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Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare

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Chaplains in healthcare increasingly work in interfaith roles with patients and families from a range of religious and spiritual backgrounds. Some move with ease between their own religious backgrounds and those of the individuals with whom they work. Others encounter tensions as their status as a person of faith comes into conflict with their status as an interfaith chaplain. We explore the two main strategies—neutralizing and code-switching—chaplains at one large academic medical center use when working with patients and families whose religious and spiritual backgrounds are different from their own. Through training in clinical pastoral education and experiences on the job, chaplains learn to neutralize (use a broad language of spirituality that emphasizes commonalities rather than differences) and to code-switch (use the languages, rituals, and practices of the people with whom they work). To the extent that the strategies evident here are present among chaplains in a broader range of institutional settings, they suggest a kind of spiritual secularism or broad approach to meaning makings that may be facilitated by interfaith chaplains in a range of settings.

Keywords: *religious diversity, healthcare, organization, chaplain, secular.*

INTRODUCTION

In a recent critique of the sociology of religion as a field, colleagues and I call on scholars to consider religion from four edges or new perspectives in order to "de-center many taken-for-granted ways of thinking about religion" (Cadge, Levitt, and Smilde 2011:438). This approach will diversify the study of religion, lead scholars to question conventional conceptualizations, and encourage a wider range of social scientists to consider how religion intersects with other aspects of social life. "Questioning conventional categories and wisdom" will lead sociologists of religion "to creatively rethink core concepts and to engage more fully with sociology in general" (Cadge, Levitt, and Smilde 2011:447).

We take up this call here by focusing on religion outside of religious organizations—one of the four edges we identify. Religion is present (and must be negotiated) outside of religious organizations in public life and through holiday displays, rules about dress, casual conversation, and in the religious beliefs and practices of staff and constituents in secular organizations (*Adding Eid* 2010; Bender 2003; Calhoun 2010; Heclo 2003; Pierce 2008; Taylor 2007; Trautner and Kwan 2010). While sociologists have focused significant attention on the dynamics of religious organizations, less is known about how religion is present and negotiated in secular organizations

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(Chang 2003; Demerath et al. 1998).[1] Classic secularization arguments are partially to blame as scholars historically argued that institutional differentiation would lead religion or the sacred to disappear from secular organizations (Demerath et al. 1998). It clearly has not and failing to ask about how religion is present and religious differences negotiated in secular organizations furthers what Ammerman calls "one of the ... great 'problems' of modernity ... the differentiation of institutional spheres, the separation of one part of life from another" (2007:228). We respond to this problem here by investigating one of the "multiple spaces (including secular ones) where religious sensitivities and selves are robustly explored and cultivated" and asking how religious diversity is negotiated as different spheres of life come together in one place (Bender 2010:182).

We focus on how secular organizations negotiate religious diversity through the case of one secular academic medical center. While much has been written about religion, health, and healthcare, little focuses on how healthcare organizations themselves manage religious diversity (Cadge 2009; Cadge and Fair 2010; Chatters 2000; Chatters, Levin, and Ellison 1998; Ellison and Levin 1998; George et al. 2000; Koenig, McCullough, and Larson 2001; Miller and Thoresen 2003; Sherkat and Ellison 1999; Weaver and Ellison 2004). Isolated studies describe how hospitals attempt to accommodate members of particular—usually religious minority—groups, but few studies focus on how chaplains as religious professionals in healthcare manage religious differences in their work (Abu-Ras and Laird 2011). While chaplains historically worked with people from their own religious backgrounds, increasing religious diversity in the United States and corresponding changes in chaplaincy as a profession led many chaplains to work as interfaith chaplains today engaging with people from a range of spiritual and religious backgrounds (Cadge 2013; Sullivan 2010).

Institutional sectors vary in how they staff and prepare individuals for interfaith chaplaincy. In healthcare, chaplains are increasingly required to be "board certified," which requires them to have a bachelor's degree and a graduate-level degree in theology, have completed four units (1,600 hours) of clinical pastoral education (CPE), have paid dues to one of the professional chaplaincy organizations, and be endorsed and in good standing with their personal faith tradition. In addition, the "Common Standards for Professional Chaplaincy" adopted in 2004 by the main professional organizations for chaplains in healthcare stipulates that chaplains are to "provide pastoral care that respects diversity and differences including, but not limited to culture, gender, sexual orientation, and spiritual / religious practices" (PAS3). A separate portion of these standards stipulates that candidates for board certification "develop, coordinate and facilitate public worship/spiritual practices appropriate to diverse settings and needs" (PAS8).[2]

While professional chaplains in healthcare settings have long been committed to not proselytizing, the growth of interfaith chaplaincy raises questions about how chaplains who must be endorsed in one faith tradition to be "board certified" work with patients and families from other spiritual and religious backgrounds (Cadge 2013; Holst 1982, 1985). Research about people of faith and chaplains in other institutional settings points to the ways some experience tension as they attempt to play "a number of roles simultaneously" (Burchard 1954; Rhodes 2011). In healthcare, interfaith chaplains may experience tension when their status as a religious person endorsed by a particular religious organization conflicts with their responsibilities as an interfaith chaplain working with all people.

We focus here on how healthcare chaplains who work in one large academic medical center we call Overbrook Hospital work with people from religious backgrounds that differ from their own.

[1]While the question of what constitutes a secular organization requires an article itself we operationalize it here as an organization without a self-identified religious mission or identity. For a more detailed and nuanced description of such distinctions, see (Demerath et al. 1998).

[2]These standards are available at http://www.spiritualcarecollaborative.org/docs/common-standards-professional-chaplaincy.pdf.

