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Leder / Editorial
Chaplaincy – temanummer om institusjonsprestetjeneste

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Praktisk teologi har tradisjonelt vært langt mer opptatt av prestetjeneste i menighet enn i offentlige institusjoner. I dette temanummeret gir vi et bidrag til å balansere dette, av særlig to grunner:

For det første er det viktig å ha oppdatert kunnskap om et omfattende område av prestetjeneste og kirkelig nærvær i samfunnet, nemlig prestetjeneste i institusjoner. Artiklene i denne utgaven gir en oversikt fra Norden og Nederland med tanke på praksis og organisering, historie, teologi og utdanning.

For det andre får artiklene frem hva som er aktuelle utfordringer i dag, bl.a. endringer i befolkningssammensetningen mot større mangfold i kultur, tro og livssyn og økt spesialisering slik som i helsetjenestene og stramt fokus på økonomi. Hva er kvalitetene ved institusjonsprestetjeneste, som gjør at den trengs i årene fremover – kanskje mer enn noen gang? Og hva slags krav stilles til fag og profesjonalitet og evne til tilpasninger for å kunne bidra med åndelig og eksistensiell omsorg i systemer der evidens og spesialisering er førende begreper? Dermed handler ikke artiklene utelukkende om én bestemt type prestetjeneste, men gir innblikk i det som er utfordringer for *all* prestetjeneste, og kirkene overhodet, i Nord-Europa i dag – men som kanskje settes på spissen og blir tydeligere i det som internasjonalt kalles "*chaplaincy*".

I dette temanummeret brukes betegnelsen *chaplaincy* om hele den profesjonelle tros- og livssynsrelaterte betjeningen i institusjoner. *Chaplain* fungerer som et samlebegrep for prester, diakoner, filosofer, humanister, imamer, rabbinere osv., som arbeider som profesjonelle samtalepartnere i ulike offentlige institusjoner. I Norden er det store flertallet av *chaplains* prester som er ordinert i landets dominerende lutherske folkekirke, men det er også i gang et arbeid for å integrere personell med annen tros- og livssynstilknytning som *chaplains*. Eksempler på dette er i forsvaret, ved enkelte sykehus og i fengslene. Det innebærer eksempelvis at PKU (Pastoral-klinisk utdanning) for forsvaret nå er livssynsåpent, og på TF (Teologisk fakultet, Universitetet i Oslo) er det startet en livssynsåpen masterutdanning som sikter mot kvalifisering for *chaplaincy*. Det er derfor grunn til å ha det økende tros- og livssynsmangfoldet inne som en viktig del av bildet.

Noe av det særegne ved *chaplaincy* er at denne tjenesten for det første er knyttet til spesifikke institusjoner, eksempelvis et sykehus, som i prinsippet betjener hele befolkningen, og for det andre har tilknytning til ulike religiøse og livssynsrelaterte samfunn som kun en større eller mindre andel av befolkningen hører til i. I Norden er det de gamle lutherske folkekirkene som har dominert, og fortsatt dominerer, denne yrkesgruppen med spesialprester i sykehus, forsvaret, fengsler og universiteter. I Norge er 70 % av befolkningen medlemmer i Den norske kirke. Også internasjonalt er *chaplains* i stor grad

knyttet til ulike tros- og livssynssamfunn, men man ser også at profesjonelle som gir åndelig og eksistensiell omsorg, deler en felles profesjonell identitet med fokus på tro, søken etter mening og etikk, noe blant annet Hetty Zock drøfter i sin artikkel i dette nummeret.

I praksis betjener *chaplains* personer som kan tilhøre andre tros- eller livssynssamfunn enn sitt eget. Det er også tilfelle for menighetsprester – de har sjelesorgsamtaler med folk med ulike tros- og livssynstilhørigheter, ikke kun folk fra egen menighet. Men når det kommer til rituelle praksiser, kan behovet for religiøst eller livssynsmessig samsvar komme i forkant. Sjelesorg både i institusjoner og i lokalsamfunn har utviklet seg i retning av mer diakonal omsorg med vekt på å gi hjelp til å arbeide med en rekke eksistensielle temaer relatert til tro, håp, død, liv etter døden, sykdom, relasjoner til andre, ensomhet, gudsbilder, tilgivelse osv. I det danske bidraget i dette nummeret gis det resultater fra forskning som viser at hva det snakkes om i sjelesorg, varierer med hvor alvorlig sykdommen er: Uhelbredelig syke pasienter snakker mer om tro, håp og spørsmål om liv etter døden, mens pasienter med mindre alvorlige lidelser snakker om temaer som ensomhet og relasjoner til andre, identitet og mening (Se mer om dette i artikkelen til Thomsen m.fl.). Vi kan ane en utvikling av sjelesorg både i lokalsamfunn og i institusjoner fra en "religiøs modell" i retning av hva vi kan kalle en "eksistensiell modell" der spørsmål om tro og bruk av religiøse ritualer kan høre med, men ikke nødvendigvis (Se mer om dette i artiklene til Stifoss-Hanssen m.fl. og Thomsen m.fl.). Dette er en utvikling som i økende grad stiller krav til kompetanse som samtalepartner om eksistensielle temaer, og kanskje åpner det for at *chaplains* kan ha en løsere tilknytning til trossamfunn. Vi mangler kunnskap om hva som er f.eks. sykehusphresters primære identitet i spennet mellom kirke og helseinstitusjon (Se mer om dette f.eks. i bidraget fra Finland, Saarelainen m. fl.).

Den doble tilknytningen er uten tvil viktig for *chaplaincy*. Prester er symboler for den kirken de assosieres med og de tradisjonene, tekstene, ritualene og symbolene som folk forbinder med denne. Dette er noe av prestetjenestens egenart i befolkningen som også spiller en viktig rolle i institusjonsprestetjeneste. Dette er på lignende vis i andre religioner og livssynssamfunn som pasienter har tilhørighet til. Professor og overlege i Oslo Universitetssykehus (OUS), Vegard Bruun Wyller, gir i en artikkel et eksempel på hvordan en muslimsk familie fikk støtte og hjelp gjennom religiøs tro og bruk av ritualer etter en ung gutts lengre sykeleie og død. Det var et stort spørsmål etter åndelig og eksistensiell støtte, og spørsmålet om Gud var påtrengende i det som Wyller betegner som et ensporet teknologisk sykehus. Han refererer til guttens muslimske far som "syntes vi var absurd sekulære, til tider kyniske, i vår holdning til liv og død. Han ønsket å finne Gud på hospitalet – men alt han fant var maskiner" (Tidsskr. Nor. Legeforen. 2015; 135: 507).

I dette temanummeret har vi i utgangspunktet alle former for *chaplaincy* i tankene; det vil si både i forsvaret, utdanningsinstitusjoner, fengsler osv., men det meste av referansene vil gjelde *chaplaincy* i helseinstitusjoner siden dette tjenestefeltet er mest utforsket og også representerer den største andelen av *chaplains* i de involverte landene. Men håpet er at dette temanummeret også kan ha relevans for *chaplaincy* i andre sammenhenger – og også ha overføringsverdi til prestetjeneste i lokalsamfunn.

Med unntak av denne innledende artikkelen har vi valgt å utgi hele dette temanummeret av TPT på engelsk. Det er fordi det vil bli lest av kollegaer i Finland og Nederland og andre steder. Slik sett er dette nummeret et bidrag til nordeuropeisk utvikling av *chaplaincy*. Norden og Nederland har mange fellestrekk med tanke på velfungerende velferdsstater og stabile økonomier og politiske systemer. Mellom de nordiske landene er det også mange fellestrekk ved at de har gamle majoritetskirker som fortsatt størstedelen av befolkningen tilhører, men samtidig økende pluralisering når det gjelder religion, livssyn og kultur.

Et fellestrekk er også økende andel innbyggere i de nordiske landene som ikke har noen tilknytning til et registrert tros- eller livssynssamfunn. Tallet på "*nones*", altså personer uten slik tilknytning, nærmer seg 20 % i Norge. I Nederland er antallet "*nones*" hele 68 %. Vi vet lite om de som

får den litt underlige betegnelsen "*nones*", men trolig er de en stor blanding av folk der noen er uten religiøs tilhørighet, andre tilhører uregistrerte trosfellesskap, noen er eksistensielt eller livssynsmessig likegyldige, og noen kan være assosiert med ikke-religiøse livsynsgrupper, men uten medlemskap. Disse utgjør altså to tredeler av befolkningen i Nederland, og det kan kaste lys over at også en økende andel *chaplains* i helseinstitusjoner mangler religiøs tilknytning.

Som vi har vært inne på, er det mange fellestrekk mellom de nordiske landene når det gjelder religion og livssyn, men vi ser forskjellige modeller for finansiering og organisering, og ulike teologiske strømninger har virket inn på institusjonsphresters rolleforståelse og på hvordan relasjonen mellom prestenes to tilhørigheter, *kirken* som de har sin ordinasjon fra, og *institusjonen* de betjener, forholder seg til hverandre. Ulik historie har ført til ulike løsninger, og dette virker inn på om *chaplains* betraktes som helsepersonell eller ikke, noe de etter loven ikke er i noen av disse landene, men kanskje likevel i praksis overfor pasientene. Det er noen gråsoner i dette landskapet, som artiklene bidrar til å belyse.

Artiklene i dette temanummeret er resultat av arbeidet i en forskningsgruppe (*Research on Chaplaincy – "ReChap"*) med forskere fra Norden og Nederland. Først presenterer vi artikler fra hvert av de fem landene der det gis oversikter over feltet, historie, teologi, kvalifikasjoner og aktuelle utfordringer for hvert av landene. Fra Norge kommer i tillegg en artikkel som særlig går inn på problemstillinger som henger sammen med behovet for *chaplaincy* med andre utgangspunkt for tro og livssyn enn Den norske kirke (Grung & Bråten). Samlet sett belyser disse artiklene interessante strømninger som har preget feltet, og vi får innblikk i faglige diskurser, eksempelvis om hva som kjennetegner åndelig og eksistensiell omsorg, se bidragene fra Danmark (Thomsen m.fl.) og Sverige (Rydinger & DeMarinis).

De siste artiklene i dette nummeret gir eksempler fra forskningen på *chaplaincy* fra både Norge (Frøkedal & Austad) og Nederland (Muttert m.fl.), og en artikkel drøfter muligheten for systematisk pasientorientert kvalitetsvurdering av *chaplaincy* (Visser).

Det skjer mye og god forskning og fagutvikling på feltet, og det er lite tvil om at kunnskapsgrunnlaget for *chaplaincy* er i ferd med å bli grundig styrket. I så måte er Norden del av en tydelig internasjonal satsing på kvalitetsarbeid, noe som ikke minst det europeiske nettverket *Erich (European Research Institute for Chaplains in Healthcare)* er eksponent for. Dette lover godt for den faglige og profesjonelle utviklingen, rolleavklaring og yrkesidentitet. Utfordringene framover ligger i rammebetingelser som økonomi og kutt i budsjetter, men også i nye krav til kompetanse og kunnskapsbasering av tjenesten og det å kunne ivareta endrede behov relatert til religiøse og kulturelle endringer i befolkningen. Det er ingenting som tyder på at behovet for åndelig og eksistensiell omsorg er blitt mindre med årene, og vi har stor tro på at *chaplaincy* – om enn på litt endrede og fornyede måter – vil ha store og viktige oppgaver i helse- og andre institusjoner i årene framover.

Bakerst i dette nummeret trykkes en norsk oversettelse av sammendragene for alle artiklene.

God lesning!

Editorial
Chaplaincy – how and why?

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Chaplaincy – professional spiritual and existential care in institutions – has a long tradition, but it is changing at a fast pace. What do the identity and role of the chaplains entail today? And how do secular healthcare systems and increasing pluralisation in society affect chaplaincy? In this special volume we will focus on chaplaincy in five Northern European countries with a similar cultural background, providing an updated report for each country and discussing relevant issues in the field. The primary focus is on health care chaplaincy, but hopefully the volume also will have transferability to chaplaincy in other institutional contexts such as prisons, the army and universities.

Pastoral care is probably the least documented area in practical theology. This is due to the confidentiality surrounding these practices and the lack of reports and recordings from what pastoral caregivers actually do. Thus, a good deal of the knowledge and disciplinary development of these practices has been built on anecdotal information. This is in the process of changing, and the number of international studies in pastoral care in local communities as well as in institutions is increasing (Galek et al., 2009; Stifoss-Hanssen et al., 2019). A recent Danish study (referred to in this volume by Thomsen et al.) shows that patients of all ages consult chaplains during hospitalisation about existential, spiritual and psychosocial themes, as well as issues on dying and death, disease and health. This corresponds with what was found in studies on community pastoral care in Sweden (DeMarinis, 2003) and in Norway (Grung et al., 2016). Also, it is seen that incurably ill patients were more likely to talk about spiritual issues related to hope and afterlife, while other patients were more likely to talk about existential experiences of loneliness, identity and meaninglessness (See Thomsen et al. in this volume). This is recognisable for all of us who have practiced as chaplains in hospitals.

Changing societies – changing practices

We address chaplaincy in four Nordic countries (Denmark, Finland, Sweden and Norway) and the Netherlands. The four Nordic countries share similar religious histories, characterised by close connections between state and church since the Reformation. The Lutheran Folk Churches remain dominant, with membership between 60–70 % of the respective populations. It is highly interesting to include the Netherlands

in this volume, as there are many similarities between the Nordic countries and the Netherlands when it comes to political and financial stability, well-functioning welfare models and highly specialised hospital systems. On the other hand, the Netherlands is a more pluralised society with no majority denomination, and as many as 68 % of the population have no affiliation to a registered faith- or worldview community, so-called "nones". The number of "nones" also increases in the Nordic countries, with Norway approaching 20 %. In the Netherlands an increasing number of chaplains have loose or no denominational affiliation as well. The spiritual caregivers share a common identity across religious demarcations, as professionals with focus on meaning, belief systems and ethics (See Zock's article in this volume).

This development is interesting and raises some questions: What happens if the chaplains no longer carry a symbolic representation of religious affiliation? What does it mean if chaplains instead represent themselves and a professional pool of spiritual caregivers? And is it so that the professional spiritual caregivers are welcomed in the healthcare – as well as in other public institutions – no matter if they carry a faith- or worldview representation or not? In Norway the preconditions for faith community independence are possible, as long as the hospitals are hiring and paying the chaplains. This is also the case in the Netherlands. However, in the other Nordic countries the health care chaplains are hired by churches or other faith- or worldview communities, which also is the case for prison chaplains in Norway.

The elephant in the room

There is an increasing focus on person-centred care, and the focus on religious, spiritual or existential care is explicit in some parts of health care, as, e.g., in palliative care. Furthermore, the issue of spiritual care is more and more often addressed in different areas of medical treatment. Professor Vegard Bruun Wyller, physician at Oslo University Hospital (OUS), gives an example in an editorial article in a leading Norwegian medical journal. He tells the story of a seriously ill boy from a Muslim family for whom he had the medical responsibility. He writes that the boy's father in periods was very frustrated, not only about his son's sickness; he disliked what Wyller calls the hospital's technological one-sidedness: "He thought we were absurdly secular, sometimes cynic, in our attitudes towards life and death. He wished to find God in the hospital – but all he found was machines," Wyller writes, stating that the talk of God is the "elephant in the room", acknowledged by different kinds of believers, as well as non-believers. For a physician it seems to be "harder to address a patient's personal faith life than her personal sex life," as Wyller frames it. Being the physician in charge for the young boy's treatment, he witnessed the religious ceremonies after he died. It was "a strong demonstration of collective faith and reconciliation with a hard fate". Wyller states that it is unprofessional not to identify the elephant, especially in a society characterised by increasing religious and worldview heterogeneity, concluding that existential questions can and should be touched upon in the doctor–patient relationship (Wyller, 2015).

Similar stories have been witnessed in many hospitals, and very often chaplains are working closely with families from different cultures and worldview communities. Recently the hospital in Oslo where Wyller works, OUS, celebrated 100 years of hospital chaplaincy, and many other well-established hospitals in Northern Europe have similarly long histories of chaplaincy. There is a long history of spiritual and existential care in hospitals, and it can be argued that chaplaincy is more integrated than ever. Chaplaincy has no doubt been increasingly professionalised, and if we paint the development broadly there is a reason for arguing that it has moved from a "religious model" towards what can be called an "existential model" of care (See Stifoss-Hanssen et al. in this volume).

Chaplaincy in secular contexts

The Nordic countries and the Netherlands are in many studies regarded to be the most secularised in the world. This makes sense if the proof of secularity is the prevalence of regular church attendance or faith in God. Only 10–15 % of the Nordic population responded that they "know

without any doubt that God exists", versus 61 % of the population in the US, according to the International Social Survey Programme from 2008 (la Cour, 2014). That could indicate that the Nordic countries are more secularised than the US.

However, when including responses on more open questions like "I believe in some kind of higher power" or "I have some doubts, but still I feel like I believe in God" some two out of three of the Nordic populations have an open attitude towards the existence of a supreme being (la Cour, 2014). Furthermore, religion and spirituality are more than belief systems. They also include ritual practices, emotional experiences, values and function. Ritualising is an example of an existential meaning-making activity that has increased abundantly, not at least in the wake of disasters and other deeply moving experiences (Post, 2015; Danbolt & Stifoss-Hanssen, 2017). Furthermore, to a huge extent people use the churches for passage rituals, e.g. still more than eight out of ten of the funerals are performed by the dominant folk churches in the Nordic countries. This makes it likely that many of the persons who are hospitalised or in prison probably have experiences from ritual practices with the national churches or other denominations. It is not unreasonable therefore to regard Nordic religiosity to be occasion related. For many persons issues of God and other religious matters are not very prominent in their daily lives, but when something profoundly disturbing happens in life, an existential crisis might occur making the need for meaning intrusive. For many persons, pastoral care consultations and different ways of ritualising are available and used means for spiritual or existential meaning-making.

It can be argued that ways of spiritual meaning-making are not contradictory to secularity. Peter Berger regards religion as a human enterprise used for making a holy cosmos in chaos (Berger, 2011). This is a more fruitful setup than placing the sacred in opposition to the secular. People live secular lives, and it is within the structures of secularity that there sometimes are intrusive needs to make sense of what happens and for establishing a holy cosmos in chaotic situations, as might be the case when life takes an unexpected turn. However, it is not necessarily so that patients experience conversations with a chaplain at a hospital as a religious activity, and as seen in the recent Danish study, in more than half of their conversations, chaplains did not make use of particularly religious means like rituals, prayer etc. (See Thomsen et al. in this volume).

Chaplain identification – what to identify and how

A basic task for spiritual care has been the delimitation of its area. For a long time in the research world, spirituality, especially in North American studies, has been linked to the religious perspective. However, in pace with increasing secularisation over the last few decades the area has increasingly been related to the European existential tradition, based on existential psychology, philosophy and theology. One has searched for a universal, broad definition that includes both religious and non-religious perspectives (McKee & Chappel, 1992; Swift, 2014; Thierfelder, 2017). Spirituality has been linked to a person's "purpose in life", "connection to something greater than oneself" (Meisenhelder, 2006), or to "perceived meaning", "hope" (Breitbart, 2002). Although the current view is that spiritual care covers a broad spectrum of religion, private faith, and existential perspectives, some important differences between North American and European traditions can still be seen. (See the European Association for Palliative Care and "The National Consensus Project for Quality Palliative Care", Van de Geer et al., 2011).

If one starts from the phenomenological perspective where it is evident that secular people think of existence with the help of both secular, spiritual and religious terms (la Cour & Hvidt, 2010), it is then well motivated to have a complex understanding of where the spiritual and existential areas overlap and the choice of an overall term relates to cultural logic, interpretation preferences and also the influence of different language (Note for example spiritual health in England and existential health in the Nordic countries). Regardless of whether one claims

that spiritual needs include existential issues, or vice versa, it specifically means that the scope of chaplaincy is extended and that both researchers and chaplains are interested in getting more comprehensive information about every patient's thoughts and needs. Here, however, challenges arise in the meeting between chaplains and nursing staff. Since spiritual care is very much based on hospital referrals and interactions, the views of other professionals, as well as patients and relatives, on what is identified or included are important as well. The perceptions vary depending on the professional group and between staff and patients/relatives. In an American study (Galek, 2009) of over 58,000 chaplain visits in the New York area, it was found that health professionals made the most referrals, and generally the reasons for these included emotional expressions, such as anxiety, anger, dissent; rarely were religious needs identified. In cases where patients and related persons referred, the case was the reverse. In order to be able to work with spiritual needs in a more systematic and comparable way, over the last 20 years instrument development for screening and assessment has been in focus, having the dual purpose of better helping the patient and enabling communication of ideas and assessments between different professions (Mundle & Smith, 2013).

In these studies, however, it has been found that assessments can vary widely even between different groups of chaplains. In a study where three chaplain groups with different church backgrounds and education reported on 30.700 visits, it was found that the results of the assessments depended on which group of chaplains performed such, so that they were on the border of predictable (Montonye & Calderone, 2009). Based on these results, it was important to ask whether identification is more a reflection of the chaplain's needs than of the patient's. Intercultural aspects must be considered as well. In a study examining 33 Muslim and non-Muslim chaplains' offerings of spiritual care to Muslim patients in 40 New York hospitals (Abu Ras & Laird, 2011), it was found that whereas the non-Muslim chaplains had a strong belief in their ability to relate to Muslim patients' reference frameworks and to identify needs of all patients irrespective of religious tradition, Muslim chaplains, however, identified a multitude of needs in Muslim patients not identified by the non-Muslim chaplain group.

Handling of cases – isolated efforts or care plans, process or results and documentation

When it comes to managing the needs chaplains identify, challenges are raised about a common terminology for defining work areas, approaching goals, and/or establishing targets for work management and how such management is documented. All of this also concerns the relation to other health care professions, since the ambiguities surrounding these areas make communication with staff more difficult. Efforts have therefore been made to produce an empirically substantiated "standard terminology" that can be used by chaplains in different contexts. In a North American study (Massey et al., 2015) more than 400 different concepts were collected that were linked to chaplains' handling of cases. These were reduced to 100 concepts, which in a second phase of the study were tested in daily activity routines. Through this study it became evident that the concepts associated with management need definition and categorisation because they include a mixture of concrete actions, methods, expressions of goals or desirable results. Secondly, it became evident that a categorisation led to chaplains becoming more accustomed to regarding their activities in a larger perspective and creating a "spiritual care plan" instead of seeing their contributions as single, isolated efforts.

Another important area concerning the management of the patient's needs concerns documentation. Already in 2009, the Association of Professional Chaplains decided that clinical documentation would become a "standard of practice" in emergency care in order to better communicate the chaplain's activities to large care teams. The Association for Clinical Pastoral Education emphasises that chaplains must provide clear, accurate, professional communication that effectively documents their contribution to the right place of care. While staff can the-

reby see that chaplains provide a unique contribution to care, it has been found that the information is often not clinically relevant in the sense that it contributes to improving patient care. In a study from several intensive care departments at a university hospital in the United States, the documentation made by 152 different patients was analysed in the hospital's Electronic Medical Record system (Lee et al., 2016). Here it was found that the information given was not in accord with the given protocol used by the staff. There was a noted lack of a spiritual assessment and spiritual treatment plan for a better understanding of the patient's needs, resources or expected outcomes. There was also a passivity regarding follow-up. However, the documentation provided insights related to the dynamics of relationships in the patient's family, or between families and the medical team. The authors indicate that the study showed the need for a standardisation of chaplaincy documentation, especially since all the top-rated hospitals in the US provide chaplains access to the medical record system.

Chaplain and Health Care Team – Important Aspects of a Functional Role

As proper identification and management of patient needs is closely linked to the health care staff's understanding of the role of chaplains, many chaplain organisations have emphasised that chaplains must understand their professional role and know how to work effectively as part of a multidisciplinary team (Cf. ACPE, Association for Clinical Pastoral Education). For the team to work, not only the right mix of knowledge and skill is needed, but also an understanding and appreciation of each other's competencies. Studies have shown that there are major challenges. In a national US survey study involving more than 1,500 chaplains, physicians, nurses and social workers, a coherence between chaplains' and staffs' perceptions about more traditional functions such as work with grief and death, prayer and emotional support emerged, but that both physicians and social workers and to some extent also nurses had a limited understanding of the chaplains' further competence and education (Flannelly et al., 2009). However, in cases where chaplains had established co-operation with the interdisciplinary care teams, it was found that there was a more diverse understanding of the function of chaplains and that teamwork had contributed to mutual respect for and integration of each other's competencies. In a US study with chaplains and physicians at 8 different Paediatric Palliative Care programs (PPCs), it was found that the health care professionals in the teams had a positive view of how chaplains dealt with basic "spiritual suffering", offered rites, improved care in various ways, assisted communication between family and staff, and also contributed to the staffs' resilience by providing a sense of security and competence (Fitchett et al., 2011). A striking difference, however, was the different perspectives on what was considered important knowledge to convey about spiritual care, while chaplains tended to focus on the actual work process, the physicians were instead interested in how the chaplain's work could contribute to good results.

Since teamwork has a positive effect on the health care staff's understanding of the chaplain's competence, studies highlighting strategies that can strengthen the chaplain's legitimacy have been conducted. A Canadian in-depth interview study at 9 different hospitals with 21 spiritual care providers and volunteers stressed strategies that were aimed at creating a presence and making themselves visible (documentation, social time with staff, accessibility, clarification of the business boundaries). In contact with heads of operations and hospital administration, the strategies dealt with giving concrete examples of what the work contained, providing empirical material that showed how inclusion of spiritual care positively influenced care, and a philosophical perspective for linking the activity to some form of a holistic view of the patient (Pesut, 2012).

Central issues for professional chaplaincy

Specialised chaplaincy education and training, such as the CPE programs (Clinical Pastoral Education), have contributed to the professionalising of chaplaincy during the recent decades. Together with a significant increase in interna-

tional research this has given way for setting high standards for chaplaincy, but there seem to be some of the same challenges for chaplaincy practice as seen in the research documented above.

First, there is a need for delimitation, exploring the relationships between religious and secular anchoring of chaplaincy. Who is the chaplain, where does he/she belong, and for whom and for what purpose is this practice? Does the chaplain's religious/worldview background matter? Is it so that chaplains with similar background as the patients' can identify more issues than others; cf. the study by Abu Ras & Laird (2011)? And if so, does religious homogeneity make the chaplain blind to other important issues that could have been highly relevant to address? And whose needs determine the themes to be talked about: The patients' or the chaplains'? This relates to the chaplain's understanding of his/her role and identity.

Second, who provides the referrals to chaplains? As shown in a Danish study (See Thomsen et al. in this volume), about half of the initiatives for conversation is taken by patient (42 %) or his/her relatives (16 %), while health care professionals count for 32 % of the referrals and 10 % is initiated by the chaplain. This might indicate that the chaplain partly runs his/her own business within the system. Another question regarding these, relates to access to journal systems and documentation of the chaplaincy practices. Here the question of confidentiality is an issue, but also the rather strict EU-GDPR (European General Data Protection Regulation) which in fact makes it problematic for chaplains to have their own notes or recordings on information about patients.

Third, questions relating to implementation and inter-disciplinary work in hospitals point to not only documentation, but probably also to a standard terminology for communicating how colleagues with different skills, education and backgrounds can work together in teams and to share and/or plan goals for appropriate treatment. As shown by Fitchett et al. (2011), while chaplains focused on the actual work process, physicians seemed to be more interested in the results of the chaplains' contributions. Related to this, the issue of assessment tools and plans for treatment and care are raised. How can chaplains contribute to well-functioning treatment plans for spiritual and existential care? In the Nordic countries an aspect of this is the need for cooperation across care levels (specialist health care and municipality health care) as pointed to in the (Norwegian) governmental Cooperation Reform (St. Meld. 47).

Fourth, the professionalising of chaplaincy and spiritual/existential care in institutions calls for continuous work on knowledge development and research. The present volume of this journal is a contribution to this, based on work from a Northern-European research group in chaplaincy studies (ReChap). This is a part of a bigger effort in European and American research on spiritual and existential care in institutions. Over the last twenty years, the body of theoretical and empirical chaplaincy research has expanded greatly (Poncin et al., 2019). Here the European Research Institute for Chaplaincy in Healthcare (ERICH), founded in 2000, must be noted. A current ERICH project concerns a spiritual Patient Reported Outcome Measure (PROM) to research the impact of chaplaincy interventions on patient wellbeing in six different European countries (cf. Visser's article in this volume).

Preview

The articles in this volume document the state of the art in chaplaincy in the Nordic countries and the Netherlands, especially related to history, organisation, theology, education and research. Contemporary challenges are discussed, such as the increasing pluralisation and secularisation of society happening simultaneously with an increased interest in and deeper understanding of the importance of existential meaning-making processes for wellbeing, and the ongoing changes in the health care systems with enhanced demands for professionalisation and specialisation.

Common to all the countries focused on here, is that they are secular welfare states with hospital systems characterised by an intention of serving the entire population with what is called evidence-based treatment, in somatic as well as

in mental health care. This requires high professional standards in diagnostics, treatment and care – including spiritual care. We present examples of research such as in the article by Muthert et al. on a Dutch case study project in healthcare chaplaincy, and in Frøkedal's & Austad's paper on existential groups led by chaplains. Visser discusses in her article how patient-reported outcome measures (PROM) can be useful in healthcare chaplaincy to get information about patients' experiences.

In line with Don Browning we regard practical theology as "*the disciplines that study the caring, preaching, worshiping, and teaching tasks of the church with real people in their actual lives*" (Browning, 2006:85). As such we regard research on what is at stake for institutional spiritual and existential care as an example of empirical research and knowledge development in practical theology.

The volume will highlight central issues, but we are aware that it does not provide exhaustive answers to all the challenges in this area. Yet this volume can help elucidate the status of chaplaincy in the Nordic countries and the Netherlands and contribute to practical theological research and professional development in the field of spiritual and existential care.

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VITENSKAPELIG / PEER REVIEWED

Chaplaincy in the Netherlands. The search for a professional and a religious identity[1]

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ABSTRACT

This article presents an overview of the state of chaplaincy in the Netherlands. It sketches the history, religious and theological climate, training, organisation, and current practice. Two important recent developments are discussed: The rise of nondenominational spiritual care, and spiritual caregivers becoming involved in community care. Spiritual care in the Netherlands has gone through a long process of professionalisation, in which the relationship between the chaplain's professional and religious identities had to be continually redefined. It is argued that although Dutch spiritual care is still organised denominationally, spiritual caregivers share a common professional identity as professionals who focus on the search for meaning, belief systems, and ethics.

KEYWORDS

Professionalisation, religious identity, pillarisation, nondenominational spiritual care, community care

> *Spiritual care is professional support, guidance and consultancy regarding meaning and belief systems. Spiritual caregivers enter the scene at times when the routine of normal daily life is disrupted: in situations of life and death, parting and loss; when there is an intense sense of belonging, or abandonment; or when moral dilemmas present themselves. They are experts in dealing with existential questions, questions on the meaning of life, spirituality and ethical considerations.*
>
> VGVZ Professional Standard (Dutch Association of Spiritual Caregivers), 2015, p. 5

INTRODUCTION

Chaplains in the Netherlands are working as employees in healthcare institutions, the military, and the judiciary, and for the past 20 years also as self-employed professionals.[2] Providing spiritual care for people in public institutions is considered to be a public task, and – as in Norway but unlike Denmark, Finland, and Sweden – is financed by the state. However, because of the separation of church and state, organisation and content of spiritual care and the education of those who provide it is seen as the primary responsibility of the churches and other worldview organisations, together with the professional organisations. The presence of chaplains in public institutions is based on the Dutch Constitution, which guarantees freedom of religion and worldview (art. 6).[3] This means, for instance, that every person who resides in an institution such as a hospital, a prison, or the armed

forces for more than 24 hours should have free access to spiritual care, "without control or approval by any third party". This is called the "sanctuary function" of the chaplain (referring to the old practice of people being able to take refuge in churches).[4] In healthcare, professional chaplains have been present since 1970, in the judiciary since 1950, and in the military the first chaplains started some 100 years ago in World War I.

The position of chaplains in healthcare is somewhat different from those in the military and the judiciary. In this article I will focus on healthcare chaplaincy – not only because it is the biggest group of chaplains (around 1,200; there are 150 in the military and 137 in the judiciary), but also because here the process of professionalisation that started in the 1960s, and the impact of the changing religious landscape and societal developments are most clearly visible.

The history and transformation of chaplaincy in the Netherlands is best illustrated by the history of the VGVZ, the Dutch Association of Spiritual Caregivers, which was founded in 1971. At the moment the VGVZ has about 1,000 members. Originally, it was a professional organisation for chaplains in care institutions, but since 2015 it has also been open to spiritual caregivers from other settings – although its Professional Standard (2015)[5] still focuses on chaplains in healthcare. The VGVZ has always played a key role in the professionalisation of Dutch chaplains, and serves as a lobby and pressure group.

Definition and domain: Meaning and belief systems

The Dutch term for chaplain is *geestelijk verzorger,* "spiritual caregiver". "Spiritual" (*geestelijk;* cf. the German *Geist*) is an ambivalent term in Dutch, because it has associations with both the religious, clerical field and that of mental health care.[6] The VGVZ clarifies "spiritual" as pertaining to "the human desire to derive meaning from and assign meaning to life, which expresses itself in an active appreciation of life and a quest for connection and orientation" (VGVZ Professional Standard, 8). Hence, spiritual care is defined as "the professional support, guidance and consultancy regarding meaning and belief systems" (VGVZ Professional Standard, 5). Thus, the term meaning (the search for meaning, meaning-making) is central in this definition. The notion indicates the more active, informal and individual aspects of how people search for orientation and meaning in life. "Meaning" is specified as having four dimensions: Existential (pertaining to existential experiences in everyday life and contingent experiences), spiritual (pertaining to transcendental[7] meaning and experience), ethical (pertaining to values, norms, and responsibility) and esthetical (the formative experiences of beauty in nature and culture).[8] The term belief systems (*levensbeschouwing* – worldview, philosophy of life) stands for the reflective/substantive, formal and collective/social aspects of meaning, as embodied in for instance religious and other worldview traditions.[9]

An individualised and de-institutionalised religious climate

It is important to note that the definition given above phrases the profession's domain in general, formal, non-substantive terms rather than religious, theological, pastoral-care language. The definition aims at encompassing all different views of life. This is typical of spiritual care in the secularised, multicultural Netherlands. At the moment only 32 % of the population have an affiliation with a religious or other worldview organisation (Bernts & Berghuijs 2016).[10] However, the 68 % "nones" may be religious/spiritual too: There is much religion and spirituality outside the churches.[11] We see a decline of the established churches, next to a great deal of free-floating spirituality ("new spirituality"). So, religion is to a high degree individualised and de-institutionalised. Spiritual caregivers have had to adapt to this development, and in the process their own religious identity has always been a relevant but highly contested issue.

Preview

First, I will sketch the history of the profession since the 1960s and the societal context in which it arose and was able to develop in its present form. Second, the theological context will be discussed briefly. Third, two recent develop-

ments which have had great influence on the identity, organisation, and practice of present-day spiritual care in the Netherlands will be presented: the turn to nondenominational spiritual care, and the increasing stress on community care/extramural care. I will then discuss current organisation and practice, the required qualifications and training, and present some earlier research on the subject.

HISTORY AND CONTEXT[12]

The 1960s and 1970s: Becoming a care professional; de-pillarisation and the start of professionalisation

The actual position of the spiritual caregiver in Dutch healthcare institutions can only be understood against the background of the so-called *pillarisation*: the organisation of Dutch society in "pillars" (streams) based on religion or worldview. Each pillar (Protestant, Catholic, socialist) had its own schools, hospitals, etc. Until the 1960s, Protestant ministers and Catholic priests/rectors delivered pastoral care in confessional hospitals but were not in the employ of these institutions. They were "guests" representing the churches (either paid or as volunteers).[13] In the confessional care institutions, then by far in the majority, a Protestant minister or Catholic rector/priest often had a seat on the board.

In the 1960s the pillarisation system began to collapse, and in 1969 the pillarised structure of the hospital organisations was disappearing. Protestant and Catholic hospitals merged into public hospitals, working together under the umbrella of the Dutch Council for Hospitals (*Nationale Ziekenhuis Raad,* NZr). The new healthcare structure constituted a challenge for the organisation and identity of the spiritual caregivers. A NZr report stated that pastoral care should be regarded an integral part of hospital care, in which patients' needs should be central rather than a missionary message. Spiritual caregivers were supposed to work for all patients who ask for "spiritual help", not only for those belonging to their own faith/worldview group (NZr, 1974). Integration started at academic hospitals, which organised the different chaplains together in ecumenical and later interreligious "Spiritual Care Services" (*diensten geestelijke verzorging*); other hospitals followed the example.

This was an important turning point: spiritual care was now considered a public service provided by the welfare state, and not primarily the responsibility of the churches. The traditional role and function of pastors in hospitals changed accordingly. Although the chaplains were also office holders on behalf of their own religion/worldview institution, a professional orientation was already visible currently. The importance of paying attention to "the context of ultimate meanings and concerns" for care and wellbeing was emphasised.[14] So, already in the 1970s spiritual caregivers were supposed to work as integrated staff members – for the wellbeing of all patients and the hospital care, rather than and not primarily from the perspective of their own religion/philosophy of life and worldview institutions. This also explains the long tradition of the "territorial approach" – where the wards are divided among the spiritual caregivers, instead of their working along confessional lines – although patients can always ask for a spiritual caregiver of their own denomination.[15]

In 1971 the Protestant and Catholic associations of spiritual caregivers together founded the VGVZ (then called the Dutch Association for Spiritual Care in Hospitals), which was also open to Jewish and humanist spiritual caregivers. In 1975 a "non-church sector" was established for humanist chaplains; their aim was to offer care to patients who were not members of a church. In 1980 the humanist sector of the VGVZ was established, and in 1990 the Jewish sector. Later, when the Netherlands became culturally more varied, Muslim, Hindu and recently Buddhist sectors were established, and finally in 2015 a nondenominational sector.

Since the 1980s the professional orientation has become even stronger, and the impact of spirituality on health and wellbeing grew increasingly more important for legitimatising and positioning spiritual care. The role of the spiritual caregivers' own worldview had to be addressed in new ways again.

The 1980s and 1990s: Threats, consolidation, and further professionalisation

In the 1980s the position of spiritual caregivers was questioned again – induced by budget cuts and increasing secularisation. Why should spiritual care be financed publicly? Why should churches not partly pay for the costs of spiritual care? Do not religious practices belong primarily to the private sphere? In the political struggle between Christian and secular political parties about the state financing religious practices such as spiritual care, the CIO (*Contact in Overheidszaken*, Interdenominational contact for governmental affairs) played an important role. In 1987, the NZr found a compromise: The spiritual caregiver should be both a professional and endorsed by[16] a religious or other worldview institution.

