be regarded as a specification of Linell’s strategic moves; it is influencing the conversation without dominating it in an oppressive way, thereby allowing meaning to be co-created. Moreover, these strategic moves include both ‘agential’ and ‘receptive’ power dynamics (Doehring 2015), which point to different ways of adding to the meaning-creating process within chaplaincy.

Feminist theories make a strong distinction between a power-control and love-empathy model of relating (Jordan 2004), as two different kinds of power dynamics that exclude each other and in which one is ‘good’ and the other ‘bad’. Focusing on humanist chaplaincy, it would be tempting to connect this practice with a love-empathy model and transformative power only. But according to the philosopher Harry Kunneman, humanism needs to face both sides of power, the good and the bad, the peacefulness and the violence, as two sides of the same coin (Kunneman 2007). The theoretical framework outlined here, makes it possible first, to look at power as relational and dynamic, in which both chaplain and patient ‘take turns’. Secondly, it also helps to see how power is involved in the co-creation of meaning, including both dominating and transformative power. Thirdly, it also allows to make a distinction within the transformative power, between more agential and receptive forms of power and how these foster the co-creation of meaning. Lastly, it may help to see how agential power and receptive power can turn into dominating forms of power, and vice versa.
3. Methods

An explorative narrative study is conducted into the power dynamics in the interaction between chaplain and patient in different hospital conversations. We focus on the narrative as a co-creation that unfolds in the meeting of chaplain and patient, and in which both partners participate.

3.1. Data Collection and Ethical Accountability

In previous research conducted at the University of Humanistic Studies, the researcher approached 23 humanist chaplains from his network to participate in his study by making at least one audio recording of a conversation with a client (Vos and Braam 2021). Ten Dutch humanist chaplains working in different general hospitals in The Netherlands agreed to participate; the others did not participate for several reasons (Vos and Braam 2021). These ten participants were then given written information about the current study in a letter and were asked for consent to re-use their data by the researcher of the previous study, whereof six (2 m; 4 f) replied and gave consent for the current research. The research proposal and data management plan were approved by the university ethics committee. All data are safely stored on a research drive at the university.

3.2. Participants

All six chaplains work in a hospital. Chaplains recorded one or two conversations with a patient. They were free to choose their interlocutor, there were no restrictions. The conversations lasted between 24 and 70 min (see Table 3) Because of privacy, the patient characteristics were not registered in the previous research, therefore no other information about the patients is available then gender and what is mentioned in the conversation by the patient themselves. From the audiotapes, it can be assumed that there were no verbal or cognitive impairments that may have influenced the conversation.

Table 3. Data Recordings and gender patient/chaplain.

| Code | Duration of Conversation | Gender Patient | Gender Chaplain |
|------|--------------------------|----------------|-----------------|
| G1   | 24 min 31 s              | f              | f               |
| G2   | 60 min 22 s              | f              | m               |
| G3   | 26 min 26 s              | f              | m               |
| G4   | 53 min 5 s               | m              | f               |
| G5   | 50 min 33 s              | m              | f               |
| G6   | 70 min 2 s               | f              | f               |

3.3. Transcription and Analysis

Recorded conversations were transcribed verbatim in Dutch language and afterwards translated into English. The verbatim transcripts put emphasis on the form of speech and the interaction, including simultaneous speech and silences, in order to analyze the power dynamics in conversations. Pseudonyms were given instead of the real names to ensure privacy of all participants. An interaction analysis was conducted, using the types and strategies of dominance (Table 1) and responses outlined by Mooren (Table 2). New strategies were added when there was no accurate description for the strategy used. We firstly analyzed the dynamic of each transcript in its entirety by: the content (what did the interlocutors say? What did they aim for?); and the expression (how did the interlocutor speak? e.g., specific questions, metaphors, utterances with distinctive vocalizations).

Secondly, we analyzed the power strategies used in the entire conversations, the most outstanding fragments were selected. Criteria were that the fragments are exemplary for the diversity within the conversations and that these fragments are clear examples of possible power dynamics within the conversation.

