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Participation in Existential Groups Led by Norwegian Healthcare Chaplains—Relations to Psychological Distress, Crisis of Meaning and Meaningfulness

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ABSTRACT

Spirituality groups led by healthcare chaplains have been found to aid patients' recovery processes in US psychiatric units. In Norway, existential groups (EGs) led by healthcare chaplains and co-led by healthcare staff members are offered at psychiatric units; these groups share commonalities with spirituality groups, group psychotherapy, existential therapy and clinical pastoral care, facilitating patients' reflections regarding existential, spiritual and religious issues. The study aimed to examine associations between patients' participation and topics discussed in the EGs and their experiences of psychological distress, crisis of meaning and meaningfulness. A cross-sectional design was applied among 157 patients attending EGs led by healthcare chaplains across Norway. Multivariate regression analyses assessed the strength of possible associations, adjusted for relevant demographical variables. Significant association was found between lengthier EG participation and lower levels of psychological distress, while discussion topics concerning religious and spiritual issues were significantly associated with the experience of meaningfulness.

Introduction

Spirituality groups led, or co-led, by healthcare chaplains have been employed in treatment programs at various psychiatric units in the United States (Hirschmann, 2011; Jensen et al., 1998; Kehoe, 1998; Revheim et al., 2010). These types of groups commonly combine elements from group psychotherapy, the recovery movement, emotion-focused coping and religious coping (Gangi, 2014; O'Rourke, 1996; Revheim & Greenberg, 2007). Participation in spirituality groups has been shown to have significance for patients' recovery processes (Gangi, 2014; Jensen et al., 1998; Kehoe, 1999; Kidd et al., 2001; Popovsky, 2007), including in comparison to non-attendees (Revheim et al., 2010).

In Norway, healthcare chaplains have the main responsibility for leading existential groups (EG); these are co-led by healthcare staff members and are offered at 49 psychiatric units within Norway's specialist mental health services (Frøkedal et al., 2017). The EGs have integrated a diversity of therapeutic strategies influenced by group psychotherapy, existential therapy and the clinical pastoral care tradition (Frøkedal et al., 2017). The Norwegian EG practice is believed to have evolved from the

chaplain-led spirituality groups in the United States, likely linked to Norwegian chaplains' participation in clinical pastoral care programs (CPE) in the United States from the 1960s onwards (Farsund, 1980, 1982; Høydal, 2000).

Patients suffering from mental illness may at times consider themselves a burden, and believe themselves incapable of making a difference in the life of another (Yalom & Leszcz, 2005). Building on these assumptions, the EG practice is aimed at giving patients the experience of being valuable to others, as well providing a therapeutic safe space in which to explore existential ultimate concerns (Yalom & Josselson, 2014; Yalom & Leszcz, 2005).

The Norwegian EG practice

The arrangement and composition of patients participating in the EGs may vary greatly, depending on the type of unit in which the EG is offered (Frøkedal et al., 2017). For instance, healthcare chaplains will have a different approach to leading an EG at an acute psychiatric care unit compared to at an inpatient unit in a community mental health centre. In general, it can be argued that EGs offered at hospital units entail a more supportive approach from the healthcare chaplains, while EGs offered at a lower care level – such as outpatient units – may have a more explorative phenomenological approach.

The patients participating in the EG practice are invited to share their thoughts, feelings, reflections and personal stories with each other. Common topics of discussion include how to find meaning in life despite illness, how to cope with everyday life and hopes or hopelessness related to mending broken relationships (Frøkedal et al., 2019, 2017). Patients often share their fears around never again being well or able to have a good life; in addition, feelings of loneliness, being an outsider and not belonging in society are also often touched on, as are religious and spiritual issues (Frøkedal et al., 2019). In the EGs, patients are given the opportunity to reflect on their own identity and what it may mean to be a human being in the world.