We identify two main strategies used by the 20 full- and part-time staff chaplains at Overbrook Hospital. While some chaplains certainly refer patients to chaplains or community clergy whose religious backgrounds matches that of the patient, most *neutralize* religious differences and/or *code-switch* between different religious languages and symbols when working with people whose religious backgrounds are different from their own. Chaplains who neutralize differences use a language of spirituality and seek commonalities in their interactions with patients and families. Those who *code-switch* move to the religious language, rituals, or practices of the individual with whom they are working. While a few of the chaplains we interviewed experience tensions in these situations, most described using these strategies without conflict or difficulty.

Showing how interfaith chaplains respond to religious differences in healthcare furthers one of the analytic edges my colleagues and I identify elsewhere (Cadge, Levitt, and Smilde 2011). From their positions at the edge of healthcare organizations, chaplains provide a window into how religious and spiritual differences are negotiated there that complements related research about physicians, nurses, and other healthcare staff (Cadge, Ecklund, and Short 2009; Chibnall and Brooks 2001; Grant 2004; Messikomer and De Craemer 2002). More importantly, their strategies point to how religious differences might be addressed by chaplains in other secular institutional settings more generally. To the extent that the strategies evident here are present among chaplains in a broader range of institutional settings, they suggest what Sullivan calls "areligious secularism"—or emerging "post-Christian space[s] where religion is honored as a human universal and religious pluralism can be creatively negotiated in sites of cultural exchange" (2009:230). Such spaces might also be seen as evidence of spiritual secularism or the ways people find meaning in a myriad of ways outside of formal religious traditions across seemingly secular institutional settings as facilitated by interfaith chaplains.

Background

In *American Grace*, Putnam and Campbell (2010) analyze national survey data to argue that many people in the United States experience religious diversity regularly as they interact with family members, friends, and colleagues in their daily lives. Beyond the statistics, however, Wuthnow (2005) argues that sociologists know little about how people in the United States experience and respond to this diversity in their everyday lives. Evidence from Hindus, Muslims, and Buddhists, Wuthnow (2005) argues, suggests that people are more comfortable thinking about religious diversity around legal questions of civil rights than in terms of cultural aspects of inclusion.

In addition to knowing little about how individuals respond to religious diversity, social scientists also know little about how people experience and manage religious diversity in organizations like workplaces and schools, and how organizations themselves respond to religious multiplicity. Classic secularization arguments have led scholars away from these questions as they historically argued that institutional differentiation would lead religion or the sacred to disappear from secular organizations (Demerath et al. 1998). In an important exception, Bender (2003) shows in *Heaven's Kitchen* how religious differences were negotiated informally at a secular AIDS social service organization in New York as religiously diverse volunteers spoke of attending religious services, preparing for holidays, and parodying public figures.

In some secular organizations, including hospitals, prisons, and universities, it is chaplains who are formally responsible for addressing religious differences among staff and constituents. The history of chaplaincy varies by institutional sector though chaplains across sectors have been challenged to adapt their work to growing religious pluralism in recent years (Sullivan 2010). Universities and the military added their first Muslim and Hindu chaplains in recent years and many chaplains in other sectors regularly interact with people from a wider range of religious and spiritual backgrounds than they did in the past (Bergen 2004; Cadge 2013; Sullivan 2010).

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In healthcare this has been formalized through the creation of interfaith chaplaincy positions and in the decisions some hospitals have made to change the names of their departments from chaplaincy or pastoral care—which point to the profession's Christian history—to departments of spirituality or spiritual care services, which they see as more inclusive and broadly welcoming to a wider range of people (Cadge 2013).[3]

Most healthcare chaplains working in religiously diverse geographic regions today interact with people from a range of religious and spiritual backgrounds. While some healthcare organizations continue to organize chaplains' work by religious traditions, many are moving towards an interfaith model in which chaplains are assigned to hospital units and see everyone on their unit regardless of their religious backgrounds (Cadge 2013). Overbrook organizes the work of chaplains this way, leading all staff chaplains to regularly come into contact with people from a range of religious and spiritual backgrounds. This staffing model means staff chaplains are assigned to particular units of the hospital like the emergency department or the medical intensive care unit and are responsible for all of the patients on that unit. If a particular chaplain—like the Catholic priest—is needed to provide Catholic sacraments that only a priest can perform the staff chaplain on the unit pages that individual after assessing the need.

While a growing body of research describes who healthcare chaplains are, how they work, and what their work includes, few studies analyze how they respond to religious difference in their work (Angrosino 2006; Barrows 1993; Flannelly et al. 2005, 2006; Galek et al. 2011). In her anthropological study of what she calls the "ambivalent chaplain," Norwood (2006) focuses on how healthcare chaplains move between discourses of religion, spirituality, and medicine rather than among different religious and spiritual languages and practices in their daily work. Outside of healthcare, a study of prison chaplains in the United Kingdom shows how Church of England chaplains facilitate prison access for Buddhist, Muslim, and Sikh chaplains so they can visit members of their traditions, but little else is known about how chaplains in other sectors respond to religious diversity in their work (Beckford and Gilliat 1998).

As people trained in religious organizations but working—as religious professionals—in secular ones, chaplains occupy intriguing positions, frequently on the edge of both sets of organizations (Holst 1982). As my colleagues and I argue (Cadge, Levitt, and Smilde 2011), sociologists have rarely considered how religion is present in secular organizations and lack theoretical frameworks or models for conceptualizing how religion is present there. While chaplains have long worked in prisons, the military, healthcare organizations, universities, some workplaces, and even the U.S. Congress, sociologists know little about the roles they play as religious professionals in secular organizations and the people who frequently negotiate religious differences in these organizations (Beckford 2001; Bergen 2004; Lupu and Tuttle 2007). We consider the work of chaplains as one, of many, ways of starting to theorize how religion is present and operates in organizations that are not themselves religious. While others have asked this question in other organizations (Bender 2003), we shift the unit of analysis in this article to the professionals working at this intersection in the healthcare sector in an effort to better understand the organizational dimension.