Thirdly, we analyzed those fragments in more detail. In what manner were these strategies used? And what was the spill-over or effect of the communicative-acts for interlocutors?
4. Results

The analysis showed that both chaplain and patient use power strategies in their conversation and how these can inhibit the narrative co-creation of meaning or foster it. In this section, we will outline first inhibiting strategies, used by chaplains and patients; and then fostering strategies used by both. We illustrate these with a selection of fragments that encompass these strategies. Although in some instances, chaplain or patient seem to be the main actor in inhibiting the co-creation of meaning (indicated between brackets), it is important to remember that actions in relationship are always co-action and that in a next part of the conversation, the dominance positions may change. Moreover, these examples are illustrative, but do not cover the whole power dynamic within a conversation neither are they exhausting, since many more strategies could be found. However, they show the diversity of strategies and how they possibly function in the co-creation of meaning.

4.1. Inhibiting Co-Creation by Talking Simultaneously (Chaplain and Patient)

A conversation becomes more complex when patient and chaplain talk simultaneously, which is the case in fragment 1. The patient is divorced. Her ex-husband has a new relationship with one of her best friends. For that reason, she disconnected with that friend. Now her ex and new girlfriend are meeting the children. She says this makes her jealous somehow.

Fragment 1—G3

P: It's right then too. My sister gives me the instruction to . . . just take a moment to look and then to let it rest. (Ch: hehe). So I try that two days (Ch: Yes, yes). I know, I know //

Ch: that you cannot run away or so

P: I know, how these things go. //

Ch: for example, that you, do you have any idea, that, this confrontation

P: well, that you just, I cannot run from it, it's just what it is. Hey. (Ch: Yes). That relationship exists (Ch: hhmhm) and next Saturday she is going to meet my children, what I terribly . . . (Ch: Yes, yes, yes-yes-yes-yes) what I terribly do not want to happen (Ch: No). I [explicitly] am the grandma of these little boys (Ch: Yes, yes), these are my [with emphasis] children. (Ch: Yes, yes) But she is his partner (Ch: Yes, yes) thus that, that (Ch: You can't avoid it no.) I can't avoid it. Both chaplain and patient fill the air with continuous speech. This is a very dense conversation, with few silences and a high tempo of speech. The patient seems to struggle to find her words (P: I know, how these things go) and the chaplains seems to be unable to form complete sentences (that you cannot run away or so). When the chaplain stops speaking while the patient talks, the sentences change toward complete sentences and a coherent story (well, that you just, I cannot run from it, it's just what it is. Hey. (Ch: Yes). That relationship exists (Ch: hhmhm) and next Saturday she is going to meet my children), but as soon as the chaplain starts to talk more than one word again the sentences of the patient fall apart (what I terribly . . . terribly do not want to happen). The density of the conversation, the constant sound of voices complicate hearing, thinking, contemplating or responding. There is only a short amount of time to hear what the other is saying and to think about the content and shape one's own thoughts, which makes co-creation of meaning very difficult.

4.2. Inhibiting Co-Creation by Avoiding Self-Disclosure (Chaplain)

In fragment 2 chaplain and patient do not seem to understand each other well. Patient and chaplain talk about the patient’s struggles to stay close to herself while being in a hospital.
Fragment 2—G6

P: Uuuuhm, well.. I think . . . uuuh.. I have that right now slightly he, as that- that I also said.. that I have the feeling that I, can’t really be myself, because I thought (Ch: hmhm) that I had found myself, you know. And.. that is of course.. something very difficult to describe he? Being yourself. (Ch: Yes) Could you describe it? (/ /Ch: Yes)

... 

Ch: [clearing her throat] Well, may be, with, because the word uuh, uuh, finding no peace recurs over and over again hey (P: Ah yes, yes, yes) In that you notice.. yes, maybe that you.. uuh . . . yes you, can’t stay true to yourself, that, and all the time things happen and you need to relate to that, and.. you have to do something.. with it? hmm Yes.

P: Yes, that’s true. And-ehm . . . but.. well, I thought usually, when I got to know my husband, he is true to himself.. he dared to be in church when they had little money at home and then he had some collecting money that he just put down on the pews.

Fragment 2 is a tranquil conversation because of the many silences and the low tempo of speech. We can see that the tranquillity in the conversation facilitates time for thought and mutual response. Here, the patient asks a question (Being yourself. Could you describe it?) for mutual human-to-human exchange of experiences. The chaplain is not receptive for this but uses reflection as a strategy to respond, she answers by mirroring the patient her words. With her reflection, the chaplain does not self-disclose, thereby not bringing in their own experiences and possibly helping the co-creation of meaning with the patient.

