

# Health care chaplaincy in the Nordic countries Transformations and perspectives <sup>1</sup>

Lars Johan Danbolt (1), Hans Stifoss-Hanssen (2)

(1) Professor in practical theology and psychology of religion, MF Norwegian School of Theology,  
Religion and Society and Innlandet Hospital Trust, Center of Psychology of Religion

(2) Professor in Diaconia and Professional practice, VID Specialized University,  
Center of Diaconia and Professional practice

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**Résumé :** In this article we present some developmental patterns in the 100-year-long history of health care chaplaincy in the Nordic countries, particularly in Norway. We argue that a shift is gradually taking place from what can be regarded as a *religious service model* to an *existential care model*. This can be seen within the context of specialization and professionalization both in health care and chaplaincy, as well on the background of pluralization in society. We point at some challenges for chaplaincy regarding delimitation and the relationships between religious and secular anchoring of chaplaincy, the routines for referrals to chaplains, implementation of chaplaincy and inter-disciplinary work in hospitals, and the need for continuous work on knowledge development and research.

**Mots-clés :** chaplaincy, religious support, existential care, spiritual care, Clinical Pastoral Education (CPE), hospital.

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## 1 Introduction

Both the health care systems and the chaplaincy practices are changing in Norway, as is the case in the other Nordic countries. There is a turn in direction of more specialized care in hospitals and a broader spectrum of generalist care in municipalities.

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1. This article is a revised version of Danbolt's lecture at 'La Clinique du Sens/The Clinic of Meaning', Colloque International held at the University of Lausanne on November 14-15 2019. The content of the paper refers to the collaborative works on chaplaincy by both authors and parts of this is presented in : Stifoss-Hanssen, Hans ; Danbolt, Lars Johan ; Frøkedal, Hilde (2019) "Chaplaincy in Northern Europe : An overview from Norway", Nordic Journal of Practical Theology, Vol. 36, No. 2, p. 60-70. Furthermore, there are integrated some perspectives which also are presented in the Editorial article in the same volume by Danbolt, DeMarinis, Rydinger and Zock.

These changes challenge the traditional ways of doing chaplaincy. In addition the increasing pluralization in society calls for diverse competence and challenges what might have been a “one-size-fits-all”—way of managing spiritual and existential care in health institutions. In this article we will present and discuss what we regard as prominent features of chaplaincy in the Nordic countries. One main trajectory points to a development from religious support towards existential care.

## 2 The elephant in the room

In an editorial article in a leading Norwegian medical journal, Professor Vegard Bruun Wyller (2015) presents the story of a seriously ill boy from a Muslim family. The boy’s father was very frustrated at times, not only about his son’s sickness, but about the hospital’s technological one-sidedness. Wyller, who had the medical responsibility, writes that the father “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.”<sup>2</sup> (Wyller, 2015, p. 507).

Wyller states that to talk about God is the “elephant in the room”. For a physician it seems to be “harder to address a patient’s personal faith than her personal sex-life”. As the responsible physician 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 destiny”. Wyller states that it is unprofessional not to identify the elephant, especially in a society characterized by increasing religious and worldview heterogeneity. Existential questions can and should be touched upon in the doctor-patient-relationship, Wyller concludes (Wyller, 2015, p. 507).

A hundred years ago Oslo University Hospital, where Wyller works, hired its first chaplain. And during these years, chaplaincy has become a more and more professional service in Nordic hospitals.

A couple of years ago we established a research group for chaplaincy studies in the Nordic countries and the Netherlands. The Nordic countries means : Denmark, Sweden, Finland and Norway. The idea of this research group, which we call “ReChap”, is to perform studies in chaplaincy regarding current status and challenges, history, practice, ideology, function and organization. So far we have produced a special volume in *Tidsskrift for Praktisk Teologi / Nordic Journal of Practical Theology* on the state of the art of Chaplaincy in the Nordic countries and the Netherlands (Danbolt *et al.*, 2019). This paper reflects some of the perspectives outlined in that volume.

## 3 A context of occation-related religiosity

The Nordic countries are in many studies regarded as the most secularized in the world (Schmidt & Botvar, 2010)<sup>3</sup>. That makes sense if the proof of secularity is the

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2. Our translation.

3. In Norway 70% belong to the Church of Norway, a Lutheran church which until 2017 was regarded by the Constitution as Norway’s official religion. Muslims, Catholics, Pentecostals, Buthists, Humaists and other religious or worldview communities counts 1-3 % each, but the largest growing group are the so called “nonnes”, people who are not members of any registered faith community, counting about 18% (Statistics Norway, 2017).

prevalence of regular church attendance or reported faith in God. Only 10-15% of the Nordic population responded that they “know without any doubt that God exists” on the International Social Survey Programme 2008 (La Cour, 2014). If we compare with the US, 61% of the population reported such strong belief in God, according to the same survey. Thus, it is really not a big surprise that American researchers regard Scandinavia as highly secularized.

