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PÄIVI THITZ, MIKKO MALKAVAARA, LEA RÄTTYÄ AND MINNA VALTONEN (EDS.)

Diaconal nursing in Finland

Theory and practice

Päivi Thitz, Mikko Malkavaara, Lea Rättyä
and Minna Valtonen (Eds.)

DIACONAL NURSING IN FINLAND
THEORY AND PRACTICE

Diaconia University of Applied Sciences
Helsinki 2021

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ABSTRACT

Päivi Thitz, Mikko Malkavaara, Lea Rättyä & Minna Valtonen (eds.)

DIACONAL NURSING IN FINLAND: Theory and practice

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The publication discusses the development of diaconal nursing in Finland, from its historical background to the present day. It focuses on the definition of diaconal nursing, related phenomena, and nurse-deaconesses' professional skills and duties in a range of settings.

Diaconal nursing is a relatively new concept, but its historical roots in Finland are in the 1860s. The understanding of diaconal service and its relationship with nursing duties has changed with society. Diaconal nursing education has evolved from the training of sisters in deaconess institutes to the present university of applied science degree which grants its holder eligibility for both nursing duties and service in the church's diaconal work. Nurse-deaconesses are registered nurses (RN).

The theoretical basis for diaconal nursing is in care studies and theology, but it also draws on social sciences and pedagogy. Diaconal nursing is holistic encounter and assistance, based on a Christian view of people and value basis. The premise for encounter is neighbourly love and respect for a person's uniqueness and beliefs. A focus on people, resource-centricity, holistic health and welfare promotion, and maintenance of perspectives of hope at the fore are key to diaconal nursing.

Nurse-deaconesses' professional identity is built on a broad-based education and the opportunities to deploy their skills in a range of work settings. The nursing competence in a parish's diaconal work is particularly visible as the ability to identify changes in a person's physical and mental welfare, and to provide companionship when serious illness and death are encountered. Diaconal nursing competence is particularly useful when encountering the most vulnerable, older people, families in difficulties, or people suffering from mental health problems or other diseases and symptoms.

In care work, a nurse-deaconess's strength is the ability to use spiritual and diaconal nursing assistance methods when encountering patients and their next of kin. In practice, this competence is seen in the ability to encounter spiritual distress, existential angst, suffering, loneliness and fear of death.

Diaconal nursing professionals are equipped to consider the meaning of various cultural traits and living environments for a person's general welfare. This is predicated by a courage to encounter diversity and an interest in each person's cultural background and life story.

On the one hand, the future of diaconal nursing in Finland is linked to the discussion of the understanding of diaconal work and the diaconal office. The Evangelical Lutheran Church's present ordination practices limit ordination to diaconal office to the church and Christian associations. This is at a time when the parishes' diaconal work duties are increasingly diverse and broad-based. On the other hand, future scenarios are linked to the ability of the church and the health services to recognize and identify diaconal work competence. Nurse-deaconesses' broad-based competence will be increasingly needed in future.

Keywords: diakonia, diaconal work, deaconess, spirituality, nursing

TIIVISTELMÄ

Päivi Thitz, Mikko Malkavaara, Lea Rättyä & Minna Valtonen (toim.)

Helsinki
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DIAKONINEN HOITOTYÖ SUOMESSA
Teoria ja käytäntö

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Julkaisussa käsitellään diakonisen hoitotyön kehittymistä Suomessa sen historiallisesta taustasta nykypäivään. Keskiössä on diakonisen hoitotyön määrittely ja siihen liittyvät ilmiöt sekä sairaanhoitaja-diakonissan ammatillinen osaaminen ja tehtävät erilaisissa työympäristöissä.

Diakoninen hoitotyö on käsitteenä melko uusi, mutta sen historialliset juuret ulottuvat Suomessa 1860-luvulle. Käsitys diakonisesta palvelusta ja sen liittymisestä sairaanhoidollisiin tehtäviin on muovautunut yhteiskunnan muutoksissa. Diakonisen hoitotyön koulutus on kehittynyt diakonissalaitosten sisarkasvatuksesta nykyiseksi ammattikorkeakoulututkinnoksi, joka tuottaa kelpoisuuden sekä sairaanhoitajan tehtävään että kirkon diakonian virkaan. Sairaanhoitaja-diakonissat ovat rekisteröityjä sairaanhoitajia.

Diakonisen hoitotyön teoreettinen perusta pohjautuu hoitotieteeseen ja teologiaan, mutta se hyödyntää myös yhteiskunta- ja kasvatustieteitä. Diakoninen hoitotyö on kristilliseen ihmiskäsitykseen ja arvopohjaan perustuvaa kokonaisvaltaista kohtaamista ja auttamista. Kohtaamisen lähtökohtana on lähimmäisenrakkaus ja ihmisen ainutlaatuisuuden sekä vakaumuksen kunnioittaminen. Diakonisessa hoitotyössä keskeistä on ihmislähtöisyys, voimavarakeskeisyys, kokonaisvaltainen terveyden ja hyvinvoinnin edistäminen sekä toivon näköalojen esillä pitäminen.

Sairaanhoitaja-diakonissojen ammatillinen identiteetti rakentuu laaja-alaiselle koulutukselle ja mahdollisuuksille hyödyntää osaamistaan erilaisissa työympäristöissä. Hoitotyön osaaminen seurakunnan diakoniatyössä näyttäytyy erityisesti kykynä tunnistaa muutoksia ihmisen fyysisessä ja psyykkisessä hyvinvoinnissa ja kulkea rinnalla vakavan sairauden tai kuoleman kohdatessa. Diakonisen hoitotyön osaamisen merkitys korostuu erityisesti kohdatessa haavoittuvimmassa asemassa olevia ihmisiä, ikääntyneitä, vaikeuksissa olevia perheitä tai mielenterveyden häiriöistä ja muista sairauksista ja oireista kärsiviä.

Hoitotyössä sairaanhoitaja-diakonissan vahvuutena on mahdollisuus hyödyntää hengellisen ja diakonisen hoitotyön auttamismenetelmiä potilaiden ja heidän läheistensä kohtaamisessa. Käytännössä osaaminen näkyy esimerkiksi kykynä kohdata hengellistä hätää, eksistentiaalista ahdistusta, kärsimystä, yksinäisyyttä ja kuoleman pelkoa.

Diakonisen hoitotyön ammattilaisella on valmiuksia huomioida erilaisten kulttuuristen erityispiirteiden ja elinympäristöjen merkitystä ihmisen kokonaisvaltaiselle hyvinvoinnille. Lähtökohtana on rohkeus kohdata moninaisuutta ja kiinnostus kunkin omaa kulttuurista taustaa ja elämäntarinaa kohtaan.

Diakonisen hoitotyön tulevaisuuden näkymät Suomessa liittyvät yhtäältä keskusteluun diakoniakäsityksestä ja diakonian virasta. Kirkon nykyiset vihkimyskäytännöt rajaavat diakonian virkaan liittyvän vihkimyksen pääasiassa kirkon ja kristillisten järjestöjen piiriin. Samaan aikaan seurakuntien diakoniatyön tehtäväkenttä on yhä moninaisempi ja laaja-alaisempi. Toisaalta tulevaisuuden näkymät liittyvät siihen, tunnistetaanko ja tunnustetaanko diakonisen hoitotyön osaaminen kirkossa ja terveydenhuollossa. Sairaanhoitaja-diakonissan laaja-alaiselle osaamiselle on entistä suurempi tarve tulevaisuudessa.

Asiasanat: diakonia, diakonissat, hengellisyys, hoitotyö, spiritualiteetti

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Päivi Thitz

INTRODUCTION

The idea of neighbourly love and care for the most vulnerable lies at the heart of diaconal nursing. According to the Bible, the love of Christians for one another was one of the hallmarks of the early church. Helping the suffering, supporting the oppressed and various ministries have spread the love of God and have been central to the church's essence.

Organized charity within the church, and the church's and Christians' relief work, is chiefly referred to as diakonia, or diaconal ministry, in the Lutheran and Reformed Churches of Northern and Central Europe, and those in their sphere of influence. The word diakonia occurs quite often in the New Testament, so it is used throughout Christendom. In the Orthodox, Catholic and Anglican worlds, diakonia refers to the office or function of the deacon, which is for the most part associated with worshipping life. For centuries, deacons in the Catholic and Anglican churches have been assistants at the eucharist who are later ordained priest. Today the churches have also had a permanent — or "distinctive" — diaconal office.

As a result of ecumenical links and conversations, the idea of caritative and social diaconal work that focuses primarily on the functions of care and nursing has expanded to all the churches to some extent. However, the word diakonia is not well established in everyday language in the English-speaking world, where people are accustomed to using the terms "Christian social practice" or "parish nursing" when referring to the phenomenon which we mean in speaking of diakonia.

The subject of this volume is diaconal nursing, the roots of which can be seen in the care and nursing by the church for those in suffering. The concept of diaconal loving service became associated with nursing education in Germany in the 1830s and in Finland in the late 1860s. In Finland the task of deaconesses who had received medical training was to alleviate the plight of the sick and organize the church's care for the poor. For a long time deaconesses' work lay in home nursing and its associated social and spiritual care.

Diaconal nursing has been discussed in Finland since the 1980s. Diaconal nursing has become a professional job in which highly educated and registered nurse-deaconesses work in parishes' diaconal work, in community health care or in the third sector.

A characteristic of diaconal nursing is that it has been shaped over time. As we enter the 2020s the key drivers of change affecting diaconal nursing are an ageing population, growing health inequalities, global and regional migration, climate change, digitalization, and rising exclusion associated with inequality. At the beginning of the new decade, ethical issues related to the care of the elderly, disparities between well-off and disadvantaged areas, increasing mental health problems among young people, the situation of the undocumented, and the financial distress and loneliness called by the coronavirus pandemic have emerged in the societal debate.

Amidst these changes diaconal nursing is also seeking models of action that support people's health and wellbeing, as well as strengthening horizons of hope and support for the individual's resources. The nurse-deaconess accompanies people, especially when they face suffering, pain or death.

As in other northern European countries, the importance of religion in Finland is changing. Finns' commitment to the church has weakened in the twenty-first century, and the role of religion in people's lives has changed. A wide range of different forms of religiosity has emerged alongside that of those committed to the teachings of the traditional church. In diaconal nursing neo-spirituality and spirituality are also increasingly seen as a factor that influences a person's health and wellbeing.

This publication is based on the Finnish work *Diakonisen hoitotyön perusteet ja käytäntö* (Diaconal Nursing: Theory and Practice), which was published in the autumn of 2020 (Thitz, Malkavaara, Rättyä & Valtonen, 2020). The aim was to provide material for the definition of diaconal nursing, the construction of theology and the development of practice. The book was also a response to the need of Diak, the Diaconia University of Applied Sciences, for learning material for diaconal nursing students. When the book was published, the need arose to translate the articles for the use of international partners and as English-language material for students.

Fifteen of the twenty-two articles in the Finnish book were selected for this translated publication. Some of the original articles have been slightly modified to make them understandable for an international readership. Moreover, this volume

includes a new article by Ville Päivänsalo that discusses the ethical and theological issues of diaconal nursing.

The articles in this volume treat of the development of diaconal nursing in Finland from its historical background to the present. The publication focuses on the definition of diaconal nursing and the nurse-deaconess's special expertise. Finally, the development of the deaconess's role in the church from the perspective of the diaconal office is considered, as well as the opportunities for using the skills granted by the dual degree in the work and community of the church.

The articles in the publication were written by experts in various fields and perspectives of the church's diaconal work and diaconal nursing, and especially in the parish and community, as well as in nursing and diaconal nursing education. The publication was edited by employees of Diak, the Diaconia University of Applied Sciences.

I
DEVELOPMENTS IN DIACONAL NURSING IN FINLAND

Mikko Malkavaara

1 DEVELOPMENT OF FINNISH DIACONAL WORK

The first chapter of this book explores the basis of diaconal work and examines how it has developed in Finland and how the concept of diaconal work has been used in different periods. The article traces the formation of Finnish diaconal work and its development in four phases. The turning points have mostly been influenced by large social changes which have been reflected in the church. Meanwhile, "diaconal work" has been understood in different ways at different times, sometimes more broadly and sometimes more narrowly.

Diaconal work as the essence of the church

Diaconal work means service. Particularly in the Protestant churches, diaconal work is understood as Christian service of one's neighbour which the church does as the expression of its responsibility and duty. Diaconal work is done when the church serves the suffering and those in difficulties. It is an expression of God's love and clemency to people and a service which fights with divine righteousness on behalf of the oppressed or downtrodden. Diaconal work exists for all who suffer, which is why it aims to collaborate with all humanitarian and social activities. It takes suffering seriously and does not seek to bolster the church's honour or influence.

Diaconal work belongs to the essence of the church. At the third assembly of the World Council of Churches, in New Delhi in 1961, the church was described using the tripartite division of proclamation (kerygma), service (diakonia) and communion (koinonia). The meeting of the Commission on Faith and Order of the World Council of Churches in Montreal in 1963 summarized the church's faith in the words liturgy (liturgia), service (diakonia) and witness (martyria). Service is present in both.

In theological terms the church's diaconal essence proceeds from Christ's task, the service of love. Diaconal work is not charity or a practical form of the church's work. The church must be diaconal; otherwise, it is not the church. Diaconality

is manifested in many different ways, but it is the manner of being of each local parish. The nature of diaconal work includes the crossing of boundaries.

The diaconal renewal which occurred in Protestant churches in the 19th century emphasized above all the caritative task of diaconal work, which means care and treatment for those who need it. Diaconal work is also associated with liturgical and catechetical tasks. In the work of the deaconesses and deacons of the Evangelical Lutheran Church of Finland, caritative and social duties have been so emphasized that only in recent decades has the office's liturgical and catechetical nature become somewhat visible. Simultaneously, questions have been raised about the problems presented by the role's multidisciplinary nature and depth.

The Protestant, and mostly northern European, understanding of the content of diaconal work expanded somewhat to other churches as a consequence of the ecumenical movement from the 1970s onwards. However, a reaction to it soon began, largely due to New Testament study. Such study held that diaconal work, as a biblical term, meant any service and indeed duties whatsoever, but no particular sense of treatment or care. The discussion has caused confusion but also supported the constant diversification of diaconal work.

The deaconess institutes, the beginning of modern diaconal work

The Lutheran diaconal movement began when a small nursing school and a teaching hospital were founded in Kaiserwerth, near Düsseldorf in 1836. Twenty-five years later there were almost thirty institutes following the example of Kaiserswerth around Europe, including in Stockholm and St Petersburg. A responsible Christianity which tended to its neighbours took place in societies and institutes rather than parishes (Malkavaara, 2015, pp. 75–77; Paaskoski, 2017, pp. 21–29).

Initiatives were also taken to establish a deaconess institute in Finland as early as the 1850s. However, it was not until the influential Aurora Karamzin, the widow of a wealthy colonel, took up the matter that the necessary permits were obtained and the Helsinki Deaconess Institute was founded in 1867. A deaconess institute was founded in Vyborg two years later, this time with the support of the Hackman family of industrialists.

The institutes offered women education and responsible duties for the welfare of the poor, usually women and children. Although it was a modest beginning, it started a new era in Finnish Christianity. The reaction of the church fathers and

clergy was largely one of astonishment (Malkavaara, 2015, pp. 84–86; Paaskoski, 2017, pp. 31–39).

Discussion about diaconal work

Although the church has always cared for the poor, orphaned and sick, the transfer of poor relief had left the church without an organized diaconal function. The insufficiency of poor relief prompted a discussion about the need for it. Hopes were expressed for both female and male employees of the parishes to care for the ill and the poor, and to perform outreach (Malkavaara, 2015, pp. 83–84, pp. 86–88; Paaskoski, 2017, pp. 29–32, pp. 62–69).

At the same time, there was an active conversation about the position of women. Calls were made on the church to open the path to the deaconess profession without a life-long commitment to the oversight of an institute. The free churches demanded a return to the Bible's original ideals. While outreach and diaconal work had until then been understood as an activity of individual Christians and societies, the new thinking began to activate laypeople and generate new forms of work (Mustakallio, 2001, pp. 32–33, pp. 39–44; Mustakallio, 2009, pp. 205–206; Paaskoski, 2017, pp. 90–93; Penttinen, 2018, pp. 34–35).

A freer form of diaconal work based in the parishes and developed for Finnish conditions interested the clergy. As of 1889, only two deaconesses worked in parishes.

