Chaplaincy in Northern Europe

An overview from Norway



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ABSTRACT

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

1. Introduction and definitions.

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

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

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

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

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

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

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

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

2. Organisation

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

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

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

3. Public presentation of the chaplains' services

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

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

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

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

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

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

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

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

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

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

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

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

4. Chaplaincy in society

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

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

Even if the health sector is here a chief

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

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

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

5. Chaplaincy and religion

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

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

me (Grung, Bråthen).

6. Chaplaincy and theology

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

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

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

7. Development from religious services to spiritual and existential care

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

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

8. The rise of Clinical Pastoral Education (CPE)

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

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

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

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

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

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

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

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

However, with the whole society becoming

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

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

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

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

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

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

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

10. Concluding remarks

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

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

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

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

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

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Notes

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

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