The EGs are normally offered once a week, with a duration of 45 minutes. While healthcare chaplains have the main responsibility for the EGs, the groups are usually co-led by a psychiatric healthcare staff member in a fixed, random or rotating arrangement. The patients generally negotiate which topics are to be discussed within a group session, although the healthcare chaplains, as group leaders, may also influence the choice of topics. In general, healthcare chaplains lead two or more EGs each, per week. The patients are assigned to a group depending on the unit in which they are hospitalized. In general, patients are not required to have a diagnosis to be included in an EG. Nevertheless, when the group is offered in, for example, a psychosis unit, most patients in the EG have diagnoses tied to this spectrum.

The existential framework of the EG practice

Scandinavia is characterized as one of the most secular areas in the world (la Cour, 2008; la Cour & Hvidt, 2010; DeMarinis, 2006). Consequently, it has been suggested that religious thinking, religious institutions and religious behaviours have changed in these countries, and that an existential framework accommodating existential, religious and spiritual issues is therefore needed (la Cour, 2008; la Cour & Hvidt, 2010; DeMarinis, 2006). As such, the existential dimension in this study is perceived as an overarching concept encompassing secular, spiritual and religious domains (la Cour & Hvidt, 2010; DeMarinis, 2003, 2008). Existential issues from these three domains – concerning beliefs, values and ultimate meaning in human life – have been used interchangeably (Sinclair & Chochinov, 2012). However, existential issues within a secular domain might refer to ultimate concerns in life regarding death, loneliness, freedom and a search for meaning unrelated to religion or a transcendent reality/divine being (Yalom, 1980). Spiritual issues within a spiritual domain may be related to the search for the sacred within a personal context (Zinnbauer & Pargament, 2005); the search for the sacred

unfolding within traditional and organized sacred contexts may, in turn, be understood as belonging within a religious domain (Hill et al., 2000; Zinnbauer & Pargament, 2005).

The existential framework in the present study is understood as existential meaning-making that may be both functional and dysfunctional (DeMarinis, 2003, 2006, 2008). Functional existential meaning-making includes an existential worldview suitable for meeting one's existential needs in life, helping people to function in both their daily lives and in situations of crisis of meaning. The core task of an existential worldview is to provide people with narratives, values and ritual behaviours that function as sources of meaning in times of both hope and crisis. In this context, and following Schnell (2009), we understand "meaningfulness" as a fundamental sense of meaning based on an appraisal of one's life as coherent, significant, directed and filled with a sense of belonging.

Dysfunctional existential meaning-making may be understood as occurring when members of a culture do not have access to the culture's internal and external representations necessary for human development and identity. This can eventually lead to poor mental health, characterized by random or abrupt decision-making, mental paralysis or even identity problems (Bauman, 1998; DeMarinis, 2006, 2008). In this context, and again following Schnell (2009), we understand "crisis of meaning" as experiencing one's life as frustratingly empty, pointless and lacking meaning. According to Schnell (2009), a crisis of meaning might be activated by a disruption of one's sense of coherence, a personal failure, biological threats, threats to the ego or the disorganization of psychological operations.

Context of the study

The Norwegian healthcare system is government-funded and consists of two levels, to which all citizens have access: primary healthcare (community-based) and specialist healthcare. Mental healthcare has been integrated into hospital and community mental health centers organized by 19 (county) health trusts, and includes units for inpatients, outpatients and day patients. In Norway, all healthcare chaplains are funded by the hospitals (Stifoss-Hanssen, Danbolt et al., 2019), and may be defined as a hired professional working with spiritual and existential challenges in institutions like hospitals (Stifoss-Hanssen, Danbolt et al., 2019). The Norwegian healthcare chaplains are, through their educational background, closely tied both to the group psychotherapy tradition and to the CPE tradition (Frøkedal et al., 2017). The Institute of Group Analysis in Oslo has held a central role providing comprehensive, multi-professional education in formal group psychotherapy in Norway, in which Norwegian healthcare chaplains have long taken part (Frøkedal et al., 2017; Island, 1995; Lorentzen et al., 1995).