Thus, the organisation of spiritual care has been ambiguous until today. On the one hand it is seen as a religious activity: Chaplains are supposed to be office holders as well as staff members, their expertise and legitimation coming from their respective worldview organisations. The old pillarisation structure is still visible: All worldview pillars should be represented, and the proper character of the various denominations should be kept. On the other hand, a clear professional orientation can also be discerned. Spiritual caregivers are supposed to be embedded in the staff ("integrated"), for the benefit of both the care institution and the patients. Yet they are supposed to have "their own authentic spirituality, which they actively maintain, and which constitutes the foundation of their work" (VGVZ Professional Standard, p. 6). This double identity, professional and religious, has frequently led to tensions. For instance, spiritual caregivers may hesitate to share information in multidisciplinary teams, because of the confidentiality linked to the sanctuary position. Also, conflicts with managers and care staff may arise when spiritual caregivers criticise non-patient centred treatment or technocratic management.

It was not only the organisation but also the daily work practices that changed in the 1980s and 1990s. Spiritual caregivers began to contribute to the education of care professionals (for instance giving clinical lessons) and were involved in moral counselling, ethics committees, and the like. The increasing religious diversity led to multicultural, interreligious, and even supra-religious spiritual care being developed. Quality management and improvement became an important issue in healthcare, and this raised the question what competencies to require from chaplains (Smeets 2006). The process of professionalisation was also enhanced by the demand for accountability, evidence-based working methods, and managerial efficiency.[17]

Overall, in the 1980s and 1990s we see a consolidation of the position of spiritual care. Moreover, the spiritual care profession became less denominationally centred and more oriented towards competence and professional development.

THEOLOGY

A consequence of the pillarised religious organisation of spiritual care is, ironically, that there is no joint theological underpinning of the profession, as already appears from the general phrasing of the profession's identity. Each worldview sector of the VGVZ, though, has its own particular theological and/or philosophical inspiration for the work. Notwithstanding the theological variety, there is one theologian who has been hugely influential in the Netherlands since the 1940s: Karl Barth. This may be the reason for the rather ambivalent attitude of Dutch spiritual caregivers towards psychology. Barth's focus on the "otherness" of God led to a distrust of looking at the human foundation of faith. Although since the 1970s psychodynamic knowledge and techniques introduced by the Clinical Pastoral Education movement have been part of the training of spiritual caregivers, there has long been a mistrustful attitude towards a psychological approach and the use of therapeutic techniques.[18] It was argued that spiritual care is radically different from therapy, which is methodical and goal-oriented, leaving insufficient room for the revelatory presence of God in human interactions. This idea also explains the resistance towards pastoral diagnostics and the like (Bouwer 1998).[19] The theological/philosophical motivation for and underpinning of spiritual care was

found in religiously inspired humanity and solidarity – talking to the patient as a fellow human being. Inspirational sources range from Augustine, Thomas Aquinas, Luther and Calvin to Martin Buber and Emmanuel Levinas, Hannah Arendt and Martha Nussbaum, Thomas Halik, Christian Wiman, and Alain de Botton. Until very recently, the theories most frequently used were Rogerian counselling and the so-called "presence approach" promoted by Andries Baart, who emphasised "being present" as the most important method for spiritual care.[20] At the moment, the discussions about psychology and spiritual care have become much more nuanced, and spiritual caregivers use psychological methods and theories more freely.

RECENT DEVELOPMENTS (2000 – present)

Non-denominational spiritual care

The highly individualised and de-institutionalised religious climate in the Netherlands has greatly influenced the organisation and content of spiritual care. Spiritual needs and practices vary widely and are often not recognised; they remain under the surface. A new language and different, more "general", inclusive rituals (such as alternatives for weekly Christian services) had to be developed. Religious services in the care institutions usually have an ecumenical or a general, supra-confessional character, and focus on spirituality and the search for meaning, borrowing liberally from various traditions. The hospital chapels changed into supra-confessional and general "rooms of silence" (Holsappel-Brons 2010), where Christians, Muslims etc. could feel at home, as well as "nones" who want to meditate, burn a candle, or just sit there for a while.

The changing religious climate has also affected the spiritual caregivers themselves: The link with their traditions and institutions became less important, and more and more spiritual caregivers did not want "official" endorsements, because they no longer felt at home in their church or considered their membership irrelevant for their work as chaplain. Moreover, their employers – this applies to care institutions, not the military and the judiciary – often did not require such an endorsement, and traditional chaplaincy services such as official religious services, blessing of the sick, and baptism were less asked for. Further, the number of chaplaincy students enrolled in confessional programs decreased whereas a growing number of students wanted to train for chaplaincy, but not in a confessional program leading to an endorsement. These students may consider themselves Christians, humanists, Buddhists, etc., or see themselves as drawing from different traditions at the same time. They may either have been raised in a religious tradition or not, and either have a religious/worldview affiliation or not. Around 2000, the first academic programs for non-denominational spiritual care were developed.[21]

A problem was that these new spiritual caregivers were not allowed to become members of the VGVZ, which required an official endorsement for membership.[22] The average age of the VGVZ members rose, while the number of non-denominationally working spiritual caregivers increased rapidly.[23] In 2008 the VGVZ established an "Endorsement Committee", and later the so-called *Regiegroep* (steering committee) to solve this issue. The Regiegroep consisted of representatives from the field of spiritual care and the endorsing institutions. Their task was to develop an organisational structure in which the "spiritual competency" of chaplains could be guaranteed (next to a master degree, which guarantees the other competencies), and the sanctuary position and the legal underpinning of the profession could be safeguarded as well. In 2015 a solution was found: A Council for Non-Denominational Spiritual Caregivers (RING-GV) was established to test "spiritual competency", comparable to the testing of Protestant, Catholic and humanist graduates by religious institutions. Since then, the VGVZ requires for membership either an endorsement by a religious or worldview institution, or a "mandate" by RING-GV. A new worldview sector was established: the SING (Sector for Institutionally Non-affiliated Spiritual caregivers). This new "pillar" (it is in fact an ironic remnant of pillarisation) has grown rapidly in four years and now constitutes 20 % of the VGVZ members.

So, since 2015 nondenominational spiritual caregivers can become members of the

VGVZ.[24] We may conclude that the professional identity of the spiritual caregiver in the Netherlands is gradually changing from primarily a religious office holder endorsed by a religious/worldview community and providing religious care, to a specific healthcare professional specialised in meaning-making and belief systems (Zock 2008). However, the discussion about nondenominational spiritual care is still going on. Research needs to be done about the spiritual/worldview background of the nondenominational spiritual caregivers (which is highly varied), how it is being maintained, and what role it plays in the daily work.

Spiritual caregivers in community care

As in other countries, in the Netherlands we see an increasing decentralisation of healthcare. A 2015 act makes municipalities responsible for the distribution of care.[25] The idea is that the patient is treated and cared for at home and if possible, not being interned in a hospital, a nursing home or another care facility. This applies to the care for the elderly and people with chronic diseases (fast-growing groups), but also for palliative care (for patients dying at home or in a hospice instead of in a hospital) and for psychiatric patients. In brief: there is a shift from intramural to extramural care. Regarding the necessary specialised care, there is an increase of outpatient clinics and transmural care.

In the extramural and transmural care, spiritual care does not have a structural place yet. People dealing with serious life problems, illness, and death, or with handicaps at home do not have access to spiritual care. In the multidisciplinary teams in towns and cities there is no spiritual caregiver, and most of the people do not belong to a religious community and hence have no access to pastoral care.

The decentralisation of care has been accompanied by enormous budget cuts, especially in nursing homes and psychiatric hospitals. Many spiritual caregivers lost their job and became entrepreneurs in extramural settings. They work as self-employed professionals, but also together in independent practices ("centres for life questions"), and collaborate with general physicians, organisations for home care, local communities, palliative teams, churches, and volunteer organisations.

The background to this decentralisation is a financial one, but it is also related to a new philosophy of care, focusing on the needs of the patient as a person, in his/her specific context. Further, a new view on health is embraced: health is no longer defined as the absence of symptoms or disease, but as *positive health*; i.e. the ability to adapt and self-manage (Huber 2014).[26] This new philosophy is linked to dominant cultural values, such as autonomy, being able to participate in society, and the ability to cope for oneself.

The new care philosophy and community care do not always work out well. The process of decentralisation of care is still in its infancy, and there are many people who are left by the wayside. Yet the concepts of person-centred care and positive health fit in with what spiritual caregivers have always being doing in hospitals: assisting in handling life crises, dealing with existential questions, and finding spiritual sources for coping. So, they can form alliances and help develop good extramural care.

There are about 70 private, independent spiritual care practices now. They offer individual guidance, group work, advice and training of care professionals. However, financing is a problem, because spiritual care has not yet been integrated into the extramural care system. The constitutionally based regulation that every person who is staying in a public institution (such as a care facility) for more than 24 hours is entitled to spiritual care, does not apply here. Spiritual care is reimbursed by some health insurance companies but is not included in the Health Insurance Act.

The present Dutch government recognises the value of spiritual care in the home environment. In 2018, the ministry of Health, Welfare and Sport (VWS) has decided that spiritual care should also be available for people at home, and that it should be financed and become an integrated part of extramural care. The ministry has made available 15 million euros to get this implemented, starting with the palliative care and the care for the elderly. This means that the self-employed spiritual caregivers – working inde-

pendently, organised in centres or transmurally from hospitals – can get paid for their services to patients and for educational and advisory services to care professionals. The two-year program will be evaluated and a new financing system for spiritual care in the home environment must be developed.

The consequences of this new development for the identity, competencies and training of the spiritual caregivers will have to be further investigated. Competencies such as entrepreneurship, teaching, and interdisciplinary working will have to be further developed and introduced in the training programs.

CURRENT ORGANISATION AND PRACTICE

PROFESSIONAL ORGANIZATIONS SPIRITUAL CARE IN THE NETHERLANDS

VGVZ – Dutch Organization of Spiritual Caregivers https://vgvz.nl/

- 8 sectors: Catholic, Protestant, Humanist, Jewish, Hindu, Muslim, Buddhist and the non-denominational sector
- 7 fields: hospitals, psychiatry, nursing homes, youth care, people with a disability, revalidation, community care (extramural care).
- Professional Standard (2015): professional profile, quality standard, professional code.
- Journal: Journal for Spiritual Care [Tijdschrift Geestelijke Verzorging]

SKGV: Foundation Quality Register Spiritual Caregivers www.skgv-register.nl/

RING-GV: Council of Institutionally Non-Commissioned Spiritual Caregivers www.ring-gv.nl/

UCGV: University Centre for Spiritual Care https://ucgv.nl/

ENHHC: European Network of Health Care Chaplaincy http://www.enhcc.eu/

The practice of spiritual caregivers in the Netherlands differs depending on the specific care setting. Generally, functions on micro-, meso- and macro-levels are distinguished: Guidance and support of individual patients and their family (micro), support and training of care staff (meso), and giving advice concerning care management and the policy and identity of an institution (macro). In many hospitals, spiritual caregivers are involved in ethical committees, conduct moral consultation, and work as confidential advisors. Also, in many institutions Sunday services – ranging from traditional Christian services by office holders to ecumenical services or secular ceremonies – are held. There are special services focusing on sensorial experiences for people with dementia and mental handicaps. Spiritual caregivers perform traditional rituals such as baptisms, ritual blessings, and the extreme unction. Further, spiritual caregivers are involved in group work, such as support groups talking about existential issues. They frequently work with art, poetry and music –important media for addressing spirituality in a secularised context. Many old hospital chapels have been transformed into "rooms of silence" intended to appeal to people with various backgrounds.

Much-used methods and theories in the care for clients are: The "presence" approach ("listening and being present"); narrative approaches, such as life-review, personal "books of life" (life reconstruction books) in nursing homes; mindfulness; working with art and music. Spiritual caregivers increasingly use spiritual diagnostic instruments, such as the FICA[27], for interdisciplinary work and are involved in the developing of standards and guidelines, such as the Interdisciplinary Guideline for Spiritual Care in Palliative Care (Van de Geer 2017, p 53ff).

TRAINING

Since the 1970s the training of spiritual caregivers, as in Finland and Norway, has built heavily on the CPE tradition and methods, both in the initial and advanced training of pastors and chaplains. The Council for CPE and Pastoral Supervision emphasised the autobiographical approach: Learning to use oneself as an instrument via analysis of verbatims and case studies, group dynamics and autobiographical work. Internships combined with a CPE-type training

and supervision are generally part of the initial training, and many spiritual caregivers follow a full CPE trajectory afterwards. Further, each spiritual caregiver who has just started work is supposed to follow a one-week "spiritual care in organisations" course in their specific field (hospital, psychiatry, nursing home). In the past twenty years the focus of the professional training has become broader, including knowledge about management and institutions, various psychological and agogical methods, and advisory and teaching skills.

Initial training

The various MA and BA Spiritual Care programs (both confessional and nondenominational) may differ in focus but are all oriented on the VGVZ Professional Standard.

Required competencies

For membership the VGVZ requires:

- Competence: An academic or a professional master's degree in Theology, Humanistic Studies or Religious Studies, at an institution accredited by the SKGV. Spiritual caregivers with a professional BA degree can become prospective members; to become a regular member, they should have acquired an MA degree (or reached a corresponding MA level) within five years.
- Authorisation: An endorsement by a religious or spiritual organisation, or a mandate from RING-GV.
- Permanent education: Maintaining an adequate level of knowledge and skills through continuous further training (demonstrated by, e.g., a registration in the quality register SKGV).

General competencies

Each area of activity (hospital, nursing home, youth care etc.) requires its own specific competencies. However, the VGVZ Professional Standard (2015, 9f). states that all spiritual caregivers should

- be capable of reflecting on religious, spiritual and ethical issues that present themselves in their personal lives as well as within organisations.
- have a broad knowledge of meaning and belief systems, religion, spiritual resources, and ethics;
- be capable of sharing their knowledge and reflections with others, and of bringing people together;
- have their own authentic spirituality, which they actively maintain.

Three categories of competencies are distinguished:

1. Substantive competencies (hermeneutical/worldview, therapeutic, spiritual – i.e. the ability to help people discover and renew sources of spirituality and belief – ethical).
2. Process-oriented competencies, such as communicative, educational and organisational competencies.
3. Personal competencies, pertaining to integrity and self-reflection.

Becoming "research-literate" is a new requirement, as the government and the health institutions increasingly demand research on the function and effects of spiritual care, to legitimate funding and its integration in healthcare.

Permanent education

Permanent education is offered by the universities, the Council for CPE and Pastoral Supervision, and various private organisations.

Regarding permanent education the SKGV quality register requires every five years:

- a supervision trajectory;
- participation in an intervision group;
- maintaining one's spirituality (e.g. a spiritual guidance trajectory, a meditation week in a convent);
- other training or courses amounting to 50 points in total (1 point = 4 hours), such as a CPE trajectory, a master's or post-master's program in "Ethics and Policy", a training in Contextual Pastoral Care or Bibliodrama, advanced training in group dynamics or counselling techniques, becoming a mindfulness trainer, specialising in palliative care, attending symposia, workshops and conferences, or participating in research.

RESEARCH

Research on spiritual care has started some twenty years ago and has gained momentum over the last five years. In 1997 the Trimbos Institute published the first inventory of spiritual care in the Netherlands (De Roy etc. 1997), which made the profession visible and formed the basis for later research.

A subject of fierce debate is the question if and to what extent the work of spiritual caregivers and the effects of spiritual care can be empirically researched. Do not the highly dialogical and contextual listening and interventions by spiritual caregivers elude empirical research? And is not spiritual care above of all a very private and personal affair? Besides, is it not dangerous to make the availability of spiritual care dependent on its effects? Does it not rather represent "another" domain in healthcare, based on the value of humane support? These doubts explain that at first only qualitative, descriptive research was done. However, this has changed over the last ten years, under pressure of the demands for accountability regarding financing, quality improvement, and interdisciplinary working. Evidence-based working in the field of spiritual care may not be that easy, but we can aim at getting practice-based evidence, as argued by George Fitchett. Fitchett has visited the Netherlands several times and inspired the current case studies project (See Muthert in this volume). Research on PROMs spiritual care is also being done (See Visser-Nieraeth in this volume).

Recent PhD studies concern, for instance, the basic methodology of spiritual caregiving (Smit 2015), the worldview of Protestant chaplains (Huijzer 2017), training spiritual care within palliative care (Van de Geer 2017), and the question of what makes life worth living, according to elderly people dependent on intensive care (Van der Wal 2018).

Further, a great deal of other research is being carried out about such varying subjects as moral distress in the military, working with "life stories" and other narrative interventions, religious coping, religious experiences of psychiatric patients, spiritual care in extramural care,[28] and spiritual care in the Groningen earthquake area.

CONCLUSION

Spiritual caregivers in the Netherlands may draw on a variety of religious and philosophical traditions for inspiration and the underpinning of their work, but they share a common professional language of meaning-making and a sound professional standard and organisation. This is a strong foothold from which to address the requirements for the profession to acquire a new, permanent place in public institutions, which is necessitated by the changing religious and societal landscapes. Current challenges are finding a new legal foundation as to financing, becoming integrated in extramural care, and further developing new practices to address religion and spirituality in a secular and multicultural context. Training and research should respond to these developments; international exchange and cooperation will be indispensable.

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NOTES

1 I would like to thank my Groningen colleague Dr. Brenda Mathijssen and all the colleagues of the ReChap group for their helpful comments on this article.

2 For the past twenty years there have also been a few chaplains in the Dutch police force. Currently, eight new chaplains are being appointed there.

3 The responsibility of healthcare institutions is to provide adequate and high-quality care. Spiritual care is further specified in the Healthcare Quality, Complaints and Disputes Act (WKKGZ), article 6 and in the Healthcare Clients Participation Act, article 3.

4 “Spiritual caregivers help safeguard the constitutional freedom of religion and belief for people living in a healthcare institution, for detainees, and for military personnel. This is referred to as the “sanctuary” function, as it offers access to spiritual assistance to all citizens, without control or approval by any third party.” VGVZ Professional Standard 2015, p. 5.

5 Quotes in this article are from the draft English translation (2017) of the VGVZ Professional Standard 2015. The first edition of the Professional Standard is from 2002.

6 The term “spiritual care” is increasingly favoured over “chaplaincy”. As Constanze Thierfelder (2017) states: “favouring of the term ‘spiritual care’ is not only a tribute to the changing situation in German-speaking countries, but also a way pastoral care takers want to deal with the challenges they face in a secular, multicultural Society”.

7 The term “transcendent” is used in a very broad sense, referring to both “vertical transcendence” (such as belief in a divine being) and “horizontal transcendence” (transcending the self, for instance in relationships with others or nature).

8 “Meaning”, in this broad sense of the word, equals the American term “spirituality”. See for instance the definition of spirituality by Christina Puchalski (2009) and the Dutch multidisciplinary guideline for spiritual care in palliative care, which is based on this definition: https://www.pallialine.nl/zingeving-en-spiritualiteit.

9 The domain of spiritual care is also summarised in the Professional Standard (p 42) as “context of ultimate meanings and concerns”.

10 Protestant: 13 %, Catholic: 12 %, Islam: 5 %, other religions: 2 %.

11 About 42 % of the population consider themselves “believers”, about 30 % say they are “spiritual”, and almost 50 % report praying.

12 This section is mainly based on Doolaard 2006 and the VGVZ Professional Standard 2015.

13 Besides, there were a few representatives of the Jewish organisations and the Dutch Humanist Association.

14 However, this integrated way of working was questioned from a religious perspective. Protestants asked, for instance, if the minister’s “office” could be combined with integrated working, and if the hierarchical structure of the spiritual care services (with one of the chaplains as head) did not conflict with ecumenic cooperation, which implied equality.

15 “Spiritual caregivers can be called on by anyone, irrespective of the caller’s religion or convictions. In principle, each spiritual caregiver can provide spiritual care to each client. A client who specifically wishes to see a spiritual caregiver of the same background will be referred accordingly” (VGVZ Professional Standard 2015, p 4).

16 An endorsement testifies that the spiritual caregiver has been educated and trained within his/her own religious/spiritual tradition, and may act as (ordained) representative of the endorsing organisation, and in some cases as a celebrant/officiating priest leading ceremonies, performing particular rituals and rites (VGVZ Professional Standard 2015).

17 In 1994, the VGVZ established a Professionalisation Committee to specify professional requirements and advance the professional expertise and working methods of spiritual caregivers.

18 In Denmark there has long been a similar distrust of psychology in spiritual care, also due to the influence of dialectical theology (See Thomsen in this volume). In Norway and Finland, on the other hand, psychological and psychotherapeutic theories have always been more welcomed in spiritual care (See in this volume Stifoss-Hanssen, Danbolt & Frøkedal, and Saareleinen respectively). In Norway the strong tradition of psychology of religion has been an influential factor in this respect. In Finland psychology and psychotherapeutic techniques constitute an important part of the chaplaincy training program.

19 Jan Hein Mooren, formerly teaching at the University of Humanistic Studies, has written an influential booklet on the tension between psychology and spiritual care (1989). He argues that theology/worldview constitutes the primary frame of reference of the spiritual caregiver, and psychology the secondary frame of reference. For the psychologist this is the other way around.

20 Baart’s agogical method was developed in the field of urban mission, carried out in several poor and disadvantaged neighbourhoods and districts in the Netherlands, and is presented as an alternative for the theory- and goal-driven intervention approach. For an English-language introduction to this approach see http://www.presentie.nl/publicaties/item/283-presence-approach-introduction.

21 The first nondenominational master's program was established in 2004 in Groningen. At the moment there are three master's programs in spiritual care which are not connected to a confessional, denominational school such as a theological seminary or the University of Humanistic Studies. An important incentive for the universities to develop these new master's programs was to compensate for the decrease of students in confessional training programs.

22 Many of the spiritual caregivers who would not or could not receive an endorsement became members of the alternative professional organisation Albert Camus, which was established in 1995 for spiritual caregivers who had a professional bachelor's degree in theology (They could not become members of the VGVZ either, because of the requirement of a master's degree).

23 The nondenominational chaplain has been a highly disputed figure in the VGVZ for years. Various practical and principled arguments were heard (such as who would control education and worldview expertise; what the nondenominational approach meant for the sanctuary position and the legal foundation and financing of spiritual care; and that the identity of the "general" spiritual caregivers was unclear to patients).

24 This solution was possible because of the position of spiritual caregivers in healthcare: They are neither paid by nor appointed by the churches. This is different in the military and the judiciary; the spiritual caregivers there are employees, but for the content of their work accountable to their church, the Humanistic Association etc. This is called the *duaal-paritaire structuur* in the judiciary (Van Iersel & Eerbeek 2009). In the military, there is a similar structure. See *Professional Standard for spiritual caregivers in the military,* 2017–2021. In both cases it is the CIO which appoints the spiritual caregivers.

25 It starts with so-called "kitchen table conversations": If you suffer from a chronic disease, are in the early stages of dementia, or have a handicap (either mental or physical), members of the local multidisciplinary care team come to your house, talk about what kind of care you need, and not in the last place about what you can do yourself and who in your social network can help you.

26 Huber and colleagues (2014) speak of *positive health,* arguing that the WHO definition of health as complete well-being is not adequate, given the rise of chronic diseases. They propose changing the emphasis towards the ability to adapt and self-manage in the face of social, physical, and emotional challenges. Huber distinguishes six dimensions of health: Bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning. She considers the spiritual/existential dimension the factor which contributes most to health.

27 FICA: *F*aith and Belief, *I*mportance, *C*ommunity, and *A*ddress in Care or Action (Puchalski and Romer, 2000).

28 These are three projects (PLOEG) financed by ZonMw, the Netherlands Organisation for Health Research and Development.

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Healthcare Chaplaincy in Finland

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ABSTRACT
The article provides an image of the beginning, growth, and current situation of healthcare chaplaincy in Finland. The history of the chaplaincy takes us back decades, yet the healthcare chaplaincy as we know it today was formed in the 1960s. The Evangelical-Lutheran Church of Finland has played a significant role in the development of the chaplaincy. Two contexts exist as chaplaincy locales: Healthcare and the Evangelical-Lutheran Church of Finland. It took decades for healthcare chaplaincy to find its place within and between these two contexts, yet the recent cutbacks in personnel do not promise easy years for the future. Research within this manifold subject is diverse, but new studies are still needed to tackle the challenges of the changing context, work climate, and divergent needs of the patients.

KEYWORDS
Healthcare chaplaincy, Development of chaplaincy, Finland

Introduction
This article focuses on Finnish healthcare chaplaincy – its formation, history, and current situation. We will begin with the history and theological roots of healthcare chaplaincy in Finland. Then we will introduce the two contexts of the chaplaincy: The Finnish religious climate and the healthcare environment. Analyses on chaplaincy training and recent research on the topic follow. At the end of the paper, we will map the current situation and identify some future challenges.

The article is based on the existing literature; in addition, to have a full picture of past events and to be able to grasp the current situation of healthcare chaplaincy, the first author conducted three specialist interviews. Of the interviewees, Rev. Kirsti Aalto (former Direction of Healthcare Chaplaincy, National Church Council) shared her knowledge on the historical events; D.Th. Matti-Pekka Virtaniemi (former Educator from the Church Educating Centre) focused on the impact of clinical pastoral education (CPE) and on supervision (in terms of work-based counseling); and Rev. Virpi Sipola, the current leading advisor of pastoral care and counseling at the

National Church Council, provided information on the present situation and on the future of hospital chaplaincy. As the hospital chaplaincy is fully based on the education and finances provided by the Evangelical-Lutheran Church of Finland (ELCF), it was natural that the interviewees were found in the same context. In the paper, we will discuss what it means for chaplaincy and its' future that the work is closely bound to ELCF.

History of Healthcare Chaplaincy and Theological Formation

The strong impact of the Evangelical-Lutheran Folk Church

The origins of healthcare chaplaincy in Finland can be traced back to the 1600s (Sippo, 2004: 1–16.) Pastoral care was understood to be a task that is carried out in general pastoral activity, which did not follow Martin Luther's tendency to personal comfort (e.g. Ebeling, 1997: 449–471). This liturgy-oriented old-Lutheran pastoral tradition formed the mainline scheme of pastoral care in Finland (Saarinen, 2003: 413).

In the late 18th century, pietistic pastoral care was constructed on the idea of spiritual rebirth: The aim of all pastoral action was to guide personal experience of faith (Saarinen, 2003: 412–413; Peltomäki, 2019: 24). In the first half of the 20th century, the task of pastoral care was carried out through moral upbringing, proclamation, and guidance to a closer parish connection (Kilpeläinen, 1966: 17–19), and thus the introduction of modern psychology did not have much influence on the pastoral care approach before the 1950s.

After the wars in Finland, the former military pastors experienced that preaching was not adequate to counter suffering and as a result the church began new forms of work such as family counseling and healthcare chaplaincy (Ylikarjula, 2005: 11–12, 14; Sippo, 2004: 66–67). These changes raised a need for therapeutic approaches to pastoral care. Yet these new forms of church work provoked suspicious discussions, as at the same time pietism was losing its grip while folk church ideology was being empowered (Ylikarjula, 2005: 13–14).

The therapeutic turn grows from and within the changes in the field

Healthcare chaplaincy was established during the 1960s and became recognised by the bishops' conference (Ylikarjula, 2005: 19, 33). The therapeutic turn was explicated by the female healthcare chaplain Irja Kilpeläinen (Kilpeläinen, 1969) at the time when the role of church discipline began to loosen (Peltomäki, 2019: 20–22, 24–25). The educational model and the pastoral care movements in the UK and the United States provided inspiration for the education of the Finnish chaplains (Sippo, 2004: 66–67). Kilpeläinen's patient-centred method emphasises the idea that the confident discovers personal ways to encounter suffering with the support of the chaplain (See Peltomäki, 2019: 20–22).

The Christian three-fold perception of mankind – created, fallen and redeemed – is the theological basis of Finnish hospital chaplaincy (Kettunen, 2013: 55–58; Kettunen, 1990: 60–64). In the early years, biblical words "I was sick, and you visited me" provided grounds for the chaplaincy work (Aalto, 2019; Virtaniemi, 2019). Nowadays, the idea of the God who suffers with the suffering is seen as crucial (Sipola, 2019). Ultimately, the therapeutic approach began to shape the actions and theology of healthcare chaplaincy; theology became distinctively contextual as it developed and continues to develop strongly in the context of taking care of the ill in Finnish society.

From decades of debates to stability

The 1970s was a mixed bag for healthcare chaplaincy. Chaplains were criticised for a "psychiatric attitude" as modern psychology was exploited in chaplaincy. Chaplains were also accused of "hospital terror" when organizing devotions and discussing death with the patient. Others considered that chaplains had drifted too far from the church. (Ylikarjula, 2005: 41–43; Kettunen, 1990: 64). Nevertheless, appreciation of the chaplains among the doctors and laymen was strengthened (Ylikarjula, 2005: 50).

From the perspective of resources, the 1980s were fruitful. Healthcare chaplains were strongly involved in societal discussions and work rela-

ted to AIDS and abortion. In addition, the hospice movement was introduced, and it became understood that family members are involved in the dying process. (Ylikarjula, 2005: 53–56). Also, the education of hospice volunteers began at 1986 (Aalto, 2019). Another significant change occurred when nearly half of the female chaplains were ordained after the decision of the ELCF to ordain women in 1988 (Ylikarjula, 2005: 69; Sippo, 2004: 57). Yet some jarring notes were heard, and it was even proposed that the vacancies of chaplains should to be based on local congregations instead of hospitals. (Ylikarjula, 2005: 62–66).

Conflicts and lack of congregational cooperation finally seemed to ease up in the 1990s; still, the economic recession hit hard and more than 10 % of the chaplains were fired. To secure the pastoral care of the ill, the collaboration between chaplaincy and local congregations was found to be crucial (Ylikarjula, 2005: 79–80, 87). Furthermore, congregational clergy became more and more interested in the education of the healthcare chaplains as local congregations found that people's need for pastoral care and counseling was increasing (Ylikarjula, 2005: 75–76). Nevertheless, the rise of pastoral psychology once again evoked some discussions on the relationship between church and psychology (Ylikarjula, 2005: 91–92). The appreciation of chaplaincy became evident in the 90s. Among laymen, 84 % of Finns found the work of healthcare chaplains important or extremely important in 1999 (Ylikarjula, 2005: 87, 92).

Currently, chaplaincy has established its significance in hospitals (Avohoito, 2019), and after the millennium most of the congregational personnel found healthcare chaplaincy to be important or extremely important (Ylikarjula, 2005: 109–110). Still, it seems that the future holds insecurity and the threat of cutbacks when the finances of congregations are declining; filling the posts of hospital chaplains needs to be negotiated often (Sipola, 2019).

ELCF and Healthcare Environment Provide Context and Organisation

We have shown how context and history have impacted the formation and work of chaplaincy. In this section we present the current context and organisation of healthcare chaplaincy in Finland. The section describes how the context of healthcare chaplaincy is constructed on religious and spiritual grounds as well as on the status of Finnish healthcare.

Finnish constitutional law declares that everyone has freedom of religion and freedom of conscience. Furthermore, the legislation regulates church law and church order of the Evangelical-Lutheran Church (ELCF) and the Orthodox Church. Both churches are entitled to collect taxes from their members. Other registered religious communities are financially supported by the government. The Finnish religious constituency has been highly homogeneous throughout the years. Today, the reduced percentage of members is 69.7 % in the ELCF. For the Orthodox Church, the membership had decreased to 59,560 (Finnish population is 5.5 million) by the end of 2017 (Seppälä, 2019). Around 1.6 % of the population are members of other registered communities. Jehovah's Witnesses, the Evangelical Free Church of Finland and the Catholic Church in Finland form the largest body of registered communities. Furthermore, there are tens of thousands of Muslims living in Finland, but only a minority of them are registered members of any Finnish religious community. (Ministry of Education and Culture, 2019; Info Finland, 2019).

Even today, Lutheran impact can be seen in Finnish values. For Finns, values such as aspiration to the common good, responsibility to one another, understanding work as a calling and service to others as well as bringing up children with strong values carry high cultural importance (Ketola, 2016: 85–87). Even though the number of Lutheran rites has decreased, the number of Lutheran burial rituals has remained relatively stable and nearly 90 % of the people are still buried with a Lutheran service (Sohlberg & Ketola, 2016; Toimintatilastot, 2019). In addition, a strong foothold of congregational youth work exists, as most 15-year-olds attend confirmation rites (e.g., in 2016, the number of confirmands was 85.5 % of the age group; Rippikoulu ja Rippikoulun käyneet, 2018). It can be concluded that the use of traditional Christian rituals has

decreased in Finland, while the use of religious practices has diversified (Palmu et al., 2012: 37–39).

The Finnish healthcare system is very much based on public healthcare that provides low-cost care for clients. Care for children and minors is free of cost. For adults, the maximum fee for the calendar year is set at 603 euros; when an individual reaches this limit, all subsequent care and medication is free of charge. Healthcare is carefully regulated with legislation and generally the Finnish healthcare system is considered one of the leaders in international comparison (e.g. Quality of care, 2015). Nonetheless, in a study that compared the of quality of death by ranking palliative care across the world, Finland was placed at 20th based on the regional differences, low number of volunteers, and lack of community (Economist, 2015). Furthermore, the limits of costs for homecare are not set and municipalities have varieties of ways of addressing the costs. The political will related to such care shows a strong urge to shift the care of the elderly and dying back to individual homes. In 2015 legislative changes were made to affirm home-based elderly care. In Spring 2019, the parliament resigned after not being able to find consensus for a new model for healthcare that had been in preparation for years (e.g. Yle, 2019). In sum, the context of healthcare is going through a period of transformation, and as of now no clear directions or indications about healthcare reform can be made.

Healthcare chaplaincy is fully based on the personnel of the Lutheran Church of Finland. Chaplains work within these two constantly shifting contexts: The changing spiritual climate and healthcare reform. The current organisation of the chaplaincy is based on a tripartite agreement made in 1965. It was agreed between the government of the church, the government of medication and the association of hospitals that healthcare chaplaincy was recommended as part of the work in hospitals (Ylikarjula, 2005: 21–22; Sippo, 2004: 70–72).

The two bases of the hospital chaplaincy are also made vivid in the document "The principals of hospital chaplaincy 2011," which defines the goals of the chaplaincy as follows:

> The aim of health care is in the promotion of health, prevention and treatment of disease and alleviation of suffering. The objective of pastoral care is to address the religious, spiritual and life-view questions of the sick and suffering. A pastoral caregiver respects the human dignity, beliefs and the integrity of the patient regardless of his/her background or view of life. Self-determination is clearly stated in the Constitution of Finland and in the Act on the Status and Rights of Patients. In helping the sick and suffering, the values of health care and pastoral care meet; both health care and pastoral care view people holistically, considering their physical, mental, social and spiritual needs.

The quotation highlights that two bases of healthcare chaplaincy – healthcare and pastoral care – are merged as one. Human dignity grows from respect for an individual; the legislation provides a starting point for holistic encounters. From the point of view of the legislation, the role of healthcare chaplains began to change in 1993. In the 1990s patient law was interpreted so that chaplains were not seen as integrated staff members (Ylikarjula, 2005: 85–86). Similar discussions appeared in 2011 when the Act on the Status and Rights of Patients was updated. Nowadays chaplains are authorised to see the medical record of the patient only with the permission of the patient (Principles for Hospital Chaplaincy, 2011).

In this section we have discussed how strong the Lutheran impact on healthcare chaplaincy in Finland is even though it is obvious that religious freedom and various religious denominations exist in Finland. Next, we will explain how religious diversity is dealt with in the training and daily practices of the chaplains.

CPE-based Training as Grounds for Respectful Practices

The education of healthcare chaplains established in the 1960s greatly improved the psychological understanding of the patients in the practices of chaplaincy Finland. Psychodynamic studies have since been integrated into the healthcare chaplain training, and chaplains are guided to get a full psychotherapeutic education (Aalto, 2019; Ylikarjula, 2005: 75). The training of hospital chaplains was based on ideas of clinical pastoral education (CPE) although this has

not been explicated in written sources. Still, in the early years of such education, several practitioners got their training at CPE centres in the US. (Virtaniemi, 2019; Sipola, 2019).

The original CPE education highlighted the importance of understanding people from different religious backgrounds. The idea of accepting and cherishing religious diversity was fostered among the chaplains in the late 1960s: it became crucial to understand the emotions behind the words of the client. The introduction of CPE also affected the formation of supervision of chaplains in Finland, as there had been two competing traditions. One tradition highlighted the importance of dealing with the patient's situation in supervision; the other focused on the experience of the counsellor him- or herself. The contribution of CPE made it clear that supervision had to include both aspects to meet the needs of chaplains (Virtaniemi, 2019).

Today the training of hospital chaplains is based on CPE ideas, although some modifications are made, and the training is provided only by the ELCF. The three-year training consists of 60 credits (1 cr. = approximately 27 hours of work) and includes five thematic modules (Orientating module 5 cr.; Progression as healthcare chaplain 10 cr.; Pastoral care and counseling 20 cr.; Specific questions of healthcare chaplaincy such as pastoral care, psychology of health and mental health, couple and family relationships, developmental psychology, crises and traumas, therapeutic methods 20 cr.; and the final project 5 cr.) (Training, 2019). Those ordained ministers who have a permanent post or long-term contract as a healthcare chaplain are obligated to take the training. In addition, deacons whose main work is based on hospital or in social care context, can apply to the education. Still, candidates must fill out a motivational application and pass psychological tests before the training begins (Sipola, 2019).

For healthcare chaplains, a new training group begins approximately once every three years. Therefore, the training model of each group can be slightly modified depending on the needs of the group and the societal situation. Furthermore, education is constantly provided on topical issues: for instance, the questions of how to meet the pastoral needs of transgender individuals were recently discussed in the educational course. Therefore, people who come to work as chaplains know how to discuss and deal with a variety of minority groups. It is also a task of the hospital chaplains to form networks with other religious groups in the area so they can be contacted if there is a patient in need of chaplaincy from some individual religious group. Within hospital chaplaincy, it is taken for granted that trust, respect, and equality are the pillars of the chaplaincy. Patient-centred care is the premise of the hospital chaplaincy. Therefore, chaplains also provide existential and spiritual care for non-religious people. (Sipola, 2019).

