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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