Relevant research

There is scant literature and research on chaplains' group work in mental health (Gangi, 2014; Kidd et al., 2001; Popovsky, 2007). The existing research shows that these types of groups provide a therapeutic context for examining patients' spiritual dimension, aided by psychological theories, the recovery tradition and the use of narratives aimed at psychospiritual growth (Gangi, 2014; Genia, 1990; Hirschmann, 2011; Jensen et al., 1998; Kehoe, 1998, 1999; Popovsky, 2007; Revheim & Greenberg, 2007). Topics such as love, forgiveness, fear, anger, gratitude or suffering are discussed in the groups (Hirschmann, 2011). Participation in a spirituality-based therapeutic group has been examined compared to nonparticipation among patients hospitalized with schizophrenia (Revheim et al., 2010). Participation was significantly related to the attendees' spirituality status, compared to non-attendees. No differences were found between the groups for self-efficacy or quality of life. However, group attendees were significantly more hopeful compared to non-attendees, and hopefulness was significantly associated with their degree of

spirituality. The findings lend support for offering spirituality groups and positive coping throughout patients' recovery from psychiatric disabilities.

Correspondingly, little research exists on the EGs led by Norwegian healthcare chaplains (Frøkedal et al., 2017). However, research has shown that the EG practice draws on psychodynamic, narrative, coping, system-centred and thematic approaches, in which the psychodynamic approach seems to be the most prominent (Frøkedal et al., 2017). Improving one's life reflection, gaining acceptance regarding one's illness, getting to know oneself, and improving one's relationships were shown to be core aims within the group practice. Working in the here and now and using narratives were further reported to be core therapeutic strategies within the EGs (Frøkedal et al., 2019, 2017).

A recent qualitative study that explored EGs led by Norwegian healthcare chaplains from a patient perspective found that several patients experienced their participation in the EGs as positive – moreover, they reported increased self-reflection, learning new skills, strengthening self-confidence, and reducing loneliness as added values of participation (Frøkedal & Austad, 2019). The EGs were also described by patients as providing religious and spiritual growth and enhanced existential reflection (Frøkedal & Austad, 2019).

Religious and spiritual factors in psychotherapy groups have shown to be poorly conceptualized, making it difficult to conclude what, precisely, influenced the outcome of the therapy (Viftrup et al., 2013). Addressing religious and spiritual issues in group psychotherapy is often reported to be difficult and uncomfortable (Wade et al., 2014). However, when religious transformation in group psychotherapy is addressed, it may enhance mental health, both from a perspective of meaning systems and religious development (Viftrup et al., 2016).

Participation in these types of groups has also been found to strengthen participants' motivation to participate in psychotherapy (Viftrup et al., 2013). Research on psychodynamic groups integrating existential, religious and spiritual issues with a one-year follow-up design has revealed that participation significantly reduced symptoms and improved patients' relational patterns (Stålsett et al., 2010, 2012). A qualitative study on group therapy for patients suffering from chronic mental illness (Johnson, 1997) reported that it was important for patients to be given a space in which to discuss existential issues and fears in life. In this study, participants also reported renewed strength from battling with their existential struggles in group therapy.

Previous research indicates inconsistency concerning the relationship between gender and meaningfulness. Some studies have reported higher meaning among men (Orbach et al., 1987), while others have found higher meaning among women (Mascaro & Rosen, 2008; Reker, 2005) or no differences between the genders (Martela & Steger, 2016). It has also been argued that meaning in life, understood as a sense of coherence, develops through life stages and becomes stable after the age of 30 (Antonovsky, 1987). However, when tested, sense of coherence was equally stable both below and over the age of 30 (Feldt et al., 2003). Other studies have reported meaningfulness to be lowest in adolescence, and high and stable between ages 35 and 60, after which it remains at a high level (Damásio et al., 2013; Schnell, 2009). A relationship between crisis of meaning and age has not been identified (Schnell, 2009).