The Bishop of Kuopio, Gustaf Johansson, proposed in 1890 that the church arrange diaconal work, as the social poor relief was insufficient. The outreach committee that had been appointed proposed a new form of work for the parishes, which was called an ecclesiastical diaconate. Its spiritual side brought "pure and Christian-minded" laypeople into the parishes to teach the word of God in Sunday schools and devotions. The other side required "deaconesses, that is, female carers of the sick" of the church for the "poor sick people". The diaconal question and the need to provide duties for laypeople were combined (Mustakallio, 2001, pp. 45–48; Mustakallio, 2009, p. 206; Penttinen, 2018, pp. 36–37).

Parish diaconal work is born

In March 1893 the Finnish Senate approved a regulation on the diaconate drafted on the basis of the stipulations of the Church Act regarding care for the poor and ill. Deacons, men with knowledge of the word of God, were to be chosen for the

work of proclamation, and deaconesses were to be appointed for the care of the physically needy. This marked the beginning of organized parish diaconal work in Finland. However, no diaconal education yet existed, and all that was required of deaconesses was personal suitability and the most rudimentary nursing skills. Notwithstanding, the church recognized the offices of both deacon and deaconess (Mustakallio, 2009, p. 207; Penttinen, 2018, pp. 37–38).

Disagreements arose on the hiring of deaconesses. The Diocese of Porvoo instructed parishes to recruit deaconesses from the Helsinki and Vyborg deaconess institutes, which would care for the deaconesses until they died. Other dioceses wished to make diaconal work a statutory form of work in the parish (Mustakallio, 2009, pp. 207–208; Paaskoski, 2017, pp. 94–96).

The labour shortage was most acute in the parishes of northern and eastern Finland. New deaconess institutes were founded in Sortavala in 1894 and in Oulu in 1896. The example for the Sortavala Deaconess Home was the short parish sister education which had begun in Oslo. Nurses' uniforms were not worn, and there were no graduation ceremonies. The deaconesses, then referred to in Finnish as "diakonitar", literally "female deacon", proceeded to work for the parishes or societies as their employees. The female deacons of Sortavala in the 1910s were the first to be called deaconesses (Finnish: "diakonissa") (Mustakallio 2001, pp. 63–119; Pyykkö, 2004, p. 118; Huhta, 2005, p. 24; Mustakallio, 2009, pp. 208–209; Malkavaara, 2015, pp. 89–90; Paaskoski, 2017, pp. 97–98; Penttinen, 2018, pp. 53–55).

The deaconess course at the Oulu Deaconess Home was even shorter than in Sortavala. Most new deaconesses were employed by rural parishes. However, in 1911 the institute became a sisters' home, which gave ageing and ill deaconesses the support of a community behind them (Mustakallio, 2001, pp. 134–141, pp. 476–522, pp. 554–555).

The establishment of the Sortavala and Oulu institutes expanded the concept of diaconal work as a task of the parish. The Helsinki Deaconess Institute considered the new educational institutes a criticism of the sisters' home system and retained its policy, under which the deaconess vocation required celibacy, the sisters' home and long practice in hospital. Friction arose between the old and new institutes (Paaskoski, 2017, p. 98).

Otto Aarnisalo

An important reformer of Finnish diaconal work was Pastor Otto Aarnisalo (until 1906: Lillqvist). Aarnisalo demanded of the church and parishes an active approach to helping those in distress. Statutory poor relief, humane charity and Christian clemency were not mutually exclusive; they merely had different aims. The aim of diaconal work was "the poor person's eternal good", and the aim of diaconal work must be that of the church: it could not be left to societies, institutes, charities or well-meaning Christians. Although diaconal work was every Christian's duty, it needed the support of a church diaconal office or diaconal function, both of which to Aarnisalo meant the same thing.

To Aarnisalo, diaconal work meant intervention in social evils using the means of Christian neighbourly love. Work "on behalf of silent plight" was for him a distinguishing feature. For him, diaconal work was just as essential a part of the church as the proclamation of the Word of God (Mustakallio, 2002, pp. 208–209; Huhta, 2005, pp. 24–27, 30; Malkavaara, 2007a, pp. 97–99; Malkavaara, 2015, pp. 90–91; Paaskoski, 2017, pp. 98–100; Penttinen, 2018, p. p. 114).

Aarnisalo's achievement was the Internal Mission Society of the Finnish Church, founded in 1905, of which he became director. The Society educated men as deacons in Sortavala, and alongside it operated institutes for the intellectually disabled and the mentally ill. The diaconal education trained men for diaconal work, service as outreach preachers and for various auxiliary functions in parishes, even cantor organists, and expanded the concept of diaconal work in the direction of parish work. The Sortavala diaconal school ceased operations in 1921. Thereafter, education in the diaconal field was for decades aimed solely at women (Huhta, 2005, pp. 29–31; Malkavaara, 2015, pp. 91–92).

The change in parish diaconal work was fast and also affected the Helsinki Deaconess Institute, which had increasingly been sending deaconesses into parish work. However, the concept of diaconal work was unknown to the wider public. People spoke of sisters and parish sisters rather than deaconesses.

Aarnisalo pursued the inclusion of regulations on diaconal work in the Church Act. Under his proposals, deaconesses would be employed by the parishes and overseen by the diocesan chapters. He did not secure the general synod's majority support for establishing the mandatory nature of diaconal work via legislation. However, a regulation exhorting the organization of diaconal work was a great step forwards. An amendment to the Church Act which entered into force in 1918 meant the Evangelical Lutheran Church of Finland recognized diaconal work as one of its functions.

This was the basis for the development of parish diaconal work for the next two decades. Most commonly, diaconate or deaconess societies were founded in parishes. With the parishes, they raised funds for hiring diaconal workers (Mustakallio, 2001, pp. 533–545; Koskenvesa, 2002, p. 53; Mustakallio, 2002, pp. 215–216; Rinne, 2006, pp. 101–108; Malkavaara, 2007a, pp. 96–102; Malkavaara, 2015, pp. 92–93).

Nursing diaconal work

Diaconal work was in the 1920s primarily understood as nursing. The Helsinki, Vyborg, Oulu and Sortavala deaconess institutes founded a Diaconal Work Central Committee, which in 1925 published a regulation for the parishes. This regulation was supplemented by working instructions for parish deaconesses. The instructions were divided into diaconal care work and nursing, of which some parishes chose only one. Diaconal care work was social work performed by the deaconesses in the parishes. Nursing consisted of home nursing visits.

The instructions emphasized the imminent change in deaconesses' duties, as society was taking responsibility for medical treatment. Diaconal work would then be left primarily with caring for children, youth, the disabled, prostitutes and "other fallen people".

Nursing was bolstered as part of deaconesses' identity in 1929, when the Finnish state unified all nursing education. The three-year course taught in Helsinki, Vyborg and Oulu fell under the supervision of the National Board of Health. As the new legislation was being prepared, Sortavala extended its previously two-year course to three years, but retained so much general knowledge and "care sister" material in its programme that it did not fully conform to nurses' education. Thus, the deaconesses who graduated from Sortavala were approved by special application only as junior nurses, but not as trained nurses, that is, senior nurses (Mustakallio, 2002, p. 216; Määttä, 2004, p. 13; Paaskoski, 2017, pp. 183–188).

Aarnisalo thus retained his programme, according to which the place of diaconal work was in the parishes. When it began to become clear that the Sortavala deaconesses were not gaining the rights of fully fledged nurses, the education of care sisters was emphasized further. The question of the social emphasis of diaconal work was part of the ecclesiastical discussion throughout the 1930s (Pyykkö, 2004, pp. 120–122; Huhta, 2005, pp. 34–35, p. 95; Malkavaara, 2015, p. 94).

In many places, deaconesses were employed jointly by the parish and the municipality and cooperated closely with the municipal doctor. An estimated 80 per

cent of visiting nurses in 1930 were deaconesses. The church's leaders hoped for a renewal of diaconal work in the direction of social work, but this foundered on the state aid which the parishes received for to hire deaconesses with nursing qualifications.

The state did not open up the opportunity of social work for the parishes in the same way as nursing. The diaconal work regulation made a clear distinction with municipal poor relief, but made no similar distinction with municipal healthcare, as the deaconesses worked as part of the public health service (Kansanaho, 1964, pp. 290–299).

The Internal Mission Society retained its position that a deaconess was not just a visiting nurse but a parish worker who had to go everywhere there was need or want. The discussion about care sisters continued in the Diaconal Work Central Committee, and the Helsinki Deaconess Institute, for example, planned a care sister course. However, the development of the social and healthcare field and the numerous new laws in the 1930s aroused concern for the future of diaconal work. The fear was that the aid provided by societies would lose its meaning as nursing and social care became wholly public functions (Kansanaho, 1967, pp. 225–233; Pyykkö, 2004, p. 121; Paaskoski, 2017, pp. 189–190).

Mandatory diaconal work for the parishes

The general synod again considered the amendment of the Church Act with regulations on diaconal work in 1938. Professor Eino Sormunen, later the bishop of Kuopio, had actively lobbied for the formalization of diaconal work in line with Aarnisalo's thinking. The matter was first assigned to the bishops' conference, which appointed a committee to investigate it. It emerged that of the church's 598 parishes, only 177 lacked a deaconess. Nevertheless, the parishes were rather unaware of diaconal work. The committee proposed making diaconal work and its offices compulsory for the parishes.

When the matter returned to the general synod, the special diaconal committee it had appointed conducted an elucidatory discussion on the concept of diaconal work. In the opinion of a large minority, diaconal work ought to be defined primarily as nursing, but the majority thought such a definition would hinder the development of diaconal work (Koskenvesa, 2002, p. 54; Mustakallio, 2002, pp. 216–217; Huhta, 2005, p. 92; Wirilander, 2011, pp. 40–41; Paaskoski, 2017, pp. 257–258; Penttinen, 2018, pp. 242–243).

Diaconal work, and the office of deacon or deaconess, became statutory functions of the parishes by a decision of general synod made in the midst of the war in the summer of 1943. The disruption of the Second World War had made the social and national responsibility of the church even more important.

According to the form of organization of the church (Section 11 of the Church Act), "each parish shall exercise the Christian clemency function and bring into its employ people necessary for that [task]". Diaconal work is defined in further detail in Section 88 of the Church Act: "The purpose of the Christian clemency function is the provision of spiritual, corporeal and material aid flowing from Christian love to those in need, and it shall be especially aimed at those whose need is greatest or whom other assistance does not reach. For the exercise of the parish clemency function, each parish shall employ the necessary deacons and deaconesses."

The formulation was in practice the programme pursued by Aarnisalo. The wording "whose need is greatest or whom other assistance does not reach" became established as the basic definition of diaconal work (Malkavaara, 2002a, pp. 225–226; Wirilander, 2011, p. 41; Malkavaara, 2015, p. 96; Penttinen, 2018, pp. 245–248). When diaconal work was included in the parishes' statutory duties in 1944, it was a question of restoring, reviving and renewing an old social task. With this may be equated the inclusion of missionary work in the parishes' tasks in 1954. Together, they broke the old and static perception that the parish cared only for its own members (Pirinen, 1977, p. 121).

Parish diaconal work directed towards social work

The second phase of diaconal work is called the period of parish diaconal work. The wartime reforms thus marked the first turn in diaconal work. At the Tampere church days of 1943, the desire, born of the national state of emergency, to create a serving folk church was crystallized. The engines of change were the "brothers-in-arms" priests who had received a social awakening on the front. The church's responsibility for tackling unjust structures was placed on a par with the immediate aid of those suffering on the front.

The folk church programme of the "brothers-in-arms" priests created new ways of working and fresh thought. The individualistic salvation message and the philosophy which highlighted social Christianity were polarized. When peace came, the Central Federation of Parish Work of the Church of Finland (Finnish abbreviation: SKSK) received the task of functioning as the church's social work committee. A wide range of political parties and civic organizations was represented

there. It became the church's leadership and planning body for common diaconal work (Murtorinne, 1995, pp. 278–279; Malkavaara, 2002a, pp. 222–225; Wirilander, 2011, pp. 45–46).

The new diaconal work adhered to the post-war social policy, which had become a force for national reunification, until the "caritative" diaconal work, based in a view of direct service of individuals, again defeated the social influence camp. The traditional structure of the workforce was the backdrop to this. The diaconal workers were almost all parish sisters with nursing qualifications.

During the short period of prevalence of the "social" view of diaconal work, a church diaconal structure was formed. The SKSK founded the office of church social work secretary, and the dioceses established their own diaconal work council, in which the chairperson was one of the assessors, and the executive director was a social work priest from the diocese.

The social work priests led and developed the diaconal work in their own dioceses. They were obliged to maintain a close working relationship with the church's social work secretary. The church's social work was not defined as complementary to that of the deaconesses; the parishes' diaconal work was understood as part of the church's social work. Gradually, "diaconal" replaced "social" in titles. This was ultimately a question of the content of the concept. "Diaconal" was so strongly associated with care for the sick that replacement terms of broader meaning had to be sought in the realm of social and societal responsibility (Koskenvesa, 1980, pp. 51–52, p. 55; Malkavaara, 2002a, p. 223, pp. 225–226, p. 230; Wirilander, 2011, pp. 47–48; Malkavaara, 2015, pp. 96–99).

Development of diaconal work in the late 1940s and late 1950s

The education of deaconesses was harmonized, and the parishes' aims were clarified. All institutes educating deaconesses received approval for awarding nursing qualifications from the National Board of Health. The central principle of the parish diaconal work regulation was to complement public-sector healthcare. Indeed, after the reforms, deaconesses' work in the parishes was focused on nursing in the home. (Pyykkö, 2004, p. 123, pp. 125–126).

During the war, the institutes of the Internal Mission Society had been transferred from Sortavala to Pieksämäki and from Vyborg to Lahti. A new Deaconess Institute opened in Pori in 1949.

The catechism (Kristinoppi) of 1948 classified the offices of deacon and deaconess as parish offices in addition to that of priest. The office of the church was divided into the word and the sacrament, on the one hand, and the duties of the service of love, on the other. The office of the parish was "the divinely appointed office of the Holy Spirit", which was divided in two: "the office of the word, which includes the episcopate, and the office of the parish servant, that is, deacon and deaconess". The latter meant "the search and care for children, the ill, the poor, prisoners and others lacking security". The catechism defined the revival of diaconal work as "the reopening of the long neglected early Christian office of blessing" (Katekismus, 1948, p. p. 56; Malkavaara, 2015, pp. 99–101).

A significant reform was the diaconal education begun at the Finnish Church Parish Institute in Järvenpää in 1953, which no longer linked diaconal work to healthcare but rather to social work. Instead of relieving acute distress, diaconal work was to chart the reasons for and tackle the structural problems behind social ills. The new course reopened diaconal work for men. Men would also later be able to train as deaconesses (Malkavaara, 2015, p. 101).

The initiator of the course in Järvenpää, Institute Director Aarne Siirala, held that diaconal work should establish where aid was needed in areas statutory social work did not reach. Diaconal work had to be familiar with public sector social work, but to assure its viability it had to retain its parish connection. Without it, diaconal work would lose its context and diaconal nature. The parishes were to become "living diaconal cells", and they required new educated diaconal workers (Ahola, 1996, pp. 100–109, pp. 121–122; Malkavaara, 2004, pp. 38–40).

In 1958 the sisters' home system came to an end following a lengthy dispute. The public health system's nurses were focused on care for children in the municipalities, while the parish sisters saw to care for adults and the elderly in the home. The development of municipal healthcare placed mental and spiritual aid in an ever more substantial role in the deaconesses' home visits (Malkavaara, 2002a, pp. 245–247; Pyykkö, 2004, pp. 124–127; Paaskoski, 2017, pp. 284–287).

International diaconal work expands the diaconal philosophy

The Lutheran church of Finland went from being a receiver to being a giver of aid in the 1950s. As Finland prepared to host the Lutheran World Federation assembly in summer 1963, the decision was made, like other Nordic Lutheran churches, to start actively fundraising for foreign aid. The mechanism was the annual large

diaconal event run since 1950, the Common Responsibility campaign. Half the funds raised in 1963 were spent on foreign aid.

To give oversight over the new type of work, an international church aid organ was established. From 1965 onwards it has been known as Kirkon Ulkomaanapu (in English: Finn Church Aid). The term international diaconal work began to be used for this new area. Funds were primarily directed at sites chosen by the Lutheran World Federation and the World Council of Churches.

The Common Responsibility campaign and diaconal workers were the backbone for international diaconal work. A new element was the concept, flowing from the UN's international human rights philosophy, of giving aid regardless of faith, race, conviction or nationality. The view spread to diaconal work, which began to take responsibility for poverty and injustice worldwide (Malkavaara, 1997, pp. 14–20; Malkavaara, 2001, p. 147, pp. 154–155; Malkavaara, 2002a, pp. 238–241).