The chaplains’ reflections focus the conversation back to the experience of the patient. The patient goes along with this strategy of the chaplain: the question does not return.

4.3. Inhibiting Co-Creation by Ignoring the Other (Patient)

Fragment 3 demonstrates a difficulty of understanding each other. The chaplain and patient talk about the difficulty of being in a hospital with the patient’s leg recovering very slowly and the loss of the patient’s wife a year ago. The patient questions if there was anything more he could have done to keep his wife alive.

Fragment 3—G5

Ch: Yes, yes. No that’s how it works, but it’s good to realise to make the self-blaming somehow less heavy, because it is understandable that it pops up, but it’s also.. limiting.. yourself when.. you blame yourself. (P: Yeahhhh, that’s right) Because that’s not, it’s simply unjustified (/ /P: No.) and then it becomes difficult hey, to stay positive and therefore [inaudible]. (/ /P: Well, I)

P: I do, when I’m-uh.. here, like I am here.. eeh I-eh have less-uuh.. that I actually.. am thinking about it, on the one side. When I am home for example, then I am alone and I am constantly confronted with it, but because I, for example, am here, I have completely [nothing], yes I have a-eh smartphone with some picture of her but [-]

The patient speaks with a waterfall of words. The chaplain mixes interpretation and reflection as strategies to pinpoint towards consequences of blaming oneself and the difficulty of staying positive. Somehow this does not match with the aims of the patient in this conversation. The patient is not receptive for the strategic moves by the chaplain, but ignores the chaplain’s reflections through sticking to the topic and continuing it. The patient does confirm the chaplain (Yeahhhh, that’s right) but when the patient takes the floor again none of the shared reflections seem to have moved him for further reflection.
4.4. Inhibiting Co-Creation by Using Control (Chaplain)

Fragment 4 demonstrates how the chaplain moves the conversation from how the patient experiences his cancer towards a breathing exercise she gave him last week; and how the patient beats about the bush the practical advice of the chaplain.

Fragment 4—G4

Ch: And eeeh Have.. you.. had the chance the past few weeks to.. do the breathing exercises?
P: I have done the relaxation-eh, I still do.
Ch: Yes. Could you do that?
P: Yes, it succeeds.
Ch: Well done.
P: Yes, you did not allow me to do it for a longer time, so-eh I just do it-eh, so yes. [laughs]
Ch: He, but you could do it more often hey?
P: Yehes, but not longer.
Ch: No. But are you, did it succeed more often?
P: Yeeeeehah.
Ch: Look, look, look, here we come to a minor problem! [laughs] //
P: that, that, that goes, that goes, sometimes it does and sometimes it doesn’t.
P: You see, you have to think about it.. that’s easy, but the moment that everything goes well.. (Ch: Yes) when you are already relaxed. Yes-uuh and at that point to take time to sit down, then I think well, I mean-uuuh hmuh then you also forget . . .
Ch: Unfortunately, that’s how the human mind works. Yes.

In this example, the chaplain puts pressure on the patient. She asks the patient a closed question concerning exercises for relaxation. With this question, she checks the patient’s efforts so far; it is a strategy to control. The patient confirms that he does the exercise, but he also confesses that he likes to do the exercise longer than she told him to do (Yes, you did not allow me to do it for a longer time). The patient feels the pressure the chaplain puts on his shoulders. He skirts around it by giving an explanation for his behaviour (when you are already relaxed. Yes-uuh and at that point to take time to sit down, then I think well, I mean-uuuh hmuh then you also forget . . .). And the chaplain gives in.

4.5. Fostering Co-Creation by Sharing (Patient) and Leading Indirectly (Chaplain)

Fragment 5 demonstrates how chaplain and patient respond and give initiatives towards each other’s content. They talk about the patient’s hospital experience and when she was given medication which made her delirious.