The current number of healthcare chaplains working at the field is 117. Altogether the number of chaplains is 132 when taken the number of team leaders into account. (in March 2019, Henkilöstötilasto, 2019; Sipola, 2019). During the previous decade, the number has decreased around 9 %. The main work of chaplains is based on individual conversations with the patients (more than 33,794 consultations per year); in addition, conversations are held with family members (11,808 conversations) and the hospital staff (9423 conversations). In 2018, worship services and Lutheran rites were held 2933 times in the hospitals; these services reached more than 39,000 individuals. In addition, chaplains organised 3708 devotions and other events during 2018. (Statistics, 2018).

Research on Hospital Chaplaincy

In this part of the article we introduce that practice-oriented literature and PhD-level research which has analysed chaplaincy or more widely the practice of pastoral care in Finland during the past thirty years.

As previously explained in this article, Irja Kilpeläinen was very influential in developing hospital chaplaincy in Finland. Her books on a patient-centred counseling model (Kilpeläinen, 1969) and on death and dying (Kilpeläinen, 1978) are widely read classics even though they are based on practical experience and not on empirical research. *The Finnish Journal of Pastoral Care* (*Sielunhoidon Aikakauskirja*), launched in 1988(–2009) and edited by Kirsti Aalto, was a

central vehicle for discussing topical issues. The journal demonstrates that topical questions primarily concentrated on practical work and pastoral psychology as the key theoretical framework (See Ylikarjula, 2005: 71). Chaplaincy was discussed in various issues, for example, from the point of view of the theology of care (Erikson, 1992) and the nature and goals of pastoral practice in hospitals (Sainio, 1993). This journal was widely read among chaplains and other Lutheran ministers and thus influenced the discussion on chaplaincy. The journal was recently relaunched as an internet-based journal that seems to be practice oriented in the sense that chaplains are writing their experiences and ideas based on their work (Sielunhoidon Aikakauskirja, 2018).

Among the first ThDs was a quantitative study on pastoral counseling in Finnish hospitals, the results of which revealed that patients experience a chaplain simultaneously as a preacher, a servant, and a participant (Kruus, 1983). These results indicate that even though a patient-centred model was actively followed, patients in the 1980s still saw that preaching of the gospel was an important role of a hospital chaplain. Other studies in the 1980s and 1990s dealt with religiosity of the patients and patients' understanding of dying. A study on the worldview and religiosity of elderly chronic patients focused on the importance of a shared life story between an elderly patient and the chaplain and discussed issues connected with values, religiosity, and attitudes toward approaching death (Gothóni, 1987). A health care chaplain, Kalervo Nissilä, conducted two further studies, the first focused on immortality of the dying (Nissilä, 1992) and the second on a suicidal person's understanding of his/her own dying (Nissilä, 1995), both of which were based on interview data of hospitalised patients.

Some studies focused on the congregational context but also contributed to the hospital setting. Among these was a study on grief group counseling in congregations (Harmanen, 1997), which has been widely read among theologians and thereby influential on healthcare chaplaincy in Finland. Most of the authors during this early phase were chaplains themselves, and they collected the empirical data from the hospitals in which they worked. The exception was Paavo Kettunen whose dissertation was based on the written training material of healthcare chaplains in the ELCF between 1960 and 1975 (Kettunen, 1990). Even though Kettunen's dissertation was defended in 1990, it contributes to this early period because the focus is on the patient-centred model in which the concept of man was defined inductively from the life situation of a person and additionally the study is based on data from these years.

Most of the dissertations around the turn of the century also focused on patients' experiences. Among them was a study on the integrity of life of aged pacemaker patients (Ylikarjula, 1998) and the pastoral expectations of cancer patients (Lankinen, 2001). There was an interesting follow-up study on the Specialised Training Program in pastoral care and counseling (Hakala, 2000). This training was offered to hospital chaplains but also to chaplains working in other specialised ministries. The aim of the study was to examine the changes that occurred during the training in the ways in which trainees practiced pastoral care and how they understood their caregiver identities. The data were collected by interviewing 17 students both before and after the training. The results show that training strengthened pastoral caregiver identity and increased the spiritual aspects of pastoral care. Additionally, the study included recommendations on how to improve the specialised training. These suggested improvements included integration of self-directed study, seminars, and supervision (Hakala, 2000: 357–365). The study findings were later used when planning new chaplaincy training. The same year, Sippo's (2000) study focused similarly on the chaplain's professional identity. This study reveals that chaplains focus on their patients but that their professional identity is built on both the healthcare and the congregational contexts. This underlines the argument we have shown elsewhere in this paper that these two contexts form the work spaces and identity of a chaplain in Finland. Here we must note that there are two different models of how the leadership of chaplains is organised: The superior is either a vicar or a

leading chaplain. The first model focuses more on the parish context while the second model is in the healthcare world.

During the past ten years, pastoral theological research has focused on spirituality and health. Among these is a study on the significance of the loss of a child for the formation and development of parents' spirituality (Koskela, 2011). Even though this study does not focus on the clinical setting or on the role of chaplains in the parents' narratives, it does contribute to the wider discussion on spirituality and health. A quite similar study on parents' narratives of grieving and recovery processes after the death of a child reveals that chaplains were more prepared to face the grieving parents than the parish pastors were (Itkonen, 2018). This is an important finding because currently there seems to be pressure not to continue with chaplains but that parish pastors should take care of the hospitals in the area instead.

The two most recent studies have focused on patients' experiences with spirituality and health. The first one dealt with young cancer patients and analysed their coping narratives (Saarelainen, 2017). This study found that most of the emerging adults interviewed would have benefited from additional psychological and spiritual support. Most of the interviewees had not met healthcare chaplains during their cancer process even though they experienced strong existential questions and spiritual seeking. A second recent study focused on the purpose of life of ALS patients (Virtaniemi, 2018), which revealed that the existential process of an ALS patient consists of two separate but connected processes. The first one deals with the ultimate concerns in life while the other addresses the issues of meaningfulness and meaninglessness in life. Both studies deal with an important issue of chaplaincy, the discussion on the meaning and purpose of life when facing death.

All these recent dissertations have contributed to the understanding of Finnish spirituality during loss and illness in which Lutheran traditions combine with everyday spirituality and the search for meaning in life. The researchers during this phase have a variety of backgrounds from emeritus pastoral care trainer Matti-Pekka Virtaniemi to the first non-Lutheran researcher Harri Koskela. It is interesting that none of them worked as a chaplain during the research and they thus did not collect the data while working in a hospital themselves. From ongoing studies, Virpi Sipola's dissertation focuses on chaplaincy encounters from the perspectives of both chaplains and patients.

Various course books focusing more widely on pastoral care and counseling have been used during the theological training and have thus influenced future chaplains as well. The Handbook of Pastoral Care and Counseling gave a good overview of the background and practice of pastoral care and counseling in Finland (Aalto, Esko & Virtaniemi, 1998). Another handbook on hospice care gave a multidisciplinary overview of the new approaches to palliative care (Aalto, 1986/2000). Two course books dealt with the theology of care (Latvus & Elenius, 2007) and on pastoral care and counseling (Kiiski, 2009), both of them giving an analysis of various approaches to pastoral care and counseling in Finland based on the analysis and structure by Norwegian Tor Johan Grevbo (2006). Grevbo has been widely read and discussed in the early part of this century by Finnish chaplains and has influenced both the practice of and research on chaplaincy in Finland. A bit later, a two-book series on the caring encounter was written in which the first volume focused on the history and theology of pastoral care and counseling (Kettunen, 2013) and the second volume on methods and practice (Gothóni, 2014).

Challenges of the Future in Chaplaincy

In this article we have presented an overview of hospital chaplaincy in Finland. We have shown how the Finnish context played a significant role in the formation of the chaplaincy and its theology over the years. Still today, the context for hospital chaplaincy exists within the contexts of healthcare and the ELCF. Even though the impact of the ELCF is and has been strong, the CPE tradition has provided for chaplains to be trained to answer the needs of all the people. With 2020 right around the corner, we see two great challenges for hospital chaplaincy in Finland: the lack of research and the risk of cut-

backs in the number of chaplains. In this last part of the chapter, we will discuss these challenges in more detail.

The early focus of chaplaincy research in Finland was on the chaplains themselves, which led to a focus on the experiences of patients. Still there seems to be a significant gap in knowledge on the needs of existential support of religious and non-religious minorities in Finland. Further, only some studies scrutinise the attitudes of care personnel toward sexual minorities (Hentilä et al., 2012; Mäntylä & Tuokkola, 2013). These studies did not deal with healthcare chaplains; however, they reveal that sexual minorities had negative experiences from healthcare because of the care personnel's old-fashioned attitudes. The most recent theological study shows that more than half of the ELCF ministers would perform a Lutheran wedding service for same-sex couples if this were allowed by the bishops (Kallatsa & Kiiski, 2019). This study shows a positive attitude towards minorities but does not scrutinise how the LGBT people experience chaplains nor how the chaplains are prepared to serve their LGBT patients. In sum, studies indicating relations between health, wellbeing, and religion as well as correlations between the experience of meaning and wellbeing have mainly been conducted with a quantitative approach (la Cour & Hvidt, 2010) and have often focused on the majority populations in their respective countries. There are few exceptions dealing with minorities or on interfaith approaches. None of these have studied the Finnish context.

It took decades for the Finnish healthcare chaplaincy to grow and develop as a tangible and respected part of the healthcare system. Harsh tones and lack of congregational understanding have been evident during the past decades. When looking to the future, relief cannot be guaranteed: the number of hospital chaplains is decreasing, and more cutbacks are expected. The church policy seems short-sighted when the chaplaincy personnel are let go even though the need and value of the chaplaincy is well known at the hospitals (See Karhu, 2019; Sipola, 2019). Chaplaincy follows Lutheran traditions, and this has not been openly challenged as is the situation for example in the Netherlands (See Ganzevoort et al. 2014, and Zock's article in this volume). This need to widen the religious scope of chaplaincy has not been much noted in public discussion or scholarly works.

There is an urgent need to stronger societal discussion on the role and expectations on the chaplaincy. World health organisation (WHO) has identified that holistic and compassionate healthcare should be secured for each patient. Further in the statement on the palliative and end of life care the Finnish Ministry of Social Affairs defines that each person working with the dying patients should be at least able to identify existential and spiritual needs of the patients and their careers. In the same document, hospital chaplains are positioned as a stakeholder to provide existential care for inpatients and homecare patients (Saarto et al., 2017). The question of multi- or inter-faith pastoral care remains untouched in political discussions. Hospital chaplaincy continues to be bound to the financial politics of the ELCF; yet, in the same time state seem to expect the chaplains to have more resources and developed skills to meet the needs of the diversifying patient groups. Even with the current number of healthcare chaplains, it is impossible to meet all the needs of the chaplain services (See Karhu, 2019; Sipola, 2019). Healthcare chaplains are deeply committed and motivated in their work. Yet it seems that when 2020 is reached, hospital chaplaincy in Finland will have to testify to its importance once again.

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Institutional Spiritual Care in Sweden

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ABSTRACT

This article presents historical and contemporary perspectives on institutional chaplaincy with a special focus here on hospital chaplaincy in Sweden. The term spiritual care is used as the overall descriptor of all the different functions and activities in which the hospital chaplain is engaged. In this overview article we hope the reader will get a glimpse into the complex ways in which hospital chaplaincy has evolved and the numerous societal actors and political decisions that have been and continue to be involved in how the work of the hospital chaplain is both defined as well as organised in terms of the larger societal structure. In our contemporary perspective, it is important to understand the different kinds of challenges as well as possibilities that multi-cultural and multi-faith needs have raised in the Swedish cultural context, considered to be one of the most secular in the world. These challenges and possibilities have brought to the forefront critically important insights related to the understanding of spiritual care as a dimension of healthcare that is important for all persons, for all patients, and that person-centred care necessitates the inclusion of this dimension.

Historically one could argue that the Swedish state, through different "decisions", has been a guarantor of all, or at least part of spiritual care from the 1600s until today. Some decades after Sweden was united under one kingdom, it was decided through a royal decree in 1553 that the Church of Sweden, the state church, was supposed to oversee spiritual care in hospitals. In the Church Decree from 1571 it was declared that all larger hospitals needed to have a chaplain "*capellan*" who could "care for the souls of the sick", and who could preach, read, conduct mass and provide comfort (Robertz 1970). More than 400 years later the act of religious freedom was passed in Sweden, and through a decision in parliament other Protestant churches gained access to providing spiritual care in hospitals. They are also provided governmental financial support, and a governmental injunction promotes Christian ecumenical work at hospitals. Finally, in 1998, the door was opened for other Christian, but above all non-Christian denominations such as Muslims, and Buddhists, as it is decided that a government agency will provide financial, as well as strategic and organisational support. Because of that, spiritual care is today established at not less than 92 % of the Swedish hospitals.

While the government through decisions in parliament and financial support influenced/coloured the spiritual care, it still has a relatively strong confessional profile. Today the "*capellan*" has for centuries been replaced by "hospital priests", "hospital deacons", "hospital pastors", and in the later decades by "hospital imams" and Buddhist monks who "care for the souls of

the sick". All of them employed and sent from their own local parishes. This confessional aspect is also evident by the definition of spiritual care, where it above all is connected to the executors and not primarily the content. Spiritual care signifies "the work that representatives for different religions execute on the hospitals as a support for patients, relatives/supportive persons and staff" (Grunddokument, Sjukhuskyrkan 2017). The Agency for Support to Faith Communities, which supports Muslim, Buddhist, and other mainly Christian faith communities, replaces the word "religions" with the word "faith communities" and defines spiritual care as "the work that faith communities execute on hospitals and other healthcare facilities and include spiritual care, rituals and counselling" (Andlig vård inom sjukvården, MST). In sum, there is a dynamic between a governmental control/governance when it comes to establishment as well as maintenance, combined with a clear confessional responsibility for the direction, content and education in the area.

History and context

In relation to the previous mentioned contexts, spiritual care development can be organised into three periods. The first, and by far the longest, extends up to the beginning of the 1960's, during which spiritual care is formed through agreements between the state church, the state and healthcare institutions. The second period reaches from the 1960's up to the millennium shift and is characterised as an ecumenical project. Finally, there is the contemporary third period, which is above all characterised by the multi-faith spiritual care.

Spiritual care in the hands of the state church and healthcare institutions

As a result of the Reformation in the early 1500's the Swedish state church was established and remained such until the separation of state and church in the year 2000. The state church was a governmental agency, joining Swedish citizenship with church membership. Regarding the church and healthcare, the Reformation continued the tradition from the previous period when monasteries took responsibility for physical, mental and spiritual care. Through a royal decree it was decided that the church was to oversee hospitals, and in the first Church Council from 1571 the responsibilities for these hospitals were specified. Until the middle of the 19th century the church was an integrated part of governmental control of society's development, as the church and the state as well as the parish and the city were part of the same agency (Bäckström et al 2004). At the end of the 1800s, however, a process was started leading to the relinquishing of healthcare responsibilities from the church. The process involved, by royal decree, the establishment of a directorate for hospitals and children's homes, and later in the 1860's, the state and cities took over the responsibility through delegation to municipal authorities. In connection to this, priests were employed by their local hospitals and several directives that regulated spiritual care were written. The priest was assigned to supervise the sick in religious and moral concerns. During the first part of the 1900's the directives regarding spiritual care were further specified. Being a governmental agency as well as a faith community the church became a tool in the "*folkhemsbygget*" (construction of the welfare state), through which Sweden was reformed from an agricultural society, with strong family ties as a safety net, to an industrial society with the need for a national welfare system (Bäckström et al 2004). Spiritual care was to be offered in all larger hospitals and the board of each hospital was to employ a priest. The tasks were: 1) in accordance with the hospital board offer worship services and devotions, and 2) register all births, baptisms, deaths and funerals, and 3) offer the "*prästerliga förrättningar*", pastoral ceremonial functions, that were needed (baptisms, weddings, funerals) (Robertz 1970).

Changes for hospital spiritual care

In 1962 there was a governmental reform that substantially changed the conditions for hospital spiritual care. A parliamentary proposition stated that the responsibility for hospital spiritual care was to be handed over to local parishes, which in turn meant that the state church lost its favourable position at hospitals as the door

was opened to other Protestant Free Churches. This change came about as a result of a discussion that had been going on concerning how the state should regard the role of the church in public institutions and educational systems. Through the Act of Religious Freedom in 1951, also formulated as the "negative principle of religious freedom", for the first time it was possible for a Swedish citizen not to belong to the Church of Sweden or any other religious congregation (Bäckström et al 2004).

Church of Sweden organises hospital spiritual care on different levels

When the local congregations became responsible for spiritual care workers, the concept "hospital priest" was established, and a regional organisation was constructed in each diocese where an "officer" was appointed as a promotor of spiritual care work. At the parish level the decision was taken to establish positions at hospitals instead of having congregational priests who switched between spiritual care in hospitals and in the congregation.

Congregations became responsible for employing hospital priests and for providing handbooks, literature, and ritual objects according to a formulated list, while the hospital institution, if possible, would continue to provide local facilities for spiritual care (service room, chapel, quiet room). Even though the congregations now were the employers, the hospital institutions still had recommendations. Among other things it was recommended that the congregations also provide non-clerical assistants, which resulted in the employment of deacons and congregational secretaries. An instruction manual for hospital priests was formulated (Robertz 1970). The manual somewhat reflected the changed position of the church in society. It was emphasised that spiritual care should focus on the patient's voluntary participation, and that most emphasis should be given to individual pastoral care. The hospital priests should not participate in the regular hospital rounds and collective manifestations such as preaching, and devotions should be toned down.

In the recommendations and instructions received, there was a need for hospital priests to motivate their presence, while at the same time highlighting the new congregational connection. There was an emphasis on the need for "coworking for the patient's best" and for an understanding that "each member of the health care team is to be understood as a diagnostic instrument that has to be used" (Robertz 1970). It was essential to establish contacts and develop relations to the health care staff, there were recommendations on how to reach out, through leaflets and other kinds of information, as well as reminders of providing services for those institutions responsible for health care education (Robertz 1970). But it wasn't just important to be seen, but also how you were seen. Official clerical vestments were not suitable, instead the clergy were advised to use the round collar, which was the same for priests regardless of denomination, or just a badge with the title "hospital priest"(Robertz 1970).

The ecumenical project

From 1962 other Christian congregations could ask the hospital management to be granted to serve as spiritual care professionals (Robertz 1970). For these congregations to adjust their work to the hospital setting the Council for the Free Churches established an organisation for the Free Churches' spiritual care at hospitals. Each hospital should have an assigned pastor, "contact pastor for spiritual hospital care", whose work was to promote and coordinate the work of the Free Churches. Among other things, it was emphasised that spiritual care should not just be directed towards congregational members, but towards other patients as well, and that you should not represent your own Free Church denomination, but all of them (Robertz 1970; Larsson 1984).

The major shift to ecumenical cooperation within hospital spiritual care didn't happen until 20 years later, in the wake of a long-lasting discussion in society on "care ideology". Spiritual care had been pretty much ignored during the 60's, while at the same time the need for reflection on the ideology of care had increased. After a strong focus on the medical and pharmaceutical development, and a movement of rationalising and centralising healthcare into huge hos-

pitals, there was a reaction in society against the dehumanisation and depersonalisation of hospital care. As a result, during the 60s and 70s there was an increasing debate within healthcare, highlighting the need for a healthcare ideology where the patient's perspective and important core values were emphasised (Kallenberg 1983).

The debate resulted in a new Healthcare Law in 1982 where patients' rights were increased and a stronger emphasis on rehabilitation was included. Healthcare was supposed to be planned in agreement with the patient, meaning more knowledge and information presented in an understandable way (Kallenberg 1983). Parallel to this development came demands for concrete changes in spiritual care through directives from the government and parliament that wanted to see an ecumenical development. In 1979 a proposition on spiritual care at hospitals and correctional institutions (DsKn 1979:2) it was suggested that the Free Churches and the Church of Sweden should have equal responsibility for spiritual ecumenical care, and that 1200 "beds" should amount to two fulltime positions: one priest and one pastor. In order to enable this the Free Churches were granted governmental funding in order to establish positions for "hospital pastors" (Lundgren 1982). Three important decisions contributed to some stability to the ecumenical project – common guidelines, common education, and continual deliberations among the ecclesiastical organisations (Larsson 1991). When it came to education an early decision was made that it should be developed and implemented together, which led to the establishment of an ecumenical organisation for training. At the same time, in order to develop their own work and identity, the organisations were strengthened on both regional and national levels for the Church of Sweden as well as the Free Churches, while a Council for Cooperation was established in order to promote the ecumenical dialogue. Finally, the common guidelines for the new ecumenical construction "The Hospital Church" gained great significance.

From the seal of confession to the seal of spiritual care

While the guidelines brought forth a perspective that promoted cooperation between the churches, they highlighted a perspective of professional secrecy that complicated the cooperation with healthcare. Before the congregational shift in 1962 there was little discussion of employees within spiritual care being included in healthcare teams. It was very much left to the different expectations of hospitals and the individual preferences and competencies of the spiritual care employees (Lundgren 1982). This didn't change after the shift, but during the 70s the Church of Sweden, through a change in legislation, received an even more extensive interpretation of professional secrecy, where what was shared in general individual spiritual care was given the same secrecy as that shared in confession. However, with the help of the argumentation of one bishop, a door was opened to an interpretation that made it possible to share some information within the spiritual care team, for the sake of the patient's best. The information could however not be extended to the healthcare team. The discussion surfaced decades later triggered by Bergstrand's book that questioned the purpose, functionality and theology behind professional secrecy (Bergstrand 2005).

In 2006 the discussion was raised at the Church Meeting[1], as a need for a clarification of professional secrecy among clergy, and the possibility to share some information with healthcare staff in order to facilitate cooperation for the patient's sake. It resulted in an ecclesiastical inquiry where once again the relationship between the priest and the patient was emphasised as well as the value for the patient in meeting with someone independent of the hospital organisation. Furthermore, it was noted that the spiritual care employee is subordinate to the ecclesiastical legislation, and that it was doubtful that the hospital church could be a part of healthcare work since there are no contracts that regulate this. Still, one noted that "an employee in the hospital church might be torn by the working situation" as hospital staff might find it desirable that the hospital priest or hospital deacon participates in the healthcare team for the pa-

tient's sake, yet the employee might be insecure if he/she risks breaking professional secrecy (SKU 2010). Due to a formulation in the paragraph that regulates professional secrecy it is today unclear whether this extended interpretation, binding for priests in the Church of Sweden, Free Church pastors and Roman Catholic priests, also includes imams and other representatives with corresponding responsibilities in their congregations. Therefore, it is now under investigation on request from the Swedish Agency for Support to Faith Communities (MST).[2]

More Faith communities at the table

At the turn of the last century the major actor within spiritual care, the Church of Sweden, was in a situation where it needed to work on its identity. The ties to the state was almost gone, and the membership had during the last 30 years decreased from 95 % of the Swedish population to approximately 80 % (Bäckström et al. 2004). At the same time the memberships in other faith groups increased, for example the population with a Muslim cultural background increased from under 50 000 in the 70's to around 350 000 at the beginning of the second millennium (Larsson 2014). According to governmental statistics from 2016, 154 140 persons were served by Muslim congregations, and 148 279 by Orthodox and Eastern churches (MST 2018). Parallel to the growing cultural and religious plurality, the Swedish healthcare system changed as it encountered people with experiences from a diversity of medical, as well as cultural and religious traditions. The holistic perspective/view was also clarified: Healthcare should be based on the individual's total situation, "physical as well as psychological, social, cultural and existential needs and expectations are considered" (Värdegrund 2002). In the 1982 Healthcare Act/Law it was stated that the entire population have the right to have access to healthcare on equal terms, leading to a multicultural perspective included in the Patient Law from 2014. The new law aimed at strengthening the patient's participation in healthcare, whereby the patient's linguistic background and personal prerequisites should therefore be considered when giving information'(PL, SFS 2014:821).

The multicultural development also affected spiritual care. Up till now, the Hospital Church had been responsible for covering multi-faith contacts. Through new legislation on faith communities and on support and governmental funding for faith communities, a new governmental agency became the centre for the development of multi-faith spiritual care.

The agency, the Swedish Agency for Support to Faith Communities (MST), whose main purpose is to distribute funding to faith communities, promotes dialogue between the state and these communities, and has the responsibility to support spiritual care in hospital contexts. The support is mostly aimed at building a structure for spiritual care in hospitals and at financing the employment of spiritual care workers. The registered faith communities entitled to such support today include the Free Church (6 denominations), Islamic national organisations (7), Lutheran churches (8), Orthodox and Eastern churches (17) and Other communities, including the Buddhist organisations (Fredriksson & Panova 2018), (Stockman 2018). Multi-faith spiritual care in other institutions such as correctional facilities, police, military or university is not included.

Muslim spiritual care presently extends only to 22 % of the country's hospitals, but as the multicultural perspective is given more space in spiritual care, more general questions have been raised concerning the suitability of an organisation of spiritual care that is based solely on faith communities (Willander 2019). These challenges to spiritual care in Swedish multicultural healthcare are also confirmed by studies that strongly question the way patients from different cultures often are sorted into religious groups instead of regarded as individuals with complex relationships to religion and spirituality (Nordin & Schölin 2011). Within healthcare there has been a surge in the research on existential issues (Lloyd et al., 2017; Lilja et al.2016; Udo 2014; DeMarinis 2014), and some definitions of spiritual care have been suggested that are not based on the fact that it is executed by persons from faith communities (Lundmark

2005). Some regional healthcare boards, although cooperating with current spiritual care workers, have also been presenting new guidelines for spiritual care at hospitals (Andlig vård Region Jönköpings län). The Church of Sweden simultaneously is investigating the need for support for spiritual care outside the congregations, and critique has been raised concerning the lack of responsibility for spiritual care as it doesn't receive the support and attention from the congregations that is needed (Bränström 2015). As the healthcare organisation is being reformed and large parts of healthcare moves from hospitals to the patients' homes, the congregations must take on even more responsibility for spiritual care such as ambulatory care and advanced care in the home. Due to this development, however there have been some efforts to create a new organisation of spiritual care where congregations in some dioceses must take on the responsibilities previously executed by the Hospital Church (Ellqvist & Edgardh 2016).

Theology

As a result of the new organisation in the 60s it became even more important for spiritual care to motivate its existence as an external agent in secularised healthcare. Furthermore, it was important to create an "ecumenical church", which didn't have any counterpart outside the hospitals. Against this backdrop two theological perspectives are important to highlight.

Pastoral psychology and a theology of spiritual care

When the care of souls geared more towards individual spiritual care than previously, naturally the new psychologically – and psychotherapeutically - influenced methods became more interesting.

This perspective on care and treatment had early on been criticised by bishops on theological grounds. From a soteriological perspective bishop Runestam argued that psychotherapy weakened the conscience that was supposed to make God's forgiveness needed, and by referring to Jesus saying "And if your eye causes you to sin, tear it out and throw it away" (Mt 18), bishop Andrae argued that the natural life was not necessarily the highest goal. Bishop Nygren emphasised that the main focus of spiritual care was on man being addressed by the gospel, and just secondarily about psychological conflicts. Spiritual care connected to conflict resolution would only result in its secularisation (Brattemo & Lundgren 1996).

Against this backdrop it became important for the development of Swedish pastoral psychology[3] to have a clear theology inspired by North American researchers and pastors like Seward Hiltner. Leading in this development was St. Lukas, an organisation/foundation established by Christian medical doctors, priests, pastors and social workers, who wanted to form a paradigm for pastoral care which was built on modern psychological research while at the same time keeping what was significant/crucial in Christian pastoral care (Brattemo & Lundgren 1996). In 1947 a training for a specially appointed group of pastoral care workers – pastoral psychologists – was started, whose purpose was to introduce the new pastoral psychology into healthcare. During the 60's it was mainly this tradition that influenced the training of workers in hospital spiritual care.

By regarding pastoral psychology as a method based in classical Christian pastoral care, new psychological theories and theology were intended to be linked. It was about spiritual healing, education and guidance regardless as to whether it was mediated through the dialogical conversation or through free associations or dream interpretation. One of the founders of St. Lukas, the Methodist pastor Göte Bergsten, argued that it was about the needs of man, but not man as the centre of the universe, rather as part of a larger context – the spiritual community (Brattemo & Lundgren 1996). This effort to make conversational methods and psychological theories subordinate to a theological basis has continued to be shaped by other theologians with a background in spiritual care, St. Lukas and psychology of religion. By arguing for a skill or method through which you can discern the gospel in spiritual care, Olivius has criticised a perspective where pastoral care is regarded as mere therapeutic technique where the gospel doesn't count. Bergstrand and Lidbeck talk about diffe-

rent levels of conversation, where one level connects the conversation to the wider context of faith and tradition (Löf Edberg 2018).

This theological focus has not just been on the "larger context" in terms of the spiritual community, but also in terms of different tools that can be used parallel to the conversation. This perspective is brought forth by the definition of pastoral care given by Owe Wikström[4] – The purpose of spiritual care is to locate the existential dimensions in the person's story, while offering the possibility of a theological interpretation of them. Here all the church's resources are needed through symbols, narratives, bible, liturgy and sacrament (Löf Edberg 2018).

The theological aspect of spiritual care has also been interpreted by hospital priests as "working with the theological diagnosis". This has been understood as a way of, through finding a common language together with the patient, formulate his/her life stance, what creates meaning and patterns in life (Brattgård 1987). The theology of spiritual care could here be an example of how the Church of Sweden during the end of the last century changed the way it viewed its role and purpose. Inspired by liberation theology, a much stronger "receiver-orientation" was encouraged in the formulation of a person's life view (Bäckström et al 2004). In spiritual care one can also see how this openness to the "receiver's" needs also parallels the differentiation of the focus of spiritual care into existential, religious and spiritual issues (Grunddokument 2004). This orientation to pastoral/spiritual care was also supported by the majority responding to a national research survey of priests in the Church of Sweden and pastors in the Free Churches in terms of how pastoral care was understood as needing to address the existential and spiritual needs of people who may have very different religious – or other types of – worldviews (DeMarinis 1993).

A theology in/for crisis

In the effort to prevent spiritual care from losing its theological dimension, emphasis was put not only on the strengthening of the individual's spiritual health, but also on connecting the conversation and the individual to the idea of a wider spiritual community or ecclesiastical tradition. In a sense this was a way of pointing towards an ecclesiological dimension in the theology that coloured spiritual care and counselling. Since the ecumenical "Hospital Church" is a rather unique construction there have been requests for studies on its ecclesiastical perspective. It is interesting to speculate whether the implicit or explicit ecclesiology of the Hospital Church suggest a "new" church with significant traits that separates it from the churches that work together there (Brodd 2018). Against this backdrop it could be interesting to highlight some changes in theological perspectives during the last decades. Parallel to new perspectives in the training of spiritual care workers, and the decreased influence of St. Lukas, there has been an emphasis on a theology that is situational, i.e. responsive to the situation of the individual and puts emphasis on the importance of unprejudiced presence. This means an emphasis on trauma and crisis where the congregational perspective is toned down and the priority is here and now.

This perspective was expressed through a reaction against how the patients' needs were argued to be subordinate to therapeutic and theological goals. "Counselling does not need to bear fruit (nor have a therapeutic function), instead one needs to have trust in the present meeting, and "love to our fellow human, trust in God's possibilities and the own resources of the one seeking help" (Björklund 1989). Through this perspective the individual and his/her needs are in focus in the encounter, while the wider context that is the congregation and the ecclesiastical tradition receives a much more retracted position. This focus also becomes evident if we look at how the new guidelines for baptism by the Free Church as the "Hospital Church" was being shaped. Since many pastors in the Free Churches came from a congregation where only baptism of adults was practiced, the Free Church Council of Sweden in 1996 needed to issue complementing instructions for baptism in order to emphasise the new role that the pastor had in the Hospital Church. In situations of crisis, pastors who were asked by parents to immediately baptise their child due to life-threa-

tening conditions, were instructed to accommodate those wishes as soon as possible (Ekedahl 2002).

This example can also be understood as an expression of how traumatic health situations can assume an important place in the understanding of the theology of the Hospital Church. The understanding that one meets people "in the most difficult situations" in spiritual care (Dillmar & Björklund 2015), has in recent years led to ecumenical theological reflections and deliberations that in turn have resulted in pastoral theological books on pastoral counselling and spiritual care. Even though more areas than crisis and trauma are touched upon, the theology relates to the hospital context with short meetings in often traumatic situations with uncertain expectations and results. Biblical motifs where Jesus heals the sick are complemented with for example the Easter motif, as it is argued that "pastoral counsellors often enter into a similar situation when they meet people in traumatic situations". The purpose is then to "look, be there, and – when the right time comes – leave and move on" (Dillmar & Björklund 2017). The spiritual care worker enters an acute situation, intervenes and then steps back. This understanding of the role of the Hospital Church can also be understood against the backdrop of the "national curative" role the Church has when it comes to situations of crisis and catastrophe in society. According to a study that was made after the Estonia disaster, when over 800 people drowned as a ferry sank in the Baltic Sea, 89 % agreed totally or almost totally with the statement that "the Estonia disaster shows that people need help to process spiritual matters in times of crisis". In crisis the church is expected to facilitate place and resources for people's needs in a way that would be regarded as almost abnormal in everyday situations (Bäckström et.al 2004).

Organisation

The organisation of spiritual care is based partly on the ecumenical organisation and partly on the multi-faith organisation that were established in 1998–99. At the same time each faith community has a central function on its own since all spiritual care workers are employed by their local congregations. The organisation evolves around two, many times overlapping units – the ecumenical Hospital Church, linked to the Swedish Christian Council, and the Swedish Agency for Support to Faith Communities (MST).

Beyond these organisations the spiritual care workers who are employed by the Free Churches and the Church of Sweden have their own membership organisations, Church of Sweden employees in the Hospital Church (SKAIS) and Free Church employees in the Hospital Church (FAS). Together they arrange annual conferences with continuing education. They each have one delegate in the Council for cooperation in healthcare, and also have representatives in the European Network for Health Care Chaplaincies.

Training

Through the influences of St. Lukas, that started up its institute for education in the late 1940's, the first training that was especially offered to spiritual care workers was very much connected to therapeutic counseling. The emphasis on this competence however became so strong that both patients and hospital staff expressed requests for a church at the hospital that was more similar to the one based in life outside the hospital. The training then started to open up to influences from the Clinical Pastoral Education (CPE) training in the US, and parallell to the establishment of ecumenical spiritual care, in 1982, a new ecumenical training was presented. It was however decided not to have full CPE-training for three reasons: 1) It was not an option to connect the training to a university since some of the spiritual care workers in the ecumenical teams were not eligible to apply for university courses, 2) required admission tests and 3) the parts of the training that requested a more cohesive education were rejected (Lundgren 1991).

During the 90's and early 2000's adjustments were made due to critique. A general complication was that the basic education and previous knowledge among participants varied to such an extent that it was hard to satisfy everyone. On top of that the participants had very different

Swedish Christian Council

an association of 26 Churches and 4 observers whose purpose is to link together the work of the members. One of these "links" is the "Hospital Church". Two consultant officers, one from Church of Sweden and one from the Free Churches links to SKR

"Hospital Church"

Consists of employees from:

Church of Sweden (216 scw, with "coordinator in each diocese)

Swedish Free Church Council

(33 scw from six different denominations, coordinated on regional levels)

Roman Catholic Church (5 scw, coordinated by Stockholm Catholic Diocese)

Christian Orthdox Congregations (7 scw, no specific national coordination)

Council for Cooperation in Healthcare

(delegates from Church of Sweden, Free Churches, Stockholm Catholic Diocese, the Orthodox Churches, SKAIS and FAS)

Works with issues that are of common interest for the Hospital Church and spiritual care for outpatients. Primary purpose is to manage the training program

Swedish Agency for Support to Faith Communities (MUF)

Main task to try the rights to governmental funding. Also functions as a forum for dialogue bw state and Faith Communities. Responsible for the organisation and education of non-Christian spiritual care workers (scw) and financial support to all the Christian Communities except for Church of Sweden.

Muslim Communities

(3 scw at hospitals, 9 coordinators) with regional contact lists who coordinate interventions by persons from local congregations. These are employed by the Muslim communities who belong to the Islamic Council for Cooperation

Buddhist communities

(2 scw and coordinators). Coordinate in the same way as the Muslim coordinators. Employed by Swedish Buddhist Council for Cooperation

Distributes financial support to all members of the "Hospital Church" except for the Church of Sweden

experience from congregational life since the Free Church required 5 years experience in order to be employeed and eligible for training, whereas the Church of Sweden had no such requirement (Lundgren 1996; Wåglund 2007). The training was changed, this time influenced by the Norwegian version of CPE (PKU) where there was more emphasis on personal and theological reflection. This resulted in a Practical Theological Part and a Pastoral Clinical Part. After some adjustments the new education was launched in 2011. The requierments for this training was that you are employed by a congregation and work at least part time at a hospital. The training, called "Upskilling program", has focused on three areas: the spiritual care worker, the patient/confident, and the communicative encounter. In the furthering of these areas one relates continually to two central themes – professional role and professional identity in relation to being sponsored by the church, and the encounter with other professionals and with other faiths.

The course has four steps:

- Step A: Participation of spiritual care workers from the Hospital Church, University Church, Church–police work, Church–workplace, and Church in correctional facilities. Focus is on what is particular for "pastoral care in institutions", as well as the exchange of experiences.
- Step B: Focuses on furthering the knowledge on spiritual care and the identity as a spiritual care worker. Introduction seminar and two separate weeks of classes. Literature reading, supervision by colleagues, 20 hours of "internship" on a ward at your hospital.
- Step C: Meeting 15 times with a counselor with focus on "what it means to be a tool yourself in the encounter with patients".
- Step D: Introductory seminar, three extended periods of seminars, and two focus weeks at a hospital. Emphasis on practical theological skills in spiritual care with the purpose of furthering theoretical and practical knowledge and the capacity to integrate one's experiences with theological reflections in the spiritual encounter. Focus is also on reflecting on your own possibilities and obstacles (Kursbeskrivning 2019).

In steps B and D there is mandatory as well as voluntary literature. In order to further your knowledge in interfaith encounter, ritual studies or research on spiritual care you will have to choose that as extra, voluntary, literature. There is also a possibility for those interested to link part of the literature studies to a theological university college.