Transition caused by the welfare state

The social work approach was received poorly by the parishes, who wanted the deaconesses to continue their traditional nursing duties. More multifaceted diaconal work only began to take root with the evolution of the Finnish welfare state and preparations for the provisions of the 1972 Primary Health Care Act.

The public health efforts cut the direct link with the municipalities. Although the deaconesses were nurses, their official roles in the health system ended. They retained a nursing role for longer in the countryside, and more strongly in the north and east of Finland than in the south (Malkavaara, 2002a, pp. 244–245, p. 248; Pyykkö, 2004, pp. 126–129; Malkavaara, 2007a, pp. 109–111).

The change of 1972 has been called the second turn of diaconal work. The end of deaconesses' nursing as a public service under the supervision of municipal doctors narrowed the role of diaconal work as a provider of welfare services. However, there was a great need for aid of the old, disabled and those living in difficulties, as well as for pastoral care. The volume of nursing care decreased but did not disappear. Communal activities — diaconal circles, excursions and camps, as well as house calls on elderly parishioners — became the backbone of diaconal work. Diaconal work was increasingly focused on specific groups, as well as consisting of spiritual direction and holistic encounters with people. Ever more deacons were being selected to fill diaconal offices. In the late 1960s education of deacons was begun in Helsinki and Pieksämäki, in addition to Järvenpää.

Change had already been ushered in that direction by the 1964 reform of the Church Act, which emphasized parishioners' role in the performance of diaconal work. Diaconal workers were to be enthusiastic about diaconal responsibility. The words for diaconal work in Finnish (diakonia, diakoniatyö) finally became established at this time. The ecumenical discussion increased understanding about how many different ways diaconal work was seen in different churches. There was a desire to expand diaconal work in the liturgical and catechetical direction (Pyykkö, 2004, pp. 128–129; Salmesvuori, 2008, p. 41; Juntunen & Saarela, 2009, pp. 38–39; Rättyä, 2009, p.32; Malkavaara, 2015, pp. 108–110; Paaskoski, 2017, pp. 291–298).

As the welfare state developed, the thinking was that aid for the poor would no longer be the parishes' responsibility. The two kingdoms doctrine was used in the idea that monetary aid was not one of the core functions of the church, but of the public sector. The church was left with the role of complementing social security and making proposals. From the Finnish state's perspective, the church's diaconal work was comparable to that of associations (Heikkilä and Karjalainen, 2000, pp. 228–231; Hiilamo, 2010, p. 7).

The golden age of the welfare state in the 1970s and 1980s did not mean the end of the church's emergency relief, social support, or nursing. The municipalities were unable to meet the need, and the parishes collected voluntary donations, helped organize voluntary work and spent their tax income on diaconal grants (Määttä, 2004, pp. 182–212, pp. 253–254; Wirilander, 2011, pp. 195–199, p. 4).

Expansion of the diaconal philosophy

Youth workers in the 1960s observed that some young people were on the one hand forming gangs, while some were on the other hand lonely and developing drug problems. They began working with gangs, but the work then developed into youth outreach work and personal counselling for young people. The work was shaped by diaconal work and the social responsibility ethos of the time. The people carrying out the work wondered how much of it was youth work and how much diaconal work. Under the influence of municipal youth work, the form of work began to be called specialized youth work in the mid-1970s, until the classifications of youth diaconal work and diaconal youth work regained prominence (Malkavaara, 2013, pp. 171–172, p. 246; Kaartinen, 2017, p. 13, pp. 37–38).

The definition of diaconal work as the assistance of those in the greatest need and whom other aid did not reach was not changed, although in the golden age of

the welfare state it only described diaconal work in part. The clearest social criticism was voiced in the circle of international diaconal work and the church's societal work. Liberation theology and its demand of the primacy of the poor also had their own effect (Malkavaara, 2002a, pp. 251–253, p. 256).

In Revival Movement theology, diaconal work arose out of the viewpoint of individual ethics or an individual's salvation. Helping the poor and the week, let alone advocacy to change societal structures, was interpreted as being less valuable than the perspective of eternity.

The independence of developing countries was followed by an expansion in global responsibility. Mortality entered the church's theology. The church sought a connection between the classic doctrine of justification and social justice. Social ethics was based on natural law, which was not at all a requirement of unselfish love but of the security of equal rights and obligations. The shift to a thinking governed by the post-war revival movements' theology was significant (Malkavaara, 2002a, pp. 253–255).

The impulses of the ecumenical movement supported a sharpening view on diaconal work. In the spirit of liberation theology, under discussion were prophetic diaconal work as well as solidarity in the struggle for justice, human dignity and peace. In particular, a relationship between diakonia and koinonia, between service and fellowship, was sought (Malkavaara, 2002a, pp. 256–257).

Organized neighbourly love and the assistance operations of the church and Christians are mainly called diaconal work or diakonia in the Lutheran and reformed churches of Central and Northern Europe. In the Orthodox, Catholic and Anglican world diakonia refers to the office of deacon, related to divine service. The conversation with other churches has led to an understanding of diaconal work as not only meaning compassionate neighbourly service or simply assistance functions in the liturgy, but rather both, as well as action to change societal structures (Malkavaara, 2008, pp. 20–21).

The understanding of diaconal work was affected by the social conversation and sociopolitical research, both of which in the 1980s started increasingly using the concept of exclusion. The church considered it clear that diaconal work would serve the excluded. The conversation on unequal income distribution, exclusion from work, identification of distress and the church's opportunities for relieving suffering raised the self-awareness of diaconal work (Malkavaara, 2007b, pp. 34–36, pp. 41–42).

The view of diaconal work was radicalized. The Common Responsibility campaign bypassed "honourable" targets, that is people in need of aid through no

fault of their own, such as children, the disabled and older people, in favour of "dishonourable" aid groups such as prisoners, drug addicts, problem debtors, the homeless and refugees. The Helsinki Deaconess Institute also directed its diaconal projects towards support of the worst-off. The interpretation of diaconal work deepened and broadened into societal and socio-ethical advocacy (Malkavaara, 2007b, pp. 36–46).

Recession of the 1990s renews diaconal work

The fourth phase of Finnish diaconal work is said to have begun with the recession of the 1990s. Its clients came to include the unemployed, people with mental health problems, and bankrupts or other rapidly impoverished people, who sought help in all possible places. As the number of seekers of assistance grew, new forms of work such as meals for the unemployed and food banks. The latter was based on the fact that the assistance grants for diaconal work simply stopped.
Even central government warned the church about the transfer to soup kitchen-style poor relief. For its part, this focused the church's social message and brought about a social advocacy channel, Nälkäryhmä ("hunger group"), founded alongside the church's food bank activities (Malkavaara, 2007b, p. 28; Malkavaara, 2015, pp. 173–180; Paaskoski, 2017, pp. 345–356).

This helped bridge the gap with municipal social work. The church profiled itself as filling in the cracks in the welfare state. The clients of diaconal work became younger and more numerous. This also demanded change in working methods. Clients were met more in offices than during home visits. At the same time, diaconal workers began to be concerned about diaconal work, which was approaching social work, becoming a replacement for municipal assistance, and that the support on offer was a mere sticking plaster (Kettunen, 2001, pp. 28–33; Malkavaara, 2002a, pp. 255–257; Malkavaara, 2002b, pp. 293–299; Helne and Laatu, 2006, pp. 20–22; Grönlund and Hiilamo, 2006, pp. 12–13; Grönlund and Juntunen, 2006, p. 179; Malkavaara, 2007a, pp. 114–116; Malkavaara, 2015, pp. 174–176).

The formation of the Diaconal Workers' Federation (Diakoniatyöntekijöiden Liitto) in 1991 at the start of the recession was also significant. The Finnish Church Sister Federation (Suomen Kirkon Sisarliitto, founded 1958) and the Finnish Deacons' Federation (Suomen Diakonien Liitto, founded 1960) merged with each other, with the individual federations then being liquidated (Salmesvuori, 2008, pp. 11–17, pp. 43–44, pp. 53–59).

The third turn in diaconal work happened during the recession of the 1990s. It must however be borne in mind that the change was deepest in cities, and generally in diaconal work in the south and west of Finland. Diaconal work remained unchanged in relatively broad areas (Hiilamo, 2010).

In any event, the large change in diaconal work reinforced citizens' trust in the church for years (Hiilamo, 2010, pp. 7–8). Diaconal work gained public space to allow the church to appear as an equal, initiative-taking social partner. Theory and practice met and reacted together to the emergency in their environment. Alongside the congestion in offices and the diversification of unemployed people's support and financial assistance, the creation of volunteer communities was important.

When the reasons for distress were examined, help came from natural theology. According to this thinking, the requirement of good and right living had always existed, even before Christianity. The obligation to moral good was written on every person's heart. Thus, according to St Paul, even pagans, who had no law, could at times naturally do what the law required. Associated with this was the golden rule: "Do unto others as you would have them do unto you".

After the third turn in diaconal work, the church appealed to natural sense when it gave ethical instructions on correct and good investments on the financial markets. The church's Nälkäryhmä ("hunger group") compiled an approved section of the Finnish government's programme on the grants to be assigned to poverty policy and appealed to everyone to a rationality shared by all. The Lutheran bishops appealed to the same common human sense of justice and the golden rule. They did so in a public statement entitled "Kohti yleistä hyvää" ("Towards the common good"), which criticized neoliberalism and defended the welfare state and began a lively discussion.

The third turn of diaconal work resulted in good opportunities for the church to set shared goals with others. Jaakko Ripatti has written that the church and its diaconal work at times almost dominated the public space regarding the promotion of neighbourly love and the pursuit of the common good (Ripatti, 2014, pp. 155–156).

It has also been noted that the "Towards the common good" statement mentioned above began a new era in the church's relationship with government. In this thinking, the church itself stepped away from the folk church philosophy by profiling itself as a moral voice in society. The church relinquished part of its special station by becoming part of civic society. Through involvement in the development of civic society politics, the church, in a way, weakened its position (Jalovaara & Martikainen, 2010, pp. 34–39).

Neighbourly love as the church's guiding thought

The reform of the Church Act in 1993 created a new guiding thought for the church which raised neighbourly love to the level of a mark of the church, alongside the gospel and the sacraments. In the midst of the recession this reflected an international wave of renewal in which diaconal work was understood as the task of the entire church (Malkavaara, 2002b, pp. 287–288; Malkavaara, 2007a, p. 116; Malkavaara, 2015, p. 172, p. 175).

The Luther studies school of thought emphasized the ecclesiological and Christological basis of diaconal work: in faith, a person turns towards God; in love — towards his or her neighbours. Love and diaconal work do not just follow faith; they are part of it. The motives of love, mutual caring and grace were reinforced in theology and the church's public statements throughout the twentieth century, but this provided a markedly Lutheran justification (Malkavaara, 2002b, pp. 286–287; Malkavaara, 2015, p. 168).

Three-strand office and the diaconate discussion

The 1983 BEM (Baptism, Eucharist and Ministry) document of the World Council of Churches changed the conversation about the office of bishop, priest and deacon into different strands of one and the same church office. In public debate, the office of deacon in the Finnish Evangelical Lutheran Church was not considered as originating in the early diaconate but in German internal mission work. Many thought that the lack of clarity could be resolved by placing the office of deacon as part of the tripartite division and defining it both caritatively and liturgically. However, the general synod was cautious about the proposal. Others saw in the three-strand office a threat to both the priesthood and traditional diaconal work (Malkavaara, 2015, pp. 152–157).

The general synod began discussing initiatives regarding the station and appreciation of diaconal workers and youth work leaders after the 1986 decision on women priests. Now, proposals were connected with the wider question of the office of the church. The general preparatory committee of the general synod proposed making diaconal officeholders and youth work leaders part of a reformed diaconate, as well as part of the office of the church. The initiatives were sent to the bishops' conference for consideration. A year later, the Seurakunta 2000 ("Parish 2000") working group established by the bishops' conference proposed progress on the matter (Malkavaara, 2015, pp. 157–158).

A sustainable theological basis was sought for the three-strand office. Upon investigation, it was found that the Church Act and the church handbook considered the diaconal office one part of the office of the church, but in the parishes it was thought of as a lay office. Deacons, deaconesses, parish coordinators for youth work and parish coordinators for early childhood and care cantors, readers and missionary secretaries were thought of as belonging to the diaconate (Ahonen, 1991, pp. 153–161; Malkavaara, 2015, pp. 158–159).

The Porvoo Declaration and the discussion about the office of deacon

When the Lutheran churches of Finland, Sweden and Iceland did not sign the Leuenberg Concord between Protestant churches, the Nordic Lutheran churches began to seek a closer connection with the Anglican churches. In the Porvoo Declaration, the churches recognized each other's faith and ordained office. The Declaration meant the mutual recognition of the offices of priest, bishop and deacon, as well as the acceptance of the other churches' baptized members as members of one's own. The churches undertook to strive towards a common view of the office of deacon (Malkavaara, 2015, pp. 163–167).

In November 1994 the general synod established a diaconal committee. Even though the discussion on the diaconate was many years old, the general synod's discussion of the matter was but the start of a long conversation which has yet to find a solution. The general synod did not approve the report published in 1997 by the committee it had nominated. Similarly, proposals to the general synod on the same matter failed in 2003, 2011 and 2015. The proposals are mutually similar, but they have been opposed with a variety of arguments (Malkavaara, 2015, pp. 182–220; Kirkolliskokous, 2015).

Describing the diaconate or the office of deacon at the same time as diakonia or diaconal work is essential, because the concept is the same. The proposed third ordained office of the church has in various proposals been called the diaconal office, the office of deacon, and the diaconate. One of the reasons for which the proposals have failed appears to stem from the varying use of the same concept.

The name of the new proposed ordained office would be the same as the lowest degree or ordination of the three-strand office in the Catholic, Orthodox and Anglican churches. In these churches it is often a transitional office before ordination to the priesthood. Since the end of the 1980s in the Finnish Lutheran church it has been thought that other people with broad education who perform key du-

ties in the parish, such as parish coordinators for youth work, could also be ordained to the office of diaconate (or the office of deacon) (Kirkkohallitus, 2015).

New Testament study shows that at the time of the early church diakonia meant a broad range of service tasks in the parish, not just aid or caring. This has caused confusion in the churches, as it has been seen as removing justification for how diaconal work has developed since the nineteenth century. Both research and church circles have largely accepted the new research findings. In Finland the expansion of the concept of diaconal work has been broadly discussed, primarily on the pages of the "Diakonian tutkimus" ("Diakonia research") journal.

A key reason for this conceptual analysis was the spread of Australian Bible scholar John N. Collins's research results internationally from the early 1990s on. Collins had systematically studied the parts of the New Testament related to diaconal work and shown that in the Bible diaconal work meant service alone, and that it was used in numerous meanings. In the New Testament it did not have a special meaning related to humble duty and care arising out of neighbourly love. Instead, such traits were only attributed to the word when the deaconess institutes were founded in the nineteenth century and after. The New Testament deacons were representatives, messengers and parish leaders in a broad range of areas (Collins, 1990; Latvus, 2017, pp. 17–22; Ryökäs, 2019, pp. 12–21).

The doctrinal committee of the general synod ruled in September 2015 that the new ordained office to be founded so as to induct "only employees currently part of the diaconal office" (deacons and deaconesses) in the initial stage. Thus limited, the reform would use established concepts. The committee held that the instability of the discussion thitherto had led to disagreements about how diaconal work, as a task belonging to the essence of the church, was understood. The committee believed that sufficient unanimity had been reached regarding the theology of office and its required arrangements. The diaconate reform could not be left to lapse, but the committee believed that the proposal to the general synod in 2015, aimed at a broader-based interpretation of diaconal work, would weaken the caritative position of diaconal work in the church (Kirkkohallitus, 2015; Kirkolliskokous, 2015).

The legal committee compiled the relevant report on the matter. The general synod returned the matter to the church council for fresh preparation in accordance with the committee's proposal. In a recommendation issued in May 2016, the bishops' conference strove to repair the weak points regarding the diaconal office, invitation to it, ordination, and ordination preparation, and aimed to har-

monize the dioceses' various practices (Kirkolliskokous, 2015; Piispainkokous, 2016 5. §).

In autumn 2019, the church council proposed the cessation of deliberations on the matter, as the reform could not be implemented in the then prevailing premises. The backdrop to the preparation was a report by doctor of theology Minna Hietamäki (Hietamäki, 2019).

By placing the offices of education and their equivalents in the background, the church itself took steps backwards, in contrast with earlier development. The general synod and bishops' conference wanted to limit the concept of diaconal work to the socio-caritative dimension and rejected a broader interpretation of its meaning. The cost of this was the rejection of parish offices of education and music work as lay duties outside ordained office.