Fragment 5—G1

Ch: [-] Yes, that’s a very different experience hey, when you are used to support others with their problems (P: Yes) and then (P: Yes) you find yourself there.
Ch/P: Yes.
Ch: Yes.
P: That was very difficult (Ch: yes).
Ch: What was so difficult for you?
P: t-t-that I lost my hope.
Ch: Yes, yes, that life can be so dark.
P: It was black.
Ch: Black [explicitly]
P: It was completely black.
Ch: That even the hope was gone (/P: Yes) for a while.
P: That (/Ch: Yes) everything was gone. (Ch: Yes) And I worked in healthcare (Ch: Hmhm) and I used to have a patient who told me: sister remain an optimist (Ch: hmhm), until you die. And I always kept that with me. (Ch: Yes) And that she, I’d lost everything! (Ch: yes, yes) I’d lost everything. (Ch: yes) And .. it was always a smile (Ch: yes) and never a teardrop, always a smile. (Ch: yes). Yes doctor I lost it.
Ch: Yes, yes, yes and-eh, now you are able to say, I was lost for a while.
P: I’d lost it.

The low speed and silences allow the patient and chaplain to respond to each other. The chaplain uses different receptive power strategies to lead the conversation indirectly: she listens, confirms, paraphrases; and she also makes interpretations and asks more in-depth questions. In this way, the chaplain gives direction towards the dark side of the patient her life. The patient goes along with this and adds her own experience to it (‘lost my hope’; ‘black’; ‘lost everything’). Both give direction to the conversation and weave a story together.

4.6. Fostering Co-Creation by Focussing (Chaplain)

In the next fragment 6 chaplain and patient expand on the incomprehensible experiences of the patient. There is no medical explanation for the symptoms of the patient. Chaplain and patient are exploring together what is going on by the patient. They revert to past experiences of the patient when he had a burn-out.

Fragment 6—G2

Ch: Yes, I wonder, that, those two and a half months, how was that for you? Because you are an engaged person, you’ve dedicated yourself, you work 48 h, and when you, and.. eeh going to stop. (P: Yes but, I had) How was it (P: I had) being at home?
P: I had clearly in mind, why, what (Ch: hmhm) and now it’s much less clear. (Ch: Ok) O have.. right now.. mm.. I am right now at home because I was overworked.. (Ch: hmhm) .. at the moment it has to do with, it has a physical cause.
Ch: The vomiting or the hyperventilating?
P: No, it’s not that I think
Ch: No, because that’s what (P; yes) we’re talking about, at least that’s what I, (P: [interrupting] yes, yes, yes) because that’s, partly, your struggle. And what is causing trouble in your night’s sleep.
P: [interrupts] Yes, but that’s because their question comes with those physical things, they do not find anything. (Ch: No) So, I think that it originates from something else. (Ch: hmhm) At that time, I knew, I joined a course for three days .. with the course supervisor, by chance, I spoke individually for one hour (Ch: hmhm). She said; yes you are the most at risk, you’ll get it back.
Ch: Ooh yes?
P: Yes.
Ch: What did she mean by that?
P: I kept a lot to myself. And I only, as we talked about, rationalize. (Ch: hmhm) And for me I don’t grasp it, because all those things.. were written down, rationalized hey, look that’s good, that’s good, that’s good, I did remember that, let it sink in. (Ch: hmmh) What I told you, I let it enter, I go there.. at a certain moment that starts to (Ch: hmmh), wash over me. (Hc: hmhm) Because I . . . eeeehm I also think that this a tiny part the reason right now, of our conversation last week.

This is a slowed down conversation: there is a low speed of speech with silences. The patient tries to understand what is going on, but he has trouble to connect with his inner world of feelings. The chaplain focusses on the experience and feelings of the patient, firstly by asking an open question. The patient does not answer the chaplain, but his answer connects the past experience with his current experience. Secondly, the chaplain asks the patient a closed question for clarification; are they talking about the same thing? (No, because that’s what (P; yes) we’re talking about) The chaplain leads the conversation indirectly back towards the patient’s current experience with the focus on the incomprehensible. This opens the way for the patient to give an explanation. The chaplain needs to ask what he means, causing the patient to start connecting the dots, how he deals with the outer world (what is said) and inner world (how he processes).