However, when including responses on more open questions like ‘I believe in a higher power’ or ‘I have some doubts, but still I feel like I believe in God’, all together two in three of the Nordic populations are open to the existence of a supreme being (la Cour, 2014).

Furthermore, as we well know, religion and spirituality are more than belief systems. They also include ritual practices, emotional experiences, values and functions. It is interesting to observe that collective and individual rituals are activities that have notably increased, at least in the face of disasters and other deeply shaking experiences. This is an example of contemporary existential meaning-making integrated in culture in ways it has not before (Danbolt & Stifoss-Hanssen, 2017; Post, 2015).

Also, to a huge extent people use churches for rites of passage, e.g. still more than eight out of ten funerals are performed by the dominant folk churches in the Nordic countries. This makes it likely that many who are hospitalized probably have experience in ritual practices with Nordic national churches (all Lutheran) or other denominations.

It is therefore not unreasonable to regard Nordic religiosity as *occasion-related*. For many persons issues of God and other religious matters are not very prominent in their daily lives, but when something deeply disturbing happens in life, an existential crisis might occur – making prominent the need for meaning. For many individuals, pastoral care and different ways of ritualizing are available, and people use rituals for spiritual or existential meaning-making.

It can be argued that spiritual meaning-making is not contradictory to secularity. The well known sociologist Peter Berger regards religion as a human enterprise used to create 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 strong needs to make sense of what happens and for establishing a holy cosmos in chaotic situations, as might be the case when life takes a turn one had not expected or not at all wanted.

#### **4 Is chaplaincy religious support or existential care ?**

A chaplain can be defined as 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.

Around 1950, Norway had approximately 30 health care chaplains. The number is now about 130. In addition there are chaplains in the military, prisons and university campuses, so altogether the numbers can be estimated at about 200 chaplains in

Norway. Most of whom are ordained clergy in the Church of Norway, and the majority have followed a more or less complete training in Clinical Pastoral Education (CPE).

In Norway, the health care chaplains are hired and payed by the institutions. This is different in other Scandinavian countries. In Denmark chaplains are employed by local congregations of the Church of Denmark, and in Sweden there is an ecumenical institution called “The Hospital Church” which hires chaplains and organizes implementation of chaplaincy in the hospitals.

Norwegian hospitals introduce their chaplains as professionals who are integrated in the hospital’s effort at providing complete care, and the concept of person-centered care is frequently used. A big public hospital states on it’s Internet-pages :

“ – 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 questions 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, our courage to encounter challenges, and increased abilities to embrace good things”<sup>4</sup> (Sykehuset i Vestfold, 2016).

This kind of statement is representative of hospital chaplaincies in Norway. However, all hospitals also present the possibility to receive services from a religious representative, or other services specifically adapted to the patient’s view of life or spiritual profile (Berthelsen & Stifoss-Hanssen, 2014).

In other words those are two different perspectives, which indicates that there are two ways of reasoning about the function of chaplaincies.

*Firstly* : The chaplain is providing religious services according to specific requests from patients, and based on the chaplain’s personal profile. This is a common understanding of chaplaincies. Providing such services is 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 additional regulations, and ethical codes of conduct for professionals.

For some participants in the discussion about chaplaincy, this way of reasoning is dominant, as it is in an Official Norwegian Report from 2013 called “The Faith Open Society” (Official Norwegian Reports, 2013). To some extent, prioritizing this argument may have the effect of bringing order into 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 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 for the hospitals’ own presentation of their chaplaincy services, as mentioned above, chaplaincy services

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4. Our translation.

are guided by and aimed at *providing existential care* to persons in critical and marginal life situations. The term used for this help is sometimes “spiritual”, and sometimes conversations move into the religious universe of a patient, but the aim of the talk is to take care of the other person’s existential needs.

So what is at stake here, is not primarily the person’s right to practice religion, but his or her right to receive care in a situation of crisis, and existential trouble. In this perspective, chaplains are available in institutions where people are injured, hurt, or under exceptional stress.

## 5 Whole person-body-mind-spirit

Nurses and other health care personnel are obliged to provide spiritual or existential care to patients (physical-psychological-social-spiritual care). This has for instance been clearly expressed in a Norwegian parliamentary document already back in the 1990s :

“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 consideration 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; p. 28-32)

Furthermore in a recent official Norwegian report (Official Norwegian Reports, 2017, 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 fact in their central aims (Official Norwegian Reports, 2017, p. 24).

Even if the two ways of reasoning about chaplaincy are different, we do not claim that they are necessarily in contradiction. Several modes of combining the two have been attempted, and they can take place on both individual and organizational 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 a foreign place, whereas the “existential care” model designs the chaplain more as a variety of *health care personnel*, based in the same institution<sup>5</sup>.