Aim of the study

Limited knowledge exists concerning either participation or topics discussed in spirituality groups in psychiatric units, and specifically in the EG practice within psychiatric units in Norway. With this background, the present study aimed to examine possible associations between patients' participation in EGs and the topics discussed and their experiences of psychological distress, crisis of meaning and meaningfulness.

Firstly, it was hypothesized that there would be a statistically significant association between lengthier EG participation and lower levels of psychological distress in the sample. Secondly, it was hypothesized that there would be a positive statistically significant association between the EG

discussion topics: coping, existential concerns, meaning-giving activities and religious and spiritual issues, and the experience of meaningfulness.

Materials and methods

Design

The study was designed as a nationwide, cross-sectional study to examine patients' participation and the topics discussed in the EGs offered through Norway's specialist mental health services.

Sampling procedure and participants

All patients participating in the 49 EGs offered through Norway's specialist mental health services (Frøkedal et al., 2017) who were able to give their consent were invited to participate in the study by the healthcare chaplains and co-leaders at each psychiatric unit offering EGs. The recruitment was done in 2016. Due to patient vulnerability, the recruitment period lasted for three months at each of these units.

In total, 157 patients completed the questionnaire. The participants' characteristics are shown in Table 1. Together, they represent 44 existential groups offered through 10 Norwegian health trusts.

Measures

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

Table 1. Characteristics of the study participants (N = 157), clinical unit and diagnostics group, EG participation, EG discussion topics, experience with group therapy and estimated number of participants in each EG (N = 49).

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

*Note: EG: Existential group; CMHC: Community Mental Health Center; EG discussion topics comprise 24 topics grouped into four dimensions.

EG discussion topics

The selection of EG discussion topics employed was based on topics previously applied in pastoral care sessions in Sweden (DeMarinis, 2003), and Norway (Grung et al., 2016; Stifoss-Hanssen, Grung et al., 2019). The selected topics were meant to cover a broad spectrum of patients' existential meaning-making, encompassing existential, religious and spiritual issues (DeMarinis, 2003, 2006, 2008). Possible items were presented to an expert panel – which included a psychiatrist, psychologist, psychiatric nurse and theologian possessing knowledge in the fields of group psychotherapy, psychiatry, psychology, clinical psychology of religion and clinical pastoral care – according to guidelines for item development and construct assessment (Jansen & Hak, 2005; Presser & Blair, 1994).

The selected items were then tested among 16 key informants in a web-based survey and the first author conducted individual cognitive interviews with each of these informants (Frøkedal et al., 2019). Following Beatty and Willis (2007), the interviews collected “additional verbal information about the survey responses, which was used to evaluate the quality of the response or help determine whether the question was generating the information that its author intends” (Beatty & Willis, 2007, p. 287). The cognitive interviews included techniques such as “thinking out loud” and “verbal probing” (Ryan et al., 2012). On this basis, items and topics were revised and new topics added by the expert panel with regard to construct validity.

A list of 24 EG discussion topics was ultimately included in the present study (Frøkedal et al., 2019). Based on the expert panel's assessment of relevant topics, the cognitive interviews, theoretical background and prior research, the 24 EG discussion topics were grouped into four dimensions by the expert panel. Participants were asked to answer “yes” or “no” to each item and identify whether the topic had been discussed in their EG. For each dimension scores were created by adding together item scores.

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

Meaningfulness (five items) and *crisis of meaning* (five items) were measured by two scales from the Sources of Meaning and Meaning in Life Questionnaire (SoMe) (Schnell, 2009; Schnell & Becker, 2006). *Meaningfulness* is defined as a fundamental sense of meaning and measures the degree of subjectively experienced meaningfulness. *Crisis of meaning* measures the degree of emptiness and a frustrated will to meaning. The items were rated on a six-point scale of agreement (0 = totally disagree, 5 = totally agree). The SoMe questionnaire has recently been validated in Norway (Sørensen

et al., 2019). In the present study, the reliability of the sub-scales was $\alpha = 0.88$ for meaningfulness and $\alpha = 0.92$ for crisis of meaning, respectively.