5. Conclusions and Discussion

In humanist chaplaincy, with its grounding in humanist psychology and in humanist values of autonomy and authenticity, it is common practice that the patient takes the floor both in semantic dominance as in the amount of talk. Usually the conversations revolve around the story of the patient, accordingly the patient speaks the majority of the time. Within that basic framework, however, we found a diversity of strategies that inhibit or foster the co-creation of meaning. Besides the strategies put forward by Linell (1990) and Mooren (1999), additional power strategies were found, such as ignoring the other person (fragment 3) and to beat around the bush (fragment 4). These were strategies applied by the patient, whereas Mooren outlined strategies from the position of the professional caregiver, the chaplain. The different positionings of both interlocutors may be partly associated with different power strategies.

5.1. Monologue as Inhibiting Co-Creation of Meaning

We found that conversations in which the chaplain follows the story of the patient, are not always fruitful in co-creating meaning. When the patient is verbose, leaves little space for the chaplain to respond, or is even ignoring the chaplain, then the conversation has no focus and may become rudderless. Instead of a dialogue, these patients hold long monologues inhibiting the co-creation of meaning. Here we see how the lack of receptive power (i.e., not receiving the response of the chaplain), turns into a dominating power strategy. The chaplain in turn may feel compelled to use more controlling strategies for a more balanced initiative and response.

Another way in which co-creation becomes difficult, is when patient and chaplain talk simultaneously so that they inhibit each other’s speech. Two monologues at the same time, deprives space to think, talk and respond to each other. Also speedy talking hinders a joint conversation (dialogue) and encroaches on the story that cannot be finished or continued. The danger arises that there is too little space for the story of the patient. These strategies hinder the profundity of the conversation and meaning is harder to achieve. The chaplain is situated in a field of tension between listening attentive to the patient and providing enough input to deepen the conversation (speaking).

5.2. Asking Questions as Both Fostering and Inhibiting

Mooren’s response of ‘asking closed and open questions’ is a way of exerting power by directly or indirectly leading the conversation. We found that open questioning is self-evident for chaplains and is widely used in conversations as a way of indirect leading. They foster co-creation of meaning by showing interest in the interlocutor, to align with
the interlocutor and to confirm the interlocutor (see fragment 5). Wang (2006) found that the dominating form of power is in the nature of questions because they carry the ability to control. We also found that questions can be used to control and dominate and that these mostly are closed questions (fragment 4). More interestingly however, the results also showed that closed questions are not necessarily dominating but that they can be helpful to focus the conversation and gain more insight in the interlocutor for a mutual engagement (fragment 6). Closed questions then are a form of agential power (Doehring 2015) that can support the search for common understanding when it is aimed at a shared exploration of thoughts, feelings and alike. It can clarify and deepen the conversation. In other words, closed questions can both inhibit and foster the co-creation of meaning, depending on whether they take an agential or dominating form.

5.3. Fostering Strategies Missing in Chaplaincy

When it comes to fostering the co-creation of meaning, however, chaplains may not use the full repertoire of strategies available. Firstly, we found a limited use of the strategy focussing. Focusing can be used to narrow the attention towards a topic in order to stimulate or deepen the conversation. To focus is to concentrate on a certain point, we might as well say that focusing is a way of directing the conversation. According to the myths of Mooren (1999), chaplains do not steer nor impose on the client. The myths point towards the importance of the autonomy of the individual (patient); a relational ontology, as underpinned by transformative power, is not naturally embedded in chaplaincy. Focusing explicitly aims at influencing the conversation and supporting a meaningful conversation; it is an agential power strategy that can be very effective, but which also can easily turn into a dominating strategy. Chaplains may be hesitant to employ this strategy when they feel not competent enough to hold this delicate balance between leading and controlling. Future research could focus on the worldview of chaplains to see if these myths are still prevalent and how they influence their interacting.

Secondly, in all conversations, the strategy of self-disclosure was absent, even when the chaplain was invited to self-disclose (fragment 2); while we expected self-disclosure to be present as a way to level with the patient (Yalom 2005). Self-disclosure is well-known to be rarely used by therapists because it requires substantial training (Henretty and Levitt 2010). This may be one possible explanation for its absence in these conversations. Nonetheless, the exchange of life-experiences can be an important contribution in the co-creation of meaning and for mutuality and resonance in the relationship to occur (Fedele 2004). It can be a very strong transformative power strategy, if used well, whereby both interlocutors are willing to be touched, to reveal their emotions and to receive the emotions of others. Henretty and Levitt give some training implications for therapist that may be relevant for chaplains too; ‘tact, timing, patience, humility, perseverance and sensitivity’ (p. 70).