In the debate on diaconal work conceptual analysis has had a backward effect. Efforts were made to establish what diaconal work meant in the early Christian church. This view then became a new background theory of ordained office which many felt the church needed. However, the problem was that others wished to retain what was familiar in the Finnish context, which means a narrower interpretation of the meaning of diaconal work.

The modern diaconal movement, which began in the mid-nineteenth century, narrowed diaconal work and its attendant field to socio-caritative duties to complement public social and healthcare services. This thinking became established in the second half of the twentieth century. In contrast, an internal mission movement broader than diaconal work grew alongside the latter, and it was in the context of that movement that many later forms of parish work developed. As a concept, however, internal mission work disappeared by the end of the twentieth century.

The diaconal office is a spiritual ordained office and as such a theological concept. It is an abstraction and an ideal, one which efforts have been made to develop over the decades, but which has not received sufficient support in the Finnish Lutheran church. If instituted, the office would give the church the freedom to invite, authorize and commit suitable employees in various duties needed at different times. Minna Hietamäki wrote in her report that alongside the offices of priest and bishop a recognized third office does not appear to have a particularly established field of duties. "On the contrary: the diaconal office presents as the most contextually and missionary appropriate of all the church's offices" (Hietamäki, 2019).

Narrow and broad diaconal work

The Diaconia University of Applied Sciences (Diak; began operations 1996) made Diaconia the first word of its name. Courses educating future deaconesses, deacons and parish coordinators for youth work were the core educational tasks of the national, networked church university of applied sciences. Diak was established as a university of applied sciences in 2000. Diaconal work was also on the rise elsewhere in Europe. After a hiatus of two decades research centres or faculty chairs in diaconal work were founded in Linz (1995), Oslo (1995), Utrecht (1997) and Uppsala (1999), at least.

In a few years, Diak became the site of all Finnish-language education in diaconal work and almost all education of parish coordinators of youth work. The degrees issued by Diak are specifically designed to be double degrees. Graduate deaconesses also complete a nursing degree as before, and deacons complete a bachelor's degree in social services. About 30 per cent of all Diak degree graduates have completed the dual church degree (Ryökäs, 2000, pp. 8–11; Launonen, 2004, pp. 230–232; Malkavaara and Gothóni, 2016, p. 20, pp. 23–27; Malkavaara, 2018, pp. 233–234). The stages and developmental vectors of deaconess education are described in more detail in the present work in Helena Kotisalo's article.

Diak has nurtured both the broad and narrow concepts of diaconal work. The former concerns all parish service tasks thought to be part of the diaconate, while the latter concerns everything which was historically called socio-caritative diaconal work. In its degree programmes Diak has used the social work concept of diaconal care work formed in the last decade, and the resulting concept of diaconal social work derived from it. Of these, the former is applied in deaconess education and working duties and the latter in those of deacons. The roots of the holistic and dignified encounter needed in these are in Christian faith and outlook on people. Thus, deaconesses and deacons operating in the public sector and in associations perform a church service duty (Gothóni & Jantunen, 2011, pp. 107–119; Malkavaara, 2018, p. 235).

Diaconal work may also be defined as seven circles, at the centre of which is the church's diaconate. The second circle is the view of diaconal work as the church's social work. The outer circles are the church's social and political responsibility, the church's work for the good of the entire person, and all Christians' or even all people's social and political responsibility, until the final circle is all constructive and good acts in the world.

A broad understanding of diaconal work may be defended as originating in the New Testament. This has been sensible for those focusing on the social and healthcare sectors, as well as for Diak, which has built its brand on ethical working methods and which educates professionals for the church's early childhood education and youth work tasks. The meaning of diaconal work has sometimes changed to include doing good, even in accordance with its most open definition. At the same time, the question of whether the core has been blurred has had to be asked (Malkavaara, 2018, p. 236).

Changes in the 2010s

A new recession began in 2008 and continued until at least 2016. Society became used to slow or negative economic growth, high unemployment, increasing numbers of poor people and the growth of social differences. The number of rich people increased.

However, diaconal work did not operate in the same way as in the 1990s, nor did it display quite the same signs of providing security of last resort for those who had fallen through the safety nets, or of defending the very poorest. All of this was done, but without the same enthusiasm and publicity as during and after the recession of the 1990s (Hiilamo, 2016).

Decreased resources can explain only a small part of the fall in diaconal work statistics. Diaconal work did not react to the financial crisis which began in 2008 in a way which responded to increased poverty, proof of which was a greater need for long-term social assistance payments. The clients of diaconal work do not have subjective rights to the services; the parishes may decide themselves what kind of help diaconal work can provide. Much thought has therefore been devoted in recent years to why changes have occurred in diaconal work, and whether it is in general applied in the Finland of the 2010s to those in greatest distress who are not helped in other ways (Hiilamo, 2016, pp. 298–299).

Diaconal work has gained new traits since the 1990s. As social deprivation has become more manifold, diaconal work has had to recognize its helplessness in the face of accumulating and often hereditary disadvantage. It would appear that the flexible and diverse nature of diaconal work means it can only partly fulfil its defined service promise of aiding those in the greatest distress. At the same time, it encounters many people in great distress.

Regular diaconal barometer surveys have shown that diaconal work is done more professionally than before, but that the work is also splintering into ever narrower niches. Specialized caritative-social diaconal work and catechetical-liturgical diaconal work may easily find themselves in a position of mutual competition. Whereas for some the ideal is a diaconal parish in which the entire parish community lives with the weakest and defends them, the reality in many parishes is almost the opposite: the resources of diaconal work are desired for other activities (Kiiski, 2013; Gävert, 2016; Isomäki, Lehmusmies, Salojärvi & Wallenius, 2018).

When diaconal work is ever more diverse and nuanced, diaconal workers often have great liberty to decide the focus of their work themselves. Some approach their work pastorally, while others tackle bureaucracy on their clients' behalf. In many parishes diaconal work is done by broad volunteer networks. The large influx of migrants in 2015 changed the concept of diaconal work in many parishes, whereas others continued as they previously had, with non-diaconal workers bearing responsibility for asylum seekers (Isomäki, Lehmusmies, Salojärvi & Wallenius, 2018).

A new feature of diaconal work in the 2010s was that the number of deacons serving in parish diaconal functions exceeded the number of deaconesses in 2012. In 2018 the diaconal workers serving in parish offices consisted of approximately 40 per cent deaconesses and 60 per cent deacons (Diakoniatyöntekijöiden liitto 2011, 2012, 2018).

Some of the newest findings of a diversifying diaconal work have been communal ways of working. Among these, conviviality — living together — has become the ideal. Low-threshold spaces, encounter coffee shops, fixed-price shops, and cheap or free meals bring people together as equals. Instead of definition as an object, the newcomer is offered responsibility and peer support. There are no ready-made answers; instead, people stop for a moment together to ponder life. The step from the rather mechanical 1990s thinking of medicating poverty with material aid is large.

The rise of the communality and conviviality ethos has also consisted of quiet bridgebuilding and the search for reconciliation between people as strong differences of opinion escalate in society. It is probable that the emphasis on community will gradually change diaconal workers' assisting and caring role more in the direction of enabling presence and community life.

Sources and literature

Ahola, M. (1996). *Ihanteena yhteys. Aarne Siirala, Seurakuntaopiston kiistelty johtaja*. Kirjaneliö.

Ahonen, R. (1991). *Diakonaatin uudistus. Diakonian viran kehittäminen Suomen evankelis-luterilaisessa kirkossa ja muissa luterilaisissa kirkoissa*. Kirkon tutkimuskeskus.

Collins, J. (2000). *Diakonia – Re-interpreting the Ancient Sources*. Oxford University Press.

Diakoniatyöntekijöiden liiton vuosikertomus (2011). Diakoniatyöntekijöiden liitto.

Diakoniatyöntekijöiden liiton vuosikertomus (2012). Diakoniatyöntekijöiden liitto.

Diakoniatyöntekijöiden liiton vuosikertomus (2018). Diakoniatyöntekijöiden liitto.

Gothóni, R., & Jantunen, E. (2011). Diakoniatyön käsitteitä. *Diakonian tutkimus*, (2), 105–120. https://journal.fi/dt/issue/view/7863/1296

Grönlund, H., & Hiilamo, H. (2006). Diakonian resurssit ja alueellinen tarve. Panostetaanko diakoniaan kunnan huono-osaisuuden mukaan? In E. Juntunen, H. Grönlund, & H. Hiilamo, *Viimeisellä luukulla. Tutkimus viimesijaisen sosiaaliturvan aukoista ja diakoniatyön kohdentumisesta* (pp. 9–28). Kirkkohallitus.

Grönlund, H., & Juntunen, E. (2006). Diakonia hyvinvointijärjestelmän aukkojen tunnistajana ja paikkaajana. In E. Juntunen, H. Grönlund, & H. Hiilamo, *Viimeisellä luukulla. Tutkimus viimesijaisen sosiaaliturvan aukoista ja diakoniatyön kohdentumisesta* (pp. 177–185). Kirkkohallitus.

Gävert, T. (2016). *Diakoniabarometri 2016*. Kirkon tutkimuskeskus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/1519

Heikkilä, M., & Karjalainen, J. (2000). Vuotoja hyvinvointivaltion turvaverkoissa. In M. Heikkilä, J. Karjalainen, & M. Malkavaara (Eds.), *Kirkonkirjat köyhyydestä* (pp. 212–266). Kirkkopalvelut.

Helne, T., & Laatu, M. (2006). Johdanto: "Hyvinvointipolitiikka" ja sen vääryydet. In T. Helne, & M. Laatu (Eds.), *Vääryyskirja* (pp. 9–40). Kelan tutkimusosasto.

Hietamäki, M. (2019). *Selvitys diakonian viran uudistusprosessin tilasta 2019*. [Raportti kirkkohallitukselle]. Retrieved January 15, 2020, from https://evl.fi/documents/1327140/38205823/Selvitys+diakonian+viran+uudistusprosessin+tilasta+2019.pdf/f933a79c-1515-0be5-da32-51ab709081b3?t=1572266367000.

Hiilamo, H. (2010). Laman uhrien auttaminen diakoniatyössä 1990-luvulla. *Diakonian tutkimus*, (1), 7–26. https://journal.fi/dt/issue/view/7863/1293

Hiilamo, H. (2016). Miten kirkon diakoniatyö reagoi 2000-luvun talouskriisiin? *Yhteiskuntapolitiikka, 81*(3), 288-300. https://urn.fi/URN:NBN:fi-fe2016102525579

Huhta, I. (2005). Sisälähetyksen synty. In I. Huhta, & M. Malkavaara, Suomen Kirkon Sisälähetysseuran historia. Vuodet 1940–2004 (pp. 13–37). Kirkkopalvelut.

Isomäki, P., Lehmusmies, J., Salojärvi, P., & Wallenius, V. (2018). *Diakoniabarometri 2018. Yksinäisyyden monet kasvot*. Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Jalovaara, V., & Martikainen, T. (2010). Suomi maallistumisen jälkeen. Valtiokirkollisuudesta uskontojen markkinoihin. In T. Martikainen, & V. Jalovaara (Eds.), *Uskonnon ylösnousemus. Kirkon, uskonnon ja kulttuurin murros* (pp. 27–39). Magma.

Juntunen, E., & Saarela T. (2009). Seurakuntadiakonian perustehtävä ja diakonian kysymykset. In K. Kinnunen (Ed.), *Sairas köyhyys, tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä* (pp. 36–50). Kirkkohallitus.

Kaartinen, J. (2017). *Selviämistarinoita. Snellu 50 vuotta. Juhlakirja*. Helsingin seurakuntayhtymän erityisnuorisotyö.

Kansanaho, E. (1964). *Suomen Kirkon Sisälähetysseuran historia. Sortavalan aika 1905–1944*. Suomen Kirkon Sisälähetysseura.

Kansanaho E. (1967) *Sata vuotta kristillistä palvelutyötä. Helsingin Diakonissalaitos 1867–1967*. Wsoy.

Katekismus. (1948). *Suomen evankelis-luterilaisen kirkon katekismus*: hyväksytty Suomen kuudennessatoista varsinaisessa kirkolliskokouksessa vuonna 1948. Suomen Kirkon Sisälähetysseura.

Kettunen, P. (2001). *Leipää vai läsnäoloa? Asiakkaan tarve ja diakoniatyöntekijän työnäky laman puristuksessa*. Kirkon tutkimuskeskus.

Kiiski, J. (2013). *Diakoniatyöntekijä – rinnallakulkija ja kaatopaikka. Diakoniabarometri 2013*. Kirkon tutkimuskeskus.

Kirkkohallitus. (2015). Kirkkohallituksen esitys 1/2015. Uutta diakonivirkaa koskevien säännösten lisääminen kirkkolakiin ja kirkkojärjestykseen. [Asianro 2015-00012].

Kirkolliskokous. (5.11.2015). Kirkolliskokouksen pöytäkirja 5. marraskuuta 2015. – Perustevaliokunnan lausunto 2/2015 lakivaliokunnalle kirkkohallituksen esityksestä 1/2015; Lakivaliokunnan mietintö 5/2015 kirkkohallituksen esityksestä 1/2015.

Koskenvesa, E. (1980). Kirkon diakoniatoimikunnan asettaminen. In J. Pihkala (Ed.), *Spiritus et institutio ecclesiae. Libellus in honorem Erkki Kansanaho* (pp. 48–77). Suomen Kirkkohistoriallinen Seura.

Koskenvesa, E. (2002). Diakonia kirkon elämässä ja toiminnassa. In R. Helosvuori, E. Koskenvesa, P. Niemelä, & J. Veikkola (Eds.), *Diakonian käsikirja* (pp. 35–58). Kirjapaja.

Latvus, K. (2017). *Diaconia as Care for the Poor? Critical Perspectives on the Development of Caritative Diaconia*. Kirkon tutkimuskeskus.

Launonen, P. (2004). *Nuorisonohjaajasta nuorisotyönohjaajaksi. Suomen evankelis-luterilaisen kirkon nuorisotyönohjaajien koulutus ja ammattitaidon muuttuvat tulkinnat 1949–1996* [Doctoral Dissertation, Helsingin yliopisto]. Diakonia-ammattikorkeakoulu.

Malkavaara, M. (1997). Suomen luterilainen kirkko ulkomaisen avun vastaanottajana (1945–1952). In Y. Höysniemi (Ed.*), Kansainvälisen vastuun oppivuodet. Kirkon ulkomaanavun kehityslinjoja* (pp. 6–20). Kirkon Ulkomaanapu.

Malkavaara, M. (2001). Från biståndsmottagare till biståndsgivare. Finlands kyrka och den internationella biståndsverksamheten. In J. H. Schjørring (Ed.), *Nordiske folkekirker i opbrud. National identitet og international nyorientering efter 1945* (pp. 145–159). Aarhus Universitetsforlag.

Malkavaara, M. (2002a). Sodasta laman kynnykselle. Köyhyys ja diakonia hyvinvointivaltiota rakennettaessa. In V. Mäkinen (Ed.), *Lasaruksesta leipäjonoihin. Köyhyys kirkon kysymyksenä* (pp. 221–260). Atena.

Malkavaara, M. (2002b). Nälkä ja köyhyys kirkon asiaksi. Näkökulmia laman ja markkinakilpailun aikaan. In V. Mäkinen (Ed.), *Lasaruksesta leipäjonoihin. Köyhyys kirkon kysymyksenä* (pp. 283–312). Atena.

Malkavaara, M. (2004). Diakonikoulutus Järvenpäässä 50 vuotta. *Diakonian tutkimus*, (1), 37–44. https://journal.fi/dt/issue/view/7863/1314

Malkavaara, M. (2007a). Suomalaisen diakoniatyön taustat ja nykytilanne. In K. Latvus, & A. Elenius (Eds.), *Auttamisen teologia* (pp. 83–121). Kirjapaja.

Malkavaara, M. (2007b). Diakonian muutos alkoi jo ennen lamaa. *Diakonian tutkimus*, (1), 26–49. https://journal.fi/dt/issue/view/7863/1314

Malkavaara, M. (2008). Lähetystyötä, kehitysyhteistyötä vai kansainvälistä diakoniaa. *Diakonian tutkimus* 1/2008, 5–34. https://journal.fi/dt/issue/view/7863/1291

Malkavaara, M. (2013). *Nuori Tampere. Seurakuntien nuorisotyö Tampereella 1930–2010*. Tampereen ev.lut. seurakuntayhtymä.