We ask how staff chaplains at one large medical center respond to patients and families whose religious and spiritual backgrounds are different from their own. While the hospital addresses religious multiplicity in additional ways, such as through the design of the chapel and ways it frames the work of chaplains generally, we focus specifically on how chaplains themselves negotiate religious differences in their daily work (Cadge 2013). We identify two strategies related

[3]The *Oxford English Dictionary* (1989 ed.) defines a chaplain as a "clergyman who conducts religious service in the private chapel of a sovereign, lord, or high official, of a castle, garrison, embassy, college, school, workhouse, prison, cemetery, or other institution, or in the household of a person of rank or quality, in a legislative chamber, regiment, ship, etc."

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to *neutralizing* religious differences and *code-switching*, or moving between different religious languages, symbols, and practices in daily work. Such strategies are shaped by chaplains' training as well as by the time they spend with patients and families mostly in one-on-one conversation.

Research Methods

We focus on 20 staff chaplains employed full-time, part-time, and on a regular per-diem basis at Overbrook Hospital.[4] Overbrook, founded through the merger of several different hospitals in the last 75 years, is located in a large religiously diverse northeastern city. The hospital first started a chaplaincy department in the 1970s that has transitioned from being mostly Protestant to including chaplains that are Catholic, Jewish, Muslim, and Unitarian. The hospital also transitioned slowly, over time, from hosting chaplains who were paid by the local Catholic archdiocese and Protestant groups outside the hospital to employing and paying chaplains themselves. In addition to paid staff chaplains, the department includes Catholic volunteers who deliver communion to patients, Protestant pastoral visitors, and students in educational programs affiliated with local theological schools, seminaries, and the archdiocese. This includes a clinical education program with students working in a range of different units in the hospital.

The Chaplaincy Department has shifted over time to welcome as wide a range of people as possible. In its mission statement it describes itself as "offering compassionate spiritual care and emotional support as resources for healing." The Department uses a language of spirituality intentionally to signal its attention not just to people's institutional religious affiliations, but also to what it sees as a common sense of spirituality or meaning making it believes everyone shares. "In some places" in the hospital, Pat the Department Director explained, chaplaincy "gets equated within religion rather than with spirituality ... and gets undervalued." Unlike religion, spirituality—in her view and as used by chaplains throughout the hospital—is a characteristic of all people. It is synonymous with the ways people make sense of life, especially its difficult parts. "Why is this happening? How do I understand what's happening? How am I going to live with what's happening?" These are all spiritual questions, according to Pat, that chaplains help people address.

Despite this emphasis on spirituality, the hospital gathers information about patients' religious affiliations when they are admitted. On a randomly selected day during this research, Overbrook inpatients were 42 percent Catholic, 20 percent Christian (not Orthodox), 14 percent none, 8 percent unknown, 7 percent Jewish, 4 percent unaffiliated, 4 percent other, and 2 percent Christian Orthodox.[5] The 20 chaplains interviewed for this article included eight full- and part-time staff chaplains, five chaplains in training, six people who worked as per-diem chaplains, and a chaplain who used to direct the department. The largest fraction of chaplains was Catholic (40 percent), followed by Protestants (25 percent), Jews (15 percent), Unitarian Universalists (10 percent), Muslims (5 percent), and Pentecostals (5 percent). The majority (70 percent) were women and all but two were white. About half of the full- and part-time staff chaplains were board certified and about half of the chaplains in training and people working as per-diem chaplain were working to obtain the certification.

The data analyzed here were gathered during one year of fieldwork conducted by the first author. She shadowed chaplains, attended staff meetings and other departmental events, and interviewed a range of staff and volunteers. Shadowing took her through the hospital with chaplains, to committee meetings, orientations for new hospital staff, organ donation trainings, the morgue, and on patient visits. She also attended services in the hospital chapel and spent time

[4]Overbrook is a pseudonym as are the names of all of the respondents quoted in this article.

[5]The percentages do not sum to 100 because of rounding.

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watching how the space was used. She interviewed former department directors and reviewed historical materials as well as current demographic and statistical reports. Much of the data presented in this article was gathered in semistructured interviews with full- and part-time staff chaplains including per-diem chaplains who often worked overnight. Interview questions relevant to this analysis asked chaplains how they pray with patients, how their personal faith tradition informs their work, and how they work with patients and families whose religious or spiritual backgrounds are different from their own. Interviews lasted between 45 and 90 minutes and were recorded and professionally transcribed (Cadge 2013).

Findings

Chaplains at Overbrook interact daily with patients and families whose religious backgrounds are similar to and different from their own. We identified two main strategies—*neutralizing* and *code-switching*—chaplains use in working with patients whose religious backgrounds are different from their own. Chaplains also occasionally referred a patient to another chaplain whose religious background matched that of the patient—but usually only if the patient was specifically requesting it.[6] Making these matches took time, however, and it was not uncommon for chaplains to attempt to neutralize differences or to code-switch as they waited for another chaplain to be located.

Neutralizing

Chaplains most commonly try to *neutralize* religious differences or overcome the ways they are religiously different from some of the people with whom they work by emphasizing what they have in common.[7] Pat, the director, spoke of how happy patients usually are to have a chaplain, regardless of whether the chaplain comes from their own religious background. "We find that among adults most are happy just to have a chaplain." Chaplains make clear early in their visits with patients that they see themselves as supporters of the patients' particular religious traditions rather than as representatives of their personal faith traditions. Kim, a per-diem chaplain, explained: "Sometimes people [patients and families] will say . . . . what church do you go to? And I'm always careful to say that . . . . I work at the hospital and I'm not here from a particular church. I'm here for the patient's tradition, not my own . . . and 99% of the people will say something like, 'Oh, that's fine, we all pray to the same God.'" She understands patients' openness saying: "Distinctions among traditions are more important to the denominations or the hierarchy or to the clergy than they are to the average person here. The average person/patient . . . I think is more interested in, you know, someone that is willing to listen and is open to wherever they're at."