5.4. The Sloppiness of Professional Conversations

We may conclude from our analysis that conversations are inherently sloppy; a conversation is always unpredictable (Stern 2004). We do not know how the other is going to act or re-act. Interlocutors respond intuitively in the current moment, searching how to meet or how to defend themselves against the other. From the outside, what happens in a conversation can appear clear. But inside the conversation. ‘while it is still happening, its path appears less clear, simple, and directional’ (p. 150). We, as researchers, took an outsider-perspective which made it possible to analyze the dynamic between interlocutors than being inside and moving along with the other. Being in the conversation is a more complex interactional process which includes thinking, feeling, connecting with the other, sharing, listening, responding; and in which the dynamic between two people is not so obvious while being in the interaction.
5.5. Recommendations for Further Research

In this last part, we want to discuss some methodological issues and propose some ideas for further research.

First of all, only six audio recordings were analyzed from humanist chaplains that were selected in previous research on the basis of convenience. This sample cannot be seen as representative for all humanist chaplains working in general hospitals, since we do not know if and how their characteristics differ from the general population. However, it does give insight into the workings of power dynamics and how specific interactional moves can inhibit or foster meaning creating process as the overall goal of chaplaincy. Fostering meaning creation at least requires more direct strategies, such as focusing, asking direct questions and self-disclosure. These are strategies in which the chaplain is more ‘present’ as a person and professional with their own values, however without imposing these on the patient. Further research could be conducted to find out what chaplains need to employ these kind of strategies and their effects within the conversation.

The particularity of the sample size also limits the possibility to generalize the findings to chaplains that work within a religious tradition. In the current sample the ‘myths’ that stem from humanist psychology (Mooren 1999) seem more prevalent then in religion-based chaplaincy in which the ‘vertical relationship’ with God enables chaplains to be more open about their perspective, at least in conversations with clients of the same religion. Follow up research with chaplains from different dominations would help to fill this knowledge gap.

Thirdly, we analyzed the interactional process within one conversation between chaplain and patient. The interactional process can change within the conversation but can also change over the sequence of conversations. The dynamic might change, the conversation might touch upon topics not addressed previously and the conversation might move in another direction. It would be interesting to investigate how the power dynamics between chaplain and patient evolve and how they co-create meaning in consecutive conversations.

Lastly, our analysis was based on audio-recordings of the verbal interaction between patient and chaplain. We did not have any information about non-verbal aspects of this interaction or how they influenced the power dynamics. It is well-known that the physical position in the space, the posture, body characteristics (for example height, gender, skin color), facial expression et cetera, all accomplish power dynamics (Doehring 2015). Further research should be done in how they influence the interaction and the co-creation of meaning.

Author Contributions: Conceptualization, K.A.d.L. and G.J.; formal analysis, K.A.d.L.; investigation, K.A.d.L.; methodology, K.A.d.L.; supervision, G.J.; writing—original draft, K.A.d.L. and G.J.; writing—review & editing, G.J. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Ethics Committee of the University of Humanistic Studies (8 June 2020) for studies involving humans.

Informed Consent Statement: Written informed consent was obtained from all participants involved in the study.

Data Availability Statement: The data supporting the reported results are archived in a research drive at the University of Humanistic Studies.

Conflicts of Interest: The authors declare no conflict of interest.

References
Baker Miller, Jean, and Irene Pierce Stiver. 1997. The Healing Connection: How Women Form Relationships in Therapy and in Life. Boston: Beacon Press.
Baker Miller, Jean. 1992. Women and Power. In Rethinking Power. Edited by Thomas Wartenberg. Albany: SUNY Press.
Brammer, Lawrence D. 1974. Het Helpende Contact. Vormen en Functie. [The Helping Contact. Forms and Functions]. Haarlem: De Toorts.
Brown, Jason. D. 2019. Anti-Oppressive Counseling and Psychotherapy. Action for Personal and Social Change. New York: Routledge.
Cliteur, Paul, and Douwe van Houten, eds. 1993. Humanisme—Theorie En praktijk [Humanism—Theory and Practice]. Utrecht: De Tijdstroom.