Research

The research on spiritual care is very limited, whereas there are more published books on pastoral theology that also are used in spiritual care. This could be an expression of an idea that spiritual care workers nurture, namely that it is hard to see what a presumably detached approach with emphasis on measurement used by researchers could contribute to a relation-centred work, with emphasis on responsive presence. On the contrary, one understands spiritual care as an alternative to the evidence-based practice used in healthcare, which runs the risk of losing central inter-human aspects by reducing the individual to the diagnosis. Another perspective is to view this situation as part of a larger challenge for churches where some discern a gap between academic and ecclesiastical theology (Bäckström 2004). The academic theology is based on a systematic approach that divides aspects that are kept together in the congregational life, which in turn might result in losing the connection to important issues that are raised in the praxis of the congregation. However, the more practically applied theology, which is formulated in church might, without the distance which the academy offers, lose its intellectual sharpness and become increasingly pragmatic.

Quite a lot of research on the existential perspective in healthcare has been presented by former hospital priests such as Kjell Kallenberg and Ingrid Bolmsjö, but the focus for this section will be on research on spiritual care. Among PhD research, there are two dissertations that have focused on spiritual care in hospitals. Both focus on coping strategies, but from two different perspectives. The first, written by Andersson Wretmark, was based on interviews with 79

women who had been going through perinatal loss (Wretmark 1993). The study showed how healthcare routines in these situations hindered the parents from their possibilities to cope with their sorrow. The practice of hiding the children from the mothers, not letting them know their gender, nor having the opportunity to bury them resulted in the mothers getting stuck in their grief. The study had a great impact on healthcare routines and led to a new role for spiritual care workers through different kinds of participation when the parents were offered new possibilities to say goodbye to their children and/or bury them. The second dissertation was also based on interviews and focused on coping strategies of priests and pastors in spiritual care, and published in article form (Ekedahl 2002, 2008). It used the expression "multifaceted stress with existential dimensions" in order to describe the stress which spiritual care workers needed to handle. The dissertation also described how this kind of stress is handled with the help of religious as well as personal aspects of their orientation systems.

Besides these dissertations spiritual care has also been touched upon in studies in palliative care and from nursing perspectives. The largest study was based on a survey from the beginning of the second millennium which focused on the counselling of hospital priests (Strang & Strang 2002, 2006). When they reported on what kind of conversations they had with patients, the result showed that they often were used for counselling in areas that many times went beyond the religious area, which in turn meant that their relevance for healthcare, and for patients, increased. Other studies have highlighted spiritual care from the perspective of hospital staff. This has led to the identification of several problems associated with spiritual care, such as the staffs' own relationship to religion, lack of education in the field and an inadequate organisation. Although it was evident that spiritual care was far from being implemented in daily healthcare practices, it was still regarded as an obvious part of holistic healthcare. It is also of interest to note that the definition of spiritual care, used in these studies, did not relate to faith communities, yet rather to certain aspects of the function of nurses (Lundmark 2005, 2006). Finally, it is important to mention a recent article where the organisation of spiritual care, based on religious faith communities, is problematised from a pluralistic perspective (Willander et al. 2019).

At Uppsala University there have been several doctoral dissertations in psychology of religion of relevance for this area. These include Belfrage's research (2009) on clergy stress, existential meaning and burn-out; Lundström's research (2010) on the importance of existential rituals for patients who have lost a child through sudden infant death; Lloyd's research (2018) on existential meaning and mental ill-health among young adults; and Schumann's research (2018) on existential meaning and youth.

Ongoing and upcoming research in spiritual care

In light of the population changes in Swedish society and the new interest in and need for a better understanding of spiritual care and existential information, the Wellbeing and Health research area of the nationally-funded Uppsala University Impact of Religion research program included a research project on Existential Information in Patient Care. The project was conducted by the authors of this article and examined understandings of and experiences with using existential information in healthcare contexts. The study populations included patient groups, spiritual care staff members, and other healthcare professionals at a large urban hospital in Sweden. The study's first articles are under preparation. The results from this study as well as critical reflection on the spiritual care situation outlined in this article will be used to conduct a national survey of spiritual care professionals' experiences serving in hospital chaplaincy, which will also include representatives serving in this function for Roman Catholic, Orthodox, Buddhist and Muslim communities. The purpose of this study is to give feedback on and recommendations for spiritual care needs in relation to society's needs and spiritual care professionals' needs.

Concluding remarks

One can characterise the development of institutional spiritual care as a field where purpose and content through the years have been negotiated by church, government and healthcare. Theological values and healthcare ideology to some extent have been altered or changed course in accord with political decisions as the "players" have changed. The early domination of the state church has been challenged by the ecumenical and interreligious context, and recently by representatives from healthcare professions. This means that the field of spiritual care now consists of representatives from different contexts, where different existential worldviews and understandings of what might constitute relevant knowledge and skills coexist and challenge each other. In this respect the current situation in many ways reflects the wide variety of existential worldviews present in the Swedish population as DeMarinis previously outlined as an area for public health attention (DeMarinis, 1998). Besides being a situation, which raises important questions on how to handle issues such as cognitive dissonance, it also highlights interesting challenges related to the professionalisation of spiritual care workers. How shall, for example, spiritual care be defined, and by whom? What role should confessional belonging play in the qualifications of spiritual care workers? And what kind of knowledge should count for spiritual care to be relevant in a highly pluralist context where also evidence-based research more and more contributes to the understanding of existential issues. The development of professional identity will also be dependent on or affect how one understands the relationship to other health care professionals as well as to the faith traditions that now are responsible for the employment. Finally, this development also needs to be reflected in the training and thus poses questions regarding what fields of knowledge should be included, or given priority, and which organisation(s) or institution(s) would be best equipped to provide this.

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Notes

1 A lesser decision-making body in the Church of Sweden.
2 Information in e-mail correspondence, 20190815, from Gunnel Andreasson, konsulent at MST.
3 The term pastoral is used in the texts mentioned. It can also be linked to spiritual care as discussed in this paper.
4 Owe Wikström's work has played a central role in the literature related to spiritual/pastoral care in co. For a complete list of his publications please see appendix in (DeMarinis et al., 2013).

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New wine in new leather bags?

Hospital chaplaincy in Northern Europe – The Danish case

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ABSTRACT

Focal points of this article are preconditions and obstacles for the further establishing and increasing professionalisation of a specific field of pastoral care in the Lutheran Folk Church of Denmark (CoD). Since the mid-eighties general specialisation in society has implied a development of a multitude of chaplaincy in public domains in Denmark (Kühle & Christensen, 2019:182). This has generated an increase in numbers of chaplains in health care. In this paper we aim to show main trends in the development and current state of spiritual care[1] and hospital chaplaincy in Denmark and include first results from a proscriptive audit pilot developed for internal quality assessment and development.[2]

1. Introduction

What do we mean by "chaplaincy"?

A chaplain was, traditionally, a clergyman/-woman. In the broader international context, however, the chaplain might also be a rabbi or any other representative of a religious or philosophical tradition, a humanist or an atheist, as is the case in increasing numbers especially in the US, England and Holland (See Zock in this issue). In a Danish context in most cases it would imply ordained clergy within the Church of Denmark all though later years have seen the arrival of a Muslim hospital chaplain, as well as a few Muslim prison chaplains (Baig 2019).

Since Denmark has only recently and to a somewhat limited extent embarked on the journey towards a multi-ethnic, -cultural and -religious society, reminiscences of the old dominating Christian culture of premodernity is still somewhat prevalent and thus motivates the dominating presence of clergy affiliated with the CoD working as chaplains.

What are we talking about: How to define "Spiritual Care"?

Spiritual care as concept is found in the notion of Total Pain. Dame Cicely Saunders, founder of the modern hospice movement, was the first

to formulate the concept of Total Pain and described it as the overall situation of the seriously ill and dying. She defined the concept of total pain as holistic suffering encompassing a person's physical, psychological, social, spiritual, and practical suffering (Richmond 2005).

The understanding of total pain is reflected for instance by WHO as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (World Health Organisation, 2019). In continuation of the WHO's attention to existential and spiritual challenges, spiritual care is defined by the Danish Council on Ethics as "a care that includes both the specifically religious about grief and the consideration of the existential issues and concerns that may arise in any dying person, regardless of whether these questions and concerns of the individual are more or less or not at all characterised by religious aspects" (Tiedemann, 2002).

Distinguishing between "religious" and "spiritual" makes way for a broader understanding of chaplaincy traditionally understood as pastoral care, since spirituality is a broader term than religion. Although not everyone has a religion, everyone who searches for ultimate or transcendent meaning can be said to have a spirituality (Sulmasy, 2002: 25).

Accordingly, this article will understand both "spiritual and existential care" and "pastoral care" as just "spiritual care". A definitive definition on "spiritual care" intervention is contested and might be grouped into several general categories (Hummel, Galek, Murphy, Tannenbaum & Flannelly, 2008: 49), but we find it helpful to identify the spiritual component in spiritual care as a care regarding: 1. The possibility of another reality than already known (vertical transcendence); 2. Context, specific situations, activities or acts; 3. Individual longing and experiences of a special relatedness" (La Cour, Ausker & Hvidt, 2012: 80). Much along the same lines Stifoss-Hansen & Kallenberg writes their definition on spiritual care in health care: "... to be aware of the patient's existential issues and resources, to listen to the meaning they have in the patient's life history, and to assist the patient in his/her work on existential issues based on his/her own view of life" (Stifoss-Hanssen & Kallenberg, 1999: 23).

The strange Danish case Religion and research?

1. Religion and religious adherence

Sociologists have described Denmark as the "least religious society in the world". And surveys do show that Danes generally are among the least religious Europeans – who in general are less religious than people in other parts of the world. PEW research[3] in a 2018 survey thus ranks Denmark no. 32 of 34 out of the least religious countries in Europe (Pew research 2018). If value studies are consulted, however, a more differentiated picture appears indicating that a lack of traditional religiosity of Danes does not mean that Danes are not religious. The European Value Survey find that more people believe in a spiritual force (39 %) than in a personal God (16 %), which is an expression of a tendency towards non-traditional confessional spirituality to be expected as a result of an inclination towards individualisation. This is accentuated by a membership decrease of CoD from 86 % in 2008 to 77 % in 2017. Also, one finds that since 1981 there has been a steady decrease in the proportion of those who say they believe in God from 64 % in 2008 to 53 % in 2017, and in 2017 60 % say they are believers compared to 72 % in 2008 (Frederiksen, 2019: 236.).

2. Clinical studies of existential and spiritual needs

International studies show that patients in general, in different clinical contexts and across age groups, express existential and spiritual needs, and want to talk about issues related (Koenig, King & Carson, 2012). Danish studies suggest that Danes experience something similar in connection with life-threatening illness and crises. Research projects from Danish research institutions have provided insight into the spiritual needs of Danish patients and relatives (Opsahl, T. 2017). Ingeborg Ilkjær has shown that

existential reflections are intensified in patients with severe lung disease, and furthermore, that they often miss care directed at existential and spiritual conditions (Ilkjær, I. 2012). Lene Moestrup has uncovered that dying patients and their careers, even at hospice, often have uncovered ambivalent spiritual needs (Moestrup, L., 2015). Similar findings have been indicated from around the turn of the millennium when interest for the research area began. In 2006 a Danish Cancer Society survey study noted that 17 percent of the participating cancer patients responded that their illness had given rise to religious considerations (Grønvold, Pedersen, Jensen, Faber & Johnsen, 2006). A study from 2008 showed that patients intensify their thoughts about faith, doubt, meaning, life and death, and that religious considerations are part of this picture (Ausker, la Cour, Busch, Nabe-Nielsen & Pedersen, 2008).

A study points out that "the belief in something bigger and patients' religiousness is not an irrelevant factor in connection with serious illness, even in a secular society such as the Danish", and that "the healthcare professionals and, for example hospital pastors/imams [...] could address the patient's spiritual and existential beliefs in order to identify and resolve possible negative ideas" (Pedersen, 2013).

The studies indicate that what has been called a "crisis religiousness" is activated in many patients, and that some patients experience that religious and existential thoughts are not given enough attention. A study points toward the fact that 45 % of doctors in general practice state that they take part in existential and spiritual care only once or less per year, which leads to the assumption that spiritual care issues might be unattended (van Randwijk, Opsahl, Hvidt, Kørup, Bjerrum, Thomsen & Hvidt N.C., 2017).

1. History: Church and chaplaincy in a transition period

The last 5 decades have seen the church of Denmark develop into a hot house of activities exploring new liturgies, expanding the traditional understanding of church and church gatherings and establishing new positions for clergy. Accordingly, the field of function and profile pastors, which is the term used in Denmark since the international term chaplain is not used, is growing. Thus, of the total number of clergy which makes approximately 2000, a little more than 1 in 6 is now working as a function or a profile pastor, often in combined positions also working as a parish pastor. This implies that every sixth pastor is working in an area of specialised responsibility (Center for Samtidsreligion, 2018).

Clinical Pastoral Education, a bypassed contribution.

An obvious contribution towards spiritual health care in a Danish context might had come from the clinical pastoral movement. Alas, the Clinical Pastoral Education (CPE) never made it to Denmark. The holistic orientation and integration of theory and practice of CPE has not been "*kosher*" in a Danish setting and for several reasons. Furthermore, the theology developed in relation to CPE was easily criticised (Howard, 2017). The CPE movement was brought to Europe via the Netherlands and Germany, where it gained influence, just as in Norway and Finland, becoming a formalised and recognised part of the church's work with spiritual care. This influence has bypassed Denmark partly because it seemed foreign to Danish theological education and attitude after World War II which was oriented towards dialectical theology and propounded especially by Tidehverv[4], and despite, one might add, the fact that influential theologians as Grundtvig, Kierkegaard and Løgstrup observe and work with matters well known to pastoral care. Partly, also, the bypassing was due to the fact, that in Denmark, academic theology has been promoted at the expense of the theological reflection that grows out of the encounter with practice. More to this point down standing.

Function pastors and profile pastors

There is no single term equivalent to the generic term "chaplain" (Kühle & Reintoft Christensen 2019: 187). But a report on chaplaincy has been compiled contributing towards a concept clarification as to how and when we talk of function pastor and of profile pastors: "The work of the function pastors usually takes place outside the

physical framework of the church, while the work of the profile pastors usually takes place within a church context. One might say that the work of the function pastors is 'outward', while the work of the profile pastors is 'inward'" (Kühle, Christensen, Asboe, Dollerup, Damgaard, Brodersen & Flyvholm, 2015: 14).

The underlying challenge of categorising clergy working as function or profile pastors is a matter not just about where and how they work but also how they are paid and thus has political implications. The numbers are compelling: If chaplains serving in the armed forces as well as other chaplaincy are included, the total number of chaplains is about 345 (Kühle et al 2015: 157). If one compares the number of chaplaincy working in health, prisons, universities and higher education as well as DanChurchSocial, the total figure has been growing from a mere 37 in 1971 to 78 in 1994 finally reaching 226 in 2015. Numbers of pastors working in health is even more significant as they have rocketed from 14 in 1971 to 102 in 2015 (Kühle et al 2015: 156). In this article the distinction between function pastors and profile pastors are maintained and the two together labelled "specialised" pastors.

Pros and cons towards specialised pastors.

The development towards function and profile pastor didn't take place without opposition. CoD is characterised by being a parish-oriented church with its emphasis on the local parishes.

This inherent understanding of CoD is reflected in the fact that almost all specialised positions are shared positions containing a specialised part and a traditional parish part. Compared to the other Nordic countries where much the same development took place, specialised pastors in Denmark, to a certain extent, was considered a danger to the church's anchoring in the local parish. The resistance towards specialisation of clergy was the case especially throughout the 1960s and 1970s being a result of the dialectical theology's strong position in Danish theology and church life. Reminiscences of this resistance were reflected throughout the 1990s and still prevails although the development must now be regarded as reversed. Nevertheless, there is little doubt that a certain scepticism towards particularistic congregations and pastors still exists (Iversen 2013: 64).

Several things worked in favour of the chaplaincy movement. First, the *Zeitgeist* worked in favour of a general specialisation of society: Cost benefit analyses meant bigger hospitals, which again implied a certain division of labour between clergy. Also, the role of religion in Western societies was redefined. Freud wrote "The future of an illusion" and meant "the end" of it (Freud, 2008). For most of the twentieth century sociologist worked from the expectation that modern age societies would become increasingly secularised and religion loose relevance. At the closing of the century, sociologists reached the opposite conclusion; religion was alive and kicking albeit in the post-modern clothes of spirituality, individualisation and a strong distaste for dogmas, clergy and institutions. The development is personified in sociologist and Protestant theologian Peter Bergers work and his late announcement, that he, in his secularisation-theories known from bestseller The Sacred Canopy and other works, had been all wrong stating that "the world today is as furiously religious as it ever was." (Berger 1967 & Berger 2005). Habermas emphasised that in post-secular societies, religion has an unforeseen role, because of the increasing differentiation most notable in the prevailing of individualisation (Habermas 2008). Contemporary sociology of religion is preoccupied with "lived religion", a phrase coined by Meredith McGuire and others, which has paved way for a new understanding of religion and its role in society (McGuire 2008). Researchers argue that especially the historic majority churches are viable and frame how religion is perceived and framed in the public sphere (Nielsen 2019).

2. Theology and spiritual care. In the shadow of dialectical theology.

The development of, and increase in, positions and subsequent professionalisation of chaplaincy as described above has, curiously, developed alongside the somewhat late development of the field of spiritual care. The field of spiritual care has during the 20th century undergone quite a different development than from that of other

Nordic countries due to dialectical theology, in Denmark in shape of the aforementioned Tidehverv, which, since the early nineteen-twenties until recently, has been a strong influence in the CoD especially among the clergy. In this very Danish trope of Neo-Lutheranism a heavy emphasis has been on the Word. Practical theology disciplines, and spiritual care as one of them, thus came to be understood as being of secondary importance. As consequence spiritual care was not considered a subject of its own for most of the 20th century and for a long time lived unnoticed as a discipline in its own right. In so far that spiritual care was dealt with, it was from the perspective of dialectical theology and Thurneysen's kerygmatic spiritual care (Harbsmeier & Iversen, 1995: 393).

This implied a contradiction between theory and practice, preventing the thinking together of theory and practice of spiritual care (Bach, 2007: 344). Moreover, a contradiction was presupposed between theology on the one hand and psychology on the other. The training of spiritual care givers was therefore essentially looked upon with a distinct distrust because of the supposed inherent threat of this leading to a psychologising of the theology, but also because education in this area was understood as a professionalisation that basically was at odds with the hart of pastoral care. Insofar as a Danish spiritual care tradition can be spoken of, through most of the last century, theology and spiritual care was not conceived of nor practiced in interaction with each other. Academic theology traditionally never made much of an effort on behalf of practical theology as a discipline, not to mention its subdomain of spiritual care.

The call for training.

In Denmark spiritual care is taught infrequent in different contexts for both professionals and lay; however the range of courses and competence-giving training offered in spiritual care is limited, and to a large extent offered ad hoc, with one exception. It wasn't until the early 1990s that a distinct and formulated interest towards education and professionalisation within spiritual care began to emerge due to a demand for supervision from the associations of hospital and prison pastors. A conference was set up in 1993, and in the aftermath, initiative was taken to establish a chair in spiritual care and pastoral psychology at The Pastoral College (Præstehøjskolen).[5] This was established in 1995.

Graduates in theology aspiring to an office in the CoD, do, in connection with a 5-month course at The Pastoral Seminars in Copenhagen or Aarhus, receive training in basic spiritual care. At university level offers remain scarce and infrequent. One existing offer is the Flexible Master at the University of Copenhagen, which offers the possibility to incorporate one and up to three "compact courses" in the area of spiritual care. A university level introduction to the "proprium" of spiritual care is not to be found. A master's degree focused at core areas of spiritual care was offered 2012–2013 at University of Copenhagen but was substituted by the above mentioned and somewhat fragmented – specialised? – model consisting of compact courses offering freedom in thematic choice and suspected lack of cohesion and an overall profile. Because of the "empirical turn" and the inherent growing interest for Practical Theology[6], spiritual care and related subareas has seen a growing interest resulting in an increasing number of Master projects as well as Ph.D. dissertations at the Theological Faculty in Copenhagen as well as at the Institute of Theology, Faculty of ARTS, University of Aarhus.

Compared with the Dutch situation the educational scene in Denmark is rather minimalistic. A multi-religious education program as initiated in Norway has been discussed numerous times but until now rejected (See Grung in the issue).

Training aside, in current years, CoD are looking to strengthen the spiritual care provided to members and non-members alike. An increasing number of parishes provide internet spiritual care, as do the websites Cyberkirke.dk and Folkekirken.dk. The CoD has been criticised by the Danish Deaconess Council for not focusing on young people's need for spiritual care (Dansk Diakoniråd, 2018). However, the church tries to meet the needs also of young people by reaching out. The website Sjælesorg.nu. (Spiritualcare.now) is a three-year project and the National

Church's latest effort in offering confidential conversations through chat with a pastor on the www.

Private agents as the Colony of Philadelphia and the St. Luke's Foundation in Copenhagen provide spiritual care training for caregivers at intervals. For many years, the St. Luke's Foundation and DanChurchSocial have provided counselling and telephone spiritual care, and IKON has provided spiritual care for people affected by the New Age or alternative religiosity.[7] For almost three decades Nordic Spiritual Care Symposium has arranged annual gatherings in the Nordic countries. Journals such as the "Critical Forum for Practical Theology" (Kritisk Forum for Praktisk Teologi) periodically publish thematic issues as "Disaster Theology" or "Spiritual Care". Furthermore, Norwegian based "Journal of Spiritual Care" (Tidsskrift for Sjelesorg) has a wide circle of Danish subscribers. The Norwegian milieu has been an inspiration and, for some time, the most obvious context for doing a CPE or other certified spiritual care courses, for instance at Modum Bad.

In the absence of lay courses in spiritual care, the right-wing context within the CoD seems to be the most persistent provider of such assisted by free church initiatives. One exception is biblical spiritual care courses now offered by the Danish Bible Society (Bibelselskabet, 2019).

3. What are you really doing, chaplain? Self-understanding, organisation and practice.

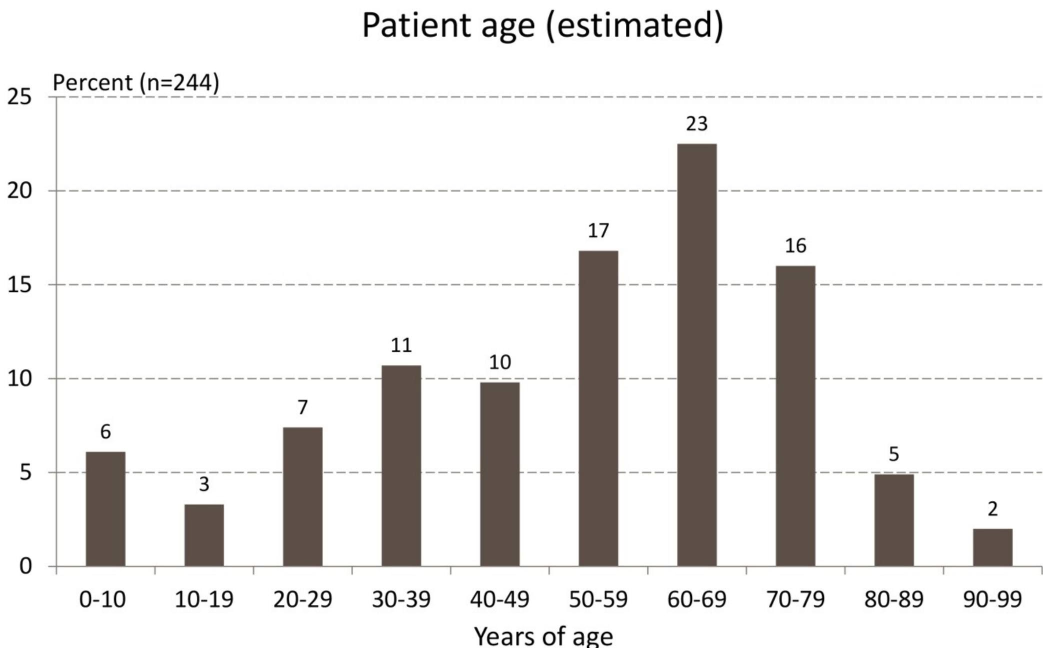
Several chaplains have met a welcoming attitude from staff when visiting wards, but also the somewhat curious question above.

This has to do with mainly two aspects. First, the organisation of chaplains as kind of a "go-between" in the overlapping areas between hospital and church. Second, it also points to the self-understanding of chaplaincy as being on the fringes of public healthcare.

Self-understanding and organisation

Self-understanding has to do with the greater organisation and result in a certain practice. So, first a few remarks on the organisation. Historically, public hospitals with patients coming from a large area had their own churches and clergy to serve the patients. In cases with smaller hospitals it was the parish vicar who visited "parish-

Figure 1.



ioners" and performed emergency baptisms and lead the worship services.

Following the structural reform in 2007 hospital chaplaincy is now organised regionally, with biannual or yearly regional meetings in a more or less formal cooperation with the bishops. At national level, structural reform is reflected in the fact that there now are regional representatives forming the board of directors of PRIS (Præster i sundhedssektoren), an abbreviation for Clergy in the Health Sector (Præsteforeningen, 2019).

Chaplaincy in the healthcare sector are employees of the CoD, and as such they are under supervision of local deans and bishops. However, in recent years, establishing of hospital chaplaincy deans has gradually been seen in several dioceses and/or regions.

Thus, in organisationally terms, the hospital and hospice chaplains are closely related not only to the diocese but even to the parish. They are, however, not formally part of the organisation of the institution in question. The hospital chaplain attends local conventions and collaborate with the parish clergy in local activities. At the same time, they participate in the parish, in council meetings, parish activities, and committee assignments to an extent equivalent to the percentage of their total employment in the parish.

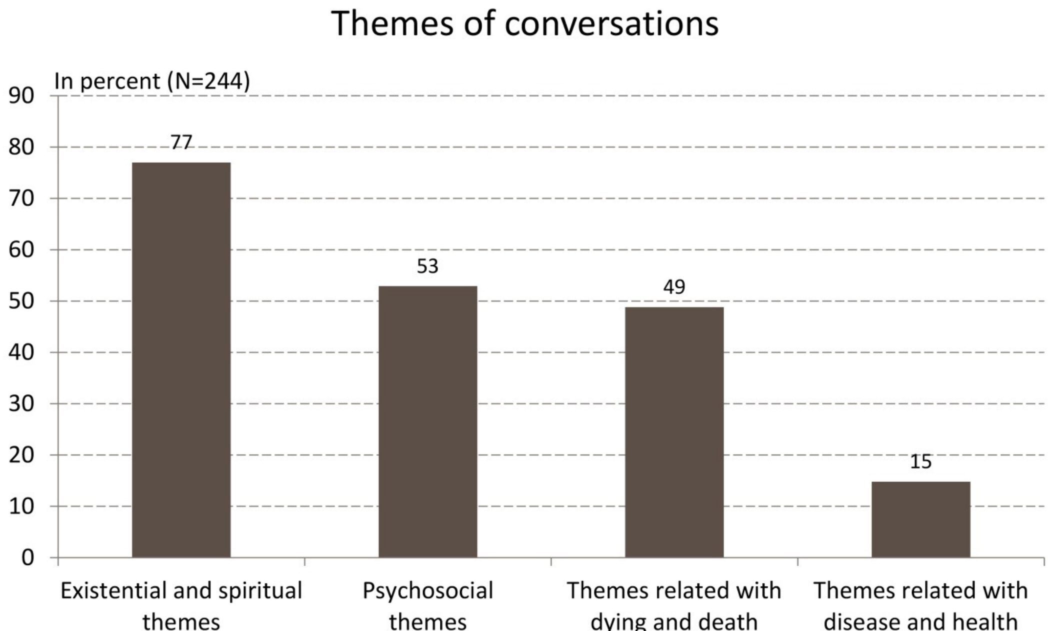
The dean oversees and allocates financial resources to hospital chaplaincy and negotiates the part of the chaplain's employment for hospital duties. When a position is vacant, the institution participates in the hiring process by reading the applications, participating in interviews, and, if desired, submitting a statement to the bishop. When a chaplain is hired, an agreement is made between the diocese and the hospital management outlining the broad lines of the future common cooperation. The hospital chaplain is thus one coming from outside the clinical world and at the same time belonging to the institution as well.

Practice: Introducing APO

Conversations between chaplaincy and patients make up the bulk of most hospital chaplains' everyday activities, with an average of 46 conversations per month, hospice chaplains a little less, namely 39 (Kühle et al 2015: 90).

Other tasks might be conversations and tea-

Figure 2.



ching (and, for some chaplains, supervision) with staff, staff meetings, interdisciplinary meetings, administrative work, attending ecclesiastical duties, to name a few.

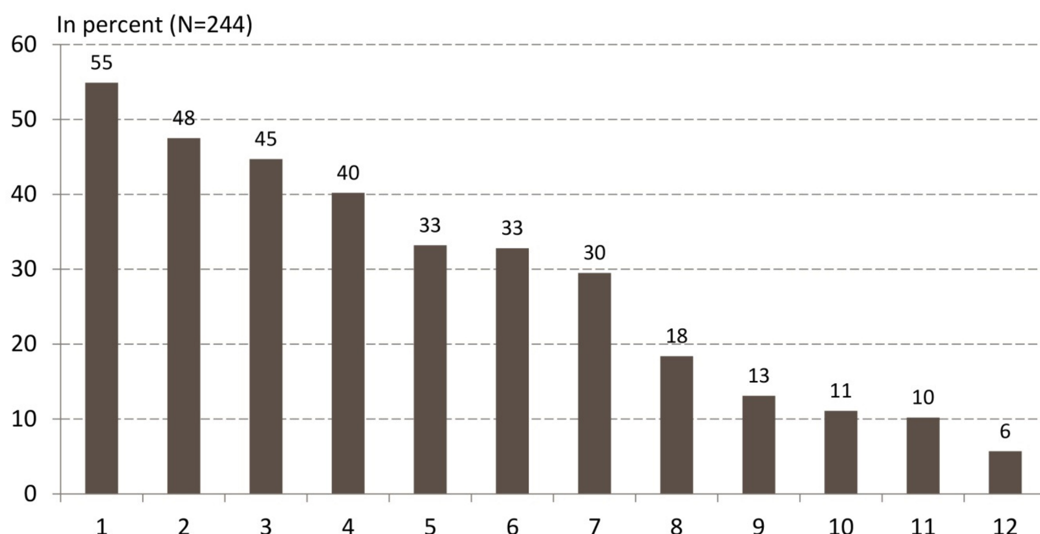
But what might then be the typical conversation? Results from a pilot audit gives a first hint. Audits record characteristics of each patient encounter for the professional to obtain better knowledge about his/her way of work and to compare it to other participants in the audit (Munck, A 1998).

Now, the preliminary results of the first APO-audit among Danish hospital chaplains have become available offering a first glimpse.[8] Due to the limitations of this article results will be more elaborate described elsewhere.[9]

The audit shows that the bulk of conversations last between 30 minutes and 69 minutes, ranging from 10 to 100 minutes. We have defined a conversation as any contact lasting more than 10 minutes. Very few conversations lasted less than 30 minutes, perhaps indicating that most of them were pre-arranged, thus making it possible to leave other health issues aside. There is a slight gender difference demonstrating that women talk with chaplaincy more frequently than men, indicated by a difference of 50.8 % to 46.3. Furthermore, the audit show chaplains are used by a variety of patients from early childhood to retirees, the ones using the chaplain the most aging 50–79 years (figure 1). This is hardly surprising as most hospitalised patients are in the range from mature adults to elderly people. Also, there is a coincidence in age groups between patients and chaplains, especially when it comes to the age span from 50 to 69 years, as we know many of the chaplains are in this age group (Kühle et al 2015: 85). One might expect an easy and trustful interaction between people of the same age indicating that chaplaincy ought to be represented by a variety in age.

The initiative towards a conversation is taken by a patient in 41.8 % of the cases. The department accounts for 32,4 %, next of kin 15.6 %

Figure 3.



and the chaplain for 9.8 %. The rather small number representing the chaplains' initiative is significant and might be interpreted in several ways. First, it might be due to the culture of chaplaincy in Denmark. Chaplaincy has traditionally not been characterised by culture of "outreach" into wards. Rather, the connection between chaplain and staff implies that chaplaincy to a large extent rely on the initiative from staff when it comes to the actual patient contact. Secondly, it might also signify that chaplains do have the necessary and adequate contacts through calls from patients, relatives and ward.

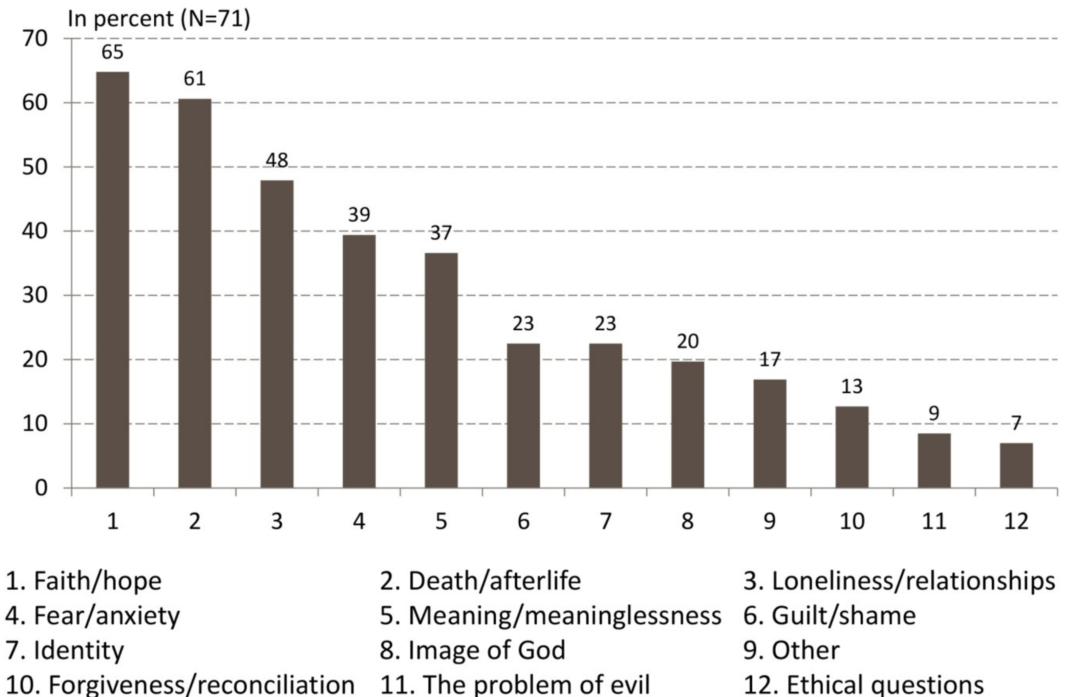
Finally, it should be added that the statistics are based on information given by the chaplains and remain questionable since it is unclear whence the chaplain has her or his information.

In 80.3 % of the cases the conversation partner was a patient, in 29 % a relative. Staff was represented by 3.3 %, perhaps indicating that chaplains as a possible conversation partners are unknown to staff members. It might also be a question of embarrassment or lack of relevance on behalf of staff. The perhaps surprising high score on behalf of the relatives might be explained by the boost of the inclusion of two palliative wards which traditionally are characterised by a greater degree of relative involvement than most somatic wards.

In the audit we chose to make an overall distinction between 4 main categories also used widely in the literature (fig. 2).

Since we suspected that the existential and spiritual category would be the most used, we chose to focus on this category, breaking it into 12 points showing the most common conversation themes. The 12 themes were, like the APO study as such, discussed and selected through a process spanning over three meetings with a group of chaplains. One could argue that pairing the themes, as for instance, "faith/hope", would make the answers less significant but to the chaplains it made sense to see them as pairs pertaining a connected context.

Figure 4.



A comparison of the group of incurably ill patients with less seriously ill patients (figure 4 and 5), visualises the range of needs and anxieties of patients indicating the most common themes from the left and the less common themes at the right in percentage.

A closer look at figures 4 and 5 illustrates that patients in general wants to talk with chaplains on themes such as 1: Loneliness/relationships and 2: Meaning/meaninglessness and 3: Fear/anxiety, all of which are among the top-5 regardless of their diagnosis being "incurably ill" or "less seriously ill".

The questions making the bottom 5 – apart from "ethical questions" – are just as significant, as they are notoriously theologically loaded and don't seem to be of any remarkable significance indicating a less dogma-orientated and a more explorative conversation.

This might be confirmed as we turn to the means invested in the conversation in terms of prayer, reading, etc. (Figure 6).

The numbers indicate, perhaps somewhat surprising, that in most conversations, chaplains did not make use of any traditional Christian means of consoling her or his conversation partner in terms of prayer etc., indicating that Danish chaplaincy is as religious as her or his conversation partner calls for. Traditional chaplaincy understood as primary religious – and as such less asked for by patients – are increasingly understood as existential orientated and patient centred spiritual care.

This "turn" is a common marker in all countries represented in this issue; see for instance Zock and Stifoss-Hanssen, Frøkedal & Danbolt.

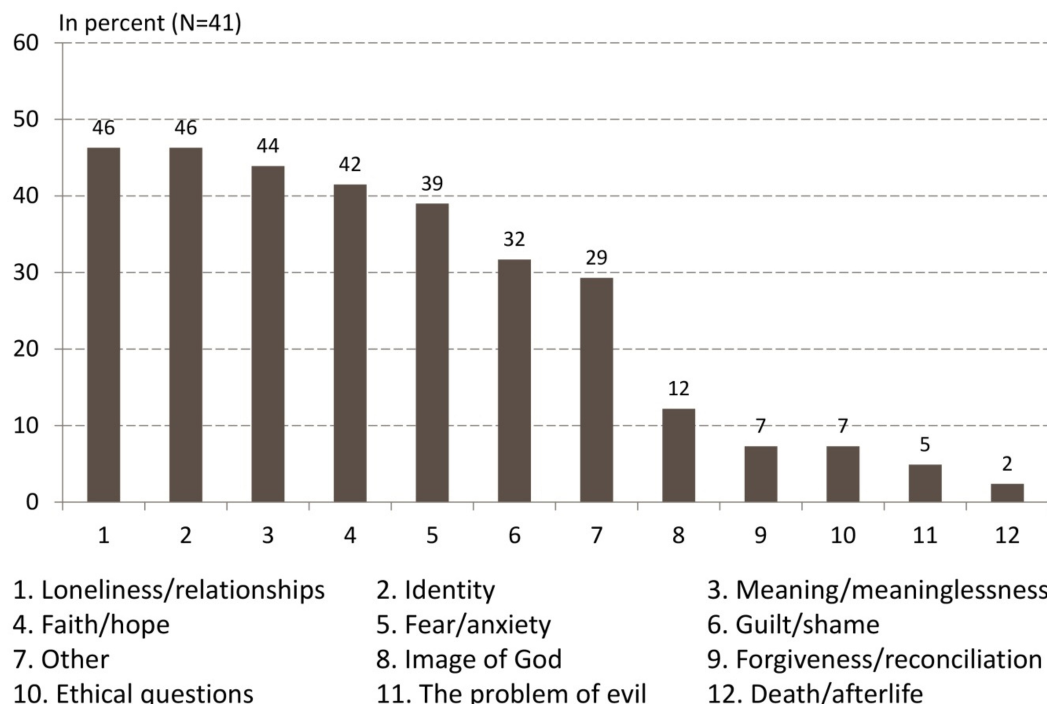
4. The future. Concluding remarks

The scope of this article has been to describe broad outlines of establishing and increasing professionalisation of spiritual care personified by chaplains within the CoD.