Chaplains further neutralize or bridge religious differences by emphasizing human—which they increasingly call spiritual—universals they believe connect all people. One of the chaplains in training emphasized such themes in a story he told about spending time with a patient who identified as an atheist. "It's the humanness that we share," he stated before telling his story. "One man [patient], right away told me, said, 'I'm an atheist.' My first reaction was 'So what?' . . . I said, 'You're here sick, you're hurt. That is why I am here. I'm not here to bring you religion. I just want you to know that we care about you . . . . you're not alone.'" Another chaplain told a similar story of connecting with a nonreligious patient by developing a relationship with him and

[6]If there was not a match among the staff chaplains, chaplains looked to a list of community clergy the department maintains specifically for this purpose.

[7]Apart from religion, there is a long history of neutralization in the social sciences as related to deviance and juvenile delinquency; see, for example, Sykes and Matza (1957).

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then finding something they could talk about that might decrease the man's pain. This chaplain explained, "I said I think there's something that you can do that will help you deal with the pain .... tell me about where you go fishing. So I got enough details ... and I basically gave a guided meditation with him about his fishing pole and he really relaxed by the end of it." When the patient asked what the experience of guided meditation was called the chaplain responded, "I call it meditation but if you want to call it fishing, it's ok. It doesn't really matter what you call it. You've got the ability to go there when you want to. The ability to not focus on the pain." In both of these examples, chaplains work with patients to make meaning, broadly understood, quite apart from traditional religious categories or beliefs.

In another example, Michelle, a chaplain from a Protestant background, spoke of a Jewish patient who had recently had surgery for a brain tumor and wanted to see a rabbi. The patient called the chaplaincy office late at night but there was not a rabbi available to see the patient until morning. Michelle remembers going to the patient's room and finding her furious because she wanted a rabbi, not Michelle, who was the only chaplain available in the hospital that night. She remembers saying to the patient: "There won't be anyone [a rabbi] tonight. Why don't we spend some time together and the rabbi can see you tomorrow?" They ended up having what Michelle described as a "very profound conversation" about this woman's situation—not an explicitly religious topic at all—which Michelle said she heard (years later) had made a big impression on this woman.

Many chaplains speak about presence and about spirituality in neutralizing differences and emphasizing what they have in common or share with the patients and families in their care. Scott, a staff chaplain, explained that what chaplains most offer in hospitals is their presence. "Just somebody who walks in, takes them [the patient or family] as they are, listens to their stories, shares their concerns .... I think the most we can offer them is just a listening ear, and a caring heart, and somebody who takes them the way they are, who has no expectations." Sarah, a staff chaplain at Overbrook, shared with Scott the importance of presence, saying: "There's a challenge to put words to what we do .... It is about presence, about being present for whatever happens." Because staff chaplains, like Pat quoted above, believe that everyone is searching for meaning or to answer questions like "Why is this happening? How do I understand what's happening? How am I going to live with what's happening?" they believe everyone is spiritual and increasingly use the language of spirituality as an overarching theme when talking about their work (Cadge 2013).

Many chaplains learned to neutralize or move beyond religious differences through training in clinical pastoral education that taught them to listen without judgment and to be present with people without an agenda. At Overbrook such messages were further evident in how staff chaplains worked with chaplains in training who were taking clinical pastoral education. These messages were particularly evident at the graduation ceremony the Department held for the chaplains in training at the end of their year in the hospital. Scott, a staff chaplain, opened the short graduation ceremony by quoting *The Little Prince* and describing how wonderfully these five individuals cared for patients in the hospital and for each other. He went on to say: "as chaplains, we are inviting people to share their soul prints with us as they tell stories about what it is like to be who they are." He spoke about each chaplain by focusing on how she or he creatively connected with a patient not by emphasizing their differences—religious or otherwise—but by neutralizing them and focusing on their shared humanity. He described chaplains in training hugging patients, bringing photos of Winnie the Pooh printed from the Web to help them connect with patients, singing to patients, and communicating with non-English-speaking patients in gestures. Interactions between chaplains in training and patients that were celebrated at the ceremony were impromptu, improvised, and centered on shared humanity, neutralizing religious differences, and helping patients tell their own stories. As staff chaplain William explained: "What I came to realize is that what's most important in ministering to patients is to make the relationship." The "sacramental services," he explained later in the conversation, can be "added to" the relationship but it is the relationship that is central (Cadge 2013).

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Because most chaplains at Overbrook are religiously progressive and open to other religious traditions, they did not regularly experience tensions as they attempted to neutralize or ease religious differences.[8] On the few occasions when they did encounter tensions, however, most were not bothered. Chaplain Meg, a Protestant, experienced these tensions mostly "around end of life issues" when religious or moral beliefs were leading a family to make one decision and she would make another. The tensions did not, in her words, "conflict with my supporting someone who doesn't believe that .... because I can step out of what my belief is to support somebody. It doesn't take away my belief. It doesn't challenge it. It has [in the past] but not in a long time."[9]