Derkx, Peter. 2015. The Future of Humanism. In The Wiley Blackwell Handbook of Humanism. Edited by Copson Andrew and A. C. Grayling. Chichester: John Wiley & Sons, pp. 426–39.

Doehring, Carry. 2015. The Practice of Pastoral Care. A Postmodern Approach. Louisville: Westminster John Knox Press.

Dominelli, Lina. 2002. Anti-Oppressive Social Work Theory and Practice. New York: Palgrave MacMillan.

Fedele, N. 2004. Relationships in groups. Connection, Resonance and Paradox. In The Complexity of Connection. Edited by Judith V. Jordan, Maureen Walker and Linda M. Hartling. New York and London: Guilford Press, pp. 194–219.

Held, Virginia. 1993. Feminist Morality: Transforming Culture, Society, and Politics. Chicago: University of Chicago Press.

Henretty, Jennifer R., and Heidi M. Levitt. 2010. The role for therapist self-disclosure in psychotherapy: A qualitative review. Clinical Psychology Review 30: 63–77. [CrossRef]

Hermans, Hubert, and Agnieszka Hermans-Konopka. 2010. Dialogical Self Theory. In Positioning and Counter-Positioning in a Globalizing Society. Cambridge: Cambridge University Press.

Jordan, Judith V. 2004. Relational Resilience. In The Complexity of Connection. Edited by Judith V. Jordan, Maureen Walker and Linda M. Hartling. London: Guilford Press.

Jordan, Judith V., Marueen Walker, and Linda M. Hartling. 2004. The Complexity of Connection. New York and London: Guilford Press.

Jorna, Ton. 2008. Echte Woorden. Authenticiteit in de Geestelijke Begeleiding. Amsterdam: SWP.

Kunnen, Harry. 2007. Critical Humanism and the Problem of Evil: From Vertical to Horizontal Transcendence. In Probing the Depths of Evil and Good. Multireligious Views and Case Studies. Edited by Jerald D. Gort, Henry Jansen and Hendrik M. Vroom. Amsterdam and New York: Rodopi, pp. 319–42.

Levi, Daniel J. 2017. Group Dynamics for Teams. London: SAGE Publications Ltd.

Linell, Per. 1990. The power of dialogue dynamics. In The Dynamics of Dialogue. Edited by Markova Ivana and Klaus Froppa. New York: Harvester Wheatsheaf.

McLeod, John. 1997. Narrative and Psychotherapy. London: Sage.

Mooren, Jan Hein. 1999. Bakens in de Stroom. Naar Een Methodiek van Het Humanistisch Geestelijk Werk. Utrecht: Uitgeverij SWP.

Roselle, Laura, Alistair Miskimomon, and Ben O’Loughin. 2014. Strategic narrative: A new means to understand soft power. Media, War & Conflict 7: 70–84.

Schumann, Carmen, and Annelieke Damen. 2018. ‘Doordrongen van de raadselachtigheid van het leven’: Over de spirituele dimensie van humanistisch geestelijke verzorging. Waardenwerk 72: 77–87.

Stern, Daniel N. 2004. The Present Moment in Psychotherapy and Everyday Life. New York and London: W.W. Norton & Company.

Surrey, Janet L. 1991. Relationship and Empowerment. In Women’s Growth in Connection. Writings from the Stone Center. Edited by Judith V. Jordan, Alexandra G. Kaplan, Jean Baker Miller, Irene P. Stiver and Janet L. Surrey. New York and London: The Guilford Press, pp. 162–80.

Van Praag, Jaap P. 1946. Modern Humanisme, Een Renaissance? [Humanism, A Renaissance?]. Amsterdam: Contact.

Van Praag, Jaap P. 1953. Geestelijke verzorging op humanistische grondslag. In Om de Geestelijke Weerbaarheid van Humanisten. Edited by Peter Derkx and Jaap P. van Praag. Breda: Uitgeverij de Papieren Tijger.

Wang, Jinjun. 2006. Questions and the exercise of power. Discourse & Society (SAGE) 17: 529–48. [CrossRef]

Yalom, Irvin. 2005. The Theory and Practice of Group Psychotherapy, 5th ed. London and New York: Basic Books.