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

The demographic variables and variables concerning participants' characteristics are displayed in Table 1.

Data analysis

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

To assess the external validity of the questionnaire, a confirmatory factor analysis using principal component analysis and an Oblimin rotation was performed (Field, 2009). The proposed four domains explained 50.3% of the variation in the original data. All the items loaded most on one domain, which also confirmed that all the items covered one underlying construct. Further, a majority of the items loaded highly on the anticipated domains, thus confirming the underlying structure.

Three multivariate regression analyses were performed to assess possible associations between patients' EG participation, the EG discussion topics and patients' experience of psychological distress, crisis of meaning and meaningfulness, adjusted for selected demographic variables.

A block-wise regression analysis was chosen as we wished to demonstrate how selected groups of variables (blocks) were associated with the outcome. In addition, we also estimated how much additional variance was explained by these blocks. In Block 1, EG participation and the EG discussion topics of religious and spiritual issues, existential concerns, meaning-giving activities and coping were analyzed. In Block 2, age groups, gender, level of education and work status were added to adjust for possible confounders.

Assumptions in the linear regression analysis regarding normality, linearity, homoscedasticity and multicollinearity were adequately met (Field, 2009). Missing data were replaced with the person mean score of the variable when missing one answer (three cases) (Ruel et al., 2016) and removed when missing more (seven cases). All analyses were performed using SPSS version 25.0. The significance level was set at $p \leq .05$.

All the analyses were considered exploratory, so no correction for multiple testing was performed.

Ethical considerations

Informed consent was obtained from the participants. The Regional Committee for Medical Research Ethics in Norway approved the study (# 565978). Only patients with the ability to grant consent were included in the study.

Results

Psychological distress

A statistically significant negative correlation was identified between EG participation and lower levels of psychological distress (-0.25) (not shown).

A statistically significant negative association was found between EG participation and lower level of psychological distress in Block 1 ($B = -1.17$, 95% CI $[-2.33; -0.01]$) (See Table 2). This association

Table 2. Summary of block-wise regression analyses depicting associations between EG participation, EG discussion topics and psychological distress, crisis of meaning and meaningfulness (N = 157), also adjusted for selected background variables.

	Block-wise Regression				Final model			
	R ² *	B	95% CI	p-value	R ²	B	95% CI	p-value
A) Psychological distress	.10				.43			
Block 1								
EG participation		-1.17	-2.33; -.01	.05		-1.07	-1.99; -.14	.03
EG discussion topics: Religious and spiritual issues		-.53	-1.73; .66	.38				
EG discussion topics: Existential concerns		-.01	-.77; .76	.99				
EG discussion topics: Meaning giving activities		-.75	-1.91; .40	.20				
EG discussion topics: Coping		.06	-.92; 1.04	.91				
Block 2	.41							
Gender		.72	-1.39; 2.82	.50				
Age-group		.22	-.78; 1.21	.67				
Education		.33	-1.88; 2.55	.77				
Work-situation		-.58	-2.04; .87	.43				
Crisis of meaning		1.77	.94; 2.60	<.001		1.61	.83; 2.40	<.001
Meaningfulness		-2.36	-3.29; -1.42	<.001		-2.33	-3.23; -1.43	<.001
B) Crisis of meaning								
Block 1	.02				.35			
EG participation		-.03	-.26; .19	.77				
EG discussion topics: Religious and spiritual issues		-.07	-.30; .16	.56				
EG discussion topics: Existential concerns		-.01	-.15; .14	.92				
EG discussion topics: Meaning giving activities		-.06	-.28; .16	.59				
EG discussion topics: Coping		.01	-.18; .19	.95				
Block 2	.38							
Gender		-.17	-.57; .23	.40				
Age-group		.11	-.08; .30	.26				
Education		-.13	-.55; .29	.55				
Work-situation		-.05	-.32; .23	.74				
Psychological distress		.06	.03; .10	<.001		.06	.03; .10	<.001
Meaningfulness		-.38	-.57; -.20	<.001		-.38	-.57; -.20	<.001
C) Meaningfulness								
Block 1	.12				.48			
EG participation		-.05	-.24; .15	.64				
EG discussion topics: Religious and spiritual issues		.27	.06; .47	.01		.18	.02; .34	.03
EG discussion topics: Existential concerns		.03	-.10; .16	.63				
EG discussion topics: Meaning giving activities		.04	-.16; .23	.70				
EG discussion topics: Coping		.05	-.11; .22	.53				
Block 2	.43							
Gender		-.02	-.37; .33	.91				
Age-group		.21	.04; .37	.01		.16	.03; .29	.01
Education		.01	-.36; .37	.98				
Work-situation		-.08	-.33; .16	.49				
Psychological distress		-.07	-.09; -.04	<.001		-.06	-.09; -.04	<.001
Crisis of meaning		-.29	-.43; -.15	<.001		-.28	-.41; -.15	<.001