The health care context is a dynamic setting, not the least in these years. In Denmark we see

Figure 5.

Existential and spiritual themes
according to degree of disease: less seriously ill



the construction of new and bigger entities called "super-hospitals", and the structures of health care itself are remodelled with a shift from intra mural to extra mural care and a further expected rise in outpatients.

Work is done to accommodate the structures of chaplaincy to the needs of healthcare facilities and imply education, research and quality development. As we have seen there has been an extensive numeral expansion of chaplains. The efforts by FUV in the field of continuing education has paid off, implying a notion of strong professionalism and a robust identity as Christian chaplains. A newly defended PhD thesis find, that "the therapeutic ethos has not eradicated evangelical Lutheran Christianity or transformed the hospital pastors into semi-therapists" (Aalborg diocese, 2019).

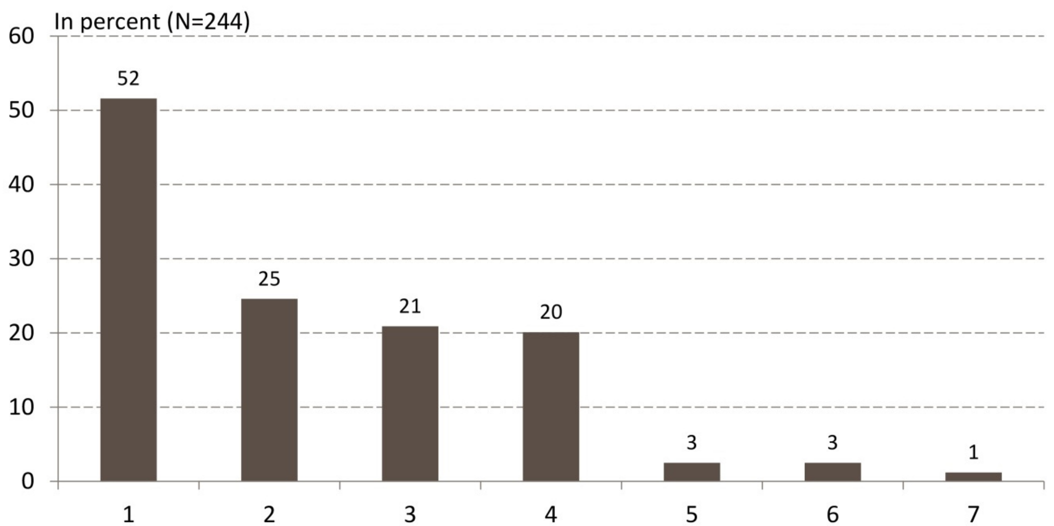
Chaplaincy operates in secular society as representatives of CoD which, as we have seen, has a solid stance among Danes with a (whopping) 76 % membership. As such, hospital chaplains represent a well-known religious and somewhat generally accepted component in a secular setting addressing the needs of believers and non-believers alike caring for both majority and minority religions (Kühle & Reintoft-Christensen, 2019: 194).

One aspect recognised by health staff and management is the "presence approach" of chaplaincy. Another aspect of chaplaincy appreciated by institutional staff and management is the counterculture brought to the fore, consisting of other value variables than the dominating rationale of the bio-mechanical perception of medicine, health and man.

An example expressing this kind of influence might be the Existence Laboratory (Eksistenslaboratoriet) developed to encourage and strengthen the existential discourse at hospitals, a project met with interest and support among different strands of clinical staff (Sygeplejersken 2018).

Scientific research in the field of chaplaincy is

Figure 6.



scarce but growing. Awareness of the need to show what chaplaincy is about are found. A PhD-project on Danish chaplaincy investigating the conversation between chaplain and patients is coming up. Completed projects have been mentioned and new Ph.D. projects and general research projects are in the pipeline. This is in line with international trends in chaplaincy referring to the importance of evidence-based studies reflecting the activities of chaplaincy, showing the public what chaplaincy is about and, at the same time, reflect on "best practice" on behalf of chaplaincy[10].

The arrival of the Nones (people with no religious affiliation) or SBNRs (people identifying themselves as "spiritual but not religious") and the call for research present new questions.

As does multi-faith teams. Also, secular, generic or humanist chaplaincy are gaining increasing public understanding in western societies. These factors might present a challenge to the until now well-established acceptance of Danish chaplaincy understood as Christian chaplaincy.

Spiritual care is contextual theology shaped in specific situations, and as such met by the dual challenge towards its relevance on the one hand and its uniqueness as a profession on the other. The situation is not new. At stake here is: How can spiritual care work on the premises of the present and at the same time preserve the opportunity to work for change, courage, reconciliation and faith?

Summing up, much is happening in the field of chaplaincy in Denmark. The adaptability of chaplaincy has been its trademark through history, and, indeed especially for the last century. Coming back to the headline of our article, we might say, that chaplaincy is a case of old wine in old baskets, but baskets accommodated for and further developed towards new contexts.

We live in exiting times. New demands and new questions point to new possibilities and opens inroads to yet unknown answers. This, indeed, is all in the trade of chaplaincy.

Note of appreciation:

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Notes

1 This article follows the definition used by The Danish Council on Ethics and clinical guidelines and use the term "spiritual care" as inclusive of "spiritual and existential care". In our understanding "spiritual care" includes "pastoral care".

2 2. APO: Audit project Odense. Located at Southern Danish University, Odense. APO is a resource center for quality development and continuing education developing and executing quality development projects based on activity registration.

3 3. Pew Research Center is a nonpartisan fact tank that informs the public about the issues, attitudes and trends shaping the world, conducting public opinion polling, demographic research, content analysis and other data-driven social science research. https://www.pewresearch.org/about/.

4 4. Tidehverv: Danish journal and theological working community influenced by the thoughts of Søren Kierkegaard and Karl Barth. Champion of Neo-Lutheran thought. Forum for ardent critic of modernity. https://en.wikipedia.org/wiki/Tidehverv.

5 Now FUV: Centre for Pastoral Education and Research (Folkekirkens Uddannelses- og Videnscenter).

6 Dan Browning has had a crucial impact with his under-

standing of theology as basically practically theology.

7 September 2019 rebranded as "Tro i Dialog" (Faith in Dialogue).

8 The pilot study involved 242 conversations between patient, relatives, staff and 9 chaplains from hospitals in cities across the country in a 10-day working period gathered in Aalborg; Aarhus, Odense and Copenhagen. For further information about this project, see https://faith-health.org/?cat=3. Of 9 chaplains two were working in psychiatric care and two others in palliative care. Results accumulated from September 16th to September 30th 2019, making an average of 26.8 conversations / 2.68 conversations per day.

9 https://faith-health.org/.

10 Highlighted by Christian Scharen in his publication "Field Work in Theology". Mary Clark Moschella has written on the importance of ethnographic studies.

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Chaplaincy in Northern Europe

An overview from Norway

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ABSTRACT

Chaplaincy in Norway has changed considerably from the 1950s. The number of chaplaincy positions has increased, although if it is seen on the background of expansion in healthcare and other public services, the increase is moderate. Several important developments have happened: A move from a "religious service" model to a "existential care" model has gradually taken place; the work of chaplains has increasingly been underpinned by a professionalisation; and a considerable volume of scientific research has been performed by chaplains – contributing to an evidence base for the activities. Alongside, the increasingly multireligious and secular profile of the population has affected the practice field in which the chaplains offer services. Recent innovations in chaplaincy give reasons to optimism in this field.

1. Introduction and definitions.

The aim of this article is to provide a qualified and updated overview of chaplaincy in public institutions in Norway. To our knowledge, such an overview does not yet exist. The overview is based on accessible sources; however, we have also drawn on our own experiences and networks, and in some instances, we have interviewed veterans in the field. In addition to the motivation presented by the lack of such comprehensive knowledge, chaplaincy in Norway and other countries now finds itself during a transformative development caused by several developmental trends which we will describe below. This development calls for a comprehensive insight into the present status.

The authors of this article all have extensive working experience from chaplaincy, in addition to several relevant research publications in the field. Our main research perspective is clinical psychology of religion, and we locate the present article and other of our publications within the growing field of chaplaincy research (e.g. Frøkedal 2016, Danbolt and Stifoss-Hanssen 2017).

The researchers' prior understanding might have influenced the research process. Being

an insider in a research field necessitates self-reflection in regard of researches preconception (Malterud, 2017). However, reflection with research colleges and theoretical perspectives brought forth an important distance from the material (Kvale & Brinkmann, 2009).

In the case of Norway, *a chaplain is a hired, professional person working on spiritual and existential challenges in institutions,* such as hospitals and other health facilities, prisons, the military, university campuses and more. A Norwegian chaplain is an instance of the international phenomenon chaplain/chaplaincy, which is organised in international bodies (The European Network of Health Care Chaplaincy, 2019). All the chaplains in Norway are financed by public funds. Most commonly, the chaplains are appointed by the institutions in which they work (hospitals, military, etc.); however, chaplains in prisons are appointed by the Church of Norway. In a few prisons, a certain degree of chaplaincy is performed by an imam or some other religious leader with Islamic background. These are appointed by the prison authorities.

Around 1950 Norway had approximately 50 chaplains as defined above, whereof 30 in hospitals. We now have 110 hospital chaplains, 25 chaplains in other health facilities; the military, prisons and university campuses can be estimated to have a total of 65 chaplains (Official Norwegian Reports [NOU], 2013:1). This makes 200 chaplains in Norway. Most of these are ordained clergy in the Church of Norway, and the majority have some or a large portion of Clinical Pastoral Education (CPE).

There has been some growth in the number of chaplains in Norway since 1950 but observe that the Norwegian society has increased its spending, and hiring of professionals in health care and education, more than 5 times during in the same period, mainly as a result of economic growth. Compared to other western countries with a dominant Christian history, the number of chaplains may be described as modest. There is no solid knowledge about the reason for this. However, recent research indicates that parish clergy performs a considerable volume of pastoral care in the local communities, and they report to a large extent to be addressing the same existential and psychosocial issues, as can be expected from chaplains (Stifoss-Hanssen et al 2018, Danbolt et al 2019).

At present (2019) several chaplains report that their positions are threatened by reductions, and some have been victims to cutbacks. It has been speculated that this is a result of ideological tensions about the religious profile of the chaplains (See NOU, 2013:1 p 435, where it is indicated that a change towards a multifaith chaplaincy should lead to a reduced resource base for the existing chaplains). However, the healthcare system has launched several reforms that may explain such cutbacks (Ministry of Social Affairs and Health, 1996–97; Official Norwegian Reports, 1995:14), like shortening of hospitalising periods, increased focus on strictly measurable results, and demographically motivated transferring of treatment and care tasks from specialist facilities to municipal services. Structural adaptations in chaplaincies to this development should be and is discussed.

2. Organisation

The organisation of chaplains in Norway is generally weak and fragmented. Differently from the situation in other countries (e.g. Sweden, Finland), Norwegian chaplains have no overarching organisational structure, with a responsibility for chaplaincy services to the population. However every three years a committee of five healthcare chaplains are elected by The Norwegian Association of Clergy (2019) The committee's responsibility and focus area are healthcare chaplains' professional qualifications and best practices.

Since chaplains in prisons, universities and the military are relatively few, the organisational situation in their subgroups is more acceptable, helped by voluntary organising, but also supported by resources from the authorities in the sectors. For healthcare chaplaincy, this organisational deficit is a palpable challenge. Healthcare facilities are divided into five self-organising regions (Ministry of Health and Care Services, 2018); in addition, situations differ among mental health care, somatic health care and substance abuse treatment. Moreover, a proportion of health care chaplaincy is performed in diaconal

(faith-based private) institutions, which makes up maybe 20 % of the chaplains. No overarching body or authority takes responsibility for seeing the whole picture, safeguarding quality in services e.g. professional competence, and discussing strategies and policies. A PHD researcher whose task was to map some aspects of mental health services in Norwegian hospitals, had to create a list of health facilities, make contacts individually with more than 40 of them, and make separate arrangements and permissions.[1] The challenges for chaplaincies to adapt adequately to secularisation and the multicultural reality is one example of a challenge that is at risk of not being well handled.

3. Public presentation of the chaplains' services

Following the common strategies of information in most fields of society, information about chaplains' offers and self-presentation is accessible on the internet, mainly integrated in the information platforms of the health institutions, and the other institutions the chaplains perform their activities in. For example, Norwegian public (and private) hospitals introduce their chaplains as professionals who are integrated in the health facility's effort at providing complete care, the concept of person-centred care is frequently used. A public hospital states:

" – alongside our work on physical and mental health, (our hospital) wishes to focus on what may be called existential health, which deals with the basic issues and wonderings about life itself, and what human life is all about. – Today, we assume that good existential health provides a kind of protection, that improves our capacity to cope with problems in life, courage to encounter challenges, and increased abilities to embrace good things" (Vestfold hospital trust, 2016).

That kind of statement is representative of hospital chaplaincies in Norway. However, all hospitals in addition also present the possibility of receiving services of a religious character, or other services specifically adapted to the patient's life stance (or view of life, spiritual profile) (Berthelsen & Stifoss-Hanssen, 2014). This addition demonstrates the existence of two ways of reasoning about the function of chaplaincies.

Firstly: Providing religious services according to specific requests from patients, and based on the profile of the chaplain, is common in the chaplaincies. Provisions of such services are usually based on human rights of patients and other users, the right of freedom of religion and of practicing one's religion. In Norway, as in other countries, this right is specified in supplementing regulations, and ethical codes of conduct for professionals. For some participants in the discussion about chaplaincy, this way of reasoning is dominant, see e.g. in the Official Norwegian Reports, 2013:1: , "The Belief Open Society: A Coherent Religion and Belief Politics". To some extent, prioritising this argument may have the effect of tidying up in a chaotic field. Patients and other users could in this perspective be orderly sorted according to their religious or philosophical positions, the chaplains could be subject to a similar process, and the groups could be matched to each other.

Secondly: The limitations of this perspective is apparent when bringing into mind that most chaplaincy work is not, and has not for a long time, been guided by providing specific religious services (Berthelsen & Stifoss-Hanssen, 2014). As the self-presentations above show, chaplaincy services are guided by and aimed at providing existential care to persons in critical and marginal life situations. The term used for this help is some time spiritual, and sometimes conversations move within the religious universe of a patient, but the aim of the talk is to take care of the other person's existential need. So, what is at stake here, is not primarily the person's right to practice religion, but her right to receive care in a situation of crisis, and existential worry. In this perspective, chaplains are available in institutions where people are injured, hurt, or under exceptional stress.

Nurses and other healthcare personnel are obliged to provide spiritual/existential care to patients (bodily-psychological-social-spiritual care). This has for instance been clearly expressed in a Norwegian parliamentary document:

> *A person with mental health problems should not be viewed only as a patient, but as a whole person with body, mind, and spirit. Necessary considera-*

> *tion needs to be given to spiritual and cultural needs, and not only the biological and social. Mental disorders touch foundational existential questions. The patient's needs must therefore be the starting point for all treatment and the core of all care, and this must affect the structure, practices and management of all health care* (Ministry of Social Affairs and Health, 1997–1998; Note 2).

Furthermore in a recently official Norwegian report (NOU, 2017:16, p 9) the importance of applying a holistic approach in encounters with patients has been advocated. Chaplains are in this perspective a supportive resource with special competence, in providing a service that is part of the duties of the institutions, in their central aims (NOU, 2017:16, p 24).

Even if the two ways of reasoning about chaplaincy are different, we do not argue that they are necessarily in contradiction. Several modes of combining the two have been used, and they can take place on both individual and organisational levels; any model will depend on the context and the resources available. However, it seems obvious that the "religious (or philosophical) services" model would design the chaplain as a guest in the institution, based in another place, whereas the "existential care" model designs the chaplain more as a variety of health personnel, based in the institution[2].

Healthcare chaplaincy is by far the largest portion of chaplaincy in Norway, and the above characteristics are based on that field. However, the main features of chaplaincy also apply to services in other fields like prisons, universities, and the army.

An apparent difference could be seen in relation to chaplaincy in prisons: Whereas chaplains in healthcare on the whole come across as allies of the institutions, siding with the health personnel, chaplains in prisons to a much larger extent express a critical distance to the correctional function of their institutions, and in many respects appear to be siding with the inmates. This truly makes them differ from healthcare chaplains, but that could be understood based on the strictly different aims of the institutions. In both cases, it could be said that the chaplains are engaged on the side of the quality of life and dignity of the persons they serve. In none of the cases, the chaplains' aims are to implement religion in the institutions. Furthermore, this characteristic of prison chaplaincy is clarified by the prison services applying the term "imported Services" to denote functions in the prisons that are not strictly linked to correctional aspects, like healthcare, education, employment services – and chaplaincy (Norwegian Directorate of Health 2013). The term "imported" can be regarded as a principal location of those services outside the proper tasks of the prisons. If such a logic was applied to chaplaincy in healthcare, an obvious tension would be clear against arguments given above in this chapter (e.g. chaplaincy linked to the central aims of the institution), and which is further discussed below. However, this does not mean that prison chaplains fall outside the overarching aims of chaplaincy.

4. Chaplaincy in society

For the institutions, the backdrop is characterised by enormous changes since the first half of the 1900s. In Norway, the population is doubled (2019 5.3 mill); spending on e.g. health has grown from 4 % of GNP in 1950 to approximately 20 % in 2019. At present, 10 % of the workforce has a health-related professional education, and 20 % of the workforce is engaged in health-related jobs. We now have 120 000 nurses and 23 000 doctors, along with the other health related professions (Statistics Norway 2019). This makes Norway a world top in density of these professions in the population, and in spending on health.

In addition to this explosive growth, and interacting with it, there is the progress in research and the following possibilities of improving and expanding treatment of most diseases and conditions. An important implication of this has also been the accelerating professionalisation of the professional practices, including the caring professions, often under the terminology of evidence-based practice. This has made an enormous impact on how professionals are educated, and how they are expected to perform their practices. This has also been true of the situation for chaplains – this is discussed further below, in connection with the development of research on and in chaplaincy.

Even if the health sector is here a chief

example of the arenas in which chaplains are working, the same social changes affect the whole society, and provide challenges to all chaplains. And obviously, these contextual features characterise all western countries to a large degree; we highlight them here to help us keep in mind that the challenges and the changes in chaplaincy do not occur in a vacuum; these changes happen as part of a wider process, sometimes without being noticed, but sometimes as strategic responses to bigger social changes.

Most chaplains in northern Europe work within societies that have seen explosive growth in public expenses and numbers of colleagues, they interact with professionals who are increasingly professionalised, and who are specialised, and research based in their work. This journal issue will show that chaplains respond to such a state of things in their working context. Such responses are described below, like professionalised education (CPE), research, and entering cooperation across faiths. More generally, many chaplains frame their services within 24/7 schedules, and are getting involved in crisis and disaster intervention (Lars Johan Danbolt & Stifoss-Hanssen, 2007)

However, this response to the public sector should not be taken as an indication that chaplains accept developments in the surrounding culture without critical evaluation – on the contrary, chaplains have for example demonstrated active protesting against aspects of the cutbacks in the health sector lately, the following marketisation, and the attempts at utilising evidence based reasoning to underpin those developments[3]. Another example of this could be the above-mentioned positioning of prison chaplains as critical voices in the correctional system, a practice that has not prevented them from professionalising, and performance of research.

5. Chaplaincy and religion

At present, most chaplains in Norway have a background as clergypersons in the Lutheran majority church. The reason for this is the historical situation for faith communities in Norway (and the rest of Scandinavia), characterised by the Lutheran majority church having had more than 90 % of the population as members until the 1960s, with the rest mainly belonging to other Christian denominations, and very few persons belonging to non-Christian religions. This has been changing, and at the moment, approximately 70 % of the population in Norway are members of that church (Statisics Norway, 2017). At the same time, significant organised groups of secular humanists and Muslims have developed, and approximately 15 % have no affiliation.

In 2013 an important white paper from the Norwegian government addressed the altered situation regarding religion and worldviews. Including interreligious relations in public arenas and institutions (NOU 2013:1 "The Belief-Open Society: A Coherent Religion and Belief Politics"). The scope of the document was to provide a negotiated, shared public space for persons with all kinds of religious and other cultural identities. For Norway the document should be seen on the background of the decomposition of the "state church" in 2012, and the demographics sketched above. Even chaplaincies in the public institutions were discussed in the document, and the recommendations pointed to a reorganising of chaplaincy towards a multi-faith service, distributed according to the adherence of the population (or the patients) to faith communities. As a follow up of this previous work from NOU 2013:1, the government proposed to the parliament, in June 2019, a draft law of the Act of denominations (Ministry of Children and Families, 2018–2019). In the governmental document it was underscored the importance of integrating existential and spiritual care in a multi-faith perspective in institutions like the military, prison and hospital (Ministry of Children and Families, 2018–2019, Section 10). Further, enough competence to meet the existential, religious and spiritual needs in a multi-faith perspective was recognised to be of significance for the institutions to provide. Moreover, the multireligious education program established at the Faculty of Theology at the University of Oslo was acknowledged to contribute to this by qualify staff to serve in institutions and health and care services. This will be partly presented in a separate article in this volu-

me (Grung, Bråthen).

6. Chaplaincy and theology

It was not only society at large that changes during the years after 1950 – the impulses that the chaplains, mainly clergy in the Lutheran majority church, brought from their theological background, also changed alongside with the changes in society. The changes may even be labelled modernisation, which affected the church towards a less authoritarian and hierarchical identity. Theology experienced an empirical turn that resembled the move in professions towards evidence-based practice, a turn that came along with theological preferences for contextual or liberational theologies (Cfr. feminist theology, postcolonial theology). In addition, chaplains were mostly influenced by developments in pastoral counselling theories that were moving towards client-centred and egalitarian practices (Kolstad & Os, 2002). There is some dispute as to whether this development was brought about by close interaction with psychotherapy, but the development without doubt facilitated the opportunities for chaplains to communicate and cooperate with other professionals in the institutions they were serving (Farsund, 1980). Theologically speaking, the development was also served by the prominent position of "theology of creation" or the use of such interpretations, and the increasing localisation of all pastoral care and counselling under the umbrella of diaconia[4], away from the scope of preaching. (Nordstokke, 2014).

Until WW II, it is good reason to assume that chaplains did not think of their service to patients and prisoners as basically different from the service clergy provided to persons in the parishes (Farsund, 1980). This means that chaplains consulted with the patients and prisoners within the framework they conceived of as Christian – remorse, marginalisation and guilt with prisoners, and preparation for death comfort with severely ill patients. In both cases, distribution of communion was probably a central feature. There are reasons to think that the practice of these chaplains was reminiscent of ancient practices with confession, absolution and communion.

Little material exists regarding what these chaplains thought about the relationship between their services they provided, and the overarching reasons for the institutions to exist – e.g. correction of behaviour and curing of diseases. They apparently looked at their own efforts as compatible and supportive of the curative and corrective tasks of the institutions (Stendal, 2013, p 24).

7. Development from religious services to spiritual and existential care

As we have stated in the introduction, most chaplains in Norwegian institutions consider their main task to be to contribute to the institutions' overarching aim of securing and improving users' health and wellbeing, and their capacities to cope with crises and dilemmas – these dimensions of human life understood in a comprehensive manner, encompassing the need for meaning, existential and spiritual support, and comfort. Compared to earlier phases, when the work of the chaplains was more in line with a parish clergy's distribution of religious services, the present profile is generally different. Theoretically, from the perspective of the chaplains with a Christian background, this change is substantiated by theological arguments, linked to diaconal thinking (to do good) and to theology of creation (creating health is seen as contributing to God's ongoing upholding of human life).

Chaplaincy in other fields than healthcare has not necessarily followed an identical trajectory, but there are wide similarities, and all the chaplaincy fields have gone through a professionalisation and a rise in consciousness – see for example the comprehensive study of chaplaincy in all kinds of institutions in Denmark, presented by Kühle and Christensen (Kühle and Christensen 2019). If you see this process on the background of what we have discussed above, about two ways of reasoning about the function of chaplaincies: The "religious services" model and the "existential care" model, the development has been towards existential care.

8. The rise of Clinical Pastoral Education (CPE)

Historically and culturally, this change of profile to some extent reflects the impact of modern psychology and psychotherapy on society in general, but even on chaplaincy. A specific precursor of this impact was the creation of Clinical Pastoral Education (CPE) in USA from the 1930s on (Asquith, 1982; Boisen, 1951), which was a training of hospital chaplains in psychological and communicative skills and theory, inspired by training of psychiatrists, even if focus was kept on patients' existential and religious challenges[5].

Norwegian hospital chaplaincy pioneers went to USA for CPE training in the 1960s; they came back practicing the CPE inspired model in chaplaincy, and started developing a Norwegian branch of CPE education (Farsund, 1980, 1982; Høydal, 2000). In the 1970s several CPE training centres were established. Many of the participants in the training were chaplains, and quite soon CPE training became required, or preferred, to be hired as a chaplain. To be hired in chaplaincy positions in Norway there is not yet a standardised level or content of specialist skills required (See above, on the absence of a coordinated organisation of the chaplains). All clergy have a basic training and study of care and counselling, and in order to be hired as a chaplain, they are required to have some experience, and if they don't have a formal specialist competence, they are required to start such a training programme in order to be hired. The CPE programmes are most common, but some chaplains do therapy – or supervision programmes – instead or in addition (See https://www.mf.no/en/studycatalogue/clinical-counselling).

An obvious strength with the CPE model was its development of abilities to communicate with the healthcare professions, and the fact that it represented an obvious professionalisation of chaplaincy. It has, however, even been argued that the CPE model represents a weakness by opening up for a secular professional practice where chaplaincy had to negotiate the secular domain in biomedicine and by this given rise to a secularised professional practice (Lee, 2002). Turning the hospital chaplain into a spiritual care provider has been claimed to be a sign of the secularisation process (Lee, 2002).

At present, probably most of the persons working in chaplaincy and in practices of pastoral care have completed one or more units of CPE.

A feature that is dominant in CPE methodology, is the use of groupwork, with users and with patients/users (Hemenway, 2005). This can be traced as an influence in chaplaincy. In Norway healthcare chaplains have been running existential groups within specialised mental healthcare services since the late 60s or early 70s, inviting patients to talk about their life stories, meaning in life, ritualisation and existential, religious and spiritual struggles and concerns (Frøkedal, Stifoss-Hanssen, Ruud, DeMarinis & Gonzalez, 2017).

Other branches of chaplaincy also made and still makes extensive use of groups in teaching, and in counselling.[6]

As we have noted above, professionalisation of chaplaincy happened during the same time as the Norwegian society moved towards less mono-religiosity and more plurality, including the growth of a secular humanist organisation (Botvar & Schmidt, 2010), and the publishing of the White Paper on religion in a pluralised public sphere (NOU 2013:1). These developments were not unrelated to each other and might by some be considered parts of modernisation and professionalisation. It is also interesting to note that according to research the Lutheran majority church changed towards a more human-centred profile in its preaching, rituals and pastoral counselling in the same period (Grung, Danbolt & Stifoss-Hanssen, 2016; Leer-Salvesen, 2011; Madsen, 2011; Traaen, 2004).

Chaplains with a base in the Lutheran majority church for most of the period we are presenting, facilitated contact between patients and users from other faiths and religions, or at least they had that as an ideal. Internationally the "British model" for prison chaplains, where the chaplains are coming from a majority denomination and are facilitators and mediators for members of minority faiths who do not have their own chaplains, has been criticised by Beckford (2015).

However, with the whole society becoming

less mono-religious and more secularised, the somewhat hegemonic function of these chaplains has been discussed and questioned (Plesner & Døving, 2009, Furseth 2008), and several alternative models of chaplaincy have been suggested; some of them have been implemented and are being evaluated. Many chaplains from the Lutheran majority church support this development and contribute in experimenting with different models. At the core of all these experiments or models of chaplaincy lies a vision of a chaplaincy that is multi-faith, being staffed with persons with backgrounds from different Christian faiths, from other religions, from the Lutheran majority church, and possibly other relevant backgrounds like philosophy. For practicing such models several problems obviously must be solved, like access to resources, the relative distribution of chaplaincy positions, and how their services should be offered to the users. Some fear has been expressed that the model might lead to a situation where the chaplaincy services as a rule are offered to users according to an assumed match between the religion or faith of the parties in the conversation (Muslims are helped by a Muslim chaplain etc.). This dilemma can for example be discussed in the light of the two ways of reasoning on the function of chaplaincies. These innovative moves in Norwegian chaplaincy activities are further discussed in another article in this journal edition (Grung and Bråthen).

CPE, being an international concept in the field of spiritual care, is in principle a multi-faith and multi-religious endeavour, which is made clear by the basic documents[7]. In Norway, because of the mono-religious practices in chaplaincy, CPE has been and still mainly is organised as an integrated part of education of Christian clergy. However, following the transformation of military chaplaincy into an inter-religious one, CPE has also been adapted to a multi-religious ("livssynsåpent")[8] programme. Adaptation of CPE in general to a diverse group of participants stands out as a highly relevant and realistic change which would contribute to a sustainable model of chaplaincy in Norway.

9. Research in Psychology of religion – towards an evidence base for chaplaincy

As we have mentioned above, Norwegian chaplains were inspired to develop research on their field and practices, to a large degree through their contact with the research environment in Psychology of religion in Uppsala. An important example of this influence could be the work on "Religion – a support or a burden? On the role of religion in psychiatry and psychotherapy" (Wikström, 1980). This book was dedicated to helping chaplains communicate with clients in mental health, in a way that was based on broad, state of the art insight in psychopathology and psychology.

After having participated in the Swedish research community on psychology of religion in Uppsala for several years, a research group in the research field was established in Oslo, Norway from around 2008. Researchers with chaplain backgrounds made up the core of this research group, and in addition the group attracted researchers with a broader interest in the intersection between health/wellbeing and meaning/religiosity. This group is still active, and from the 1990s onwards approximately 10 persons in chaplaincy or with a chaplain background have completed their PHD theses or are in the process of completing. These projects are all based on empirical material end methods, and they cover central areas in the profession of the chaplains, like death and dying, grief and ritual, and several aspects of mental health, as well as themes from prison chaplaincy and the military etc.[9] Most of the authors were presenters at the research conference 2017 of the International Association for the Psychology of Religion (http://www.norway2017.iaprweb.org/). Some of these works have also resulted in textbooks within the field (Berthelsen & Stifoss-Hanssen, 2014; Lars Johan Danbolt, 2014; Stifoss-Hanssen & Kallenberg, 1998). It could be argued that this body of knowledge in a constructive way could be a contribution to an evidence base for chaplaincy, and for practicing spiritual care in health care, and in the other fields where chaplains practice.

Furthermore, we assume that a renewed interest in ritualisation in chaplaincy can be obser-

ved, partly for the functional effects of ritual practices, but even an interest in bringing out root phenomena, and consequently aspects of what is characteristic of chaplaincy in healthcare and prisons. Chaplains in a Norwegian prison implemented a four week Ignatian retreat with inmates, with many ritual features (PhD project by Vegard Holm); chaplains and counsellors led a two week pilgrimage with inmates, also with ritual practices (Engedal, 2011). Sørensen, Lien, Landheim, and Danbolt (2015) describes very popular ritualising opportunities offered to the patients at a substance abuse treatment centre. Gjøen's and Fransson's study on release rituals in a prison (2018) is an explicit example of research on ritual in chaplaincy, which at the same time shows the dilemmas in being inside/outside the correctional logic of the prison. A group ritual at termination of imprisonment for one inmate at a time is convincingly presented at an empowerment practice. Other studies of ritualising can be seen in the works of Danbolt and Stifoss-Hanssen on ritualising in the wake of disasters (e.g. 2016); active ritual innovation is taking place in the caring efforts for families who have consented to letting their clinically dead relatives' organs be donated for organ transplantation; and integration of ritual practices in chaplains' work with clients in mental healthcare is documented in several articles (Bjørdal, 2001; Stålsett & Danbolt, 2018). Such a possible renewed interest in ritualisation in chaplaincy may represent a development in chaplaincy characteristics, and it can also be coinciding with a raised interest in the use and usefulness of ritual in society at large.

10. Concluding remarks

Looking at the timespan from 1950, chaplaincy in Norway has changed considerably. The number of chaplaincy positions has increased, although when seen on the background of expansion in healthcare and other public services, this increase is moderate. Otherwise, several important developments have happened: A move from a "religious service" perspective to a "existential care" perspective has gradually taken place; the work of chaplains has increasingly been underpinned by a professionalisation – not the least through specialisation like Clinical Pastoral Education; and a considerable volume of scientific research has been performed by chaplains – contributing to an evidence base for the activities. Alongside, the increasingly multi-religious and secular profile of the population has affected the practice field in which the chaplains offer services. This image of the chaplains' working world gives reasons to look positively at the future, considering the observation that the group has proved able to learn and to adapt.

The challenge of manoeuvring into a situation where the complex situation of religiosity and views on life is negotiated, to a stage where sustainable compromises are reached – taking care of the users' human rights and their right to existential care, is achievable.

Recent innovations in chaplaincy give reasons to optimism in this field. Some of these include expanding the all-Lutheran chaplaincy staffs with chaplaincy workers of other Christian faiths, of other religions, and of secular humanist faiths. They also include the beginning expansion of CPE. In addition, important professionalisation has taken place in the field of meeting the existential and spiritual needs of patients and users. This development clarifies a distinct role for chaplains, as a consulting and participating resource, and in this connection, it also clarifies the obligation of the institutions to recognise and meet the existential and spiritual needs of patients and users, regardless of faiths. Recent examples are the "Guidelines regarding spiritual and existential needs in patients and families" (Retningslinjer ...[10]) in Oslo University Hospital; and the national project for creating a universal digital documentation system for patients ("Helseplattformen") has engaged the chaplaincy staff in Mid-Norway to develop suggestions for integrating existential care, spiritual care and chaplaincy into the documentation system.

Changes in public policies may prove a bigger threat and a challenge to the future of chaplaincy than strategic disagreements – the inherent character in chaplaincy of being less measurable and less immediately productive within a new public management perspective, places it in a vulnerable position. The demographically moti-

vated structural reforms intensify this challenge, and the challenge is of the same magnitude regardless of which of the two ways of reasoning about the function of chaplaincies one prefers.

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Notes

1. H. Frøkedal at VID Specialized University. See Frøkedal 2017.
2. We are aware that the "health personnel" version raises principal problems, that must and should be discussed elsewhere.
3. See e.g. https://sykepleien.no/meninger/innspill/2016/03/prestetjeneste-i-et-flerkulturelt-samfunn
4. In Scandinavia the churches use the term diaconia to describe their work on welfare and general care to the population.
5. But even other strands of psychological impulses played a role in the history of chaplaincy – important works in Psychology of religion were presented in the 1920s and 1930s (E. Berggrav, Schjelderup brothers, Raknes). Influential textbooks on pastoral counselling, based on psychological and therapeutic insights, were published from 1950 onwards (Enger, Dahl, Johnson). From the 1980s, many Norwegian chaplains were inspired and supported by the research environment in Uppsala, led by Hj. Sunden and O. Wikström.
6. H. Frøkedal's PHD includes extensive presentation of this feature, to be presented in 2019.
7. https://en.wikipedia.org/wiki/Clinical_pastoral_education.
8. https://www.mf.no/kom/kompetanse-inspirasjon-til-videre-tjeneste/pastoralklinisk-utdanning-pku.
9. We have been searching for a reference that could cover this observation, but it does not exist in a coherent form, except for the incomplete version in the programme for the 2017 conference of the IAPR, see the link given in the text. They are: Torbjørnsen, Danbolt, Stifoss-Hanssen, Moen, Austad, Berthelsen, Stendal, Søberg, Røen, Isene, Frøkedal, Buer, Mæland.
10. https://www.helsebiblioteket.no/fagprosedyrer/ferdige/andelige-og-eksistensielle-behov-hos-pasienter-og-parorende.

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Chaplaincy and religious plurality in the Norwegian context

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ABSTRACT
This article discusses chaplaincy as a professional capacity in a context of religious, demographic, and political changes. These changes are gradually converting chaplaincy services in Norway from a task that has traditionally been part of the work of the Church of Norway into more pluralistic services. We ask and discuss how pluralisation could challenge the professional paradigm of chaplaincy – with respect to both generic and specific aspects of these practices. This is done based on a sociological perspective questioning how chaplaincy is done in Norway from outside (by the institutions) and from within (from the point of view of chaplaincy and the people they are supposed to serve). Our empirical point of departure is our experiences in designing a master's degree programme in order to contribute to building chaplaincy competence for students outside the Church of Norway – and interviews with hospital chaplains in Norway related to the Church of Norway on how they interpret their role as professionals in the hospital.

Introduction
"*We call it the ministry of presence,*" said the chaplain at JFK[1], "*what I actually do, I walk through the terminals*" (Cadge 2017, 444). This quote is from an article by the sociologist Wendy Cadge on her research on how airport chaplains in the US, religious professionals in explicitly secular institutions, articulate their professional mandate, on how they define what they do in terms of presence in an everyday context where they work between the institution they are part of (the airport), their religious affiliation, and the people they are supposed to serve (passengers and staff). They do religious work of sorts on behalf of the secular institutions for persons of any religious affiliation or none at all (Sullivan 2014). That might be considered a contradiction – so, what *is* a chaplain?

The formal answer to that question, in a Norwegian context, is that a chaplain provides spiritual and existential care to people institutionalised in prisons, hospitals, and care institutions as well as enrolled in the army and as students in universities and university colleges. And there is a chaplain at the largest airport (Oslo) as well. A chaplain in a Norwegian context serves indivi-

duals of all beliefs who ponder questions on meaning, belief, and relations to oneself and others. But what does it require to do that as a professional? What is the professional capacity of a chaplain in relation to this?