Code-Switching

In addition to neutralizing religious differences, staff chaplains also *code-switch* or move between religious languages, symbols, and, sometimes, rituals in their work with patients and families (Blom and Gumperz 1972; Goffman 1979, 1981).[10] Much as the chaplain mentioned above talked about meditation and fishing in the same breath, another chaplain, Marty—himself a Catholic brother—described working with a Jehovah's Witness who had recently received a kidney transplant, an act prohibited by her religious tradition. In working with this patient Marty says he "switched. Instead of using my God-language we used Jehovah language. And ... I heard [the patient] get to the point where she discussed Jehovah as a loving God, a forgiving God ... she realized I was going to support her." He took a similar approach with a Russian-speaking patient who knew no English. He did not know if this patient was religious so guessed that she was either Jewish or Russian Orthodox. "I went online and got Psalm 23 in Russian so I figured, okay, that is Old Testament and I'll cover both possibilities this way. And I brought that [the prayer] up [to the patient's room] and they [the patient and family] were in tears [because they were so happy at the gesture]!" While Marty switched from English to Russian in this second example, he also switched from a prayer he would offer a Catholic patient to one he thought appropriate for either a Jewish or Orthodox Russian speaker as one way of trying to negotiate the religious differences present between himself and the patient in this encounter.

Chaplains' efforts to code-switch were not always easy or without personal difficulty as evident in a story Lisa, a Jewish chaplain, told about being paged to the neonatal intensive care unit to baptize a baby. Babies are not baptized in the Jewish tradition and she was not certain what to do because she did not feel, as a Jewish chaplain, that she could perform the Christian ritual needed to baptize this child. She responded creatively by trying to code-switch a bit as she stood with the parents and led them to baptize the baby themselves. She described being deeply moved by the experience and feeling God's presence "very strongly in the room. It was like you

[8]Chaplains nationally tend to be more religiously liberal or progressive than the population nationally (Cadge 2013).

[9]Two Catholic chaplains similarly described tensions they sometimes encounter when working not with people who are religiously different from them but with other Catholics. They described these tensions particularly around situations related to reproductive decision making in which they must move between their identity as Catholics supposed to abide by certain Vatican policies, their personal feelings, and those of the Catholic couples with whom they work. While both are personally opposed to abortion, for example, each emphasized the gray not always present in the black and white positions the Catholic Church takes on such issues. "Am I against abortion?" one asked rhetorically, "Absolutely. But I also don't think that God asks a couple who knows that they have a nonviable pregnancy at say sixteen weeks to carry that child to forty weeks .... I don't think God expects them to suffer like that .... I think that the institution [the Catholic Church] sees things in black and white but we live in the gray." Another said simply, "I agree with what my faith says ... but I leave it to God to make the judgment call," meaning he supports people regardless of what decision they make in cases involving reproductive decisions. "Whatever decision she makes or he makes ... it is tough on them, very tough on them."

[10]Sociologists borrowed the concept of code-switching from sociocultural linguistics and have used it to describe how people switch between (and draw on) different language styles, preferences, and attitudes moving from one domain to the next (Blom and Gumperz 1972).

could reach out and touch it." Rather than being troubled or upset by the tension she experienced in figuring out whether and how to code-switch, Lisa built on it later, developing and publishing a ritual for how to do such blessings in the Jewish tradition that would enable others—chaplains, staff, and parents alike—to code-switch a bit as she did.

The more conventional ways chaplains code-switched were particularly evident in their descriptions of how they pray with patients. Many saw prayer as an opportunity for patients and families to grapple with their realities and experiences in the midst of difficult situations. "It is an opportunity for them to name their reality and what's going on in their hearts" and for them to get a "sense of God's presence in the middle of all this stuff," Beth, a Protestant and chaplain in training, explained in an interview. Most chaplains offered spontaneous prayers out loud at the end of their visits with patients that reflected back what they had spoken about during their time together. "Prayer comes out of the visit, regardless of what the faith tradition is," Sarah a Protestant staff chaplain explained, "Prayer is kind of a universal language." Within this universality, though, Sarah recognized that people from different backgrounds have different expectations and norms around prayer and often tried to meet them.

> There are some phrases that I use and I suppose they come out of my own spirituality. But, you know, we pray, depending on the person . . . . if they're charismatic or Pentecostal or something I'm going to pray differently than I normally do. In that case I might pray for the healing light of Jesus to be poured through the patient's body, make them well in body mind and spirit . . . . But if I'm praying with a Catholic patient, they really don't want a lot of elaboration—they want the Lord's Prayer. That's it. Maybe a Hail Mary. And then if you start to say something more it makes them nervous . . . .. But basically I try to figure out what it is on that person's heart that they want to desire or lift up that day and that is what we pray about.

Within her beliefs about the universality of prayer—a belief that neutralizes religious differences—Sarah recognizes that patients and families use various religious symbols and she tries to recognize and mimic those as she code-switches between them, negotiating differences between her own beliefs and practices and those of her patients in the process.

Because many chaplains believe all people are spiritual—or seeking meaning in some way as Pat the Department Director explained—most believe it is possible to pray with anyone as they code-switch and do not find the experience of moving between prayer languages and traditions fragmented. To figure out which codes to switch to they often try to replicate the prayer style of the patient's religious tradition and/or implicitly read people for what pieces of prayer are important to them. "For the Christian patients," staff chaplain Scott—a Catholic—explained, "I'll say the Catholic version of the 'Our Father.' If they're Protestant, I'll say the Protestant version. If I'm with someone who is not religiously centered and is humanistic, I just sort of try to offer them words of peace and comfort. It gets very individual there." Some chaplains will also tailor their prayers to religious stereotypes. In the words of Judy, a Catholic chaplain in training, "If I know someone's Catholic . . . . I would probably bring in Jesus. Sometimes with women more so than men, I may bring in Mary the Blessed Mother just because of that connection of being a woman . . . . I haven't had any Muslim patients but I would probably say something about Allah than calling God by the names that they call him . . . . It's sort of always bringing forth the loving God to each of them."