Malkavaara, M. (2015). *Diakonia ja diakonivirka*. Kirkkohallitus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/1545

Malkavaara, M. (2018). Diakonia, diakoniatyö ja diakonian koulutus Suomessa. In M. Malkavaara (Ed.), *Pohdintaa oikeasta, väärästä ja diakoniasta. Kai Henttosen juhlakirja*. (Diak Puheenvuoro 16). Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-318-6

Malkavaara, M., & Gothóni, R. (2016). Diakin synty ja kehitys yksityiseksi kirkolliseksi ammattikorkeakouluksi. In R. Gothóni, Mikko Malkavaara, & Minna Valtonen (Eds.). *Muutosvoimaa – tutkielmia Diakista ja teologiasta* (pp. 19–52). (Diak Puheenvuoro 3). Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-273-8

Malkavaara, M., & Ryökäs, E. (2015). Diakonia-apu oikeutena. Suomalaisen ajattelutavan kehittyminen. *Diakonian tutkimus*, (2), 107–127. https://journal.fi/dt/issue/view/7863/1306

Murtorinne, E. (1995). *Suomen kirkon historia 4. Sortovuosista nykypäiviin 1900–1990*. Wsoy.

Mustakallio, H. (2001). *Palvelun poluilla Pohjois-Suomessa. Oulun Diakonissakoti 1896–1916*. Oulun Diakonissalaitoksen Säätiö.

Mustakallio, H. (2002). Köyhät, sairaat ja kirkko. Suomalaista diakoniaa 1800-luvulta 1940-luvulle. In V. Mäkinen (Ed.), *Lasaruksesta leipäjonoihin. Köyhyys kirkon kysymyksenä* (pp. 197–220). Jyväskylä: Atena.

Mustakallio, H. (2009). *Pohjoinen hiippakunta. Kuopion–Oulun hiippakunnan historia 1850–1939*. Kirjapaja.

Määttä, T. (2004). *"Sinne, missä hätä on suurin." Lakisääteinen diakoniatyö Kalajoen rovastikunnassa 1944–1982.* Suomen Kirkkohistoriallinen Seura.

Paaskoski, J. (2017). *Ihmisen arvo. Helsingin Diakonissalaitos 150 vuotta.* Helsingin Diakonissalaitos.

Penttinen, L. (2018). *Vaivaishoidosta yhdistysmuotoiseen seurakuntadiakoniaan. Diakoniatyö Kuopion kaupunki- ja maaseurakunnassa sekä siitä eronneissa seurakunnissa 1850–1944*. Itä-Suomen yliopisto.

Piispainkokous. (24.5.2016). *Pöytäkirja.* Retrieved May 15, 2021, from http://domus.evl.fi/ktwebscr/pk_asil_tweb.htm?bid=2112

Pirinen, K. (1977). Kirkon oikeudellisen aseman ja järjestysmuodon kehitys. In M. Heikkilä, & E. Murtorinne (Eds.), *Kirkko suomalaisessa yhteiskunnassa 1900-luvulla* (pp. 107–122). Kirjapaja.

Pyykkö, R. (2004). Valtion ja kirkon välissä: ammatillisen seurakuntadiakonian muotoutuminen. In L. Henriksson, & S. Wrede (Eds.), *Hyvinvointityön ammatit* (pp. 110–143). Gaudeamus.

Rinne, H. (2006). *Ihanteena vapaaehtoisuus. Diakoniatyö Porvoon hiippakunnan seurakunnissa, erityisesti Iitin ja Tampereen rovastikunnissa vuosina 1897–1923.* Suomen Kirkkohistoriallinen Seura.

Ripatti, J. (2014). Diakonian neljäs käänne? *Diakonian tutkimus*, (2), 55–57. https://journal.fi/dt/issue/view/7863/1303

Ryökäs, E. (2000). *Oppiiko diakonian? Vuosina 1986 ja 1987 hyväksyttyjen diakonian koulutusohjelmien onnistuneisuus*. Kirkon tutkimuskeskus.

Ryökäs, E. (2019). *Aikaan sidottu diakonia-käsite. Tiedekriittinen yritys ymmärtää suomalaista diakoniakeskustelua*. Suomalainen Teologinen Kirjallisuusseura.

Rättyä, L. (2009) *Diakoniatyö yksilöllisenä ja yhteisöllisenä auttamisena yhteiskunnallisessa muutoksessa* [Doctoral Dissertation, Kuopion yliopisto]. Kuopion yliopisto. http://urn.fi/URN:ISBN:978-951-27-1309-7

Salmesvuori, P. (2008). *Sisarliitosta Diakoniatyöntekijöiden Liitoksi – 50 vuotta liiton historiaa. – Rakkauden virassa, diakonian ammattilaisten viisi vuosikymmentä* (pp. 11–78). Minerva.

Wirilander, M. (2011). *Hiippakunta diakoniatyön tekijänä ja tukijana. Diakoniatyön kehitys Mikkelin hiippakunnassa 1945–1991* [Doctoral Dissertation, Helsingin yliopisto]. [Matti Wirilander]

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2 EDUCATION OF DEACONESSES IN THE 2020S

The education of deaconesses in Finland is more than 150 years old. In the early years they were educated in deaconess institutes and from the 1970s in diaconal colleges. Nowadays the qualification of deaconess is earned by completing the Bachelor's Degree Programme in Healthcare, Diaconal Nursing at Diak, the Diaconia University of Applied Sciences. This degree programme, worth 240 credits, grants the eligibility to work both as a nurse and a diaconal worker in the church. Both the requirements for nursing degrees and the eligibility conditions for holders of the church's diaconal offices determine the content and goals of the degree. Students gain expertise in both nursing and diaconal work in parallel.

Deaconesses have dual qualifications

Deaconess education has responded to the changing needs of both society and the church's diaconal work for more than 150 years. From the early days, providers of deaconess education, vocational education supervisory authorities, and the Evangelical Lutheran Church of Finland have ensured that deaconesses earn a dual qualification on graduation. A deaconess is qualified to work both as a nurse in healthcare and as a diaconal worker in a parish.

The nurse-deaconess dual qualification has opened opportunities for moving between employment, such as from healthcare and social care to diaconal work, or in the other direction. The dual qualification is the source of the expertise of diaconal work and diaconal nursing, which brings added value to the nurse-deaconesses. Social actors and employers value broad competence, meaning these dual qualifications offer good employment opportunities outside the church.

In the present article we provide a brief description of the development of deaconess education, from sister education to a university of applied sciences. We also review deaconess education and the expertise it produces from the perspective of competence requirements and eligibility conditions governing education.

Negotiations were held with representatives of both the Ministry of Education and Culture and the church council in 2019–20 to review the content of deaconess education. The talks led to an increase in the amount of clinical practice and a reduction in Christian education from 90 credits to 60. This article focuses on the latest curriculum, from 2021, which reflects these most recent changes.

From deaconess institutes to a university of applied sciences

Education of deaconesses in Finland began in the 1860s, when clergy and laypeople interested in diaconal work visited the Kaiserswerth, Stockholm and St Petersburg deaconess institutes. This led to the foundation of the Helsinki Deaconess Institute in 1867 and the start of Finnish nursing education. A couple of years later the Vyborg Deaconess Institute, which was influenced by the Dresden institute, was founded. The Helsinki and Vyborg Deaconess Institutes followed the template of the sister homes, with a focus on caring for the sick and operating as an institution. Student sisters were required to undergo 1–4 years of deaconess education before ordination as deaconesses. The deaconesses' tasks were to care for the sick in hospitals and homes, for the poor and for vulnerable children (Henriksson, 1998, p. 95; Pyykkö, 2011, p. 115).

Two more deaconess institutes were founded in the 1890s, first in Sortavala and then in Oulu. Their sister education was parish-centric, following a model taken from the Oslo Deaconess Institute. The sisters' vocation was the service of love, and their task was relieving patients' distress and organizing Christian poor relief (Mustakallio, 2001, pp. 64–65; Huhta & Malkavaara, 2005, p. 24, 30).

Deaconess education in these four institutes diverged in the 1890s, placing a stress either on nursing or parish upkeep work. The name of the qualification became established as "deaconess" in the 1910s, regardless of the issuing institution. The first act on nursing education (L 340/1929) raised the level of education. The deaconess institutes adjusted their sister education to meet the new nursing education. A deaconess working in a parish was called a parish sister or a parish deaconess. The parishes received state assistance in hiring deaconesses, thus making the deaconesses part of the public health system (Henriksson, 1998, pp. 95–97, p. 181; Pyykkö, 2011, p. 121).

Under the 1944 Church Act, each parish was obliged to have one diaconal office. The reform increased the numbers of deaconesses employed by the parishes

and loosened the deaconesses' ties with particular institutions. After the Second World War, in the 1940s, the Sortavala Deaconess Institute moved to Pieksämäki and the Vyborg one to Lahti. Furthermore, the Pori Deaconess Institute was established to serve the needs of western Finnish parishes. From 1957 deaconess education led, in addition to a nursing degree, to a separate degree in the office of diaconal work, which was equivalent to specialized nursing education (Möttönen, 1994, p. 14; Malkavaara, 2007, p. 106; Pyykkö, 2011, p. 123).

In the early 1970s, the Federation of Diaconal Institutions (Diakonialaitosten liitto) recommended using the term diaconal college ("diakoniaopisto") and admitting men to deaconess education. Deaconess education was included in the 1980s reform of secondary education. This ensured a firm theoretical foundation and continued dual qualifications for deaconesses. The deaconess education curriculum (Piispainkokous, 1986) included, in addition to nurse and public healthcare nurse, education for parish work (Möttönen, 1994, p. 18).

The reform of vocational education in the 1990s led to the establishment of the Diaconia University of Applied Sciences (Diak). Diaconal education gradually moved from diaconal colleges to Diak between 1996 and 2000. The task of Diak was to educate specialists with broad competence (Government Decree 256/1995). Students in the Diak Bachelor's Degree Programme in Healthcare were offered electives to qualify them for diaconal office (Piispainkokous, 1996; Henttonen, 2002, p. 375; Huhta & Malkavaara, 2005, pp. 320–322).

The demands of the twenty-first century create challenges for deaconess education. EU directives concerning nurses have become more detailed, and national skill descriptions have been expanded. This led in 2003 to the lengthening of deaconess education and the creation of a distinct specialization in diaconal nursing. This reform created earmarked admission places for deaconess students (Ammattikorkeakoulusta terveydenhuoltoon, 2001; Opetusministeriö, 2003; Diak, 2004; Kotisalo & Rättyä, 2014).

Deaconess education in the university of applied sciences

A student can study to become a deaconess at Diak through the Bachelor's Degree Programme in Healthcare, Diaconal Nursing. The programme is worth 240 ECTS and takes approximately four years to complete. At present, nurse-deaconess education is governed by the following regulations: the Acts on Professional Healthcare Staff (L 559/1994 and L 1200/2007), the Decree on Professional

Healthcare Staff (A 564/1994), EU directives (Directive 2005/36/EC; Directive 2013/55/EU), the nationally agreed general nurse education competence requirements of general nurse education (Kajander-Unkuri et al., 2020), and the church's eligibility conditions for diaconal office (Kirkkohallitus, 2020c). In the programme, 180 of the credits are for studies leading to a general nurse qualification, and 60 are for Christian studies.

From the spring of 2021, students have also been able to earn eligibility for diaconal office by completing 60 credits' worth of supplementary church studies after completion of the Bachelor's Programme in Healthcare. The Diak Open University of Applied Sciences teaches these studies (Thitz & Valtonen, 2021).

Anyone who meets the application criteria may apply for deaconess education. Even though the degree grants eligibility to serve in an office of the Evangelical Lutheran Church of Finland, the applicant is not required to be an adherent of the church. If the successful graduate nurse-deaconess wishes to apply for the diaconal work of the Evangelical Lutheran Church, he or she is required to be an adherent of the church, to be called by a parish and be ordained by a bishop to the office.

The deaconess education curriculum is designed to build up the deaconess's expertise as a dialogue between the nursing and ecclesiastical, that is diaconal, skills taught throughout the degree. The nurse and deaconess identity develop alongside each other in the programme from the first semester.

When the deaconess education curriculum was compiled, one of the key aims was to create opportunities for multisectoral cooperation during studies and to develop students' capabilities for client-centric work at the interface of social work, healthcare and the church, as well as in various environments. A holistic view of people and client-centricity are the starting premise when studying diaconal nursing and church-related topics.

The curriculum's aims predicted future needs which would demand cooperation. These are related to things such as changes in the public service system, consideration for diverse and multicultural clients, promotion of non-discrimination and digitalization. Competence in ethics, values and dialogue is developed throughout studies in both healthcare and church studies. In accordance with the Diak strategy, another aim is considering and supporting the most vulnerable in society.

The broad competence and diaconal nursing expertise generated by the degree are needed both in social care and healthcare and the church's diaconal work. This accounts for the good employment situation of graduate nurse-deaconesses. In a survey of 2019 graduates, of 31 nurse-deaconess respondents 27 were employed,

one was unemployed, and three were otherwise occupied, such as with new studies or on parental leave. Four had been employed by the church.

Social care and healthcare employers particularly appreciated nurse-deaconesses' interactive skills, awareness of beliefs, and palliative care skills (Kirkkohallitus, 2019). It appears that most graduates first find employment in healthcare and only move on to the church sector later.

Core nursing competence requirements part of deaconess education

The EU directive regulating nurse education, 2005/36/EC, was reformed in 2013 (Directive 2005/36/EC). The amended directive (Directive 2013/55/EU) defined eight competence requirements for general nurses for the first time. All EU member states had to transpose the directive into national law to ensure nurses qualifying after 2016 would meet these competence requirements (Kajander-Unkuri, 2015).

In 2018, a key project funded by the Ministry of Education and Culture began, with the aim of generating common competence evaluation methods for nursing education in Finland to ensure even skill quality could be measured. At the start of the project, the competence requirements for general nurses for 2020–2030 were updated. This stage drew on a broad expert panel which evaluated the applicability of the generated competence requirements for nursing students who had completed the general nursing section of their degree, that is, 180 credits. The updated competence requirements were published in January 2019 and supplemented in October 2019 (Kajander-Unkuri et al., 2020).

There are 113 competence requirements, and they break down into 13 competence categories: 1) professionalism and ethics; 2) client-centred care; 3) communication and multi-professionalism; 4) health promotion; 5) the employee's leadership and profession cooperation skills; 6) information technology and documentation; 7) direction and education competence and support of self-care; 8) clinical nursing; 9) evidence-based practice, use of research knowledge and decision making; 10) entrepreneurship and development; 11) quality assurance; 12) the healthcare and social service system; and 13) patient and client safety (Kajander-Unkuri et al., 2020; Korhonen & Silén-Lipponen, 2020).

These competence requirements were considered when Diak updated its curriculum in 2020 and 2021 (OPS2020, OPS2021). Since January 2020, student deaconesses have studied under this curriculum. The updated curriculum increased the amount of clinical training (Diakonia-ammattikorkeakoulu, 2020).

Eligibility requirements for diaconal office and description of core competences of diaconal officeholders

According to a decision of the church council in 2020, studies granting eligibility for a diaconal officeholder in a bachelor's degree programme in healthcare, diaconal nursing must contain at least 20 credits of theological studies, 25 credits of diaconal vocational studies and 15 credits of diaconal training (Kirkkohallitus, n.d.). Under this new decision, the volume of church studies is 30 credits smaller than other degrees on offer in Diak in other areas such as the bachelor's programmes leading to qualifications in diaconal work, church youth work and early childhood education. In these, vocational studies count for 40 credits, and the thesis counts towards church studies.

In the newest curriculum (2021), part of the course on palliative nursing and spiritual care counts towards church studies. Regarding theses, Diak has made an internal decision that nurse-deaconesses' theses must relate to diaconal nursing.

The content and provision of deaconesses' education is also affected by the church council's description of a diaconal officeholder's core competence (Kirkkohallitus, 2020a). The church's professional core skill descriptions fall into two parts. They describe the shared core competence of all spiritual work professionals in the church, as well as the specialized skills of each professional area. The shared core competence of the church's professions contains four areas, titled as follows: 1) Interaction skills; 2) Theological and value skills; 3) Operating environment and community skills; and 4) Working life and development skills (Kirkkohallitus, 2020b).

Interaction skills stress the worker's capability for presence and interest in other people. Interaction skills mean the worker can use dialogue, communication and direction skills in a variety of ways. Digital communication skills are emphasized separately in the core competence description (Kirkkohallitus, 2020b).

Theological and value skills mean the workers' knowledge of Christian and Lutheran theology, ability to interpret it, and willingness to commit to the church's values and acting in accordance with them. The premise for value skills is the ability to step into another person's shoes and recognize the diversity of life, as well as each person's value and uniqueness. Another core skill is the ability to consider people's various cultural backgrounds and encounter representatives of other faiths and views respectfully (Kirkkohallitus, 2020b).