## 6 Context of increasing health focus

For the institutions, the backdrop is characterized by enormous changes since the first half of the 1900s. In Norway, the population is doubled (5.3 million in 2019), and spendings on health have moved up from 4% of GNP in 1950 to approximately

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5. We are aware that the “health personnel” version raises major problems, that must and shall be discussed elsewhere.

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 physicians, along with the other health related professions (Statistics Norway, 2019). This brings Norway to the top worldwide in terms of density for these professions in the population, and in spending on health care.

In addition to this major 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 professionalization of practices, including health care professions, often under the terminology of *evidence-based practice*. This has made an enormous impact on how professionals are trained, and how they are expected to perform. The chaplaincy is no exception, and chaplains are more professionally educated than ever.

Furthermore there is an increase in research<sup>6</sup>, and chaplaincy has become more culturally and religiously adaptable, entering into cooperation across faiths. Many chaplains frame their services within 24/7 schedules, and are getting involved in crisis and disaster intervention (Stifoss-Hanssen & Danbolt, 2016).

At present, most chaplains in the Nordic countries have a background as clergypersons in the Lutheran majority churches. This has raised the question of a more culturally and spiritually diverse chaplaincy, which has been tested in some of the hospitals in Norway. And there are also recently established a master programme at the University of Oslo aiming to meet the need for more faith open chaplaincy education (Grung & Bråthen, 2019).

It is not only society at large that has changed during the years after 1950 – also the impulses that the chaplains brought from their theological background, which mainly was Lutheran, changed alongside with the changes in society. Theology experienced an empirical turn that resembled the change observed in other professions towards evidence-based practice, a turn that came along with theological preference for contextual or liberational theologies (*e.g.* feminist theology, postcolonial theology).

In addition, chaplains were mostly influenced by developments in pastoral counseling theories that were moving towards client-centered and egalitarian practices (Kolstad & Os, 2002).

## 7 Specialized care and Clinical Pastoral Education

It is good reason to argue that modern psychology and psychotherapy have had an impact on society in general, as well as on health care 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 for hospital chaplains in psychological and communicative skills and theory, inspired by the way psychiatrists were trained, even if focus was kept on patients' existential and religious challenges<sup>7</sup>.

6. For a brief overview of chaplaincy-related research in Norway see Stifoss-Hanssen, Danbolt and Frøkedal (2019, p. 67-68.)

7. 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 30s. Influential textbooks on pastoral counselling, based on psychological and therapeutic insights, were published from 1950 onwards.

Norwegian hospital chaplaincy pioneers went to the US for CPE training in the 1960s, and 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. In the last decade, CPE has been taught at university level, in affiliation with the MF Norwegian School of Theology, Religion and Society.

An obvious strength with the CPE model is its development of abilities to communicate with health care professionals, and the fact that it represents a professionalization of chaplaincy which is in line with requirements for health care professions.

At present, a majority of individuals working in chaplaincy and in pastoral care have completed one or more units of CPE.

## 8 Lutheran majority church and pluralizing society

Furthermore, it has been one of the tasks undertaken by chaplains—most of them being affiliated with affiliation to the Lutheran church—to facilitate contact between patients and religious leaders from other faiths and religions. However, with the whole society becoming less monoreligious and more secularized, the somewhat hegemonic function of these chaplains has been discussed and questioned (Plesner & Døving, 2009), and several alternative models of chaplaincy have been suggested. Some of them have been implemented into practice and are being assessed.

For practicing such multi-faith models, several problems obviously have to be solved, such as access to resources, the relative distribution of chaplaincy positions, and how their services should be provided. Some fear has been expressed that the model might lead to a situation where chaplaincy services as a rule are offered based on an assumed match between the religion or faith of the parties involved (e.g. Muslims are helped by a Muslim chaplain, Christians by Christians or Humanists by Humanists). This dilemma can for example be discussed in the light of the two ways of reasoning about the function of chaplaincies – the religious model and the existential model.

Clinical Pastoral Education (CPE), being an international concept in the field of spiritual care, is in principle a multi-faith and multi-religious endeavor, which is made clear from basic documents<sup>8</sup>. In Norway, because of monoreligious practices in chaplaincy, CPE has been and still mainly is organized as an integrated part of education of the Christian clergy. However, following the transformation of military chaplaincy into an interreligious one, CPE has also been adapted to a multireligious (“livssynsåpent”—“lifeview open”)<sup>9</sup> program. Generally adjusting CPE to a diversified group of participants stands out as a highly relevant and realistic change which would contribute to a sustainable model of chaplaincy in Norway.

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From the 1980s, many Norwegian chaplains were inspired and supported by the research environment in Uppsala, Sweden.