Chaplains also routinely carry with them items—like rosary beads—used to pray in different religious traditions. As a non-Catholic chaplain prayed with a Catholic patient, it was not unusual to see him or her take out rosary beads as they switched their prayer language to that appropriate for a Catholic patient. At a meeting of Overbrook chaplains, for example, this topic came up and several of the non-Catholic chaplains took rosary beads out of their pockets and put them on the table, demonstrating to others that they carried them with them. The limits of code-switching are also evident here, however, as few chaplains could switch into Hebrew or Arabic to pray with a Jewish or Muslim patient or were familiar with other prayer traditions less common among hospitalized patients.

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Although chaplains often spoke of moving between different tradition-specific prayer languages, it is important to note that they received little training in how prayer styles vary across religious traditions in clinical pastoral education or other training that prepared them to become chaplains. Most learned to code-switch in their day-to-day work, and a number looked on the Internet for information when needed. A Jewish chaplain described learning to pray spontaneously from peers during her chaplaincy training because, in her words, "Jews don't have really a developed tradition of spontaneous prayer." This included learning how to incorporate elements of the patient's religious tradition in the prayer. At the end of a visit she now asks a patient "would it be meaningful to say a prayer together?" If yes, "I will ask either what's the prayer on your heart at this moment or what are the things that you'd like to pray for? And I incorporate those things in ... if it's something that I feel like I can do." Chaplains also describe learning to speak the language of people who are not particularly religious. As Scott explained, when he prays with "someone who's not religiously centered" or "is humanistic" he tries to offer them "words of peace and comfort."

In addition to code switching in prayers and with prayer objects like rosary beads, chaplains from religious minority backgrounds frequently did a kind of code-switching as they introduced themselves differently to patients and families in their own religious traditions. Zoe, a Jewish chaplain, for example, introduces herself as a rabbi rather than a chaplain when visiting with Jewish patients. "Chaplain is not a Jewish word," she explained, "and it has a very different tone." Introducing herself this way, she finds, leads to more of a connection with Jewish patients even if the patient is not particularly religious, "It's a very funny issue .... I think there's more of a sense of connection with the Jewish patient." Aalam, a Muslim chaplain at Overbrook, acts similarly, introducing himself to Muslim patients as an imam because "chaplain is a Christian word." He explains, "when you say chaplain the first thing that comes to their [Muslims'] minds is well, a priest, or a reverend and maybe they're going to convert me ..... I don't need that." While Aalam recognizes that the hospital provides interfaith chaplaincy, he explains: "I don't think they [Muslims] know our policy ... that chaplains are here to provide a kind of service that's not offensive to any religion."[11]

The experiences of Zoe and Aalam point to the limits of neutralizing and code-switching as strategies for dealing with religious differences because even the title "chaplain" has a Christian history and likely sounds Christian to some patients and families, leading them to reject such services. While both Zoe and Aalam work as interfaith chaplains, seeing all of the patients on their assigned units, they also respond to the limits of interfaith chaplaincy by seeking out the few patients at Overbrook who are Jewish and Muslim, respectively. Zoe offers prayers in Hebrew for Jews who would like them and Aalam provides services for Muslim patients, including services for newborn babies. Aalam explained: "It is a kind of very strong position in Islam when a baby is born ... someone gets an imam or father who you know, can call, go to prayer in the right ear .... If the parent made a decision about the name then I give the name of the baby, and then offer some short prayer or recitation of Qu'ran." The experiences of Zoe, Aalam, and other chaplains from religious minority groups illustrate that while the ways in which chaplains neutralize and code-switch in response to religious differences may be effective for some patients and families, they are likely not for others—particularly families that reject the offer of a chaplain, hearing in the title a Christian bent with which they are not comfortable.

Conclusions

Staff chaplains at Overbrook interact daily with patients and families whose religious beliefs, practices, and affiliations are similar to and different from their own. As interfaith chaplains, their

[11] See also Abu-Ras and Laird (2011).

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work is structured in a way that leads them to respond to religious differences on a daily basis, and they have developed various strategies for so doing. When patients and families ask for a chaplain from their own religious background, staff chaplains try to make a referral and locate such a person from among the other staff chaplains or a list of community clergy who make themselves available to the hospital. If patients and families are not asking to be referred or are waiting for the person to whom they were referred to arrive, chaplains seek to neutralize religious differences through broad languages of commonality, spirituality, meaning making, and presence. They learn these languages in clinical pastoral education (CPE), an educational model built around listening without judging and being present (Cadge 2013; Myers-Shirk 2008). They also code-switch—as they are able—to talk or pray with someone in the religious language with which they are familiar. Most chaplains learn to code-switch from patients and families on the job and decide whether to neutralize religious differences or code-switch in the moment, based on the their own religious background, that of the patient or family, and the situation at hand.

The limits to neutralizing and to code-switching are evident at Overbrook most prominently in the experiences of Zoe and Aalam, chaplains from Jewish and Muslim backgrounds. Because the word chaplain and the profession of chaplaincy has Christian roots, some patients and families, as Zoe and Aalam explain, reject offers of visits because they are not Christian and either do not know that chaplains are interfaith or do not wish to be visited by interfaith chaplains who are themselves Christian. Zoe and Aalam respond by introducing themselves as a rabbi and imam, respectively, but patients and families in other minority religious traditions often do not have access to someone in their religious tradition without specifically asking for a referral. Some chaplaincy departments have tried to respond to the limitations of interfaith chaplaincy—and its Christian history—by having long lists of people from other religious traditions (particularly non-Christian traditions) from outside of the hospital available for referrals. More have responded by changing their names from Chaplaincy to Departments of Spiritual Care or Spiritual Care Services in an effort to remove the Christian valence and signal their shifting attention from religion as it was traditionally understood in hospitals to spirituality or broader concerns patients and families have about meaning that they might not explicitly label as religious (Cadge 2013).