Note: Bold values are $p < .05$, CI = confidence interval. *Explained variance

also remained statistically significant when adjusted for selected statistically significant demographic variables, crisis of meaning and meaningfulness in Block 2 (B = -1.07 , 95% CI [-1.99 ; $-.14$]).

Crisis of meaning

No statistically significant associations were identified between EG participation, EG discussion topics and crisis of meaning in our data.

Meaningfulness

The four EG discussion topics were positively and significantly correlated with meaningfulness; coping (.20), existential issues (.22), meaning giving activities (.23), and religious and spiritual issues (.32) (not shown). Age and meaningfulness were also positively and significantly correlated (.23) (not shown).

A positive statistically significant association was identified between EG discussion topics concerning religious and spiritual issues and the experience of meaningfulness in Block 1 ($B = .27$, 95% CI [.06; .47]) (See Table 2). This positive association also remained statistically significant when adjusted for selected statistically significant demographic variables, crisis of meaning and psychological distress in Block 2 ($B = .18$, 95% CI [.02; .34]). Furthermore, a positive statistically significant association was revealed between age and meaningfulness in Block 1 ($B = .21$, 95% CI [.04; .37]) and also remained statistically significant when adjusted for other selected statistically significant demographic variables in Block 2 ($B = .16$, 95% CI [.03; .29]).

Discussion

Lengthier EG participation was significantly associated with lower levels of psychological distress in the present study, in line with the first hypothesis. There are several ways one might interpret this finding, however. It may be interpreted according to findings from the United States (Gangi, 2014; Genia, 1990; Hirschmann, 2011; Jensen et al., 1998; Kehoe, 1998, 1999; Popovsky, 2007; Revheim & Greenberg, 2007). Revheim et al. (2010) found that a higher level of spirituality was related to higher levels of hopefulness among patients attending spirituality groups compared to non-attendees – although no differences were found regarding spirituality status related to self-efficacy and quality of life. Also, Revheim et al. (2010) examined only patients diagnosed with schizophrenia, which makes it difficult to compare their findings with those of the present study, as it included patients at various kinds of psychiatric units. Nevertheless, Revheim et al.'s (2010) findings may point to a difference between the spirituality groups in the United States and the EG practice in Norway. It might be that the aim of psychological growth is more emphasized in EG groups in Norway, while in the US there may be a stronger interest in spiritual (or religious) growth? This emphasis of psychological growth, in turn, may be explained by the close connection between the Norwegian healthcare chaplains and the group psychotherapy tradition in Norway (Frøkedal et al., 2017; Island, 1995; Lorentzen et al., 1995). The secular Scandinavian culture may also partly explain the difference (La Cour, 2008; La Cour & Hvidt, 2010; DeMarinis, 2006), although this bears further investigation.