Operating environment and community skills include themes such as sustainable development, advocacy activities and network skills. Work in the parishes is based on trust, partnership and cooperation with various organizations, communities and networks. The description of working life and development skills stresses understanding of the parishes' administrations and decision-making apparatus, conduct at times of change and process skills (Kirkkohallitus, 2020b).

A diaconal officeholder's expertise consists of encountering and supporting people, families and communities in different life situations. Crucial in the work is the holistic support and assistance of people in distress and vulnerability, the defence of inalienable human dignity, and advocacy to improve individuals' and communities' living conditions, health and welfare (Kirkkohallitus, 2020a).

The deaconess education curriculum considers both the aforementioned criteria, included in the eligibility conditions, as well as a diaconal officeholder's core competence.

The 60 credits of church studies are taught at Diak partly in conjunction with other Diak church studies, partly integrated with general nurse studies, and partly completely separated. The entirety of church studies is displayed in Table 1.

Table 1. Nurse-deaconess education church studies according to 2021 curriculum

Nurse-deaconess church studies 60 credits		
Vocational diaconal studies (total min. 25 credits)		
Course and core contents	Credit	Teaching channel
The Parish as an Operating Environment	5 credits	With other Diak church studies
Palliative and Spiritual Nursing	1 credit	The course is 5 credits in total. It is taught as part of general nursing studies.
Deaconess's Expertise in Nursing	4 credits	Specialized course in diaconal nursing.
Expertise in Diaconical Work Theology of Helping and Buidling a Diaconal Community 5 credits Metho	10 credits	Courses shared with the Diak Social Services, Diaconal Work programme students
Development of Parish Work	5 credits	Courses shared with other Diak church studies
Theological studies (total 20 credits)		
Theological Foundations of Diaconia and Christian Education I	5 credits	Courses shared with other Diak church studies
Theological Foundations of Diaconia and Christian Education II	5 credits	Courses shared with other Diak church studies
Multicultural Work and International Responsibility of the Church	5 credits	Courses shared with other Diak church studies
Modern Interpretations of Christianity	5 credits	Courses shared with other Diak church studies
Full-time placement in the diaconal work area (total 15 credits, of which 12 credits in a local parish of the Finnish Evangelical Lutheran Church)		
Familiarisation with Diaconal Work in a Parish	2 credits	Placement conducted in a local parish of the Finnish Evangelical Lutheran Church.
Expertice in Diaconal Nursing - work placement	3 credits	The placement is worth 15 credits. The placement is in a nursing environment. Of that, 3 credits are considered as a placement granting church eligibility.
Work Placement in Diaconal Work	10 credits	Placement conducted in a local parish of the Finnish Evangelical Lutheran Church. Of the credits for the placement, 6 are considered general nursing placement credits.

Theological studies and shared church vocational studies

All theological studies, as well as a large part of the church sector vocational studies in nurses-deaconess education, are conducted at Diak in a multidisciplinary church sector student group. If the multidisciplinary group represents all the church studies at Diak, it is attended, in addition to deaconesses, by deacons, coordinators for youth work and coordinators for early childhood education and care. This shared theological studies and vocational study content in the church sector stresses the shared themes of core skills descriptions for all church professionals.

Theological studies begin with Theological Foundations of Diaconia and Christian Education, taught in two courses. In the first course students learn about the birth of the books of the Bible, the history and theology of the early church, as well as the content of the New Testament. In addition, spirituality, the devotional life, and the relationship between faith and scientific knowledge are considered. In the best case, realizations are made about diaconal work and diaconal nursing, such as that the ethos of diaconal care work is derived from the early Christians' way of encountering and caring for the weakest in society (Diakonia-ammattikorkeakoulu, 2021, p. 19). The second course is about the creation and content of the Old Testament, the history and theology of the Reformation, and the theology and conduct of worship. Here too, the idea is to examine the roots of diaconal work and the church's educational work (Diakonia-ammattikorkeakoulu, 2021, p. 31).

The course on the Multicultural Work and International Responsibility of the Church, taught at the end of the programme, gives perspectives on the church's international diaconal work, mission and ecumenical cooperation, and provides readiness for faith theology and faith dialogue. The course also teaches modern church history and contextual Bible interpretation. The contents and teaching methods prepare students to encounter various beliefs and for constructive conversation (Diakonia-ammattikorkeakoulu, 2020, p. 38).

Modern Interpretations of Christianity course is generally one of the last in deaconesses' education. It provides a view of the Finnish church's recent history and an introduction to the current discussion about the church, as well as to changes to religiosity. This course also contains reflection on vocation and functioning as a church worker, providing the opportunity to form a view of the church's work and one's own identity as a deaconess, shaped over the entire degree programme (Diakonia-ammattikorkeakoulu, 2021, p. 41).

Theological studies contain theological and value skills themes which are part of the church's shared professional skills in the core competence description. It is therefore important for the church sector students to study them together. For students to have the opportunity to deepen their theological thinking on their own professional area further, church sector vocational studies also include theology. For student deaconesses, this is included in the Expertise in Diaconal Work and Deaconess's Expertise in Nursing courses, where students shape their own theology of assistance (Diakonia-ammattikorkeakoulu, 2021, p. 35, p. 38).

The shared church sector *vocational studies* begin in the first semester. In the Parish as an Operating Environment course, church sector students together form a holistic concept of the local parish and the skills needed in parish work. In practice, students often familiarize themselves with their local parish and observe various events, for example. The course provides a start for the development of pastoral care, confirmation camp skills, and a family-centric working method, as well as for skills to support accessibility and non-discrimination (Diakonia-ammattikorkeakoulu, 2021, p. 7).

Later, the shared vocational studies continue in the Development of Parish Work course, which deals with the parish organization and administration, and the laws and decisions which govern them. The course also considers management, workplace skills and parish communications (Diakonia-ammattikorkeakoulu, 2021, p. 40).

Theoretical studies supporting a deaconess's specialized competence

Part of the Palliative and Spiritual Nursing course, taught to all nursing students, counts towards church vocational studies. The course content considers the recommendations on basic education content and goals drawn up in the palliative care education development project, Edupal (EduPal-hanke, 2020). A nurse must be equipped to encounter a palliative care patient and his or her family members, encounter sorrow and death, as well as process existential and spiritual questions (Diakonia-ammattikorkeakoulu, 2021, p. 22). These themes are discussed in greater depth later in the theoretical studies and related placements of diaconal nursing and diaconal work.

A deaconess's competence and professional identity develop over the entire course of the degree, but the specialized competence of diaconal nursing and di-

aconal work expand and strengthen in the appropriate courses. The content of the Deaconess's Expertise in Nursing crystallizes the themes of previous studies, such as poverty, vulnerability and life situations requiring particular support, multidisciplinary cooperation, personal spirituality and vocation, health and welfare promotion, as well as professional advocacy, professional ethics and diaconal nursing assistance methods in a nursing operating environment (Diakonia-ammattikorkeakoulu, 2021, p. 35).

The Expertise in Diaconal Work course focuses on the content of the parish's diaconal work and is divided into two parts: the Theology of Helping and Building a Diaconal Community, and Methods and Social Advocacy in Diaconal Work. In addition to the previously described theological reflection, in this course students form an entire picture of the goals, organization and working methods of diaconal work in this course. Students gain a sense of diaconal education, confirmation camp work and bearing of diaconal responsibility in a parish. They are prepared to develop a sense of community, engagement and volunteer activities. Study of worship and the devotional life are also included in this course (Diakonia-ammattikorkeakoulu, 2021, p. 38).

In the study of diaconal work methods, crucial are client-centric, empowering and engaging methods. Students learn about counselling to promote individuals', families' and groups' operating capacity, health and welfare. Encountering sorrow and death, and pastoral care methods, are also part of the content of this course (Diakonia-ammattikorkeakoulu, 2021, p. 39).

Themes of social advocacy are discussed in this course from the diaconal perspective. Students analyse the role of diaconal work in the public-sector service system and the diaconal worker's role in multidisciplinary networks. Questions of the achievement of social justice and their maintenance in the public sphere, as well as advocacy, are crucial content in this course (Diakonia-ammattikorkeakoulu, 2021, p. 39).

Placements which deepen a deaconess's core competence

Student nurse-deaconesses participate in placements of the extent required by both the nursing degree (90 credits) and church eligibility (12 credits) during their studies. Some of the placements are integrated, with the student completing a placement in a parish, but also practising required nursing skills. The placement

is led by a nurse-deaconess who is a certified professional healthcare worker (Diakonia-ammattikorkeakoulu, 2021, pp. 39–40).

The student practises general nursing tasks in a diaconal worker's office, on house calls to clients, and in various group settings. The student learns to operate under the supervision of a nurse-deaconess, as well as in cooperation with the other diaconal workers as part of a multidisciplinary working group in the parish. For some of the placement the student actively operates in various healthcare and multidisciplinary cooperation networks with local social care and healthcare actors (such as mental health and substance abuse actors, homecare, palliative care, hospitals, nursing homes). On house calls the students meet people and families in particularly challenging situations. They learn how to evaluate the need for care, and how to direct a client to other health services. On house calls a student also learns how to evaluate and support drug treatment, support self-care and support commitment to treatment, and perform various clinical procedures such as measuring blood pressure (Diakonia-ammattikorkeakoulu, 2021, pp. 39–40).

The key client base of parish diaconal work includes people recovering from mental health conditions, substance addicts, older people suffering from health problems, decreased capacity or loneliness, the unemployed, or other socially vulnerably people. Many of these people have fallen through the cracks in the public sector's social care and healthcare services and seek assistance from a parish's diaconal workers. The diaconal work annual statistics show that the vast majority of client meetings are related to matters of health and illness. The parish is for many people a low-threshold source of help with health problems. The nurse-deaconesses and students supervised by them complement self-care and the services offered by the public sector. A nurse-deaconess learns to recognize health risks and promote health. As in the mental health and substance abuse placements, parish diaconal work also stresses the worker's interaction and counselling skills, the motivating interview, an empowering work approach, and various spiritual support methods (Diakonia-ammattikorkeakoulu, 2021, pp. 39–40).

The significance of multidisciplinary cooperation in the social care and healthcare services is constantly growing. Parish diaconal workers liaise with professionals of both the social care and healthcare sectors. Nurse-deaconesses bring a health sector perspective and competence to local cooperation. They can make holistic assessments of clients', families' and groups' situations, they recognize factors that promote and burden health, and if necessary, provide clinical help and direction to other services. Diaconal work placements prepare students to work as healthcare experts, in health centres, for example.

In their education, nurse-deaconesses receive in addition to strong clinical nursing skills an excellent capability to encounter patients and clients professionally, including in particularly challenging situations, such as when caring for the critically ill and the dying.

Questions about the future of deaconess education

From time to time there has been conversation about the necessity of deaconess education and deaconesses' employment. The tone of this discussion has doubted whether deaconesses' competence will be needed in future, as after graduation only a small proportion enter the church's diaconal work. However, this suspicion is groundless, as there is an ongoing need for diaconal nursing experts in the social care and healthcare services. They are especially needed in palliative nursing and end of life care, as well as their development, in mental health and substance abuse work, and in nursing memory loss patients. Deaconesses' expertise also consists of competence related to multiculturalism, diversity and beliefs, the needs for which is growing as Finland becomes more multicultural.

Nurse-deaconesses' competence related to human dignity, ethical competence and respectful holistic encounter are the kinds of professional competence which will be increasingly important, particularly as digitalization advances. Another task of diaconal work is to speak on behalf of people at risk of discrimination from the digitalization of services.

The perspective of promotion of health and welfare in the church's diaconal work also appears to be gaining importance. The diaconal annual statistics show that questions of health and illness have been the most common reasons for encounters for many years. (Gävert, 2016, pp. 25–26). Deaconesses' nursing expertise could also be used in more diverse ways, for example, in the local social care and healthcare cooperation projects in which parishes are involved. Lea Rättyä and Helena Kotisalo discuss health promotion in diaconal work in greater detail in their article.

However, in future the questions of how many and where deaconesses are educated need to be faced. It is important to be able to educate deaconesses where their competence is needed. Previously, by request of employers, teaching was conducted in Pieksämäki, Jyväskylä, Turku, Tampere and Lapua between 2004 and 2015, and in Ivalo between 2015 and 2018. These were conversion education for nurses, applicants to which were required to hold a college-level nursing degree. Diak, the dioceses and parishes cooperated to provide the courses. In Ivalo, teach-

ing leading to the entire deaconess degree was given. It was planned and delivered in cooperation with the Sámi Region Education Institute and supported by a project funded by the European Social Fund, entitled Nurse-Deaconess Education in the Sámi Region (Ervelius, Mertaniemi & Näkkäläjärvi, 2018, pp. 14–15).

The further studies path must also be made smoother to give graduate deaconesses the opportunity to apply directly to universities' master's degrees, in addition to higher third-level degrees at universities of applied sciences. The multidisciplinary nurse-deaconess education creates a good foundation for further studies, but much remains to be done in the identification and recognition of the skills the education provides.

Sources and literature

A 256/1995. Asetus ammattikorkeakouluopinnoista 8.3.1995/256. https://www.finlex.fi/fi/laki/alkup/1995/19950256

A 564/1994. Asetus terveydenhuollon ammattihenkilöistä 28.6.1994. https://www.finlex.fi/fi/laki/alkup/1994/19940564

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications (Text with EEA relevance) *Official Journal of European Union 30.9.2005*. http://data.europa.eu/eli/dir/2005/36/oj

Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation') Text with EEA relevance. *Official Journal of European Union* 28.12.2013. http://data.europa.eu/eli/dir/2013/55/oj

EduPal-hanke, asiantuntijatyöryhmä. (2020). *Palliatiivisen hoidon ja saattohoidon osaaminen sairaanhoitajan tutkinnossa: suositus palliatiivisen hoidon ja saattohoidon opetussuunnitelmasta*. (Kajaanin ammattikorkeakoulun julkaisusarja B 140, Raportteja ja selvityksiä). Kajaani: Kajaanin Ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-7219-56-0

Diakonia-ammattikorkeakoulu. (2020). Sairaanhoitaja (AMK) -diakonissa. Opetussuunnitelma 2020. https://www.diak.fi/wp-content/uploads/2020/06/Diak_OPS_2019_Sairaanhoitaja_diakoninen_hoitotyo_2020.pdf

Diakonia-ammattikorkeakoulu (2021). Sairaanhoitaja (AMK) -diakonissa. Opetussuunnitelma 2021. https://www.diak.fi/wp-content/uploads/2021/01/OPS_SairaanhoitajaDiakonissa_040121_WEB.pdf

Eriksson, E., Korhonen, T., Merasto, M., & Moisio, E.-L. (2015). *Sairaanhoitajan ammatillinen osaaminen – sairaanhoitajakoulutuksen tulevaisuus -hanke*. Ammattikorkeakoulujen terveysalan verkosto ja Suomen sairaanhoitajaliitto. https://www.epressi.com/media/userfiles/15014/1442254031/loppuraportti-sairaanhoitajan-ammatillinen-osaaminen.pdf

Ervelius, T., Mertaniemi, E., & Näkkäläjärvi, T.-M. (2018). Malli saamelaiskulttuurisensitiivisen hoito- ja diakoniatyön opetuksesta. In T. Ervelius (Eds.), *Sairaanhoitaja-diakonissakoulutus saamelaisalueella* (pp. 14–38). (Diak Puheenvuoro 14). Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-312-4

Gävert, T. (2016). *Diakoniabarometri 2016*. (Kirkon tutkimuskeskuksen verkkojulkaisuja 45). Kirkon tutkimuskeskus https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/1519

Kajander-Unkuri, S. (2015). *Nurse competence of graduating nursing students*. [Doctoral Dissertation, University of Turku]. http://www.urn.fi/URN:ISBN:978-951-29-6003-3

Kajander-Unkuri, S., Melender, H-L., Kanerva, A-M., Korhonen, T., Suikkanen, A., & Silén-Lipponen M. (2020). Sairaanhoitajien osaamisvaatimukset – suomalainen koulutus 2020-luvulle. In M. Silén-Lipponen, & A-M. Korhonen (Eds.), *Osaamisen ja arvioinnin yhtenäistäminen sairaanhoitajakoulutuksessa -yleSHarviointi-hanke* (pp. 22–30). (Savonia-ammattikorkeakoulun julkaisusarja 5/2020). Savonia-ammattikorkeakoulu. http://www.urn.fi/URN:NBN:fi-fe2020111089877

Kirkkohallitus (2010). *Diakonian viranhaltijan ydinosaaminen*.