These are questions we explore and discuss in this article, and we do so in a context of religious, demographic, and political changes that are gradually converting chaplaincy services in Norway from a task that has been part of the work of the Church of Norway (CofN) into more pluralistic services. This is a plurality in the making, that brings up to date the professional requirements chaplains are supposed to meet and how their beliefs, world views and religious/life stance affiliations affect their professional capacity.

We do not intend to give final answers to these challenging questions, but we do intend to elaborate and discuss them. Our discussion will be partly based on two sources. First on Grung's experiences in establishing a new master's programme at the University of Oslo for training candidates for religious and worldview pluralist leadership and chaplaincy (the master's programme will be described thoroughly below). The second is the empirical data Bråten provides from interviewing CofN chaplains working in Norwegian hospitals with a mandate to serve all patients (the data will be presented below).

We start out by presenting the Norwegian context when it comes to religious demography and the organisation of chaplaincy services, followed by sociological perspectives from earlier research on chaplaincy as a profession. We then present the professional requirements for chaplains today in Norwegian institutions and how the new master's programme relates to this. After that we explore – based on empirical interviews – how chaplains working in Norwegian hospitals today view themselves as professionals, and how they talk about their beliefs/religious affiliation as part of their professionality. Finally, we discuss how a more plural service brings the religious affiliation of the chaplain up to date, and how this is or is not regarded as a part of the chaplains' professional toolkit or professional service.

Chaplaincy in a Norwegian context

The context is Norway – and Norwegian institutions. In Norway, chaplaincy has been a task of the Church of Norway (CofN). The historical embeddedness of chaplaincy in the CofN is firmly illustrated by the terms used to describe the tasks of the chaplain, i.e., "spiritual and existential care". The notion of *chaplaincy* is generally used – in a broader Western context – to describe more pluralistic practices than those provided by clergy in Christian churches (Sullivan 2014, 64). This entails that the term includes Humanist, Muslim, Buddhist, and other chaplains in addition to Christian chaplains. *Chaplaincy*, thus, has developed into a generic term. The terms chaplain and chaplaincy do not exist in the Norwegian language, however, and the direct Norwegian translation kapellan would at present only raise connotations of a minister in the CofN. Instead, the term "spiritual and existential care" or *sjelesorg* – from the German term *Seelssorge* – is used to describe chaplaincy practices in Norway (Baig, 2019; Hirch & Røen 2016, 3).

This close connection between spiritual care services in public institutions and the CofN is mainly due to the fact of the Church of Norway as a national state church with membership consisting of a solid majority of the population. The religious demography of the Norwegian people has changed today, however. This is due to immigration, to the fact that beliefs are no longer inherited but an individual choice, as well as institutional changes. The Norwegian Constitution was transformed in 2012 and the Church of Norway (CofN) is no longer a state church. Constitutionally, it is still a "folk church", with a distinct position in Norwegian legislation,[2] but the reformed constitution mirrors a Norwegian population growing steadily more diverse in religions and worldviews. In 2017, seven out of ten Norwegian citizens were part of the CofN, which means that three out of ten were not; two of these are members of religious and life stance communities outside the CofN, while one out of ten has no religious affiliation.[3] Churches other than the CofN, Islamic communities, the Norwegian Humanist Association (Secular Humanists) and Buddhists are

the four largest worldview groups.[4] There are, however, regional and local variations in the degree of religious complexity. Oslo, the largest city in the country, has the most diverse population in this respect: 48.7 % are members of the CofN and 21.8 % are registered in other religious and life stance organisations.[5]

Formally, the Church of Norway still bears the main responsibility for religious services in public institutions – such as hospitals, prisons, and the armed forces (NOU 2013:1,165). This, however, is institutionalised in different ways – and growing religious plurality is mirrored by changes that give indications of a more religiously plural chaplaincy service to come: In 2017, the armed forces decided to hire an army imam and an army Humanist as chaplains alongside the clergy of the CofN and a priest from the Orthodox Church.[6] The government has recently proposed a pilot project to develop a plural faith and life stance service in prisons by establishing a team of representatives from different faith and life stance communities.[7] Two public hospital trusts (St. Olav in Trondheim and Helse Bergen) have employed Muslim chaplains as part of the chaplaincy service, working alongside chaplains from the CofN. Until recently, one hospital trust (St. Olav), had a humanist chaplain employed in a substitute full time position. And the hospital trust of Oslo (Oslo University Hospital) has established a group of volunteers from different beliefs. This group of volunteer conversation partners have had some training in chaplaincy and agreed to serve on a voluntary basis but receive a small fee if they are requested – and they must be requested. The group has been administered by the unit for equal services at the hospital, and, for now, the responsibility for passing on requests to the conversation partners are part of the tasks of CofN hospital chaplains working in the hospitals in Oslo. If the patient asks for chaplaincy services from someone else than a chaplain from the CofN, and is a Muslim, then a Muslim conversation partner is called. If the patient defines himself as a Humanist, one of the Humanist conversation partners is asked. The conversation partners are not, as a general rule, asked to meet patients across religious or life stance affiliations in the same way as those who are employed as hospital chaplains are (Bråten 2019).

The CofN chaplains employed by Norwegian institutions are, as a rule, required to have the theological degree of Cand. theol. (six years) from one of the four institutions offering higher education in (Christian) theology, and to be ordained as ministers (or, in health care, deacons) in the CofN. In addition, particularly at the health institutions, training in clinical pastoral education (CPE) is required.

Chaplaincy – sociological perspectives

What is chaplaincy from a sociological point of view? Winnifred Fallers Sullivan (2014) states that professional religious work is usually thought of as work performed by clergy – ministers, rabbis, priests, imams, monks – as part of a religious institution. This definition does not cover the role of chaplains since he or she works in a secular institution caring for all kinds of people, regardless of what they believe in. That is how it is in the US, the context from which Sullivan writes (See also Cadge 2012). She describes this – just like the airport chaplain quoted in the introduction – as a ministry of presence: They are experts in being present. And she discusses what it means to be present, without hierarchy. The challenge chaplains experience being between the secular institution and its projects and politics, their religious affiliation and the people they are supposed to care for, are underlined: “There remains an unresolved tension between a presence that leads to trust and an ongoing need to account to yourself, your religious masters and the institution that employs you – as to the value of what you do – a tension that makes politics difficult” (Sullivan 2014, 189). Highlighting how chaplains underline the need to be there for soldiers, prisoners, patients, or others, she problematises how the coerciveness of chaplaincy is sometimes questioned, while a bigger problem might be that the project of the institution chaplains serve, might go unquestioned (Sullivan 2014, 190). These perspectives underline how the professionality of the chaplain requires different kind of competencies as well as a constant awareness of the go-

vernmental and institutional context they are part of.

Chaplaincy, positioned as it is between the religious and the secular, does provide an interesting lens for analysing how religious and life stance plurality is politically governed in a society. That is a perspective from outside chaplaincy.

Chaplaincy positions are, as we have seen, with few exceptions, reserved for people with an educational background, grounded in Protestant Christian theological training and Clinical Pastoral Education (CPE). Against this background, we find it important to note that spiritual, religious, and existential care is also being conducted outside these official structures: It takes place within faith and life stance communities, in families or connected to other social settings. In Norway, part of this is connected to institutional structures, and therefore we will define it as "unofficial chaplaincy": Clergy from the CofN employed as chaplains have for decades called upon colleagues and resource persons from other religious communities to care for patients and inmates who wish to speak to an imam, rabbi, or Catholic priest.

The other example of "unofficial chaplaincy" is at Oslo University Hospital with its team of voluntary conversation partners or a kind of, informal chaplains, referred to above.

When compared to official chaplains, it seems obvious that both visiting clergy, i.e. resource persons engaged ad hoc for particular cases, and the team of volunteers at Oslo University Hospital are not able to care for patients and dependents with the same presence (they have to be specifically requested) and possibly not the same quality (they do not have equal access to training). A possible consequence of a poorer service would be that this way of organising a more plural chaplaincy is becoming an obstacle to a more solid pluralisation of the chaplaincy staff. This could happen because what is regarded as the poor quality of the "informal chaplaincy" work, may be connected to pluralisation itself, not to the organising of these kinds of "unofficial chaplaincy".

From within, the question would be for chaplains themselves and the population of the institutions in which they serve: How do they relate to pluralisation? The quest to pluralise chaplaincy from within is anchored in the question about what chaplaincy is, for example: What is the explicitly religious or worldview component of chaplaincy? How important would it be for a patient (and their families), a prison inmate or a soldier to meet a chaplain sharing the same worldview or religious universe? If chaplaincy is about presence, does it matter – to those the chaplain relates to – who is present? We do not know the answers to these questions because no empirical research has yet been conducted on the needs of chaplaincy clients in the Norwegian context. What we want to emphasise, however, is that if the religious majority (in Norway this would be the CofN) answers these questions on behalf of everyone – including religious and life stance minorities – that would represent a single religiously based governmentalisation. It would be a way of relating to plurality and to governing in a plural setting from the perspectives of one religious group exclusively. We think such a position goes against parts of a current and important professional paradigm: To make the needs of confidents (patients, inmates, and soldiers) a premise for the service.

If people from outside the CofN are to be engaged in chaplaincy work, one of the salient questions is related to the possibility of their obtaining applicable competence and training. Therefore, the pluralisation of chaplaincy training and education is relevant when speaking about the pluralisation of chaplaincy in the Norwegian context – and therefore we turn to training first.

A new master's programme

The Faculty of Theology at the University of Oslo (UiO) has organised courses for religious leaders with a "foreign background" since 2007. Norwegian ministries fund the courses, and the Council for Religious and Life Stance Communities in Norway (STL) and some of the largest umbrella organisations for religious minorities are conversational partners in profiling and recruiting participants. It is possible to follow this programme without any prior formal education. Leadership, Norwegian legislation, human rights and spiritual care are the foci. More

than 100 participants from various Muslim, Christian, Sikh, Buddhist, Jewish and other religious backgrounds have completed the course over the years. This programme is not aimed at providing leaders and other key personnel in religious communities outside the CofN with skills on an equal level to what is offered in the training of ministers for the CofN.

In 2017, the faculty started to work on a more inclusive, regular master's programme on interreligious leadership, ethics, and chaplaincy ("Lederskap, etikk og samtalepraksis", with the acronym LES).[8] [9] The work was boosted by a government grant in 2018 and the master's programme was launched in the autumn of 2019. Inspired and informed by related programmes elsewhere in Europe, Canada and the US, this master's programme aims to adapt to the needs in the immediate context, and most courses will be taught in Norwegian. One of the salient features of the Norwegian context is the inclusion of the Norwegian Humanist Organisation in interreligious dialogue. The master's programme will thus include a Secular Humanist worldview perspective on chaplaincy and spiritual/existential care in addition to the selected religious traditions that are being given focus: Islam, Buddhism and Christian traditions. The master has no tuition fee and is open to all applicants who meet the required qualifications: In addition an unspecified bachelor's degree, the programme requires two years of full-time work experience within the fields of social care, health care, religious and worldview-related work or teaching – paid or done on a volunteer basis.

Having a diverse student group in the courses of the master establishes – as seen from inside the master's programme – a pedagogical advantage in exposing the students to and having them work with religious and life stance relations and encounters throughout the learning process. In its first year, the group of students is diverse and represents various religious and life stance affiliations, just as we hoped. It is, however, difficult to secure diversity in the student group based on the requested qualifications, as religious/life stance affiliation cannot be made a requirement.

The overall aim of the master program is to equip its students to become skilled, empowered, and self-reflexive within various aspects of religious and life stance leadership and chaplaincy. The connection between chaplaincy and spiritual/existential care is a premise in the structure of the programme, and a connection between chaplaincy and leadership is as well. Religious and life stance leadership is defined beyond formal community leadership. It includes youth leadership, women's leadership, and taking on various types of responsibilities within faith and life stance communities and organisations. The master's programme includes both a six weeks' supervised internship and a master's thesis. Keeping practice and theory closely together during the whole learning process is pivotal. To explore, enhance, and develop significant practical, ethical, and critical as well as constructive abilities of the students towards the whole leadership and chaplaincy field, are important learning goals.

One of the most challenging aspects of such a master's programme is, from our point of view, to grasp both the generic, shared aspects and skill-learning needs cutting across religious and life stance diversities on the one side and specific skills and knowledge from the respective faith traditions on the other. The programme needs to encounter the generic and the specific. The generic, as representing shared aspects, would be partly shaped by interreligious (including the Secular Humanists in a Norwegian context) hermeneutics, and the specific would be a matter of including traditions and their ethical and moral universes connected to chaplaincy work.

We have divided the courses between obligatory and optional courses where the obligatory courses have an interreligious (including secular humanism) perspective and some of the optional courses have a profile connected to a specific religious or life stance tradition. Three traditions have so far received their 'own" course based on their numerical representation among religious and life stance organisations in the Norwegian context: The Buddhist and Islamic traditions and a course drawing on the resources of the Norwegian Humanist Association.

The gain by including both a generic and a specific perspective on chaplaincy and spiritual care is twofold: It establishes an interreligious, dialogical teaching environment where the students contribute with their own experiences and develop self-reflexive tools, as well as providing a shared pool for diverse knowledge and building trust. The article "Teaching Spiritual Care in an Interfaith Context" is based on reflections on a related study program in a Dutch context. The authors claim spiritual care in a multi-faith context to be a "complex and hybrid" endeavour (Ganzevoort et al. 2014, 195). From different angles, this article asks how this complexity and hybridity should shape the teaching of spiritual care. In the conclusion, the authors state: "Rather than taking one shape of spiritual care – usually the Christian one – as the yardstick to measure all others, each tradition's perspective on spiritual care challenge taken-for-granted assumptions of the discipline" (Ganzevoort et al 2014, 196). In Norway, the Lutheran Protestant understanding of spiritual care is interwoven in the professional paradigm existing around spiritual caregivers (chaplains). The challenge is to introduce other traditions to the professional paradigm in addition to the Lutheran Protestant. One way of doing this is to introduce the various traditions in a conversation where a plurality of traditions is represented.

At present, the training of hospital chaplains requires courses in Clinical Pastoral Education (CPE). In general, these courses are only open to ministers and deacons in the Church of Norway. This poses a major challenge for training a plural chaplaincy within the framework of CPE. There are signs of change: In the spring of 2020 the Norwegian School of Theology, Religion and Society cooperate with the faith and world view services in the Armed forces on a course that is open to participants representing all world views. But the question remains; if and how would there be space for plurality in the design of education for spiritual caregivers within the professional paradigm of Norwegian chaplaincy? There is a need to start articulating and sharing the resources within Islamic, Buddhist and Secular Humanist traditions related to spiritual and existential care. These traditions are complex in themselves, and the effort of articulating the resources would be an intra-religious effort and involve international resources as well. If the CPE in Norway at some point in the future would develop into a plural education regarding both form and content, this may represent an excellent opportunity for a specialisation for interested candidates from the master's programme. The ambitions of the new master's programme are connected to both knowledge and personal formation. But we still do not know how this kind of training fits into the present professional paradigm for chaplaincy in Norwegian institutions. The new master's programme only partly aims to challenge the CPE, as the programme has a broader scope and will provide more of a generalist education. The supervised internship, however, in health care institutions, prisons, the Norwegian defence and various organisations is supposed to take place inside the institutions, tightly connected to the existing chaplains who will provide the supervision.

The master's programme thus accentuates the dynamics between a generic and a specific understanding of religious and life stance leadership and chaplaincy. How is this experienced by those who do chaplaincy in Norwegian institutions at present? In what follows we will turn to interviews made with CofN chaplains in Norwegian hospitals, and we will deal with questions on the generic vs the specific by exploring how they frame their religious belonging as part of their professionality.

The professional role of chaplains in hospitals – as perceived by CofN chaplains

Health services in Norway are provided as part of a universal welfare state based on public and collective responsibility for social insurance and services to all citizens. The aim of the welfare state is to promote social security, equality – and fairness (Kuhle and Kildal 2018). Patients are, by law, granted equal access to services.[10] And the aim to create services equal for all is underlined when health services to citizens with migrant backgrounds are on the agenda.[11]

Chaplains in hospitals, most of them from the CofN, are supposed to talk to all kinds of

patients, no matter what their religious affiliation might be. Based on this, it is important to ask how those who do the services, understand their role – and how they understand their belief and their position as ordained clergy or deacons in the Church of Norway as part of their professional position as hospital chaplains.

One of the authors (Bråten) conducted interviews with hospital chaplains (clergy from the CofN employed by the hospital trusts) in 2017 and 2018. Individual interviews were made with 17 hospital chaplains/deacons from the CofN serving at seven different hospital trusts. The interviews lasted from one to two hours and are mostly done in personal meetings at the hospital where the chaplain works. All but one interview was taped, and they were transcribed by Bråten. The interviews are made in Norwegian and the quotes have been translated into English by the authors of this article.

Chaplains were asked how they initiate contact with patients, how they introduce themselves, what they do in meetings with patients, and they were asked to reflect on what they do in terms of providing hospital services equally to all. It should be underlined that the interview data gives insight into the narratives of the chaplains and their interpretation of what they do but do not provide insight into their actual practices.

The interview has been analysed using a thematic analysis (See for example Braun and Clarke 2006). At first, all interview transcriptions were read completely in order to get a full overview. Then concrete questions were asked regarding the data material; the questions important for this article were the following: How do the chaplains talk about their role in the hospital? How do they relate to serving all patients? What do they underscore as their competency? How do they relate to the theological part of what they do and the religion they represent? Based on these questions, themes were defined (role, serving all, competency, theology/belief) and searched for in the interview material. Quotes were sorted based on the themes defined, and interpretations were carried out.

Role

CofN chaplains define themselves as part of the working staff at the hospitals but with a specialised task. Some define themselves as health workers, but there is also a tendency to define themselves as helpers – helpers who are present not to heal or cure but to stand by the patient. Some explicitly talk against what they describe as a hegemonic discourse in medicine, i.e., relating to humans as if they were consisted of separate fragments and, in so doing, denying a truly holistic approach that includes death as part of life. This assumedly hegemonic discourse is used by some interviewees to contradict perspectives held by the chaplain him- or herself, as one CofN chaplain puts it ironically: “Hospitals do not prevent death, they just postpone it.”

They underscore that to grieve, for example, is normal, it is not a sickness and not a diagnosis. To grieve, to face a crisis, and to die are all experiences that are normal; these experiences are difficult but need to be dealt with.

They talk about their mission as chaplains, following up on that perspective, as being able to assist in coping with challenges. Some underline explicitly that they – based on that perspective – represent a counterculture and a countercompetence inside hospitals. Another difference they are proud to represent is that they are someone patients can talk to in the hospital system who can keep confidentiality even towards other hospital staff. They are supposed to follow their own obligation of confidentiality, not sharing knowledge about the patient with the rest of the staff – unless it is necessary (a matter of life and death).

Hospital chaplains from the CofN see themselves as part of the hospital institution but also – due to their counter competence and principle of confidentiality – somewhat outside of it.

Being a professional

A salient question following the reflections above is what the particularly confessional part of the hospital chaplains’ work consists of, or, to be more precise, how they talk about belonging to the CofN as part of their professional duty as chaplains. One chaplain emphasises:

> Competence is an absolute demand. We are hired for our competence, not for our religion. We are educated on worldviews and health and we are supposed to take care of this for all patients. Our education is supposed to make us capable of seeing, understanding, and meeting [patients and their families]. (Hospital chaplain F)

Chaplains are, as spelled out by this chaplain, hired for their competence. In this quote, competence refers to the formal requirements a chaplain is supposed to meet: Clinical Pastoral Education (CPE). This is a kind of training added to their ordination as ministers or deacons in the Church, it is offered in different contexts, but it has so far – as we have described earlier – not been open to all. And, as underlined by the chaplain quoted, this particular competency makes chaplains capable of meeting people who face different kinds of crises related to health and death, meaning that conversation partners who lack this kind of competency will not be able to deal with it like professionals in the same way.

Being a professional and a believer

But then the interviewees are also clergy with their beliefs, this is part of them as individual beings but also as professionals, as one put it: "I believe, I am a clergyman after all." Their religious affiliation is an important part of the professional job they do as hospital chaplains, something that is revealed in different ways in the interviews, sometimes as part of underlining that they are not out to proselytise or intervene in a patient's religious beliefs or non-beliefs, they are not normative in that way. Still, to be a believer includes – some emphasise – a desire to make other people able to use their belief as a resource for facing challenges. The others must discover the resources they have themselves inherited; this is underlined by several as utterly important, but they do not frame it as their mission as chaplains to convince people to accept their view, to perform a missionary service. This is how two different chaplains express it:

> I can't have salvation from the evil for people facing death as my main motivation. That would have made me crazy [laughs] if I considered that as my responsibility. There are, however, Christian beliefs resonating like that, holding it as the most important. And it might be important to me, as well, beneath a lot of layers, but not in the professional job I do. (Hospital chaplain W2)
>
> [Y]ou know, I believe in a great God who is tolerant. We are allowed to respect the beliefs of others. But if you had asked me, as a Christian, I would have wished that the whole world became Christians. Because I have a comforting belief and feel that Jesus is my best friend. But as a hospital chaplain, I think that what is most important is to take care of and meet the needs they [patients and their next of kin] have. And I am willing to go an extra mile when it comes to that, because that is – if you ask me – what is most important. (Hospital chaplain D2)

But even if these chaplains, just as the airport chaplain quoted in the introduction to this article, consider their main task is *to be present*, to listen to the patient, and reply to their needs and questions, chaplains are quite often addressed as religious – or more precisely – Christian authorities by patients and families. This is made explicitly in an indirect way when chaplains refer to a tendency among patients, they meet to underline that they are not very religious. They talk about this as a tendency among patients to refer to their belief from childhood (*barnetro*), patients also talk about how they were baptised and were married in church, how they used to pray their *Fadervår/aftenbønn* ("The Lord's Prayer"/"children's prayer before bedtime") but point out at the same time that they are not that religious, or just a bit religious.

Chaplains usually talk about this tendency as examples of religious privacy and/or embarrassment. We would suggest another interpretation, reading the questions as a request to the chaplain as a religious authority: Do they qualify as religious people? Is their belief enough to face the chaplain – and to face God? The tendency among the chaplains interviewed is to be willing to meet these questions, reassuring the patient that all kinds of beliefs are good enough. Belief cannot be ranked – it is something you simply have if you have it, one chaplain underscores. And if the patient or family members want the chaplain to reflect together with them on how it is possible to use belief as an asset, how it is possible to activate resources the other inherits, they do so.

These chaplains do, as we understand it, act as a kind of religious authority. But this is not usually directly referenced as acting with authority by the chaplains in the interviews. If they do sometimes talk about themselves as religious authorities, it is usually as part of narratives where sacraments and rituals are enacted.

Serving all

The mandate of the hospital chaplains of the CofN is to serve all patients, no matter of their belief. Simultaneously they tend to underline that if someone express wishes they do not consider themselves able to meet or explicitly ask for someone else – they will get someone else to come. In most cases they will have to call someone from outside the hospital, at Oslo University Hospital from the group of voluntary conversation partners. There are also chaplains who underline that they are not satisfied or fully comfortable with the close to monopoly situation they – as chaplains from the CofN – are part of in hospitals. When they refer to monopoly, they refer to their religious affiliation. These chaplains are, as all the others, eager to underline the professional training they have had in order to make them capable of meeting and being present to everyone. They have, however, experienced as one chaplain puts it: "That not everyone wants to talk to me." This is, as this chaplain interpret it, due to his position as a clergy and the part of his professionality that has to do with religious affiliation and belief.

The chaplains interviewed express their concern to respect and even encourage other religious beliefs than their own among patients in their work. They tend to accentuate their generic competency – that is, their clinical pastoral competence – as their main asset, leaving their specific religious identity and affiliation somewhat aside as less important. They sure do talk to everyone about almost everything that is important to the patient. Still, their religious affiliation is present in their work, and they experience both to be addressed by patients as religious authorities and that some do not want to talk to them because of it.

Concluding questions

In this article, we have brought up the question of chaplaincy's professional paradigm in the Norwegian context. A question we do not try to answer is how the current Norwegian model of chaplaincy, which to a large degree could be called a *monoreligiously based interfaith chaplaincy,* could question its own professional paradigm.

We obviously need more research to explore not only the governmental but also the human aspect related to the pluralisation of chaplaincy. What happens in institutions where chaplaincy caretakers mostly represent one religious tradition? What impact does it have on the Secular Humanist, Muslim, Buddhist, and those who do not know what to believe in – when most encounters with a chaplain is automatically an interreligious encounter, where they possibly must explain and define themselves as "other"? In the LES master's programme, the students will explore possibilities of establishing a practice of spiritual care, drawing on resources from other traditions than the Christian Protestant one, as well as being trained in interfaith approaches to spiritual care. The chaplains interviewed in Bråten's project clearly identified themselves as spiritual caregivers emphasising presence and acceptance of all and tended to downplay their own religious confessional identity. Would this provide an opening for negotiating the professional paradigm of becoming religiously/worldview plural? Another possibility is that today's chaplains would rather avoid religious and worldview markers connected to chaplaincy work so that they can keep a low confessional profile. This could be a strategy that might be considered crucial for the general acceptance of chaplains from the CofN: Facing a religious plural population.

We would like to add – contributing to that discussion – that acknowledging religious belonging as part of the chaplaincy profession does not contradict the idea of chaplains being present to everyone, regardless of religion. But it might contradict a chaplaincy profession open to CofN chaplains only.

We do not have the answers to all the questions we have posed, but we believe it would be useful to explore them further in the Norwegian

context. Such an exploration would both entail comparison between Norway and other contexts more familiar with the pluralisation of chaplaincy as well as provide more knowledge about the Norwegian context itself.

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Notes

1 John F. Kennedy int. airport, New Jersey, USA.

2 As of 1 January 2017, the Church of Norway has been a legal subject, responsible for all employees in the Church. https://www.regjeringen.no/no/aktuelt/farvel-til-statskirken--fortsatt-folkekirke/id2525748/ (accessed 02 July 2018).

3 Among the 22 per cent who belong to other religious and life stance groups, more than 20 per cent are Muslims, while approximately 14 per cent are affiliated with The Norwegian Humanist Association as the largest, and 56 per cent are part of Christian communities other than the Church of Norway. https://www.ssb.no/en/kultur-og-fritid/statistikker/trosamf (accessed 10 September 2017).

4 These are numbers from Statistic Norway for 2018: https://www.ssb.no/kultur-og-fritid/statistikker/trosamf/aar The Norwegian Humanist Association is not listed in this as a separate entity, but according to their official website, they have more than 90 000 members in 2018: https://human.no/om-oss/english/ (accessed 14 October 2019).

5 https://www.ssb.no/kommunefakta/oslo (accessed 3 June 2019).

6 https://forsvaretsforum.no/soldat/aktuelt-ny-feltimam https://forsvaret.no/aktuelt/forsvarets-egen-filosof http://www.ombudsmann.no/media/1199/ombudsmannsnemnda-for-forsvarets-dok-5-2017.pdf (accessed 3 June 2019).

7 Prop.130 Lov om tros- og livssynssamfunn of June 2019 is both a law proposal on belief and life stance communities and a white paper. The white paper comprises a chapter on how belief and life stances are supposed to be handled in public institutions and in health care services. The law proposal and white paper will be discussed and voted on by the Norwegian Parliament in the autumn of 2019. https://www.regjeringen.no/no/dokumenter/prop.-130-l-20182019/id2660940/sec1 (accessed 9 September 2019).

8 One of the authors of this article, Anne Hege Grung, has been in charge of the working group developing the new master's programme and is the one responsible the programme itself.

9 For a full presentation of the programme, see the websites of the Faculty of theology, UiO: https://www.uio.no/studier/program/les-master/index.html.

10 https://lovdata.no/dokument/NL/lov/1999-07-02-63?q=pasientrettigheter (accessed 15.09.19).

11 One example is a national strategy on migrant health published by the then centre-left government in 2013: Health and care services equal for all, a national strategy on the health of migrants 2013-2017 (my translation): https://www.regjeringen.no/contentassets/2de7e9efa8d341cfb8787a71eb15e2db/likeverdige_tjenester.pdf (read 15.09.19).

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Re-evaluating a suicide pact. Embodied moral counselling in a Dutch case study of mental healthcare chaplaincy

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ABSTRACT

Case studies in the field of spiritual care provide us with important information in the search for good care practices. However, the research process in the Dutch mental health care research community shows that good reflection on practice is not self-evident. To investigate this gap between practice and reflection we introduce the concept of professional body of knowledge (PBOK) in this field. On the one hand, practitioners need to adopt an attitude of not-fully-knowing in order to be open to fruitful atonement in communication. On the other hand, they need methodological reflection to make the skills involved explicit so that they can improve the interactions next time. With the help of one singular case study about moral counselling in the context of a suicide agreement between two adolescents, we show the case study approach in the Netherlands as well as a first application of our working model on PBOK.

Introduction: The Dutch case study project

The state of the practice of chaplaincy as presented in this volume reveals a growing need for research in this field, preferably involving a range of methods. Case studies are a useful tool for obtaining good research data that adequately communicates the profession of chaplaincy. There are at least four reasons for this. First, there is an absence of good comparable examples of spiritual care interventions in the research literature. Second, and central to this paper, there is a need for more information about the specific relationships between the theories that spiritual caregivers apply and concrete practices. Third, interdisciplinary communication about good healthcare practices would benefit from clear examples, and fourth, there is a need for good educational materials. Following the general outline and initiative of George Fitchett and Steve Nolan's case studies design in the United States (2015; Fitchett 2011), Martin Walton and Jacques Körver initiated the Dutch case studies project (2017) in the Netherlands. They developed a structured research format to describe

case studies in the Dutch context that were rated as good examples by spiritual caregivers. A multidisciplinary group of Dutch researchers supported this initiative. The explicit focus is on spiritual care interventions: when discussing different cases, what kind of practices do spiritual caregivers agree upon as constituting good care? Six parallel research communities were composed, each consisting of 8–12 experienced spiritual caregivers and one researcher. Five of the groups were characterised by one the following fields: Psychiatry, elderly care, general hospital, defence and the judicial context. Spiritual counsellors from various fields took part in the remaining mixed group. A standardised procedure was developed for the research communities to work on these case studies (Cf. Walton & Körver 2017).

In this paper, we focus on the Dutch mental healthcare research community and we ask the following research question: what helps spiritual counsellors to reflect on their practices? First, we sketch a working model, based on observations made by the research community, to show what we mean by reflection on practice. Next, we present a case study and then apply the working model.

Spiritual caregivers' professional body of knowledge in mental healthcare

One of the main observations in the mental healthcare research community during the past two years (2017–2018) is the difficulty researchers experience in reflecting explicitly and adequately on the use of theoretical sources in relation to their own care interventions. This difficulty is in contrast with some of the initial group dynamics. When the group discussed a case at the start of the project, they were clearly tempted to critically assess the case study in terms of arguments containing core values and models that other research members felt attached to. *"If I was the spiritual caregiver in this case, I would have done things (completely) differently by addressing …"*. The presenters also displayed some hesitancy in introducing their cases, as though they found it difficult to believe that others would agree that their cases were examples of good spiritual care. In time, these interactions transformed into open and trusting discussions. However, they continued to find it a challenge to be clear and specific about the relationship between their own theoretical sources and practices. Other research communities in the Dutch case study project deal with similar processes. We recognise this reflective struggle of integrating practical care activities with theoretical knowledge in other settings as well. We can see this clearly when inexperienced students do their internships as part of the various Master's degree programs in spiritual care. The same is true for experienced spiritual caregivers in post-academic courses, although to a lesser extent, they also struggle to express their "professional body of knowledge" in concrete words and images. The idea that discourses of knowledge and practice are not easily bridged is certainly not new (Cf. supervision theory, such as the work of Louis van Kessel). In case study research in psychotherapy, for example, researchers seek ways to close the "science-practice gap" (Van Nieuwenhove & Notaerts 2019; Datillio et al. 2010) These authors stress the failure on the part of practitioners to keep up to date with what researchers are doing, and vice versa, which obstructs their learning from each other. Thus, we can conclude that although bridging the gap between theory and practice involves a need for explicit verbal representations of different professionals' bodies of knowledge, articulating this has proven to be difficult. A first step is to explore the concept of "professional body of knowledge" in the context of spiritual care.

In humanistic transpersonal psychology (Marrone 1990), the concept of "body of knowledge" (BOK) emphasises the lived body experience as being human, in contrast to a more separated concept of body and mind. In the cognitive approach, the term "professional body of knowledge" (PBOK) is used for more or less detailed professional standards that specific professions identify as distinctive (Morris et al. 2006). In the field of spiritual care, based on our case study group observations and the relevant theory, we propose a description containing elements that correspond to both definitions: 1) the human lived body experience, and 2) the more for-

mal professional knowledge. We would also add 3) the relational context as a building block because people communicate by combining intrapsychic processes with interpersonal ones and contextual influences (Remmerswaal 2013; Muthert 2019). We thereby build upon the following line of thought. The members of our case study research group appear rather eclectic in their use of meaningful combinations based on different theoretical frameworks. These theoretical frameworks are commonly recognised as belonging to certain Dutch educational programs and they can be related to the professional standard (VGVZ 2015) of spiritual care. One can certainly speak about PBOK as related to professional standards. However, like other professions, the way in which chaplains practice these elements and connect the various theoretical elements calls for a more personal embodied (experiential) knowledge (Cf. Weerman & Abma 2018) and relational characterisation alongside spiritual skills. Chaplains combine their professional knowledge and experience with reflective spirituality and autobiographical knowledge and experiences. The research community agrees that good spiritual care needs embodied or lived theory in order to be implemented effectively.

Based on best practices in our specific research community, we therefore propose the following working model. The way in which spiritual caregivers embody certain combinations of theoretical concepts and frameworks, in interactive alignment with inter-relational processes and cultural factors together, shapes decision-making about meaningful intervention in a particular case. This process should not be equated with doing the job purely intuitively ("without knowledge"), although it could feel like "not knowing". This is because the embodied relation creates something new by actively combining the spiritual caregiver's PBOK in a specific spiritual care context with another person's (spiritual) embodiment. The "atonement" (Stanghellini 2004, 68vv) involved may feel more decisive than any theory. This working model could at least partly explain the challenge of putting theories into words. At the same time, our research group members insisted that the growing awareness ("knowing") of their own PBOKs and that of others was rather helpful and inspirational in their present work (Cf. the notion of "stimulated recall", Chittenden 2002). They mentioned it explicitly as one of the advantages of taking part in the case study project. One could therefore argue that it increased their intrinsic work motivation (Cf. Ryan & Deci 2017). The profession thus builds on two contrasting tracks. On the one hand, practitioners need to adopt an attitude of not-fully-knowing in order to be open to fruitful atonement. On the other hand, they need methodological reflection to make the skills involved explicit so that they can improve the interactions next time.

We cannot evaluate this working model thoroughly by means of a single case study. The first author will present a more thorough study of this PBOK elsewhere (in preparation). Below, we will 1) present a case study by adhering roughly to the case study format (Walton & Körver 2017), 2) show how the spiritual caregiver reflected on her PBOK with the help of other mental healthcare professionals and the research community, 3) conclude by evaluating how the three different PBOK elements in our working definition were involved (the human lived body experience, professional knowledge, the relational context). In the presentation of the case study, the letters a–i indicate the places where the research group felt in retrospect that different moral counselling interventions took place (see table 1).

1. A promise is a promise!? Moral counselling in the event of a life-threatening dilemma

(Cf. Van Hoof, Muthert et al. 2019)

The mental healthcare research community presents the following case study as a good example of moral counselling. In this case, the counsellor is a 54-year-old woman who has worked for seven years as a spiritual counsellor in the south of the Netherlands. Her core business involves ethical and philosophical reflection in both one-on-one contact and group meetings, and policy issues in the healthcare organisation. She is familiar with the hermeneutic philosophy of Gadamer's and Nagy's contextual therapy. After a moral deliberation meeting in a residential

care facility for adolescents, the spiritual counsellor has received a referral from the client's main therapist. The client is a 15-year-old girl named Esther. Esther is struggling with an agreement she made with a friend almost one year earlier: That if one of them committed suicide, the other one would do the same within a year. Almost a year has passed since her friend killed herself and Esther is experiencing immense pressure to keep her promise. The care team doesn't know how to break the chain of compulsive thinking about this agreement, which they link to her diagnosis of autism. Different kinds of cognitive interventions have been unsuccessful. Because of the time pressure, four meetings are scheduled at short notice. As the therapist is concerned with Esther's feelings of safety and her vulnerability in making new contacts, the therapist also attends the meetings. Esther has regularly been in clinical care settings over the past few years. Her parents are divorced but she has a bond with each of them. She used to be very good at team sports. There is no prior information about her religious affiliation or beliefs.

The counselling consisted of four sessions. The focus of the first two sessions was on moral counselling. The third involved ritual counselling aimed at confirming the chosen pathway. The fourth and final session concluded matters and focused on the future.

Session 1

Esther, her therapist and the spiritual counsellor meet in the therapist's room. After a brief introduction, the counsellor says that she knows from the therapist that Esther is struggling with something difficult, but that she would like to hear the story directly from her. Esther stares at the ground and wiggles her legs awkwardly. Then she quietly says: "A promise is a promise. I think it's very important to keep my promises". She doesn't go into the nature of her promise. The spiritual counsellor responds by saying firmly that she thinks it's good when people adhere to their agreements. This response captures Esther's attention; she is clearly surprised, as is her therapist. The spiritual counsellor adds that life is much easier and more pleasant if people keep to their agreements. "If we hadn't done so, we couldn't have had this meeting today. But sometimes agreements must be reconsidered because, for all sorts of reasons, you can't or don't want to keep them." The spiritual counsellor deliberately doesn't directly address the problem of Esther's specific agreement or her persistent attitude. **(a)**

The spiritual counsellor then invites Esther to say something more about her promise. Esther recounts in a soft tone that she and her best friend made an agreement that if one of them committed suicide, the other one would do the same. The spiritual counsellor responds by saying that it must have been a very important friendship to agree to risk their lives together in this way. Esther starts crying and says she misses her friend. The counsellor invites her to talk about her friendship. **(b)** Esther says that they met about two years ago in a care institution and they clicked right from the start. They had a lot of fun together, which was a new experience. Before then, Esther had never had friendships. She was bullied at school and she didn't feel she belonged; she was lonely. Neither of them wanted to lose this experience of being together. The spiritual counsellor then asks what exactly prompted Esther to make the agreement. Esther says that she assumed that if they made the promise, it would protect them from suicide because the other's life was at stake. The spiritual counsellor says: "Your own life may sometimes make you feel that it is worth nothing, but you wanted to fight for the life of your friend!" Esther looks straight at the spiritual counsellor and says clearly: "Yes, that's it exactly." The caregiver continues: "And for you, the agreement wasn't an agreement to want to die together, but an agreement to be able to cope with life together." **(c)**

Esther is in tears again and says she would like to stop. She wants to go back to her room. The spiritual counsellor comments that she can see that her last remark has touched Esther, that Esther misses her friend very much and that she recognises this as mourning. **(d)** Esther cries softly. She looks at the spiritual counsellor and repeats that she would like to stop. The counsellor confirms that it is indeed enough for today. Respecting Esther's limits is important for the

safety of their contact. After taking Esther back to the department, the therapist expresses satisfaction with the "depth of the conversation". She sees a new perspective and she feels that Esther might too.