8. Vitenskapelig Høyskole (s.d.) : [https://en.wikipedia.org/wiki/Clinical\\_pastoral\\_education](https://en.wikipedia.org/wiki/Clinical_pastoral_education).

9. Wikipedia (2020) : <https://www.mf.no/kom/kompetanse-inspirasjon-til-videre-tjeneste/pastoralklinisk-utdanning-pku>

## 9 Growing interest in ritual practices

Regardless of whether we understand chaplaincy from a *religious service* or from a more *existential care* perspective, a renewed interest in ritualization in chaplaincy can be observed. Partly for the functional effects of ritual practices, but even an interest in bringing out more spiritually rooted phenomena. It is interesting to see parallel interests in doing rituals in hospitals and prisons. Here are some examples of innovative ritualizing: chaplains in a Norwegian prison implemented a four-week Ignatian retreat with prisoners, applying many ritual features; in another prison chaplains led a two weeks long pilgrimage with inmates, also with ritual practices (Engedal, 2011). And in a third prison chaplains practiced release rituals as a symbolic way of coming to grips with the transition outside the prison, empowering them, and at the same time showing dilemmas in being inside and outside the correctional logic of the prison (Gjøen & Fransson, 2018).

In hospital chaplaincy several innovative rituals can be observed. One example regards the caring for families who have consented to let their clinically dead relative's organs be donated for organ transplantation. Another example is integration of ritual practices in chaplains' work with clients in mental healthcare, for example together with patients suffering from pathological grief (Bjørndal, 2001; Stålsett & Danbolt, 2018). And many chaplains apply simple rituals such as benediction or lighting candles in their conversations with patients.

The innovative increase in clinical ritualizing has parallels in society at large. One nearby example is the abundant use of rituals in the wake of disasters, terror etc. Such a possible renewed interest in ritualization in chaplaincy may represent a development in chaplaincy characteristics, and it can also be seen as coinciding with a raised interest in the use and the significance of rituals in society at large.

## 10 Some challenges for chaplaincy

We can sum up that specialized chaplaincy education and training, such as the Clinical Pastoral Education programs (CPE), have contributed to the professionalizing of chaplaincy during the recent decades. Together with a significant increase in international research this has given way for setting high standards for chaplaincy, but there seem to be some challenges for chaplaincy practice, which also have been addressed in several international studies.

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? How does the chaplain's religious or worldview background matter? An American study found that chaplains with similar religious or worldview backgrounds as the patients were able to identify more issues than others (Abu Ras & Laird, 2011). If so, does this implicitly give way to a religious model of chaplaincy more than an existential model, as we have discussed earlier? And furthermore, does religious or worldview 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 referrals to chaplains? A recent Danish study (Thomsen, Hvidt, & Søndergaard, 2019) shows that about half of the initiatives for conversation is taken by the patient (42%) or his/her relatives (16%), while health care professionals count for 32% of the referrals and 10% is initiated by the chaplain. Does this indicate that the chaplain partly runs his or her own business somewhat independent of the systems of service referrals in the hospital? Or is it more likely to turn this the other way around, that patients are given an open line for existential care that does not depend on anyone in the treatment system facilitating it?

Another question regarding these, relates to access to patient journal systems and documentation of 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 interdisciplinary 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 to share and/or plan goals for appropriate treatment. An interdisciplinary study by Fitchett *et al.* (2011), showed that 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 issues 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, and probably other European countries, an aspect of this is the need for cooperation across care levels, such as specialist health care and municipality health care. This is pointed to in the Cooperation Reform, introduced as governmental policy in Norway some years ago (St. Meld. 47; Samhandlingsreformen, 2009).

Fourth, the professionalizing of chaplaincy and spiritual and existential care in institutions calls for continuous work on knowledge development and research. There are lots of interesting studies going on, like in Switzerland and in the Nordic research-group, ReChap. These are parts 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) as e.g. the European Research Institute for Chaplaincy in Healthcare (ERICH) exemplifies.

## 11 Conclusion

Looking at the timespan from 1950, chaplaincy in the Nordic countries has changed considerably. 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. Otherwise, several important developments have happened : a move from a "religious service" perspective to an "existential care" perspective

has gradually taken place; the work of chaplains has increasingly been underpinned by a professionalization—not the least through specialization 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 multireligious 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 to the future, taking into account the observation that the group has proved able to learn and to adapt.

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 professionalization 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 recognize and meet the existential and spiritual needs of patients and users, regardless of faiths.

Going back to our initial example, we think it is more needed than ever that the existential elephants in the hospital rooms are addressed by professionals educated for this. This is of great importance for the patients, but also for physicians, psychologists, nurses and other health care professionals. The role of chaplaincy is to assist people in their efforts of creating cosmos in chaos, as Peter Berger (2011) frames it, or said differently, in making meaning in particular situations in their lives.

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