Another possibility might be to view the above finding against the background of the integration of religious and spiritual issues into psychotherapy (Viftrup et al., 2013). For instance, patient participation in these types of groups has been shown to strengthen motivation to participate in therapy (Viftrup et al., 2013), and to provide renewed strength in life (Johnson, 1997). A reduction of symptoms and improvement of patients' relational patterns has also been seen (Stålsett et al., 2010, 2012). In comparison, increased self-reflection, learning new skills, strengthening of self-confidence, and reduced loneliness have been reported by both patients (Frøkedal & Austad, 2019) and clinical staff (Frøkedal et al., 2019) as added values when participating in EGs. However, it is difficult to compare findings from the present study with group psychotherapy that integrates existential, religious and spiritual issues, owing to the differences in research design and outcome variables applied in the various studies.

It could also be reasoned that the relationship between lengthier EG participation and lower psychological distress in the present study reflects the fact that the patients received other treatment that could have influenced their experience of lower levels of psychological distress. Nevertheless, the finding is still argued to be relevant because of the identified commonalities between the EG practice and other therapeutic traditions (Frøkedal et al., 2017). Interestingly, the present study identified that

nearly half of the patients had not participated in any form of group therapy before the study (see Table 1). In light of this, the EGs might be seen as a door-opener to other types of group therapies for some of the patients.

Discussion topics in the EGs concerning religious and spiritual issues were found to be positively and significantly related to the experience of meaningfulness. This was the only dimension in line with our second hypothesis. This hypothesis was based on previous research showing that EGs may provide space for patients' existential meaning-making using a diversity of therapeutic strategies across the EGs, where existential, religious and spiritual issues were included (Frøkedal & Austad, 2019; Frøkedal et al., 2019, 2017).

This finding might correspond to findings of prior studies, in which participation in spirituality groups in the United States was positively related to patients' recovery processes (Gangi, 2014; Jensen et al., 1998; Kehoe, 1999; Kidd et al., 2001; Popovsky, 2007). Higher levels of hopefulness have also been identified among patients diagnosed with schizophrenia participating in a spirituality group (Revheim et al., 2010).

The relationship between discussion topics concerning religious and spiritual issues in EGs and the experience of meaningfulness may also be viewed in light of religious coping and its significance in times of crisis (DeMarinis, 2013; DeMarinis et al., 2011; Emmons, 2005; Lilja et al., 2016; Pargament, 2001; Sørensen et al., 2015). For instance, patients diagnosed with a substance-use disorder have reported spirituality and religious activity to contribute to their existential meaning-making and their rehabilitation processes (Sørensen et al., 2015). Furthermore, it has been shown that mental illness can be interpreted through an existential framework formed by the patients' relationships with God (Lilja et al., 2016). Also, when comparing the present findings with studies employing the SoMe to investigate meaningfulness and sources of meaning, our findings may resonate well. In these studies, explicit religiosity and spirituality were amongst those sources of meaning that were significantly associated with the experience of meaningfulness (Damásio et al., 2013; Schnell, 2009; Sørensen et al., 2019).

We also found a positive significant relationship between age and meaningfulness in the present study. This finding might be viewed against the background that older people have identified religious activities, self-transcendence and tradition as important sources for perceiving their life as meaningful (Reker & Wong, 1988). Likewise, studies employing the SoMe suggest that older people tend to be more affiliated with sources of meaning like self-transcendence and order or tradition, compared to younger people (Damásio et al., 2013; Schnell, 2009). However, the finding in the present study may be challenging to interpret because sources of meaning in the SoMe related to meaningfulness were not measured. In further investigations, sources of meaning should therefore be included when examining meaningfulness, to enable comparison of findings with those of other studies. It would then be interesting to look more into whether a sense of coherence among a clinical group of patients might be viewed as a stable trait (Antonovsky, 1987) or as a dynamic orientation (Feldt et al., 2003). No association between meaningfulness and gender was reported, in agreement with the findings from a previous study (Martela & Steger, 2016).