Session 2

They meet again a week later. It is exactly three days before the anniversary of Esther's friend having taken her own life. After entering the room, Esther ducks down in a chair, her head on her chest. She talks even more softly than the first time. The spiritual counsellor asks Esther if she can say something about what is going on. She shrugs her shoulders and remains silent. After a while, the spiritual counsellor says that it must be a difficult week for her, with all the memories of what happened a year ago. Esther nods almost imperceptibly. The spiritual counsellor decides to structure the conversation. First, she briefly summarises the first conversation. She writes on the whiteboard: "A promise is a promise. If one person commits suicide, the other person does too." Esther looks up. Underneath that sentence, the spiritual counsellor puts into words what this agreement means to Esther: "The agreement is made to protect you from committing suicide." She asks Esther whether this is true. Esther nods. She is not exactly sure about what the agreement meant for her friend. However, her friend had always said that if she ended up living on her own, she would commit suicide. Just before taking her life, she had indeed been given her own apartment. The last time they saw each other, the day before the suicide, Esther said to her: "Don't make me sing!" That was also part of the agreement. If her friend committed suicide, Esther would sing a song at her funeral. The spiritual counsellor translates Esther's "Don't make me sing" as a cry for help: "Don't let me down, I want to stay here, I find life worth living." **(e)** Esther nods visibly, but her words are unintelligible.

Following this nod, the spiritual counsellor writes "I find life worth living" on the whiteboard. Then she asks why Esther thinks life is worth living. Esther says that she has hope for a better future, and that she doesn't want her family and her friends to feel the pain she felt when her friend died. The spiritual counsellor calls this love for and from those around her. She also asks Esther to reflect on the opposite: Why she would like to die. Esther says that she sees no point in living and she wants to die because of the agreement. The counsellor writes down both answers. **(f)** The spiritual counsellor then asks Esther which choice she would make right now, seeing both arguments side by side. Esther says that she would like to choose life and she cries. After a silence, the spiritual counsellor carefully summarises by saying that Esther has had a very difficult time in her past and that this particular friendship must have been a comfort. With her friend, her hope for a better future was able to grow. **(g)** Esther returns to the care unit. The spiritual counsellor promises to bring photos of the whiteboard later that day. **(h)**

In the afternoon, the atmosphere in the care unity where Esther stays is tense. The employees seem to be stressed. The spiritual counsellor sits quietly with Esther for a while. She seems more relaxed than this morning and is happy with the photos. She is pleased with the suggestion that they have an appointment on the anniversary of her friend's death.

The counsellor calls in on the therapist and shares her feedback on the atmosphere in the unit. The therapist mentions that the team is having a difficult time: there was another suicide recently. Seeking control, the team wants to make firm restrictive agreements with Esther to protect her (and the others involved) from another suicide. The spiritual counsellor argues that Esther, in addition to protection, needs to be given support and trust. **(i)** The therapist will discuss this in the team.

Session 3

When the spiritual counsellor picks Esther up, she shows her the memorial area she made, with a picture of Esther and her friend, a small book containing written memories, and tea lights. She takes these items to the counsellor's room. They first light a candle for her friend, followed by one for Esther, with the words "Let there be light and warmth for you". They then

look at the memorial booklet. Esther recounts her friendship through photos. They continue by reading her friend's farewell letter. In the letter her friend says that Esther would continue living. Earlier, Esther hadn't interpreted that sentence in the way she does now. Finally, the counsellor lets her choose two ceramic hearts. Esther places an orange one for her friend and a blue one for herself next to the candles. She is invited to take the hearts with her; the candles will burn out in the room.

Session 4

Five days later, they meet for an evaluation. Esther will move to a specialised youth clinic at short notice. School and treatment will be combined. Esther says that she no longer wants to die because of her friend's suicide. At the same time, she is often sad and has difficulties with life. The spiritual counsellor refers to the whiteboard diagram and confirms that these feelings are there and won't magically disappear. She also emphasises Esther's hope for the future and the other connections that she cares about. Both feelings belong to life. But she may have struggled more with suffering than her peers. Finally, the counsellor expresses the hope that Esther will increasingly perceive opportunities for the future. She asks whether Esther will take up sports again. Esther's face lights up and she smiles.

2) PBOK reflections of the spiritual counsellor, other professionals and the research community

Central to this case study was the question of whether Esther needed to keep her suicidal pact with her friend. Cognitive interventions did not appear to work. The spiritual counsellor opted for moral counselling – guiding and assisting clients who must make moral choices in difficult circumstances. The aim of this process is to be at peace with a choice or decision in the near future. Because the diagnosis of autism is not leading in moral counselling, the counsellor said that the client can experience more space to search for significance, meaning and reorientation. This thought is inspired by *Het geheim van het lege midden* (2003) [The secret of the empty middle space], by the systematic theologian Theo Witvliet. When asked by the researcher to elaborate on this theory before the first discussion in the research group, the counsellor highlighted the protective function of the biblical image ban. Such an "empty middle space" counteracts fixations in conceptual thinking that are too rigid. In translating this idea to her case study, she saw the cognitive perspective as being too dominant in treatment. There needs to be more space for the human struggle with life and death on an existential level.

In her first draft, the spiritual counsellor took her moral counselling approach more or less for granted. She distinguished four interventions. 1) First, she wanted to put Esther at ease and gain her trust. She therefore used self-disclosure: paraphrasing at the meaning level and allowing Esther's input on content and duration to lead the conversation. 2) Second, biographical values and meanings were examined. The spiritual counsellor used a value inquiry on the whiteboard, which promoted a fruitful distance between Esther and her concrete emotions and thoughts. The friend's perspective was also considered. 3) Third, the counsellor tried to support the team by adding her perspective to the team approach. 4) Finally, ritual guidance confirmed both the connection and the boundaries between Esther and her friend, thereby strengthening Esther's own identity.

Esther felt visibly better after the counselling. Her attitude, the way she made contact and the tone and content of her speech spoke for themselves. After evaluating the case study, Esther concluded: "I was finally able to mourn the loss of my friend." Her mother was grateful: because of the interventions, Esther was able to reconsider her agreement. One nurse used the word "magic" to describe what had happened. The team had given up on Esther changing her mind. However, she still had suicidal thoughts and existential questions. The spiritual counselling ended there because Esther moved to another institution. If Esther had chosen death over life, further guidance would have been necessary. To the counsellor's surprise, Esther viewed mourning as the most essential part of the contact, whereas she herself highlighted moral

counselling.

The therapist was not surprised about Esther's remarks on mourning in her evaluation of the written case study. That was the focus of all the therapeutic interventions, but Esther's suicide pact stood in the way. In the therapist's opinion, the counsellor's approach contributed to this. She could freely look at the client's suffering at that very moment (Muthert 2019). She could also pay attention to a specific part of the problem from different perspectives – the values involved in Esther's dilemma. Compared to the counsellor, the treatment team also had to keep an eye on many other interests, for example behaviour agreements, conflicts and department rules, future directions, contact with the parents, other patient's safety, etc. Finally, the counsellor was able to frame Esther's ideological values in a positive way.

The discussion in the research community was quite helpful in identifying more precisely what the counsellor raised in her moral counselling (Meetings I and II). First, the group invited the spiritual counsellor to be more explicit about her sources. During the discussion – based on the format-related questions and remarks (Walton & Körver 2017) – explicit theoretical sources cropped up quite naturally. Subsequently, the moral counselling actions that were identified were adequately defined (See Table 1).

3. A brief evaluation of the PBOK aspects of the case

To a certain degree, the spiritual counsellor was aware of her moral counselling abilities and knowledge in this case. It was also because of these skills that she was asked to intervene. At the same time, she did not follow a strict protocol, and she needed the interaction with her research community to identify more clearly the different moral counselling interventions involved, as well as her theoretical sources (PBOK). The research group recognised the case as an example of good spiritual care from the beginning. At the same time, the group needed the theoretical specifications to be articulated (BOK) to find out exactly what made this case worthwhile. This joint reflection (relational) led to a growing awareness of a shared idea about good spiritual care. The case study also shows the

Table 1. The different moral councelling interventions in Sessions 1 and 2 (Van Hoof, Muthert et al. 2019)

a	Creating space for the human value of adhering to an agreement and for the struggle or ambivalence involved.
b	The invitation to talk about friendship offers a different perspective on the relationship between the two girls than that of a problematic agreement.
c	The spiritual counsellor marks Esther's interpretation of the agreement as "being able to cope with life together" by/in friendship.
d	By acknowledging the loss of her friend, Esther can gradually acknowledge her own grief and loss.
e	By paraphrasing the statement "Don't make me sing!" on an existential level, Esther's deepest need is acknowledged.
f	What makes life worth living or not is clearly juxtaposed with values on the whiteboard (Cf. De Groot & Leget 2011).
g	A connection is made between the past and the future by how Esther values friendship.
h	With the concrete photos, Esther is given tangible control of her own valuing process as discussed together. This reinforces the fact that she knows that her choice has been seen and heard.
i	Linking core values from Esther's discussions with the spiritual counsellor (including safety and trust in Esther's own judgment and strength) to the department's daily routines where protection is central.

importance of direct relational aspects; the verbal and non-verbal responses of both Esther and the spiritual counsellor were decisive. It is not possible to derive from this an interview schedule that has general validity. With our working definition in mind, the spiritual counsellor "simply" worked out what to do next in atonement with her communication partner. Her (P)BOK was coloured by her knowledge of the importance of exploring values, meaning and moral decision-making. She truly embodied that kind of knowledge and theory. The concrete situation, however, led her to act in the way she did in interaction with Esther.

The concrete healthcare context seems to have been decisive as well, in addition to other contextual factors (such as her life story – her youth, parents' divorce, bullying, loneliness, a growing sense of friendship, the tremendous loss of a best friend). The department team was wrestling with the impact of a recent suicide and, therefore, tended to behave quite strictly and imposed rules. One could argue that alongside the wish to protect everyone from another suicide, a fixed idea of what was good for Esther in behavioural terms was articulated verbally and non-verbally. In short, they expected Esther to adhere to the department's rules. At the same time, they expected Esther to change her mind completely about her private agreement. One could very well argue that Esther literally needed to experience another, more open, context in order to look at her situation. The spiritual counsellor framed what happened as moral counselling, while Esther highlighted mourning. Both frameworks touched upon the existential level, where they do seem to have come together. This fruitful attuning produced something new: a new perspective on the immense existential questions of coping with freedom and death.

This analysis is only a beginning. However, we believe that the way we describe PBOK in the context of spiritual care could be fruitful for further elaboration. One question concerns the specific concepts we use. A comparison with supervision theory, for example, seems to be interesting, although the format of the case studies approach (Walton & Körver 2017) explicitly states that an atmosphere of supervision should be avoided.

We can conclude by emphasising that the mental healthcare research group in the Dutch case study project was increasingly able to articulate their spiritual care practices. The following factors seem to play a role in this: 1) Close observation and identification of interventions; 2) Theoretical articulation and explanation; and 3) Relating these interventions and explanations to concrete effects. Embodied interaction seems essential. The experience of an increased awareness has proven to be helpful in framing interventions and skills in the communication with colleagues and other mental health professionals.

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Patient-reported outcome measures (PROMs) in healthcare chaplaincy: What, why and how?[1]

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ABSTRACT

Outcome research is becoming increasingly important in healthcare chaplaincy, to improve the quality of chaplaincy care and to justify the need for healthcare chaplaincy services. Patient-reported outcome measures (PROMs) are instruments enabling the assessment of healthcare chaplaincy outcomes. In this paper, I discuss how PROMs might be implemented in healthcare chaplaincy. PROMs can be used for patient monitoring, quality improvement and external transparency. PROMs can reflect any dimension of patient health and functioning, but they must be sensitive to change and relevant to the chaplaincy care context that is being evaluated. The choice of PROs assessed reflects the vision on the profession and its responsibility. Reduction of the profession to that which can be measured with PROMs should be avoided. Thus, the selection and implementation of PROMs in healthcare chaplaincy requires careful considerations, which can be supported by use of the PROM cycle illustrated in this paper.

Keywords

Healthcare chaplaincy, outcome, assessment, spiritual care, questionnaire

List of terms

PREM: Patient Reported Experience Measure, a self-report instrument used to assess the evaluation of a care encounter

PRO: Patient Reported Outcome, an aspect of health, well-being or functioning that is affected by a care professional, intervention or organisation

PROM: Patient Reported Outcome Measure, a self-report instrument used to assess PROs

ROM: Routine Outcome Monitoring, a practice in which patients complete PROMs or PREMs at regular intervals before, during and after care

Introduction

With the secularisation of many societies, healthcare chaplaincy is increasingly defined, organised and evaluated as a healthcare profession rather than a religious profession[2]. With this development, outcome research has become one of the top priorities in research on healthcare chaplaincy in various European countries and the United Stated of America (Damen, Delaney & Fitchett, 2018; Damen, Schuhmann, Lensvelt-Mulders & Leget, 2019; Selman, Young, Vermandere, Stirling & Leget, 2014). Outcome research means that we try to understand what has been changed in a patient after seeing the chaplain. We might want to know this for several reasons, such as (a) to monitor progress of the patient in relation to their spiritual need, (b) to understand the general effectiveness of chaplaincy care at alleviating spiritual needs, (c) to compare the effectiveness of several different types of chaplaincy care in relation to a certain spiritual need and (d) between various groups of patients, (e) to explain to healthcare professionals with whom healthcare chaplains collaborate what it is that they do, (f) to compare the effectiveness of chaplaincy care at alleviating certain needs to that of other healthcare disciplines, or (g) to report on how healthcare chaplains contribute to the goals of a healthcare institution or other funding body, such as an insurance company or governmental organisation. Therefore, outcome research could provide evidence for the impact of the healthcare chaplain on the patient for use in patient care and in communication with patients, chaplains, (mental) healthcare providers, and funding bodies.

Such research can be conducted with various methods. One approach could be to use a diverse array of qualitative methods to describe the thoughts, feelings and acts of chaplaincy patients before, during and after one or several meetings with the healthcare chaplain. An important advantage of this approach is that the described outcomes are close to the actual experience of the patient and the descriptions can consider various possible contributors to this outcome. An important disadvantage is that the described outcomes can be unique to this person under these circumstances and are, thus, difficult to compare between patients, chaplains, interventions, settings, etc. In other words, the outcomes are not standardised, which makes comparative research and generalisation of findings more difficult.

A quantitative approach to outcome research will more easily allow for standardisation and, with that, the generalisability and comparability of findings. One method for such a quantitative approach is the use of Patient-Reported Outcome Measures or PROMs. In this paper, I will introduce what PROMs are, why they can be useful for outcome research in healthcare chaplaincy, and how they can be constructed and implemented. Throughout, I will provide examples of existing chaplaincy research using PROMs.

Outcome research in healthcare chaplaincy is not without controversy or challenges. Various authors have suggested that it is important for healthcare chaplains to conduct scientific research on the impact of their practices, to understand whether chaplains support patients in the ways they hope for and, with that, to enable quality improvement of chaplaincy care. Additionally, current emphasis on evidence-based practice in healthcare throughout the world, but especially in Western countries, has led to a situation in which there will be no or little funding for care if there is no evidence to support its effectiveness (Fitchett, 2011; Handzo, Cobb, Holmes, Kelly & Sinclair, 2014; Snowden et al., 2017).

However, others have argued that an emphasis on so-called Outcome Oriented Chaplaincy (VandeCreek, 2014) might devalue healthcare chaplaincy, which is strongly oriented toward a practice of presence (Nolan, 2013, 2015). Because of the value placed on presence, relationship and person-centred care, much of healthcare chaplaincy might not lend itself to the demarcation, predictability and replicability required for scientific research. In addition, there is a risk that, in the quest for evidence-based practice, healthcare chaplaincy might be reduced to the aspects of the discipline that can be assessed through scientific methods.

Damen, Schumann, Leget, and Fitchett (2019) provide counterarguments for many of the ob-

jections against outcome research in healthcare chaplaincy. Here, I would like to stress that I believe that the careful use of outcome research, that keeps in mind that not everything of value can be measured, has the potential to not only stimulate more deliberately reflexive chaplaincy practice (Asking why do we do what we do?), but also to make it more clear to chaplains themselves and to the people they interact with what chaplaincy care is about (Asking what is it that we do?).

Nevertheless, outcome research in healthcare chaplaincy is not easy, because it is diverse, sometimes unarticulated, and often unpredictable. In addition, healthcare chaplaincy affects not only spiritual, but also physical, psychological, and social aspects of patients' health and functioning (Damen, Schuhmann, Leget, et al., 2019), thereby showing overlap with outcomes of other professions. Furthermore, other care professions also affect spiritual needs (Sinclair, Pereira & Raffin, 2006), which makes it difficult to determine whether it was the healthcare chaplain or somebody else who stimulated the change in the patient's health or functioning.

Thus, careful consideration of which outcomes are to be assessed, and how and when this happens is important: What is the nature of healthcare chaplaincy in the specific context and what is the responsibility of the healthcare chaplain? If PROMs are used for this assessment, this paper can assist to embark on it with care and deliberation.

What are PROMs?

The origin of PROMs lies in evidence-based medicine. In evidence-based medicine, the individual clinical expertise of the practitioner is integrated with external evidence from systematic clinical research on, among others, the efficacy and safety of interventions to enhance the quality of decision making about treatments for specific patients (Sackett et al., 1996). Preferably, efficacy was assessed with objective measures, such as how far a patient can walk or how much damaged tissue is still present. However, it is increasingly recognised that health is a subjective experience and that emotional and evaluative factors are at least as important as objective indicators to understand the success or failure of a certain treatment. Therefore, measures that assess the patient's experience of their health are needed (Terwee, Wees & Beurskens, 2015). PROMs are such measures.

PROMs typically are self-report questionnaires on which a patient can score the extent to which a certain aspect of health or functioning (also often referred to as "quality of life") is present. These aspects are called patient-reported outcomes (PROs). If the patient is not capable of reporting on these themselves, oftentimes a representative of the patient is asked to report on behalf of the patient. PROs can cover any dimension of health or functioning, such as physical capabilities (such as being able to climb a flight of stairs without getting out of breath) or sensations (such a pain, fatigue or numbness), emotions (such as insecurity, anxiety or depression), thoughts (such as suicidal ideation or cognitive capabilities), evaluations (such as feelings of safety or overall quality of life), social experiences (such as feeling supported by loved ones or looking forward to going to social events) or spiritual experiences (such as experiences of meaning in life, connectedness to the transcendent or awe). In any case, a PRO is an aspect of the patient's health or functioning that is being addressed by the intervention or profession under scrutiny. Thus, an important characteristic of PROs is that they are amenable to change and that they are relevant for the context in which the PROM is being used (Terwee et al., 2015). For healthcare chaplaincy, this means that PROMs should only assess aspects of the patient that change due to the chaplaincy encounter.

Usually Likert-type scales are used for this self-report, in which the patient must tick a box or circle a number after each PRO on the questionnaire. The lowest score means the PRO is "absent" or "not applicable" and the highest score means it is "very severe" or "highly applicable". Jensen Hjermstad et al. (2011) suggest that no less than three and no more than seven answer categories should be offered, because otherwise the discriminatory ability of the measure is lowered. Sometimes visual analogue scales (VAS) are used. A VAS is a straight hori-

zontal or vertical line of about 10cm, either with or without indicated scores as in a Likert-type scale. The patient then must draw an intersecting line to represent the level to which they experience the given symptom (often pain).

An example of a PROM for healthcare chaplaincy is the recently developed "Scottish PROM" (Snowden & Telfer, 2017), which is currently being translated to other contexts as well by the European Research Institute for Chaplains in Healthcare (ERICH). In this self-report questionnaire, the patient is asked to tick the box that best describes their experience in the past two weeks. The scale consists of a 5-point Likert-type scale with the categories "None of the time", "Rarely", "Some of the time", "Often", and "All of the time". The five outcomes that are being assessed are: being honest with oneself about how they were really feeling, having a positive outlook on their situation, feeling in control of their life, feeling a sense of peace, feeling anxious. The Scottish PROM is a so-called generic measure, in contrast to a disease-specific measure, which assesses aspects of health and functioning specific to a certain (mental) health condition. This means that the Scottish PROM can be applied to a wide variety of patients. The outcomes that are measured by this PROM pertain to mental health, as evidenced by its strong relationship with the Warwick-Edinburgh Mental Wellbeing Scale (r = .80). This means that it is unlikely that these outcomes are specific to chaplaincy care. Other care professions, such as nurses, social workers or psychologists, might also attain them.

PROM or PREM?

The Scottish PROM is a particularly interesting example, because it also contains a PREM: A Patient-Reported Experience Measure. PREMs assess how the patient evaluates the care encounter (Bos, Zuidgeest, Kessel & Boer, 2015). This can be any aspect of the visit, from the ease of making an appointment or the ease of finding a parking space to the attitude of the healthcare chaplain. The PREM in the Scottish PROM consists of four items, that assess whether the patient felt listened to by the chaplain, was able to talk about what was on their minds, felt their situation was understood, and felt their faith or beliefs were valued. The rating scale is the same as for the PROM section of the questionnaire.

This distinction between PROMs and PREMs is important to note, because much research in chaplaincy currently uses patient satisfaction as an outcome. For example, Sharma et al. (2016) examined the difference in patient satisfaction between interventions addressing the spiritual/religious dimension of patients and interventions addressing the psychosocial dimension. Other studies have examined whether patients who had seen a chaplain during their hospital stay were more satisfied with care than patients who had not seen a chaplain (For an overview see Fitchett, 2017; Pesut, Sinclair, Fitchett, Greig & Koss, 2016). However, patient satisfaction is a PRE, not a PRO. Patient satisfaction does not reflect health or functioning, but the evaluation of the care process. Of course, it is important that patients are satisfied with their care and it is great that chaplains contribute to this. However, the general goal of chaplaincy is to alleviate spiritual needs. Thus, the extent to which certain spiritual needs were reduced would be a PRO of healthcare chaplaincy.

Unfortunately, even when research is focused on spiritual needs, it is not immediately clear whether the measure used is a PREM or a PROM. This is illustrated in the study by Flannelly, Oettinger, Galek, Braun-Storck, and Kreger (2007). They have investigated whether various aspects of the healthcare chaplain's demeanour (such as, whether the chaplain introduced themselves to the patient, provided privacy, or seemed to care) and various aspects of patient satisfaction were related with how well the patient felt the chaplain had met their spiritual and emotional needs. In this study, whether the "outcome" is a PRO or a PRE depends on how the patient interprets the question asked: "How well did the chaplain meet your spiritual needs?" If this is interpreted as whether the needs were reduced, this is a PRO; but if it is interpreted as whether the needs were addressed, this is a PRE. The patient satisfaction items used in the study were derived from VandeCreek (2004) and included, among others, the items "How satisfied were you with the chap-

lain's ability to really listen to you?" or "(...) provide a referral for other help you needed?"– clearly PREs –, but also "(...) overcome your fears or concerns" or "(...) help you tap your inner strength and resources?" – which are PROs. The VandeCreek items were more closely related to the extent that patients felt their needs were met (with r ranging from .22 to .54) than the items on the demeanour of the chaplain (with r ranging from -.03 to .38), with the two PROs showing the strongest associations (r = .53 and r = .54, respectively). Thus, it seems that most patients had interpreted the question "How well did the chaplain meet your spiritual needs?" as whether their needs had been reduced by the chaplain (as a PRO).

Why are PROMs used?

In the introductory section to this paper, I already mentioned several reasons for conducting outcome research. These can be categorised into three overarching motives: (a) individual patient care, (b) quality improvement, (c) external transparency (Verkerk et al., 2017).

Individual patient care

In individual patient care, PROMs can be used for diagnostic purposes and/or to provide the patient with more insight into their level of health or functioning. They can also be used to monitor the patient's needs throughout care. In this instance, the assessment can be used to facilitate communication between the healthcare chaplain and the patient and/or for care decision making.

Within mental healthcare, continuous use of PROMs in patient care is referred to as routine outcome monitoring or ROM. ROM makes use of computer systems in which the patient provides weekly reports on a PROM (and sometimes also a PREM) for the duration of treatment. The therapist and the patient receive feedback on the patient's progress in the form of charts or other visual representations (such as traffic lights or smileys) to evaluate whether a patient has recovered, improved, remained unchanged, or deteriorated. This can then be discussed in the next meeting and used for treatment decision making. Lambert and Harmon (2018) suggest based on effectiveness studies of ROM, that the use of ROM has a positive impact on treatment effectiveness, because it raises the therapist's and patient's awareness of the therapeutic process; it can help to make therapists expectations about the successfulness of their treatments more realistic; it can help to predict – and thereby prevent – treatment failure; and – when including a PREM – it can help to strengthen or maintain the therapeutic alliance. Especially when used for monitoring, it is useful to record the scores of the patient on the PROM in their clinical records.

Quality improvement

When using PROMs for quality improvement, the scores of individual patients are not important. Instead, the assessments from a group of patients of a specific healthcare chaplain, department or organisation are used to determine whether on average the care is showing the desired effects or, in other words, whether the desired outcomes of care are being obtained. If not, it needs to be determined why the care outcomes are insufficient and what arrangements need to be taken to improve the quality of care. Using PROMs for quality improvement often involves some type of "benchmarking": The results obtained for one professional, department or organisation are compared to a professional, department or organisation that is considered very successful (a "best practice"; Camp, 1989). When used for this purpose, the scores on the PROMs are not made public to patients or external organisations. The information is for internal organisational use only.

Research into the effectiveness of healthcare chaplaincy also falls under the quality improvement motive for using PROMs, though the findings from this research are generalised and used beyond the organisations in which the data were obtained. The general assessment of the effectiveness of chaplaincy care and comparisons between chaplaincy interventions, between types of chaplains, between types of healthcare professionals, and between patient groups all facilitate an understanding of the extent to which chaplaincy alleviates certain (spiritual) needs and what might be needed to improve

this. This knowledge can help decision-making in the individual patient encounter – in the spirit of evidence-based practice – because it can contribute to an understanding of which approach might be most helpful to whom, under which circumstances, by which care professional (especially in multi- or transdisciplinary care) or by which type of healthcare chaplain. In addition, this research can help to communicate about healthcare chaplaincy with other professions. ROM data can also be used for this research, although often the measures used in ROM do not have enough psychometric quality for scientific research. I will discuss quality criteria for PROMs in the next section.

An example of chaplaincy research for quality improvement is the Life in Sight Application (LISA) study by Kruizinga, Scherer-Rath, Schilderman, Sprangers and Van Laarhoven (2013). In this study the effectiveness of the LISA intervention, developed by the authors, is examined. The PROMs used to assess the outcomes of the intervention are the EORTC QLQ-C15 PAL, a disease-specific 15-item self-report questionnaire on quality of life for cancer patients receiving palliative treatment, and the FACIT-sp-12, a generic 12-item self-report questionnaire on spiritual wellbeing (a dimension of quality of life). Both scales are widely accepted and high-quality PROMs that are used by various healthcare professions for quality improvement and scientific research. Therefore, using these scales in healthcare chaplaincy research can facilitate comparison and communication between professions.

Kruizinga and colleagues did not find any differences on these measures between the patients receiving the LISA intervention and patients receiving "care as usual" (Kruizinga et al., 2019). There are various possible explanations for this finding. The authors suggest that the intervention may have been too brief to evoke change, the intervention may have been insufficient in providing resources for finding meaning, or the outcome measures may have been too broad. One of the patient satisfaction items included in the study sheds more light on this latter point. Eighty percent of the participants in the intervention group indicated that they would recommend the intervention to others, because they felt it had given them insight into their lives and had helped them to see their values more clearly. These outcomes are much closer to the actual elements addressed in the intervention than the outcomes assessed in the two PROMs. I will return to this issue of the specificity of outcomes in the next section.

External transparency

Using PROMs for external transparency means that they are applied at a national level and the results are made public. The idea behind this is that this information will help patients to choose the best possible care. Insurance companies can also use this information for decisions about contracts with healthcare organisations and professionals. The information could also be used by care inspectorates.

However, the use of PROMs for external transparency is problematic for several reasons (NIVEL, IQ Healthcare, VSOP & Patiëntenfederatie Nederland, 2018). First, it is based on a model of competition between care providers, which imposes a risk of reduced cooperation between healthcare chaplains themselves and between chaplains and related professions. Second, combined with the intention of accountability, it imposes the risk that chaplaincy will become focused on care for the assessed outcomes at the expense of valuable outcomes that are not assessed. This would reduce the potential richness of the profession and lead to inattention to various (spiritual) needs of patients. Third, as we will also see in the next section, the interpretation of the scores on PROMs is not easy. Particularly when using PROMs for external transparency, it is important to correct for differences between the populations of healthcare chaplains or organisations. For example, some chaplains may serve a population that, from the start, has more severe spiritual needs than the population of another chaplain. The patients of the first chaplain will likely always score lower on the PROM than the patients of the second chaplain, even though both chaplains provide the same quality of care. Alternatively, the patients of the first chaplain have much more potential for change, than the patients of

the second chaplain do. This also skews the results, when the amount of improvement is taken as the quality criterion. Thus, case-correction is essential for the use of these scores to be meaningful and fair.

Because of these difficulties, PROMs are only used for external transparency when patients are treated for a clearly defined condition, for which it is easy to determine an outcome that they will all have in common, a clear cut-off point (see the next section), and case-correction. PREMs are more commonly used for external transparency, because these are much easier to assess and to standardise across settings (for example, in the form of Consumer Quality Indexes).

How are PROMs constructed and implemented?

So far, I have discussed various purposes for using PROMs in healthcare chaplaincy and the basic characteristics of these instruments. From this discussion, it may have become clear that the choice and implementation of PROMs are not to be taken lightly. In this section, I will use the PROM cycle developed by the Dutch National Health Care Institute and the Dutch Federation of University Medical Centres (Verkerk et al., 2017) to provide some guidelines on how to go about this (see Figure 1). I will introduce the purpose of each step and highlight some important choices. More information (in English) can be found at the COSMIN initiative (Consensus-based Standards for the selection of health Measurement Instruments; COSMIN.nl).

During *Step 1* it needs to be decided for which of the three discussed purposes the PROM is to be used, who will be filling it out, and when and where this will be done. Although a PROM can be used for more than one purpose, each goal and context places different demands on the PROs to be included, the measurement qualities of the PROM and its ease of use. On the other hand, patients and care providers should not be overburdened by PROMs. Thus, this stage of the PROM cycle requires careful consideration.

The selection of PROs during *Step 2* should be a collaborative and iterative process between researchers, healthcare chaplains, patients, and – depending on the purpose – collaborative partners such as other care professions or funding bodies. That way, the most relevant PROs are selected. PROs are relevant when they match the purpose of the PROM and when they are affected by chaplaincy care. Existing research can be helpful when making this choice. For example, the LISA study discussed above shows that for healthcare chaplaincy, the levels of insight into one's values and one's life might be more appropriate PROs than other aspects of physical, emotional or spiritual well-being. Based on the review of 104 spiritual care assessments in the electronic medical records of patients at The Ottawa Hospital, Stang (2017) suggests that chaplain-

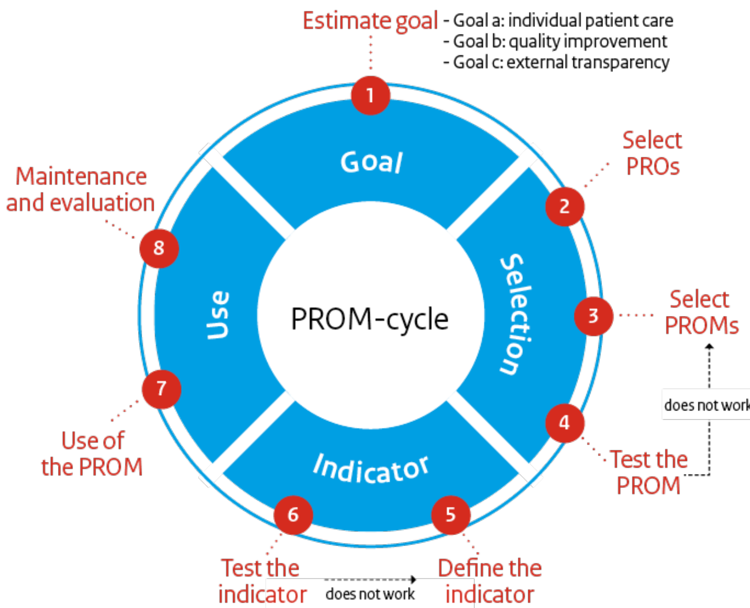

Figure 1. PROM cycle. Reprinted with permission from the Dutch National Health Care Institute (permission obtained on 22 February 2019).

cy care affects patients' ability to express emotions; their levels of anxiety, peace, positivity, vigour, hope, spiritual coping, or comfort; and the quality of their relationships. The study by Flannelly et al. (2007) discussed above also stresses the importance of anxiety reduction and tapping into inner strengths and resources as outcomes of chaplaincy. Especially relevant is the question whether the PROM should assess chaplaincy-specific outcomes or outcomes that healthcare chaplains might have in common with other care professions.

After deciding on the PROs to be assessed, during *Step 3* a PROM is selected or constructed if it is not yet available. The first consideration here is which PROMs are already in use in the organisation so as not to overburden the users. It is advisable to use an existing PROM, because often the quality of these instruments is known, and comparative research or benchmarking are facilitated. However, the desired characteristics of the PROM need to be considered before choosing one: Should it be generic or disease-specific, how should it be administered (paper-and-pencil, electronically, by telephone, etc.), what should its psychometric properties be, and what should be the level of ease-of-use? Existing PROMs for each PRO can be found through syostematic literature research or in databases such as PROMIS (healthmeasures.net), ePROVIDE (eprovide.mapi-trust.org/) or the Rehabilitation Measures Database (sralab.org/rehabilitation-measures).

Regarding the psychometric properties, several questions are important. First, the extent to which the content resembles the PROs to be measured (face validity). Second, what the validity of the questionnaire should be. A questionnaire has high validity when it measures what it is supposed to measure. Questions to be answered here are: Does it contain all the relevant aspects for the PROs, the target population and the purpose (content validity); how does this questionnaire relate to other questionnaires that are supposed to measure the same thing? I.e.: Does it really measure the supposed construct (construct validity); can the different PROs in the questionnaire be clearly distinguished from each other in the calculation of the scores. I.e.: Does the questionnaire contain clearly distinguishable subscales (structural validity and internal consistency); how sensitive is it to change (responsivity). This is particularly important for repeated assessment as in ROM; and, if the target group is very diverse, is it applicable to groups with different (cultural) backgrounds (cross-cultural validity)? Third, how reliable the assessment should be. The reliability of questionnaire is high when the answers to the questions are not influenced by external factors. This is partly related to the ease of use. The PROM should be legible, easily accessible, not too costly, easy to fill out (Think back to the desired way of completing the questionnaire), easy to process, easy to interpret (when should a score be deemed high or low, what is a meaningful amount of change), and acceptable to patients and care professionals.

A selected PROM is tested in the intended practice during *Step 4*. It is determined whether the instrument is still valid, reliable and easy to use in the target group. In addition, the suitability for the intended purpose is tested. Should it not meet the criteria, a different PROM can be selected, the PROM can be adjusted, or a new PROM can be designed.

When PROMs are used for ROM, quality improvement or external transparency, it might be necessary to define an indicator (*Step 5*). In ROM a reference score is needed that indicates the difference between "ill" and "healthy", and between "meaningful change" (either good or bad) and "no or hardly any change". For purposes of quality improvement or external transparency, it might also be necessary to determine a score that indicated "good" versus "bad" performance. Such scores are called norm scores or cut-off scores. Indicators reflect the extent to which the patient, professional, department or organisation deviates from this norm or cut-off and is often expressed in a percentage. The choice of indicator has substantial consequences for the interpretation of the PROM, so it is important to involve all relevant parties and evidence in the decision-making process and to think very carefully about which PROM will be used, when and among whom, to ensure comparability of the criterion.

To ensure that the indicator is sufficiently comparable and discriminating it is tested in a small setting during *Step 6*. In other words, it is determined whether the indicator helps to detect actual differences between patients, professionals, departments or organisations. Should the indicator be insufficient, it can either be redefined (step 5) or the PROM can be replaced, adjusted or (re-)constructed (step 3).

Finally, the PROM can be implemented in care practice for its intended objective (*Step 7*). Early in the process, practical concerns have been considered that reduce the risk of rejection of the PROM by its users, such as its understandability and ease of use. In addition, step 4 provided insight into various possible barriers to implementation and their solutions, to which the PROM may have been adjusted. Nevertheless, various arrangements might still have to be made to facilitate the implementation of the PROM, such as education of care professionals, adjustments in the care process, adjustment in patient registration forms, or encouragement by a leading figure. Two factors seem paramount to facilitate implementation of PROMs: To disrupt the usual care processes as little as possible and to reduce feelings of insecurity that professionals might experience about its use (Lambert & Harmon, 2018). Potentially, the feelings of insecurity do not only stem from a sense of unfamiliarity in using PROMs, but also from a sense of being judged. After all, the overarching purpose of using PROMs is to determine whether care professionals are "doing their jobs". Clear and truthful explanations about the purposes and use of PROMs by management, an adjustment period before receiving feedback on performance with the PROM, supportive feedback, and early involvement of the users in the PROM cycle are important ways to manage such feelings of insecurity.

For fruitful adoption, the use of PROMs in the care process and the quality of the PROM need to be maintained and evaluated on a regular basis (*Step 8*). Evaluation should concern the relevance of the PROs, the appropriateness of the PROM, the level of use in the care process, and - if applicable - the quality of the indicator. Especially when the PROM is used for quality improvement or external transparency, the scores can become so high that the PROM can no longer distinguish between good and bad practice (because all practice is good). If the objective of the PROM is not achieved or it is no longer relevant, various steps of the PROM cycle can be repeated or the use of the PROM can be discontinued.