Beyond Overbrook, this case study points to the ways religious differences are present and likely managed by chaplains in a broader range of healthcare organization. Chaplains trained in clinical pastoral education are particularly likely to use these strategies, especially that of neutralizing because it is taught in CPE.[12] Analyzing how chaplains respond to religious differences from their positions on the edge of healthcare and religious organizations draws attention to how religion (and increasingly spirituality) is present outside of religious organizations and to how "organization[s] and boundaries of religions are neither normal nor natural and that their relation to each other within various state formations are produced rather than given" (Klassen and Bender 2010:441). Chaplains are the professionals in healthcare positioned to see how and where these religious differences are present and to respond. In so doing, their strategies provide further evidence for the idea that a "universal spirituality" or broader way of making meaning apart from explicitly religious traditions is emerging across institutional sectors (Sullivan 2010). The issue of whether the strategies chaplains are using are secularizing is an important one that scholars will need to investigate with evidence about how chaplains work in a broader range of sectors. Scholars also need additional data from healthcare organizations to evaluate the extent to which the strategies evident here are unique to secular healthcare organizations or, more likely, reflect the professional training of the chaplains in question (Cadge 2013).

To the extent that the strategies evident here are present across organizations in a range of sectors, they provide evidence for what Sullivan calls "areligious secularism" (2009:230). Perhaps

[12]Surveys estimate that about two-thirds of American hospitals include chaplains but the fraction who are trained in clinical pastoral education is unknown (Cadge, Freese, and Christakis 2008).

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better termed *spiritual secularism*, this broad approach to meaning making is particularly evident as chaplains attempt to find a language of meaning while neutralizing religious differences. Additional data from chaplains in a wider range of sectors including corrections, the military, and higher education is needed to confirm or challenge these empirical findings and set the boundaries of their theoretical implications.

We encourage scholars to pursue this comparative work and not to overlook the role of chaplains as people on the edge of religious and healthcare, correctional, university, and other institutions in the process. They are often the people who not only see, but also negotiate, the ways religious differences bump up against one another in organizations. Identifying those bumps as analytic starting points and chaplains as arbiters of religious difference may go far in developing the ways sociologists think theoretically about religion outside of congregations, and in other secular organizations.

References

Abu-Ras, Wahiba and Lance Laird. 2011. How do Muslim and non-Muslim chaplains serve Muslim patients? Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of Religion and Health* 50(1):46–61.

Adding Eid. 2010. Cambridge, MA: The Pluralism Project at Harvard University.

Ammerman, Nancy. 2007. *Everyday religion: Observing modern religious lives*. New York: Oxford University Press.

Angrosino, Michael. 2006. *Blessed with enough foolishness: Pastoral care in a modern hospital*. West Conshohocken, PA: Infinity Publishing.

Barrows, David C. 1993. "A whole different thing": The hospital chaplaincy: The emergence of the occupation and the work of the chaplain. Ph.D. diss, San Francisco. University of California,

Beckford, James A. 2001. Doing time: Space, time religious diversity and the sacred in prisons. *International Review of Sociology* 11(3):371–82.

Beckford, James A. and Sophie Gilliat. 1998. *Religion in prison: Equal rites in a multi-faith society*. New York: Cambridge University Press.

Bender, Courtney. 2003. *Heaven's kitchen: Living religion at God's Love We Deliver*. Chicago: University of Chicago Press.

———. 2010. *The new metaphysicals: Spirituality and the American religious imagination*. Chicago: University of Chicago Press.

Bergen, Doris L. 2004. *The sword of the lord: Military chaplains from the first to the twenty-first century*. South Bend: University of Notre Dame Press.

Blom, Jan-Petter and John J. Gumperz. 1972. Social meaning in linguistic structures: Code switching in northern Norway. In *Directions in sociolinguistics*, edited by John J. Gumperz and Dell Hymes, pp. 407–34. New York: Holt, Rinehart and Winston.

Burchard, Waldo W. 1954. Role conflicts of military chaplains. *American Sociological Review* 19(5):528–35.

Cadge, Wendy. 2009. Religion, spirituality, and health: An institutional approach. In *Oxford handbook of the sociology of religion*, edited by Peter Clarke, pp. 836–56. New York: Oxford University Press.

———. 2013. *Paging God: Religion in the halls of medicine*. Chicago: University of Chicago Press.

Cadge, Wendy, Elaine H. Ecklund, and Nicholas Short. 2009. Religion and spirituality: A barrier and a bridge in the everyday professional work of pediatric physicians. *Social Problems* 56(4):702–21.

Cadge, Wendy and Brian Fair. 2010. Religion, spirituality, health, and medicine: Sociological intersections. In *Handbook of medical sociology*, edited by Chloe Byrd, Allan Fremont, Stefan Timmermans, and Peter Conrad, pp. 341–62. Nashville: Vanderbilt University Press.

Cadge, Wendy, Jeremy Freese, and Nicholas Christakis. 2008. The provision of hospital chaplaincy in the United States: A national overview. *Southern Medical Journal* 101(6):626–30.

Cadge, Wendy, Peggy Levitt, and David Smilde. 2011. De-centering and re-centering: Rethinking concepts and methods in the sociological study of religion. *Journal for the Scientific Study of Religion* 50(3):437–49.

Calhoun, Craig. 2010. Rethinking secularism. *Hedgehog Review* 12(3):35–48.

Chang, Patricia M. Y. 2003. Escaping the Procrustean bed: A critical analysis of the study of religious organizations, 1930–2001. In *Handbook of the sociology of religion*, edited by Michele Dillon, pp. 123–36. New York: Cambridge University Press.