Strengths and limitations

The main strength of the present study is its inclusion of patients from nearly every EG led by healthcare chaplains in Norway, many of whom were considered to be in a vulnerable situation, suffering from mental illness.

Diagnosis, interpersonal problems and functioning were not measured, representing a potential limitation, as this makes it difficult to compare findings with those of other studies including these variables. Patients are most often assigned to the EGs through staff at the unit in which they are hospitalized. Although diagnoses are not measured, units providing the EGs (such as inpatient, substance abuse, psychosis and affective units) might comprise patients with a wide spectrum of diagnoses.

A second limitation is that the response rate of the study could not be accurately determined, as the healthcare chaplains did not register the number of patients they had invited to participate; as such, we have no way of knowing how many patients dropped out or elected not to participate. However, we need to bear in mind the vulnerable position of the target population, who were hospitalized and suffering from mental illness. In the present study, one-third of the sample (50 patients) were hospitalized at the highest care level (Table 1), indicating that they were suffering from severe mental illness. To accommodate for this, healthcare chaplains across all the EGs estimated that about 252 patients participated in the EGs each week. In our sample, we included 157 participants which constitutes 62% of the anticipated number of possible participants and thus a satisfactory response rate. Therefore, we consider our study to be representative for the targeted patient population.

Third, there might have been a selection bias in that the healthcare chaplains and co-leaders invited the patients and were also involved in receiving the completed forms and questionnaires. This may have influenced the patients' responses, making them more positive toward participating and responding. On the other hand, all the patients were invited to participate. They filled out the questionnaire individually and returned them in sealed envelopes.

The present study was considered exploratory, as it was the first of its kind in Scandinavia. As such, the significance level was set to $p < .05$, which represents another potential limitation.

Finally, other types of treatment that the patients received during their hospitalization were not registered, which makes it difficult to interpret the identified association between lengthier EG participation and lower levels of psychological distress.

Conclusion

The study is the first in Norway to examine possible associations between participation and the topics discussed in EG practice and the experiences of psychological distress, crisis of meaning and meaningfulness. The study was conducted among a clinical group of patients ($N = 157$) in Norwegian specialist mental health services who attended EGs led by healthcare chaplains. Findings demonstrate a statistically significant relationship between lengthier EG participation and lower levels of psychological distress. Further, discussion topics in the EG concerning religious and spiritual issues were significantly related to the experience of meaningfulness. Lastly, a significant relationship between age and meaningfulness was identified.

Future directions

The cross-sectional design of this study did not permit us to determine the causal relationships among the variables assessed. Future studies applying a longitudinal design allowing the identification of causal relationships are therefore warranted.

In this study, we chose to omit diagnosis measures because assignment of a patient to an EG does not usually require this information. It should be recognized that this aspect may affect a lower threshold for patients to try out this type of group within a treatment setting. However, including diagnosis in future studies could be an advantage permitting to compare findings with group psychotherapy that integrates existential, religious and spiritual issues.

In the present study, it was identified that nearly half of the patients participating the EGs had no previous experience with group therapy. A primary goal for groups provided at inpatients psychiatric units has been described to create an inherent wish for the patients to continue with group therapy after the hospital discharge (Yalom & Leszcz, 2005). In the future it would be of interest to explore this phenomenon and if EGs might function as door-openers to group therapy in general.

Our findings may point clinicians and researchers toward the importance of creating spaces for existential meaning-making – including space for the discussion of religious and spiritual topics – and conducting further research in this field.

Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data is not available.

Contributions

Study design: HF, HSH, TR, VD, AV, and TS; data collection: HF and HSH; data analysis: HF, HSH, TR, VD, AV, and TS, and manuscript preparation: HF, HSH, TR, VD, AV, and TS

Disclosure statement

The authors do not have any conflicts of interest in the preparation of the paper.

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