Conclusion

PROMs are potentially useful instruments for outcome research in healthcare chaplaincy. The information can be applied to improve the quality of healthcare chaplaincy service and to communicate about healthcare chaplaincy with patients, (mental) healthcare providers, and funding bodies. However, implementation of PROMs in healthcare chaplaincy requires careful consideration of what can and should be measured, how it should be measured, among and by whom, when, and why. To be of most benefit, the content and use of the PROMs should match healthcare chaplaincy practice, which is diverse, multidimensional, sometimes unarticulated, and often unpredictable. The choice for using PROMs and the choice of PROs assessed reflect the vision on the profession and its responsibility. In this paper, I have provided some guidelines for the evaluation of these questions.

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Notes

1 This paper will also appear in Dutch in slightly adjusted form: Visser, A. (2019). Patiënt-gerapporteerde uitkomstmaten (PROMs): Wat, waarom en hoe? *Tijdschrift voor Geestelijke Verzorging.*

2 Cf. the other contributions in this volume.

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"I need someone who can convince me that life is worth living!"

Experiences from existential groups led by healthcare chaplains in Norwegian mental healthcare.

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ABSTRACT
This article explores patients' experiences of participating in existential groups led by Norwegian healthcare chaplains within mental health specialist services. A qualitative analysis based on the patients' (N = 157) answers to two open-ended responses in a questionnaire was undertaken. This showed that most of the patients evaluated the groups positively, stating that participating in the existential groups allowed them to increase their self-reflection, let out their feelings, learn new skills, strengthen their self-confidence, and reduce their loneliness. Further, the groups were described as providing spiritual/religious growth and enhanced existential reflection. These results are discussed in relation to a pluralist context and the importance of existential meaning-making for mental health.

Key words
Existential groups, existential meaning-making, healthcare chaplaincy

Introduction
Healthcare chaplains working in the field of Norwegian specialist mental health services have been running existential groups (EGs) for patients since the late 1960s (Frøkedal, Stifoss-Hanssen, Ruud, DeMarinis & Gonzalez, 2017). In this group practice, inpatients, outpatients, and day patients are invited to reflect upon existential issues, values, life experiences, meaning-making, hope, and faith. However, research on EG practice led by healthcare chaplains remains limited, particularly when it comes to patients' perspectives (Gubi & Smart, 2016).

Existential groups led by healthcare chaplains in Norwegian mental healthcare
The EGs led by healthcare chaplains are an integral part of the total treatment provided by Norwegian specialist mental health services, offering room for patients' existential meaning-making in times of crisis (Frøkedal et al., 2017). These EGs are often co-led by a nurse or another healthcare professional in a fixed, random, or rotating arrangement. Participation in the EGs can be obligatory or voluntary. All the EGs across Norwegian health trusts have been reported to discuss existential issues and concerns.

However, the EG practice is generally found to be eclectic, applying a variety of strategies representing the tradition of group psychotherapy, existential therapy, and the clinical pastoral care tradition. Five different EG approaches have been identified to enable patients' existential meaning-making – the psychodynamic, narrative, coping, systematic, and thematic approaches. Only the narrative EG approach is reported explicitly to make discussions of spiritual and religious issues (Frøkedal et al., 2017).

Existential meaning-making

The activity within the EGs can be conceptualised as existential meaning-making. Existential meaning-making has been described as a "reflection of existential life themes" and is a term commonly applied within the field of existential health in a Scandinavian context (DeMarinis, 2008; Haug, Danbolt, Kvigne & DeMarinis, 2016; Lloyd, 2018; Melder, 2011). In this study existential meaning-making encompasses (overlapping) spiritual, religious, and secular domains (la Cour & Hvidt, 2010) in which the term 'spiritual' is understood as "the feelings, thoughts, experiences and behaviours that arise from a search for the sacred," and the term 'religious' as the same search, but specifically when it "unfolds within a traditional sacred context" (Hill et al., 2000). The term secular is understood as existential meaning-making when it is not linked to religion or a divine being (Yalom, 1980).

Relevant research

Research on group psychotherapy integrating existential, religious, and spiritual concerns (E/R/S) is a developing field (Viftrup, Hvidt & Buus, 2013; Wade, Post, Cornish, Vogel & Runyon-Weaver, 2014). Two studies in Norway, for instance, have identified that participation in these type of groups significantly reduced symptoms and improved patients' relational patterns (Stålsett, Austad, Gude & Martinsen, 2010; Stålsett, Gude, Rønnestad & Monsen, 2012). A systematic review of studies of group psychotherapy integrating E/R/S concerns identified that participants' motivation to take part in psychotherapy were strengthened when participating in groups integrating E/R/S concerns (Viftrup et al. (2013). Taking the existential dimension into account in treatment settings has been shown to improve patients' mental health and reduce symptoms such as anxiety, depression, and substance abuse (Bonelli & Koenig, 2013; Gonçalves, Lucchetti, Menezes & Vallada, 2015; Heffernan, Neil & Weatherhead, 2014). It has also been reported that the existential dimension could provide an important meaning-making framework in clinical settings in times of crisis (Emmons, 2005; Lilja, DeMarinis, Lehti & Forssén, 2016; Park, 2005; Ulland & DeMarinis, 2014).

When it comes to existential groups led by healthcare chaplains, very few studies have been identified. One study from the US explored patients experience with healthcare chaplain's group practice applying biblical stories as a therapeutic approach (Kidd, Maripolsky & Smith, 2001). The study reported that the patients experienced the method to be beneficial to explore beliefs, cultures, and values during their hospitalisation.

The research context of the study

To respond to the need for further research on group practice led by mental healthcare chaplains, the first author of the current article carried out a Norwegian nationwide cross-sectional web-based study examining the EG practice from the perspectives of the healthcare chaplains, therapists, managers and patients. All the 19 Norwegian health trusts were invited to participate in the study. The study applied both qualitative and quantitative methodologies and contained three sub-studies examining the characteristics of the EG practice (Frøkedal et al., 2017), healthcare professionals views of the EG practice (Frøkedal, H., Sørensen, T., Ruud, T., DeMarinis, V. & Stifoss-Hanssen, H., 2019) and the relationship between patients participation in the EGs and the expereince of meaningfulness (Frøkedal, H., Stifoss-Hanssen, H., Ruud, T., DeMarinis, V., Visser, A. & Sørensen, T., Submittet). The third sub study, focusing on the patients perspective with quantitative methodology, found that patients who attended EG for longer periods were found to experience less

symptoms of mental illness. Moreover, the patients who reported to have spoken about religious and spiritual concerns in the EGs reported higher level of meaningfulness compared with those who reported not to have spoken about these topics in the EG (Frøkedal et al., Submittet).

Aim of the study

The aim of the present study was to examine the patients' experiences of participating in EGs led by healthcare chaplains from a qualitative point of view. Thus, the following research question was developed: *What are the patients' experiences of participating in existential groups led by healthcare chaplains in Norwegian specialist mental health services?*

Materials and methods

Design

The present study was designed as a descriptive cross-sectional study in order to explore different patients' experiences of participating in the EGs. It was based on data from the previously mentioned nationwide survey. However, only the qualitative part (2 open ended questions), which has not previously been explored, was used as material.

Sampling procedure and participants

To identify the informants participating in the EGs across all the 19 Norwegian health trusts, a stepwise identification and sampling process was organised. In this process healthcare chaplains, co-leaders (interdisciplinary staff), therapists and managers were identified by personal contact with every health trusts. The respective healthcare chaplains and co-leaders for each unit identified patients participating in the EGs and personally invited them to participate in the study. The patients that wanted to participate in the study received a consent form attached to an information letter together with the questionnaire. The questionnaires were collected during hospitalisation or while enrolled as patients at day- or outpatients' units. The patients filled out the questionnaire right after a session or at the end of the hospital stay. Patients within 10 of the 19 health trusts participated in the study. The response rate could not be determined because the healthcare chaplains did not register how many patients they had invited to participate. Moreover, the informants who did not want to participate in the study were not registered.

The demographical information is presented in Table 1. The clinical unit and patient's diagnostic group comprised inpatients (49), psychiatric geriatric patients (10), substance abuse patients (35), and day patients (21), as well as patients from psychosis units (10), affective units (16), and other units (4). The informants represented various units across 41 existential groups within 10 Norwegian trusts.

Table 1 Demographical variables illustrating gender, age, and group attendance (N = 157)

Gender	**N (%)**
Male	73 (48)
Female	80 (52)
Age group	
Below 30 years	36 (23)
30–39 years	34 (22)
40–49 years	40 (26)
50–59 years	27 (18)
Above 60 years	17 (11)
Group attendance	
1–3 times	76 (50)
4–7 times	33 (21)
8–11 times	16 (10)
12 times or more	30 (20)

Open-ended responses

In order to explore the patients' in-depth experiences of participating within the EGs, two open-ended responses were developed. The first question was presented with the instructions: "Express with your own words what kind of experiences this group has provided you with." The second question was as follows: "Is there something happening in your life right now that makes you think you can benefit from participating in this group?"

Data analysis

The qualitative data (2 open-ended responses) overlapped in terms of themes and were thus brought together and viewed as one text, which established the material for analysis. The material was characterised by handwritten shorter and longer (from one word to one page) compact texts from the informants, which contained various themes. Based on this, a qualitative content analysis with an inductive approach, as proposed by Graneheim and Lundman (2004), guided the data analysis. The coding and categorisation were carried out independently by the two authors; however, to ensure trustworthiness, multiple discussions among the authors took place concerning the various themes in the data until consensus was reached.

Ethical considerations

The Norwegian Regional Committee for Medical Research Ethics approved this study (registration number: 565978), and all 10 Norwegian health trusts provided access to data collection in their health trust. All the informants signed a consent form before participating in the study and had the right to withdraw from the study at any time. Since it was considered difficult to recruit hospitalised patients in a vulnerable condition, it was decided that the recruitment period should last approximately three months in each unit.

Results

Out of the 157 patients completing the questionnaire, 135 patients contributed with open answers. A few patients responded only to one of the two questions. We identified 4 main themes in the material; 1) evaluation of the EG, 2) perceived value from participating in the EG, 3) distinctive features of the EG, 4) motivation for future participation in the EG.

1) Evaluation of the existential group practices

Most of the patient responses contained evaluations of the EG practices, and the main finding was that those were predominantly positive. Out of the 135 patients, only 3 answered that participating in the group did not give them anything (a "waste of time" or "nothing more than a mandatory activity"). One participant explained that because she had difficulties in opening to other people, she preferred taking part in individual therapy. Eight patients answered that the group had little significance (because they had only participated once, the group size was too small, or the group did not match their situation). However, they had a positive attitude towards the group, with some feeling that the group could be relevant for other people and others expressing the hope that it would benefit them in the future.

Thus, the analysis left us with mainly positive evaluations of the EG practice. Some wrote short evaluations such as "I think the discussion group has given me a lot," "It has been beneficial to take part," and simply "great outcome." However, most of the patients explored their positive experiences in the group in more detail. In the following section, we will look more closely at how the participants considered the significance and added value of participating in the EG.

2) Perceived values of existential group participation

From the many descriptions of the added value from taking part in the EG, we identified five sub-themes.

Reflection through listening to others. The most prominent subtheme identified in the participants' text was the "benefit from listening to the other people in the group." Several informants wrote that the group participants provided new perspectives and gave insights into different ways of living with mental health problems. They also emphasised that they could recognise themselves in the other patients' stories. This left them with the experience that "more people are in the same situation as I am," as elaborated in the following quotation:

> *It is a wonderful place to share but also to listen and participate in reasoning through other people's problems, which makes me more reflective. Good to get input from others who understand you and know a lot about what you are going through.*
>
> (Man 30–39, inpatient unit)

The group conversations helped the participants to "compare one's own emotions and reactions with others and to clarify what are normal ways of thinking and behaving." Thus, it seemed that many of the group participants valued the EG as a space of mirroring and reflection. According to some of the patients, the reflective discussions contributed to enhanced self-understanding and new ways of living one's life.

A safe place to ease the pressure. The group was also valued as a place to put feelings into words, serving the function of an "outlet" and a place to "ease the pressure". Some stated that they shared things with the group that they had never told anyone before. To feel comfortable doing so, the participants seemed to be dependent on their experience of the group as a safe place. Several patients used the formulation "safe place" or "safe group" in characterising the group. According to a woman in one of the substance misuse units, "The discussion group is a safe place to meet others in similar situations." Another woman in the same group stated that "It's a good group with safety and equality. Everyone can express their opinions without being judged." Several participants emphasised that they felt accepted and not judged, which made it possible for them to share their thoughts and feelings.

A laboratory of learning and mastering skills. The patients not only valued the EG practice as a space for reflection and an outlet for feelings but also saw it as a place to learn and master social skills. As one man from an inpatient unit said: "It is nice to feel that I am mastering how to ask questions. I got nice feedback on my questions from the group leader." Another patient reflected on how the group reminded her of her own knowledge and experience, stating that she could see some of her old self-image, recognising herself from before the illness disabled her. One participant said that he had learned to "trust other people," another that he had "learned to be honest," and one patient suggested that the group provided valuable "practice in speaking out loud." Thus, seeing the group as a laboratory in which they could practice and get feedback seemed to strengthen the self-confidence of some of the participants.

Fellowship. Because the groups were situated in different mental health care units for inpatients, outpatients, and day patients, the stability of the groups differed. Some patients had only attended a few times. Others had attended the same group for two years and could report that the group members had developed a strong fellowship. Some even called the group an "anchor in life" and a "fixed point" in their daily living. However, across different length of participation, several wrote that being a member of the EG helped them to "feel less lonely," stating that the group "brought us closer to each other." They pointed to a special fellowship of people in the same situation, who had the ability to understand each other.

Spiritual, religious and secular existential meaning-making. A few of the patients stated that the group had provided spiritual outcomes. One said that he had become "spiritually richer". Another pointed out that the group had challenged her existential questions and that she had started to look at religion in a new way:

> *It has created more interest in using the Bible to help answer questions. The chaplain has also helped me to find things in the Bible and to read with an eye on myself. This may have been the reason for me starting to attend services and finding peace in church now.*
>
> (Woman 20–29, inpatient unit)

One patient, with a non-religious worldview, wrote that the group had contributed by allowing her to gain "insight into how other people think regarding their worldview and the meaning of life". Challenging and supporting the participants regarding existential questions was considered as an added value by many of the participants.

3) Distinctive features of the existential groups

In answering the questions about the significance of the group, several participants also described how they understood the distinctiveness of the existential group practice.

A different group with links to therapy. Some of the patients described the EG by contrasting it to other mental health groups and individual psychotherapy. One woman said, "Independent

of the personnel, one can talk freely, without it being assessed and written down" Another explained that she had been part of several groups, which had focused mainly on illness, "but these discussion groups are more open towards the user's explanations and thoughts – without being confronted with a 'solution,' a box in which many feel they do not fit". The group was described as "future-based, with hopes, wishes, and goals – not only digging into the past" and it was said to have "a focus on reflection rather than treatment". However, some reflected that they could bring information from the EG to their psychologist in therapy and vice versa, thus emphasising the possibility of bridging the different practices. The EG even helped to "put forward things that I had not been able to address earlier in individual therapy" and was seen as an "extension of my conversations with my therapist". Thus, although the EG was described as a different group, it could be linked to the therapy in which the patients were also taking part.

A positive encounter with the chaplain. Several patients expressed how they had experienced a positive encounter with the chaplain. The chaplain was described as nice, reliable and respectable. A few emphasised that it was good to have a chaplain whom "one could ask about everything." One valued how the chaplain had "relevant answers," while another said that the chaplain "asked good questions." One patient stated that his new chaplain was "stricter" than his former chaplain, but apart from this, there was only positive appreciation for the chaplain among those who commented on this. Such positive attitudes seemed to transcend different approaches (and styles) to leading EGs. One participant summarised her encounter with the chaplain as follows:

> *It is safe and good talking with a chaplain. Feels different from going to a psychologist, you are spared from elaborating on everything you are saying, and the chaplain may analyse a little bit what you say. You get answers and a little information that you can then bring to the psychologist. Beneficial!*
> (Woman 50–59, substance abuse unit)

A few brought up how they had "become less prejudiced towards the chaplain and Christianity" by taking part in the EG. This was also, for some, related to the chaplain's focus on life questions in the group, which was positively evaluated by several patients.

Addressing existential life questions – Through religious, spiritual and secular resources. The responses gave the impression that the groups were primarily addressing existential life questions, and it was appreciated that the group included and accepted all kinds of worldviews among the patients in their existential meaning-making. One man expressed it like this:

> *To me, the conversation groups were a positive surprise. As an atheist, I appreciated very much that there was a focus on life and difficult situations and not on religion. It helped me greatly after the first meeting where I experienced another way of thinking.*
> (Man 20–29, inpatient unit)

However, it was visible from the answers that two of the groups had another approach. They used the Bible as a resource in the meetings, and one participant reported that the people in the group were singing hymns together. The responses did not provide any critical comments on this approach; on the contrary, those who responded seemed to appreciate this way of relating religious resources to the patients' existential life questions. In general, the focus on existential life questions seemed to be relevant and beneficial, and this was also brought up as a motivation for further participation in the group.

4) Motivation for further participation in the existential group

Some of the patients described their life situation. They mentioned addiction problems and various mental illnesses such as depression, anxiety, schizophrenia, and eating disorders. Physical illnesses and struggles with existential questions and challenges regarding their life situation (e.g., bereavement and children being bullied at school) were also articulated. Others, however, not only described their situation but also linked their challenges to future participation in the group, stating that they hoped the group could help them.

Hopes of better mental health. Hopes were rela-

ted to recovery and mastering life. One woman was hoping to get rid of her withdrawal symptoms after stepping down her use of benzodiazepines. Several patients in the substance misuse units stated that they hoped the group could help them to get rid of their drug problems. Some hoped that the group could help with mastering social skills and provide better mental health.

Hopes of meaning in life. However, the most prominent subtheme in the material regarding future motivation was linked to the existential dimension. Isolation, death, shame, guilt, meaning, and hope were mentioned by several participants. One man wrote that he hoped the group could help him to "take the right choices, be a good father for my son, start loving myself again, get rid of bitterness, guilt, and shame, etc., etc., etc.". A few of the patients showed that working with existential questions was more than an intellectual enterprise. There was a lot at stake. As one woman said,

> *I am struggling with quite a few existential problems and questions—to find my place in the world and, if I can, find meaning and eventually have value as a human being. I would like to investigate the more spiritual aspect before I give up. If I can be of help for any others in the group, I should like to do so.*
>
> (Woman 20–29, inpatient unit)

One man revealed that he had thoughts about taking an overdose of medication or of placing himself on a train track, waiting for the airport train, but he hoped the group could help him: "I need someone who can convince me that life is worth living and give me a spark of life."

Discussion

The purpose of the present study was to explore patients' various ways of experience the participation in the EGs led by healthcare chaplains. The overall finding was that the great majority of the patients that filled out the open responses reported positive experiences from participating in the EGs. The perceived values of participating in the EGs was described as increased reflection through sharing own stories and listening to other peoples' stories, letting out feelings in a safe group, learning new skills, strengthening self-confidence, and reducing loneliness. Further, the groups were described as providing spiritual/religious growth and enhanced existential reflection. The EGs seemed to put different weight on spiritual, religious, and secular meaning-making. However, reflection of existential life themes like isolation, death, shame, guilt, meaning, and hope was found to be a common characteristic of most of the EGs.

Existential meaning-making as secular, spiritual and religious

The findings in this study seem to correspond with an understanding of existential meaning-making as including (overlapping) secular, spiritual, and religious meaning-making domains (la Cour & Hvidt, 2010). In this conceptual language, the existential meaning-making describes how people – through secular, spiritual, and religious cultural resources – understand, experience, and make sense of their lives in terms of significance, purposeful, directed, and belonging (DeMarinis, 2013; la Cour & Hvidt, 2010; Park, 2005; Schnell, 2009). Although the different participants and the different EGs in the current study emphasised the spiritual, religious and secular dimensions of the existential meaning-making in dissimilar ways, they all seemed to connect these dimensions to the reflection of existential life themes. The material did not give any in-depth understanding on the use of the concepts; spiritual, religious and secular. Some participants mentioned the terminology "spiritual growth" and other participants explicitly stated that their existential reflection were not linked to religion or a divine being. However, the existential life themes were more elaborated. This might reflect that the healthcare chaplains reported to be influenced by the existential tradition of Yalom (1980) that has emphasised the four ultimate concerns in human life: the inevitability of death, existential loneliness, the meaning of existence and freedom (Frøkedal et al., 2017).

Positive valuations across the different EG approaches.

The various perceived values and the different ways in which the participants characterised the

EG in terms of secular, spiritual and, religious existential meaning-making may reflect the EG as an eclectic group practice. The previous study (Frøkedal et al., 2017) investigating the Norwegian EGs from the healthcare chaplains perspective noted that the EGs share commonalities with general group psychotherapy (Karterud, 2007; Lorentzen & Ruud, 2014); group psychotherapy integrating E/R/S concerns; the existential therapy tradition (Cooper, 2012; Cornish & Wade, 2010; Viftrup et al., 2013; Wade et al., 2014; Yalom, 1980; Yalom & Leszcz, 2005); and, finally, the pastoral care tradition (Asquith, 1982; Boisen, 1951; Hemenway, 2005). Moreover, the study identified different EGs approaches facilitating the patients' existential meaning-making: Psychodynamic, narrative, coping, systematic, and thematic. The narrative EG approach explicitly reported discussions of spiritual and religious issues (Frøkedal et al., 2017), which corresponds with the responses related to two of the groups.

It is interesting that the great majority of the patients reported to be satisfied with the focus of their EG, across the various EG approaches. This may indicate that many of EGs were tailored to the different patients' group and open to individual preferences. Patients satisfaction with their EG participation may also be related to their positive encounter with their chaplain. That is, the chaplain was considered trustworthy and someone who created space for different worldviews. Even in the cases in which the chaplain was seen to explicitly present and ritualise the Christian tradition, the patients were satisfied with the openness of their chaplain. The positive evaluations of the EGs may also be related to the relevance of existential themes and life questions, although they were addressed in different ways across the EGs.

Bridging between EG and therapy.

Another prominent finding was that many of the patients reported the EG practice to be a different kind of group, focusing on their own explanation and understanding and not on predefined boxes. Future-based hope, wishes, and goals, in contrast to digging into the past, were emphasised among some of the participants. However, it was also reported that the EG practice could be an important bridge into the patients' individual therapy sessions, even contributing to the therapy process.

The patients' bridging experiences seem to correspond with mental health professionals' viewpoints. In the previous study of EG practices in a Norwegian context, healthcare professionals reported that integrating the existential dimension in treatment improved patients' recovery and strengthened other therapies (Frøkedal, Sørensen, Ruud, DeMarinis & Stifoss-Hanssen, 2019). The patients' bridging experiences also resonates well with the conclusion of Russell D'Souza and George (2006): integrating existential themes was suggested to increase the therapeutic impact of treatment interventions.

Hopes of better mental health and existential health.

Many patients described challenging life situations. These concerns were, in several of the patients' texts, linked to hopes of better mental health and better existential health through participation in the EGs. Some hoped the existential reflections in the group would improve their mental health. Others described existential health as an endpoint: They hoped to, in the midst of mental challenges, gain better existential health by finding meaning in life. Overall, hopes of mental health and hopes of existential health were closely connected.

This resonates well with the findings from the quantitative questionnaire from the patients perspective, which identified that patients who attended EG for longer periods experienced less symptoms of mental illness; and patients who reported that they had spoken about R/S issues also reported higher level of meaningfulness (Frøkedal et al., Submittet).

Meaning in life is found to be an important aspect of mental health and wellbeing (Heintzelman & King, 2014; Mascaro & Rosen, 2008; Schnell, 2009) and for instance provide patients adaptive coping (Lilja et al., 2016; Park, 2010). By contrast, the experience of crisis of meaning can be devastating and is linked with negative wellbeing that might lead to depression and anxiety (Lilja et al., 2016; Schnell, 2009;

Schnell, Gerstner & Krampe, 2018). These studies, together with the present study, strengthen the importance of addressing existential themes for patients in mental health services. It also resonates with patients, who report that existential, religious, and spiritual needs ought to be met during treatment (R D'Souza, 2002; DeMarinis, 2013; Lilja et al., 2016; Park, 2005, 2010). As one of the participants in the current study succinctly expressed, "I need someone who can convince me that life is worth living and give me a spark of life."

Strengths and Limitations

The strength of this study and its most surprising part was the low drop-out rate of the respondents in the open-ended part of the questionnaire. Given that many of the patients were in a vulnerable situation and were reported to have poor mental health, it was not expected that they exerted much effort to write longer paragraphs. The low drop-out rate makes it possible to corroborate the qualitative analysis and the previous quantitative analysis from the patients' perspective (Frøkedal et. al, submitted). A limitation, however, is that we do not know the response rate for the entire questionnaire, which means that the study may have a bias toward recruiting the most positive participants. Moreover, all the participants filled out the questionnaire right after a group session or at the end of their hospital stay. This can also explain the few critical voices in the data material. It could be reasoned that if the patients were asked to answer the questionnaire one month or a year later after their group participation, their positive impression would have perhaps been more nuanced. We assume that the present study may contain a systematic bias. However, this is in line with many other studies applying this type of methodology and research strategy. The critical responses were not only few but also short and gave very little information on why some participants experienced the groups in a negative way, although some contextual issues regarding group size and the mismatch between the EG and the patient's current situation were mentioned. It must then be underscored that our findings in this study relate to those participants who submitted their open-ended responses and shared their experiences right after, or shortly after, the group session.

Summary

By analysing answers to open responses in a questionnaire distributed to patients participating in EGs in mental health services in Norway, we investigated their experiences with the EGs. The participants provided an overall positive evaluation of the groups, which can be summarised using the following metaphors: they enhanced existential reflection through the mirroring of stories in the group; the group served as a laboratory to learn new skills and master difficult situations; and bridging between group participants, EG and therapy, and between existential life questions and spiritual, religious and secular reflections/practices.

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Norsk oversettelse av artiklenes sammendrag

(A Norwegian translation of all abstracts)

Chaplaincy in the Netherlands. The search for a professional and a religious identity

Hetty Zock

Artikkelen gir en oversikt over chaplaincy i Nederland med vekt på historien, religiøst og teologisk klima, opplæring, organisering og praksis i vår tid. To viktige nylige utviklingstrekk diskuteres: Økningen av spiritualitet uten tilknytning til trossamfunn og det at åndelig omsorgsgivere også engasjerer seg i omsorgsoppgaver i samfunnet. Åndelig omsorg i Nederland har gjennomgått en lang profesjonaliseringsprosess som innebærer at *chaplains* kontinuerlig har måttet redefinere sine religiøse og profesjonelle identiteter. Det argumenteres for at selv om hollandsk åndelig omsorg fortsatt er organisert gjennom ulike trossamfunn, deler åndelige omsorgsgivere en felles profesjonell identitet som fagpersoner som fokuserer på søken etter mening, trossystemer og etikk.

Healthcare Chaplaincy in Finland

Suvi-Maria Saarelainen, Isto Peltomäki, Auli Vähäkangas

Artikkelen gir et bilde av starten, veksten og dagens situasjon for *chaplaincy* i helsetjenesten i Finland. Historien om *chaplaincy* tar oss mange tiår tilbake, men starten på *chaplaincy* i helsetjenesten slik vi kjenner den i dag startet på 1960-tallet. Den evangelisk-lutherske kirken i Finland har spilt en avgjørende rolle i utviklingen av *chaplaincy*. *Chaplaincy* er dermed preget av to forhold: Helsetjenesten og Den evangelisk-lutherske kirken. Det tok tiår for *chaplaincy* å finne sin plass i og mellom disse to kontekstene, og nå bidrar redusering av stillingsressurser til at framtiden ikke er særlig løfterik. Det er ulike typer forskning på et såpass sammensatt tema som *chaplaincy*, men nyere studier trengs for å håndtere utfordringene ved at kontekstene, arbeidsklima og de sammensatte behovene er i endring.

Institutional Spiritual Care in Sweden

Mats Rydinger, Valerie DeMarinis

Artikkelen presenterer historiske og samtidige perspektiver på institusjons-*chaplaincy* med særlig fokus på sykehus-*chaplaincy* I Sverige. Begrepet åndelig omsorg er brukt som en samlebetegnelse for alle de forskjellige funksjonene og oppgavene som en chaplain er engasjert i. I denne oversiktsartikkelen håper vi at leseren skal få et glimt av de komplekse måtene sykehus-*chaplaincy* har utviklet seg på og de mange samfunnsaktørene og politiske beslutningene som har bidratt til at arbeidet som chaplains i sykehus både blir definert og organisert i sammenheng med det større sosiale

strukturen. I vårt samtidsperspektiv er det viktig å forstå de ulike utfordringene og mulighetene som flerkulturelle og flerreligiøse behov har reist i svenske kulturelle kontekster, som er betraktet som en av de mest sekulære i verden. Disse utfordringene og mulighetene har fått fram avgjørende viktige innsikter med tanke på forståelsen av åndelig omsorg som en dimensjon ved helsetjenesten som er viktig for alle personer, alle pasienter, og at personsentrert omsorg ser det som helt nødvendig å inkludere denne dimensjonen.

New wine in new leather bags? Hospital chaplaincy in Northern Europe. The Danish case

Karsten F. Thomsen, Niels Christian Hvidt, Jens Søndergaard

Denne artikkelens fokuspunkt er forholdene og utfordringene for videre etablering og økende profesjonaliseringen i en spesifikk del av sjelesorg i den lutherske folkekirken i Danmark. Siden midten av 1980-tallet har det vært en generell spesialisering i samfunnet som har bidratt til et mangfold av *chaplaincy* i offentlige områder i Danmark. Dette har generert en økning i antallet *chaplains*, særlig innen helsetjenesten. I denne artikkelen er hensikten å vise hovedtrender i utviklingen og dagens situasjon innen åndelig omsorg og *chaplaincy* i sykehus i Danmark. Vi gjengir også de første resultatene fra en prospektiv *audit*-studie som er utviklet for intern kvalitetsvurdering og -utvikling.

Chaplaincy in Northern Europe. An overview from Norway

Hans Stifoss-Hanssen, Lars Johan Danbolt, Hilde Frøkedal

I Norge har *chaplaincy* endret seg vesentlig siden 1950-tallet. Antallet *chaplain*-stillinger har økt, men hvis dette ses med den store veksten i offentlige tjenester innen helse og andre sektorer som bakteppe, så økningen moderat. Utviklingen i chaplaincy har flere tydelige trekk. Gradvis beveger den seg fra hva som kan betegnes som en *religiøs betjeningsmodell* mot en mer *eksistensiell omsorgsmodell*. Videre har *chaplaincy* fått en styrket faglig underbygging og blitt mer profesjonalisert, og et betydelig antall *chaplains* driver også forskning som bidrar dermed til kunnskapsbaseringen av tjenesten. Samtidig påvirker de økende flerreligiøse og sekulære trekkene i befolkningen hvordan *chaplains* tenker om og utfører sitt arbeid. Arbeidet med fornyelse av *chaplaincy* gir grunnlag for optimisme på dette feltet.

Chaplaincy and religious plurality in the Norwegian context

Anne Hege Grung, Beret Bråten

Artikkelen diskuterer *chaplaincy* som profesjonell virksomhet i en norsk virkelighet preget av religiøse, demografiske og politiske endringer. Disse endringene forandrer *chaplaincy* fra tjenester som i hovedsak har vært en del av Den norske kirkes oppgaver til å bli mer pluralistiske. I artikkelen stiller vi spørsmål og diskuterer hvordan pluralisering kan utfordre det profesjonelle paradigmet i *chaplaincy* –når det gjelder både generiske og spesifikke sider av disse tjenestene. Dette gjør vi med utgangspunkt i sosiologiske perspektiver som gir mulighet til å utforske norske *chaplaincy*-praksiser sett utenfra (fra institusjonene) og innefra (fra erfaringene til chaplains og folk de betjener). Vårt empiriske utgangspunkt i denne artikkelen er for det første erfaringer fra å designe et masterprogram som kan gi *chaplaincy*-kompetanse til studenter utenfor Den norske kirke, og for det andre intervjuer med *chaplains* med tilknytning til Den norske kirke, om hvordan de tolker sin rolle som profesjonelle aktører i sykehus.

Re-evaluating a suicide pact. Embodied moral counseling in a Dutch case study of mental healthcare chaplaincy

Hanneke Muthert, Monique van Hoof, Martin Walton, Jacques Körver

Case-studier innen åndelig omsorg gir oss viktig informasjon i jakten på god omsorgspraksis. Forskningsprosessen i det nederlandske forskningsmiljøet for psykisk helsevern viser imidlertid at god refleksjon rundt praksis ikke er noen selvfølge. For å undersøke dette gapet mellom praksis og refleksjon introduserer vi begrepet profesjonell kunnskapsgrunnlag (*professional body of knowledge, PBOK*) på dette feltet. På den ene siden må utøvere innta en ikke-vite-alt-holdning for å kunne tune seg inn i kommunikasjonen med andre på fruktbare måter. På den annen side trenger de måter å reflektere metodologisk på å bevisstgjøre seg sin kompetanse, slik at de kan gjøre interaksjonene med andre enda bedre neste gang. Ved hjelp av en enkel *case*-studie om moralsk rådgivning i sammenheng med en selvmordsavtale mellom to ungdommer, viser vi et eksempel på en *case*-studie i Nederland. Dette er også den første anvendelsen av vår arbeidsmodell på *PBOK*.

Patient-reported outcome measures (PROMs) in healthcare chaplaincy: What, why and how?

Anja Visser

Utfallsforskning blir stadig viktigere i *chaplaincy* i helsevesenet for å forbedre kvaliteten på åndelig omsorg og begrunne behovet for *chaplaincy* i helsetjenestene. Pasientrapporterte utfallsmål (*PROM*) er typer instrumenter som gjør det mulig å vurdere resultatene av arbeidet til helsepersonell – slik pasientene oppleve det. I denne artikkelen diskuterer jeg hvordan *PROM* kan brukes for å utforske betydningen av *chaplaincy* i helsetjenesten. *PROM* kan brukes til å få fram pasientenes erfaringer, kvalitetsforbedring og til å få bedre ekstern gjennomsiktighet. *PROM* kan avspeile alle slags forhold ved pasienters helse og funksjon, men når det gjelder chaplaincy er det viktig at *PROM*-verktøy er følsomme for endringer og relevante for den praksissammenhengen som vurderes. At man velger å få fram hvordan pasientene opplever betydningen av tjenesten de har mottatt (*PROM*) viser profesjonens visjoner og hvordan de tenker om sitt yrke det ansvaret de har. Det innebærer selvsagt ikke at praksisutøvelsen skal reduseres til kun det som kan måles med *PROM*. Valg og implementering av *PROM* i helse-chaplaincy krever derfor nøye overveielser, noe som kan gjøres ved hjelp av *PROM*-syklusen som er illustrert i denne artikkelen.

Experiences from existential groups led by healthcare chaplains in Norwegian mental healthcare

Hilde Frøkedal, Anne Austad

Denne artikkelen undersøker pasienters opplevelser av å delta i eksistensielle grupper ledet av norske helse-*chaplains* i spesialisthelsetjenesten i psykisk helsevern. Det ble foretatt en kvalitativ analyse basert på pasientenes (N = 157) svar på spørsmål med åpne svaralternativer i et spørreskjema. Studien viste at de fleste av pasientene evaluerte gruppene positivt, og uttalte at å delta i de eksistensielle gruppene bidro til økt selvrefleksjon, utløp for følelser, læring av nye ferdigheter, styrket selvtillit og redusert ensomhet. Gruppene ble videre beskrevet som et sted for åndelig/religiøs vekst og økt eksistensiell refleksjon. Disse resultatene diskuteres i lys av en pluralistisk kontekst og betydningen av eksistensiell meningsskaping for mental helse.

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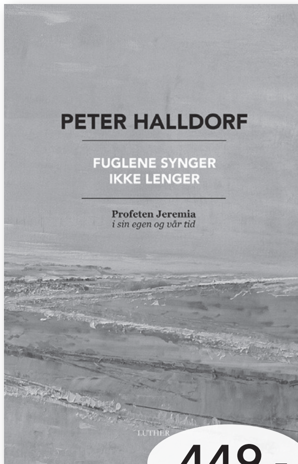

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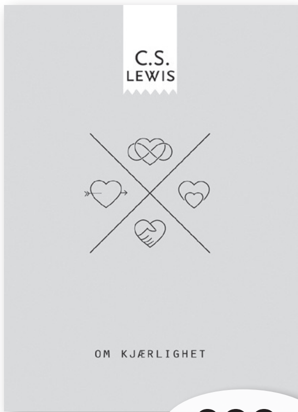
Profeten Jeremia i sin egen og vår tid

Halldorf har skrevet et mesterverk om Jeremia og profetens rolle.

Det er ingen andre profeter vi kjenner så personlig som Jeremia. Denne boken er et forsøk på å lese en av urtidens profeter ikke bare i hans egen tid, men også i vår komplekse samtid. Jeremias liv er et rop i natten, og ropet høres i dag. Han er en bror ved vår side. Poesien hans er livfull, personlig og konkret. Jeremia hjelper oss til å lese poesi som bønn og bønn som poesi. Underveis i lesingen – og i bønnen – viser det seg at de århundrer som ligger mellom oss og Jeremia, viskes bort. Profeten fra Anatot trer inn i vår tid og har noe å si oss om det vi strever med.



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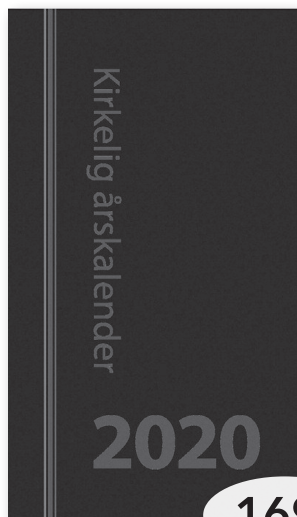

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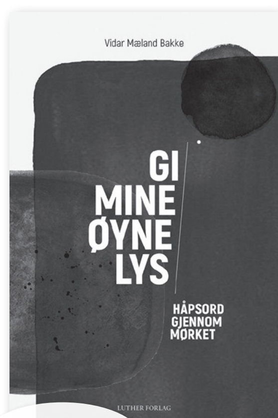

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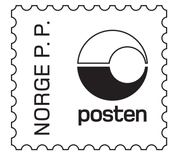

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