Kirkkohallitus. (2019). *Ammatillisen koulutuksen raportti 2018*. https://evl.fi/documents/1327140/43730976/Ammatillisen+koulutuksen+raportti+2018.pdf/28532c17-9579-2ec5-15f3-d6b1bbba843d?t=1620634292671

Kirkkohallitus. (2020a). Diakonian viranhaltijan ydinosaamiskuvaus. Teoksessa Kirkon ammattien ydinosaamiskuvaukset (hyväksytty kirkkohallituksen täysistunnossa 21.4.2020). http://kirkonydinosaaminen.fi/diakonian-viranhaltija.html

Kirkkohallitus. (2020b). Yhteinen ydinosaaminen. Teoksessa Kirkon ammattien ydinosaamiskuvaukset (hyväksytty kirkkohallituksen täysistunnossa 21.4.2020). http://kirkonydinosaaminen.fi/yhteinen-ydinosaaminen.html

Kirkkohallitus. (n.d.). Kirkkohallituksen päätös diakonian viran haltijalta ja diakoniatyötä pääasiallisena työnään tekevältä viranhaltijalta vaadittavasta tutkinnosta 22.9.2020/ Nro 141. *Kirkon säädöskokoelma*. https://evl.fi/plus/paatoksenteko/lainsaadanto/kirkon-saadoskokoelma/saadoskokoelma-nro-63/nro-141

Korhonen, T., & Silén-Lipponen, M. (7.1.2020). Osaamisvaatimusten muutokset kommenttien perusteella. *Blogit Savonia.* https://blogi.savonia.fi/ylesharviointi/2020/01/07/osaamisvaatimusten-muutokset-kommenttien-perusteella/

L 340/1929. Laki sairaanhoitajattarien koulutuksesta. https://www.finlex.fi/fi/laki/smur/1929/19290340.

L 1994/559. Laki terveydenhuollon ammattihenkilöistä 28.6.1994/559. https://www.finlex.fi/fi/laki/ajantasa/1994/19940559

L 1200/2007. Laki terveydenhuollon ammattihenkilöistä annetun lain muuttamisesta. https://www.finlex.fi/fi/laki/alkup/2007/20071200

Malkavaara, M. (2007). Suomalaisen diakoniatyön taustat ja nykytilanne. In K. Latvus, & A. Elenius (Ed.). *Auttamisen teologia*. Kirjapaja.

Mustakallio, H. (2001). *Palvelun poluilla Pohjois-Suomessa. Oulun Diakonissakoti 1896–1916*. Oulun diakonissalaitoksen säätiö.

Möttönen, S. (1994). Diakoninen hoitotyö diakonissakoulutuksessa. [Master Theseis, University of Kuopio].

Piispainkokous. (1986). *Diakonissan koulutusammatin opetussuunnitelma*. Seurakuntatyön koulutus. Hyväksytty Piispainkokouksessa 23.9.1986.

Piispainkokous (1996). *Ammattikorkeakoulututkinnon hyväksymisperusteet*. Piispainkokouksen istunto 13.–14.2.1996.

Pyykkö, R. (2011). *Hengellisen ja maallisen rajalla. Kamppailu seurakuntien diakoniatyöntekijöiden sosiaalisesta ja kulttuurisesta toimialueesta*. [Doctoral Dissertation, University of Tampere]. (Acta Universitatis Tamperensis, 1670.) Tampere University Press. http://acta.uta.fi/pdf/978-951-44-8606-7.pdf

Ryökäs, E. (2000). *Oppiiko diakonian? Vuosina 1986 ja 1987 hyväksyttyjen diakonian koulutusohjelmien onnistuneisuus*. (Kirkon tutkimuskeskus. Sarja B). Kirkon tutkimuskeskus.

II
DEFINITION OF DIACONAL NURSING

Lea Rättyä

3 PRINCIPLES AND CONTENT OF DIACONAL NURSING

The concept of diaconal nursing is most commonly used in education, when describing the specialization opportunities and curriculum for nurse-deaconess education. The theoretical foundation of diaconal nursing is based on nursing science and theology, but it also draws on social sciences and pedagogy. Diaconal nursing is based on the Christian view of the person. It consists of neighbour-centric, holistic encountering and helping performed by specially educated nurse-deaconesses in congregational diaconal work or a range of healthcare and social service roles. There is no direct international equivalent of the Finnish "diakoninen hoitotyö" (diaconal nursing), but parish nursing and faith community nursing are quite close.

Concept of diaconal nursing

The concept of diaconal nursing arose in the 1980s when secondary education was reformed. The concept had been linked to deaconess education, the context in which it appears most frequently, from the start (Möttönen 1994). As a concept, diaconal nursing has been studied little, and most studies and theses have focused primarily on describing the content of diaconal nursing (Rättyä, 2009b). In her dissertation, Marjatta Myllylä (2004) defines the concept of diaconal nursing and builds a diaconal nursing model in her research. Diaconal nursing is grounded in nursing science and theology, but it also draws on other academic fields such as social sciences and pedagogy (Myllylä, 2004, p. 43, pp. 66–67).

The diaconal nursing model sees the nursing science and theological knowledge base as linked and complementary in the context of the cultural level of religion. In this study, religion includes levels of emotion, knowledge, action and culture. The views of people that are significant for diaconal nursing are also part of the latter, alongside individual belief. In the Christian view of people, the nurse and patient meet in a nursing situation as equal neighbours. In this encounter, in

addition to the two people, a force higher than people is also present. The model stresses the meaning of hope, the equality of those needing care and those providing it, as well as the significance of diaconal nursing as a social and Christian influence. Diaconal nursing is performed by specifically educated nurse-deaconesses in hospitals, care homes and congregations (Myllylä, 2004, pp. 68–70).

According to Eila Jantunen and Helena Kotisalo (2004, p. 68), the weakness of Myllylä's model is its excessive focus on the individual, its emphasis on religion alongside theology and nursing science, as well as its view in the first instance of the person in need of help as a passive recipient. Diaconal nursing includes both individual and community forms of work and assistance methods (Rättyä, 2009a; Ahola & Pulkkinen, 2011). Diaconal nursing is always linked to its time. It renews itself, changes and foretells social development (Vuoti, 2005; Rättyä, 2009a; Helosvuori, 2012; Lehmuspuu, 2012).

Diaconal nursing is a broader concept than *spiritual nursing* or *spiritual care*, as spirituality is only one area of diaconal nursing. The tools of spiritual care may be reflection, reading, song, music, hymns, silence, devotion, prayer, religious objects, symbols and blessing. A pastoral care conversation may be part of spiritual care, but at the same time so may being silent, non-verbal interaction, listening and presence (Louheranta, Lähteenvuo & Kangasniemi, 2016). Visits from religious members of the community, grief group activities and silent retreats may also be part of spiritual care (Flinck, 2012). In holistic spiritual care, a person's entire situation is considered respectfully, sensitively, approvingly, with listening and presence (Muurinen, 2015). It is a question of positioning oneself to serve another person, not pushing or demanding, but rather walking alongside (Flinck, 2012).

From the perspective of diaconal nursing, support is provided by a person with a nurse-deaconess education with the resulting competence to consider the patient's spiritual needs and provide help. In diaconal nursing and diaconal work, the terms spiritual support and pastoral care are also often used. The instruments of spiritual support may to a large degree be the same as in the description of spiritual care, but a nurse-deaconess working in a congregation, in particular, may lead devotions, assist with the eucharist and serve the congregation in other worship-related tasks. Spirituality and faith are often present in congregational work in various forms, and spiritual care is a valued part of professional competence (Rättyä, 2009a, 91; 2016, pp. 54–58; Gothóni& Jantunen, 2011, pp. 115–116; see also Gävert et al., 2018, pp. 158–159).

According to Raili Gothóni and Eila Jantunen (2011, pp. 108–110), the distinctive traits of diaconal nursing are a Christian view of people and a basis in values, holistic encounter, spirituality and spiritual support, client-centricity, a partnership relationship, individuality, respect, presence, listening and relaying of hope. The distinctive traits of *diaconal social work* are the same for the first four traits listed above, but in this study service guidance and support, justice, community, influence and empowerment particularly describe the traits of diaconal social work (Gothóni& Jantunen, 2011, pp. 110–111).

The concept of diaconal social work was previously used to describe the specialization option of "sosionomi" (BA in Social Servces) offered by Diaconia Universtity of Applied Sciences (Gothóni & Jantunen, 2011, pp. 107–108), but nowadays the term BA in Social Services, Diaconal Work has become established. The degree programme emphasizes a person's material and social needs, as well as questions of holistic welfare, and provides eligibility for service in the office of deacon in the Finnish Evangelical Lutheran Church (Diak, sosionomi (AMK), diakoniatyö).

Diaconal work may be described from the liturgical, caritative or social work perspectives. Liturgical work includes neighbourly service in worship, and care for spiritual life. Caritative work may include individual and groupwork, mental health work, work with the disabled or elderly, financial assistance, nursing assistance, food banks, and work with offenders and substance abusers. Social diaconal work strives to establish and eliminate the reason for distress (Suomen evankelisluterilainen kirkko, diakonia). Diaconal work particularly helps people in the most vulnerable position of all and who have, for whatever reason, not been helped by other service networks.

The distinctive traits of diaconal work, both from the diaconal nursing and diaconal social work perspectives, are a Christian view of people, holistic encounter and spirituality (Rättyä, 2010, p. 47, pp. 52–56; Gothóni & Jantunen, 2011, p. 114). The ethical principles which guide the work emphasize respect for people's conviction and culture, dialogue with other denominations and religious communities, and selflessness. Helping is not used to seek benefits or return favours (Diakoniatyöntekijöiden Liitto & Diak, 2016).

Diaconal work patches and complements the gaps in public-sector services, which is important from the perspective of the individual, but in addition to directly helping people diaconal work should also aim for broader influence on society's structural faults (Rättyä, 2009, pp. 68–79; Jokela, 2011, p. 187). Diaconal workers often consider social and broader advocacy a challenge, for which they require additional skills (Rättyä, 2009, pp. 79–85).

In Finland, the concepts closely related to diaconal nursing may be considered diaconal social work, diaconal work and spiritual care work. The closely related contexts in other countries are explored below.

Content of diaconal nursing

Diaconal nursing is based on a Christian view of people (Myllylä, 2004; Gothóni & Jantunen, 2010, p. 33; Rättyä, 2012, p. 82), equal neighbourliness (Rättyä, 1998; Myllylä, 2004; Jauhonen, 2006), Christian love, Christian faith and Christian values (Gothóni & Jantunen, 2010, pp. 32–33). In addition the Christian view of people, holistic encounter and helping form a key principle and goal in diaconal nursing (Myllylä, 2000; 2004; Kotisalo, 2005; Kinnunen, 2009; Rättyä, 2010; Ahola & Pulkkinen, 2011). According to Gothóni and Jantunen (2010, pp. 32–33), the holistic nature of diaconal nursing is linked to the basic attitude of encountering a person as a whole formed by his or her various sides, needs, situations and areas of life (cf. Kotisalo & Rättyä, 2014; Gävert, Malkavaara & Porkka, 2018, p. 164). (See Figure 1).

Diaconal nursing aims to improve quality of life, support adaptation to and coping with life situations, bolster resources, support becoming more whole and integration into the community, enable hope, and alleviate loneliness (Kotisalo, 2002, p. 42; 2005, pp. 12–16; Vuoti, 2005, pp. 85–86; Gothóni & Jantunen, 2010, pp. 28–29; Kotisalo & Rättyä, 2014, p. 93, pp. 99–100). In diaconal nursing, encounter equals caring presence (Kotisalo & Rättyä, 2014, pp. 92–94), a focus on the person in need of assistance and his or her situation, as well as positioning oneself in the service of that person.

Key to encounter and an interactive setting are trust, empathy, honesty, sensitivity, authenticity, respect, seeing various opportunities, as well as valuing the client's opinions and conviction. Interaction is characterized by caring, listening, speaking and touch (Rättyä, 1998, pp. 27–28; Heikkilä, 2002; Gothóni & Jantunen, 2010, p. 33, p. 35; Rättyä, 2010, pp. 47–55; Kotisalo & Rättyä, 2014, p. 93; Cone, 2015).

Deaconesses' nursing education and work experience lower the threshold for touch and make it easier (Hautamäki, 2012, pp.74–78; see also Vuoti, 2005, p. 90). Touch can reinforce verbal communication and be used to convey God's blessing, love, care, acceptance, grace and hope (Hautamäki, 2012, pp.74–78). Deaconesses' education gives them the competences and special skills to promote

health and welfare, as well as the courage to intervene in any health-threatening factors they observe (Vuoti, 2005, p. 90; Kinnunen, 2009, p. 124).

Parish diaconal work and local cooperation networks need deaconesses' nursing and health promotion skills. It is therefore important for deaconesses to recognize their health promotion skills and be courageous enough to use their nursing skills in broader, more diverse ways in their work (Rättyä, 2009a; 2009b; Kinnunen, 2009; Rättyä, 2012; Kotisalo & Rättyä, 2014). This would make cooperation more durable and targeted, rather than random (Ahola & Pulkkinen, 2011, pp. 79–80). Barriers to cooperation may be related to organizational traits, confidentiality practices, time constraints, or unawareness of deaconesses' skills or work content (Ahola & Pulkkinen, 2011, pp. 62–63; Seppä, 2012, p. 75; Kotisalo & Rättyä, 2014, p. 80., pp. 94–95).

The key contents of diaconal nursing are promotion of health and welfare (Rättyä, 2012, pp.97–103; Rättyä & Kotisalo, 2015, pp. 134–139), as well as spiritual support (Vuoti, 2005; Rättyä, 2009a; Gothóni & Jantunen, 2010; Ahola & Pulkkinen, 2011; Seppä, 2012; Rättyä & Kotisalo, 2015), but these will merely be mentioned in this context, as there are articles on both themes later in the present volume, and they are referred to in several other articles.

In their work, deaconesses encounter individuals, families and communities (Rättyä, 2009a; 2012; Kotisalo & Rättyä, 2014). According to Ahola and Pulkkinen (2011), a deaconess's strong skill area is deep expertise on encounters with individuals. In spite of its demanding nature, deaconesses often consider work with individuals the most central and closest area of their work (Rättyä, 2009, pp. 90–92). However, encountering individuals also contains a call to community encounters and connection (Vuoti, 2005, pp. 85–86; Rättyä, 2009a, 107–113).

A deaconess's professional identity is built on commitment to work, a positive attitude and critical approach to changes at work, authentically living the spiritual life, and an appreciation of one's own work and coping at work (Vuoti, 2005, p. 86). Coping at work is supported by motivation for spiritual work, the specific traits of the work, the sensible and rewarding nature of the work, support from the congregation, and the deaconess's own professional skills (Rättyä, 2010, pp. 70–81).

Figure 1 depicts a summary of the key diaconal nursing principle and contents. Diaconal nursing may be performed in a parish, association, or private or public healthcare provider.

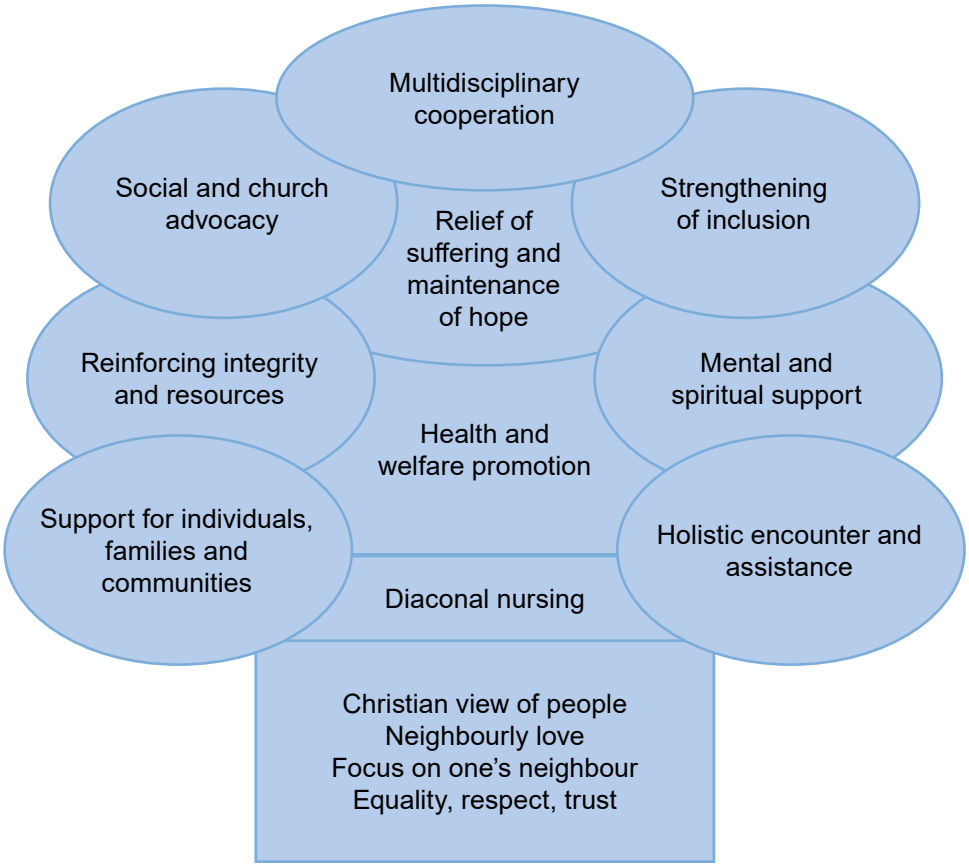

Figure 1. Principles and content of diaconal nursing

Closely related concepts of diaconal nursing internationally

Diaconal nursing appears as a concept in Finnish education, literature and culture (Myllylä, 2004, p. 64, p. 67; Rättyä, 2009), but barely appears in international research (Myllylä, 2004, p. 42; Rättyä, 2009b). In content and preconditions for the work, diaconal nursing has much in common with parish nursing and faith community nursing (Rättyä, 2009a, 48–50; 2009b 162–163). When the nursing is combined with the activities of a Christian congregation, the concept of Christian parish nursing may also be used (Van Dower & Bacon Pfeiffer, 2007). International articles and studies may also use the concept of pastoral care nursing. Christian nurses are afforded holistic encounters and nursing because of their vocational awareness, personal conviction, faith and

Christian values, according to which every person is of equal value (Cone, 2015; Rieg, Newbanks & Sprunger, 2018).