Chatters, Linda M. 2000. Religion and health: Public health research and practice. *Annual Review of Public Health* 21(1):335–67.

Chatters, Linda M., Jeffrey S. Levin, and Christopher G. Ellison. 1998. Public health and health education in faith communities. *Health Education and Behavior* 25(6):689–99.

14685906, 2013, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jssr.12008 by Wake Forest University, Wiley Online Library on [04/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Chibnall, John T. and Christy A. Brooks. 2001. Religion in the clinic: The role of physician beliefs. *Southern Medical Journal* 94(4):374–79.

Demerath, N. J., Peter D. Hall, Terry Schmitt, and Rhys H. Williams. 1998. *Sacred companies: Organizational aspects of religion and religious aspects of organizations*. New York: Oxford University Press.

Ellison, Christopher G., and Jeffrey S. Levin. 1998. The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior* 25(6):700–20.

Flannelly, Kevin, George Handzo, Kathleen Galek, Andrew Weaver, and Jon Overvold. 2006. A national survey of hospital directors' views about the importance of various chaplain roles: Differences among disciplines and types of hospitals. *Journal of Pastoral Care and Counseling* 60(3):213–25.

Flannelly, Kevin, George F. Handzo, Andrew J. Weaver, and Walter J. Smith. 2005. A national survey of health care administrators' views on the importance of various chaplain roles. *Journal of Pastoral Care and Counseling* 59(1–2):87–96.

Galek, Kathleen, Kevin Flannelly, Katherine R. B. Jankowski, and George Handzo. 2011. A methodological analysis of chaplaincy research: 2000–2009. *Journal of Health Care Chaplaincy* 17(3–4):126–45.

George, Linda K., David B. Larson, Harold G. Koenig, and Michael E. McCullough. 2000. Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology* 19(1):102–16.

Goffman, Erving. 1979. Footing. *Semiotica* 25(1):1–29.

———. 1981. *Forms of talk*. Philadelphia: University of Pennsylvania Press.

Grant, Don. 2004. Spiritual interventions: Why, how, and when nurses use them. *Holistic Nursing Practice* 18(1):36–41.

Heclo, Hugh. 2003. *Religion returns to the public square: Faith and policy in America*. Baltimore: Johns Hopkins University Press.

Holst, Lawrence. 1982. The hospital chaplain between worlds. *Health/medicine and the faith traditions*, edited by Martin E. Marty and Kenneth L. Vaux, pp. 293–309. Philadelphia: Fortress Press.

———. 1985. *Hospital ministry: The role of the chaplain today*. New York: Crossroad.

Klassen, Pamela E. and Courtney Bender. 2010. Introduction: Habits of pluralism. In *After pluralism: Reimagining models of religious engagement*, edited by Pamela E. Klassen and Courtney Bender, pp. 1–28. New York: Columbia University Press.

Koenig, Harold, Michael E. McCullough, and David B. Larson. 2001. *Handbook of religion and health*. New York: Oxford University Press.

Lupu, Ira C. and Robert W. Tuttle. 2007. Instruments of accommodation: The military chaplaincy and the Constitution. *West Virginia Law Review* 110(1):167–86.

Messikomer, Carla M. and Willy De Craemer. 2002. The spirituality of academic physicians: An ethnography of a scripture-based group in an academic medical center. *Academic Medicine* 77(6):562–73.

Miller, William R. and Carl E. Thoresen. 2003. Spirituality, religion, and health: An emerging research field. *American Psychologist* 58(1):24–35.

Myers-Shirk, Susan E. 2008. *Helping the good shepherd: Pastoral counselors in a psychotherapeutic culture, 1925–1975*. Baltimore: Johns Hopkins University Press.

Norwood, Frances. 2006. The ambivalent chaplain: Negotiating structural and ideological difference on the margins of modern-day hospital medicine. *Medical Anthropology* 25(1):1–29.

Pierce, Ellie. 2008. *Driven by faith or customer service? Muslim taxi drivers at the Minneapolis-St. Paul International Airport*. Cambridge, MA: Pluralism Project at Harvard University.

Putnam, Robert D., and David E. Campbell. 2010. *American grace: How religion divides and unites us*. New York: Simon and Schuster.

Rhodes, Jeremy. 2011. Choosing sides: An exploration of role conflict among evangelical Democrats. *Sociology of Religion* 72(1):28–49.

Sherkat, Darren E. and Christopher G. Ellison. 1999. Recent developments and current controversies in the sociology of religion. *Annual Review of Sociology* 25(1):363–94.

Sullivan, Winnifred F. 2009. *Prison religion: Faith-based reform and the Constitution*. Princeton, NJ: Princeton University Press.

———. 2010. Religion naturalized: The new establishment. In *After pluralism: Reimagining models of religious engagement*, edited by Pamela E. Klassen and Courtney Bender, pp. 82–97. New York: Columbia University Press.

Sykes, Gresham M. and David Matza. 1957. Techniques of neutralization: A theory of delinquency. *American Sociological Review* 22(6):664–70.

Taylor, Charles. 2007. *A secular age*. Cambridge, MA: Harvard University Press.

Trautner, Mary N. and Samantha Kwan. 2010. Gendered appearance norms: An analysis of employment discrimination lawsuits, 1970–2008. *Research in the Sociology of Work* 20(1):127–50.

Weaver, Andrew J. and Christopher G. Ellison. 2004. Featured CME topic: Spirituality "introduction." *Southern Medical Journal* 97(12):1191–93.

Wuthnow, Robert. 2005. *America and the challenges of religious diversity*. Princeton, NJ: Princeton University Press.

14685906, 2013, 1, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/jssr.12008 by Wake Forest University, Wiley Online Library on [04/11/2026]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License