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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