The American Lutheran pastor and professor Granger Westberg (1913–1999) may be considered the pioneer of parish nursing. He was interested in the use of the mutual relationship between religion and medicine in holistic care work. He created the parish nursing programme, which began in 1986 in Lutheran General Hospital, Park Ridge, Illinois, funded by donations. Over four years the programme employed six registered and hired nurses in several congregations (Westberg, 1999, pp. 35–41; O'Brien, 2003, pp. 35–37; Wordsworth, 2016). The experiences of parish nursing were positive, and in 1991 the National Parish Nurse Resource Center first offered teaching under the Foundations of Faith Community Nursing Curriculum (Daffron, 2015). Parish nursing and faith community nursing education has spread globally in a relatively short time, and interest in both the education and in nursing in parishes and religious communities continues to grow (Solari-Twadell & McDermot, 1999; Miller, 2000; Hickman, 2006).

Parish nursing means a holistic approach to the care and health promotion of the client and patient (Miller, 2000; Swinney et al., 2001; Tuck et al., 2001; Weis et al., 2002; Mosack, Medvene & Wescott, 2006). Parish nurses promote individual, group and community health by providing guidance on healthy lifestyles, leading various self-care and support groups, performing various health-related screens, performing home nursing duties and visiting the ill (Miller, 2000). Spiritual support and pastoral care may be used to help connect people with God and to "bring God close to a person" at a time of threats to a person's health and welfare (Van Dover & Bacon Pfeiffer, 2007, p. 218). Parish nurses help and support patients' coping with acute, short and long-term illnesses, and at the end of life, particularly when palliative care specialists are unavailable (Parish nursing ministries UK. What is Parish Nursing?).

In addition to psychosocial and spiritual support, parish nurses have good opportunities for defending health-supporting solutions in the community, promoting health, and preventive nursing. They are a link between the needs of the community and its members and the official healthcare system (Weis et al., 2002, p.112; Ziebarth & Campbell, 2019). Swinney at al. (2001) stress the significance of community in parish nursing. This is when analysis of the community's health risks, problems and needs for health promotion are crucial.

As the education and activities have spread further to various religious communities, parish nursing has been replaced with faith community nursing, which is a globally accepted concept in a variety of religious traditions (Hickman, 2006,

p. 3; Wordsworth, 2016). According to Wordsworth (2016), there are now operations in Christian churches and organizations in 28 countries worldwide. After the United States, the model was first employed in Canada, followed by Australia, New Zealand, South Africa and the United Kingdom. Later, it also spread to South Asia, sub-Saharan Africa and the Middle East. The concept of faith community nursing was also established in the American Nurses Association (ANA) from 2005 onwards (Preston, 2018, p. 8). However, parish nursing and faith community nursing are often still used alongside and as synonyms for each other (Hickman, 2006, p. 3).

Faith community nursing is strongly linked to the formation and initial stage of the entire nursing profession. Nursing in religious communities is based on a holistic view of people, caring, and promotion of health and recovery. In line with the holistic view of people, a person is seen as an entirety, formed of mind, body and soul. Caring means the readiness to care for another person and the vigilance to encounter another person's needs. Health is seen as the sum total of physical, mental and social parts. It is also seen as an experience of integrity, indivisibility, salvation, welfare and peace, and harmony in relation to the person, other people, the environment and God. Recovery is a process in which a person achieves experience of integrity, health and welfare, regardless of the illness not healing (Hickman, 2006, p. 3).

According to Ziebarth (2014), crucial to faith community nursing are the integration of spirituality and faith, health promotion, care for illnesses, coordination of assistance and services, empowerment, and guidance of health services. Faith community nurses can cooperate with hospitals, particularly to promote successful patient discharge and to achieve holistic patient care. They can give the patients and their relatives spiritual and emotional support, as well as help achieve the successful self-care of discharged patients (Ziebarth & Campbell, 2019).

Pastoral care nursing is a concept used in churches such as the Lutheran Church of Australia to describe holistic care nursing by a registered nurse in a congregation, religious community, Christian school or care home. Holistic care nursing may include initiating and managing health-related actions, individual and group activities, house calls, visits to care homes, service counselling, coordination of community resources, particularly for community members with elevated service needs, and cooperation with other parish or religious community workers. Listening, conversation and prayer are central to the work, as faith is seen as part of health. Encouraging people towards self-empowerment and taking more active responsibility for their health is also crucial (Lutheran Church of Australia, Pastoral Care Nursing).

Diaconal nursing and nursing in parishes and religious communities

Diaconal nursing, parish nursing, faith community nursing and pastoral care nursing share a great number of similarities in the fundamentals and content of the work. They also share the fact the work is performed by trained registered nurses. Both diaconal nursing on the one hand and parish, faith community and pastoral care nursing on the other share broad, holistic activities to assist the individuals, families, the community and their health. Assistance is based on the Christian view of people and neighbourly love (Rättyä, 2009b). Differences are found in training, recruitment, working hours, employees' careers and work organization. In terms of training, recruitment and the entirety of the work, the Finnish situation is unusual.

Finnish deaconess education has longer traditions than in many other countries. Finnish diaconal work is highly professional, and each parish has at least one person serving in a diaconal office. The holder of this office may be a deaconess or deacon in qualifications. In the US, training in this field began as a pilot in the 1980s, and is now provided by several institutions there (e.g. Concordia University, Westberg Institute). In the UK, training began in 2005 with a focus on the content of holistic and spiritual care, teamwork, ethics and legal matters (Wordsworth, 2016).

In Finland, the Diaconia University of Applied Sciences (Diak) alone provides deaconess education. The degree in Finland is 240 credits, as it also includes nursing education, unlike in other countries. Applicants to parish nursing and faith community nursing courses have already earned nursing qualifications and are registered nurses. Many have also built a long and varied care career in various healthcare sectors. The focus of the education is on spirituality and themes related to the life of the parish.

Deaconess education contains 60 credits' worth of Christian studies, whereas courses in countries such as Australia, the UK and the US have less theological content. For example, in the UK the training lasts approximately 35 hours. Part of the teaching is conducted as traditional contact teaching in small groups (Wordsworth, 2016). It is possible to complete education entirely remotely in many countries. Remote learning is also being used in more diverse ways in the Finnish system. As in Finland, the education provider issues course completion certificates.

Compared to Finnish deaconesses, parish nurses and faith community nurses have fewer financial employment benefits. Most of them work in congregations and religious communities part-time, or as volunteers. Some work both in a hospital and in a congregation. Diaconal offices in Finland are generally full-time, but parishes also have part-time and various combined offices whose duties include diaconal work. Both nurse-deaconesses and their colleagues in other countries may be motivated to study and work by a desire to combine spirituality more clearly with their own nursing skills, or by a need to do work corresponding to their values.

In American society, churches and synagogues have in recent years become more aware of their role in the promotion and maintenance of citizens' health. Many illnesses develop slowly, meaning their development can be slowed through sufficient early attention to risk behaviour, lifestyle and advance symptoms. Illness and vulnerability are often linked to lifestyle, circumstances, values, attitudes and life view. This justifies the integration of religious communities in healthcare (Westberg, 2006, p. 7). In Finnish society the role of the church and religious communities as promoters of health and welfare has been mentioned in strategies, but situations on the ground vary. Awareness of the perspective of and stress on health promotion in Finnish congregations' diaconal work is lower and less clearly part of the content of the work than elsewhere.

International cooperation

International cooperation in diaconal nursing is very vibrant. Countries in Asia, Europe, Africa, Australia and the Americas are involved (Westberg Institute. International Parish/Faith Community Nursing. History). Symposia and training run by the Westberg Institute, in particular, attract colleagues from around the world. The focus of the symposia varies from year to year, but themes may include religious traditions, spiritual care work in different cultures, and specialized questions of remote areas (Westberg Institute for Faith Community Nursing.2020 Westberg Symposium). The Westberg Institute for Faith Community Nursing previously published the *Perspectives* newsletter both in print and online, but the Spiritual Care Association is now the publisher. *Perspectives* focuses on education and research topics, as well as practical descriptions of nursing work in various cultural contexts (Spiritual Care Association. Perspectives A newsletter for Faith Community Nurses).

The Westberg Institute facilitates global cooperation and networking with a group on Yammer, Westberg Institute for Faith Community Nursing, and a World Forum. To streamline operations and cooperation, the forum is divided into regional networks for Asia, Africa, Australia, South America and Europe (Wordsworth, 2016). The European Parish Nursing/Faith Community Nursing network includes England, Germany, Finland, Hungary, Ukraine, the Netherlands and Scotland. The network regularly arranges meetings across Europe. A central person in the European Parish Nursing network is the English Baptist minister, the Revd Dr Helen Wordsworth, thanks to whom parish nursing operations began in the UK in 2006. Just over 100 trained parish nurses work in the churches and faith organizations of England, Scotland and Wales. (Parish Nursing Ministries UK. History). Parish nurses provide a wide range of holistic guidance, advice and support on health and illness, but they do not administer injections or prescribe drugs, for example (Macmath, 2017).

Australia, in addition to the US, has been active as a builder of international cooperation. In places in Australia, the parish nursing title is used alongside pastoral care nursing. The work of the Lutheran Nurses Association of Australia (LNAA) was crucial to achieving recognition for parish nursing operations and their significance in Australia in 1991. The first parish nurses began work in 1996 (Lutheran Church of Australia. Pastoral Care Nursing. About us). Various electronic newsletters, which are effective communication tools, are part of international cooperation. Two examples are the Lutheran Church of Australia's *Parish Nurse News* and *In Touch Newsletter* (Lutheran Church of Australia, LCA Parish Nurse News, In Touch Newsletter).

The Lutheran Parish Nurses International network connects nurses working in Lutheran parishes in places such as Palestine, the US, Canada, Germany, Finland, England, Singapore, Ghana, India, Brazil, Papua New Guinea, New Zealand and Australia. The network's activities emphasize education and research knowledge, sharing expertise and experience, as well as seminar meetings and educational visits to different countries (Lutheran Parish Nurses International).

In Germany, which can be seen as the birthplace of deaconess education, a sisters' home (motherhouse) system, which administered nursing, in line with the Kaiserwerth system, was in place until the 1960s. Such operations continued in parts of western Germany until the 1980s and 1990s (Kreutzer, 2010). The situation has since changed, but some older sisters continue to work in institutes belonging to the sisters' home system (Diakonissenmutterhaus Lachen – Speyerdorf, near Mannheim). In international parish nursing, one active German coopera-

tion partner is the Vis-a-Vis Christian service organization, whose activities focus on the areas of Speyer and Hagen (Vis-a-Vis Christlicher Dienst an Kranken und Gesunden; Wordsworth, 2014).

The long history, educational content and employment opportunities of Finnish nurse-deaconess education arouse great interest in countries where parish nursing/faith community nursing education and activities are a relatively new specialized form of nursing. In other countries, the deaconess title and diaconal work are primarily associated with institutional diaconal work and, for example, elderly care provided by care organizations (Wordsworth, 2016). In this sense, Finnish parish diaconal work is unique worldwide. Finnish deaconess education has much to offer, both nationally and internationally. It can do so in the areas of health and welfare promotion of the particularly vulnerable, assistance and counselling for the seriously and chronically ill, end of life patients, and for patients with elevated service needs, as well as in preventive individual and community health promotion, multidisciplinary network cooperation and social advocacy.

Sources and literature

Ahola E., & Pulkkinen, P. (2011). *Moniosaaja diakonissa – Vanhustyön johtajien käsityksiä diakonissan osaamisesta moniammatillisessa yhteistyössä*. [Master Thesis, Lapin yliopisto].

Cone, P. M. H. (2015). A Developing Theology of Poverty and Health Applied to Nursing Education. *Christian Higher Education, 14*(3).

Daffron, C.M. (2015). Faith Community Nurse Education: A Conceptual Model. *International Journal of Faith Community Nursing*,1(2). http://digitalcommons.wku.edu/ijfcn/vol1/iss2/1

Diakonia-ammatikorkeakoulu. (n.d.). Sosionomi AMK. Diakoniatyö. Retrieved January 13, 2020, from https://www.diak.fi/hakeminen/koulutukset/amk/sosionomi-diakoni tyo/

Diakoniatyöntekijöiden Liitto, & Diak. (2016). Diakoniatyöntekijän eettiset ohjeet. Retrieved May 5, 2020, from https://www.dtl.fi/media/dtl_eettisetohjeet_2016.pdf

Gothoni, R., & Jantunen, E. (2010). *Käsitteitä ja käsityksiä diakoniatyöstä ja diakonisesta työstä.* Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-089-5

Gothoni, R., & Jantunen. E. (2011). Diakoniatyön käsitteitä. *Diakonian tutkimus*, (2).

Gävert, T., Isomäki, P., Lehmusmies, J., Malkavaara, M., Porkka, J., Salojärvi, P., & Wallenius, V. (2018). Tulosten tiivistelmä. In P. Isomäki, J. Lehmusmies, P. Salojärvi, & V. Wallenius, *Diakoniabarometri 2018. Yksinäisyyden monet kasvot*. Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Gävert, T., Malkavaara, M., & Porkka, J. (2018). Pohdintoja diakoniabarometri 2018:n tuloksista. In P. Isomäki, J. Lehmusmies, P. Salojärvi, & V. Wallenius, *Diakoniabarometri 2018. Yksinäisyyden monet kasvot.* Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Flinck, A. (2012). Hengellisyys hoitotyössä. *Viesti* 1/2012.

Hautamäki, M.-L. (2012). *Fyysinen kosketus diakoniatyössä. Diakoniatyöntekijöiden kokemuksia kosketuksen merkityksestä ja käytöstä vuorovaikutustilanteissa*. [Master Thesis, University of Helsinki]

Heikkilä, M. (2002). *Vanhusten hengellisen tuen tarpeet ja tuen saanti sekä odotukset diakoniselle hoitotyölle*. [Master Thesis, University of Oulu].

Helosvuori, R. (2012). Vaikuttava diakonia. In R. Gothoni, R. Helosvuori, K. Kuusimäki, & K. Puuska (Eds.), *Kantakaa toistenne kuormia. Diakoniatyön perusteet ja käytäntö*. Kirjapaja.

Hickman, J. S. (2006). *Faith Community Nursing*. Philadelphia, PA: Lippincott Williams, & Wilkins.

Holstrom, S. (1999). Pespectives on a Suburban Parish Nursing Practice. In P. A. Solari-Twadell, & M. A. McDermot (edited), *Parish Nursing. Promoting whole person health within faith communities*. Sage Publications.

Jantunen, E., & Kotisalo, H. (2004). Väitös diakonisesta hoitotyöstä. Myllylä Marjatta: Diakonisen hoitotyön mallin rakentaminen. *Diakonian tutkimus* 1/2004.

Jauhonen, A. (2006). *Diakonisen hoitotyön ytimessä. Diakonissat tarkastelevat psykoemotionaalista hoitamistaan*. [Master Thesis, University of Oulu].

Jokela, U. (2011). *Diakoniatyön paikka ihmisten arjessa.* [Doctoral Dissertation, University of Helsinki). (Diakonia-ammattikorkeakoulua A Tutkimuksia 34). https://urn.fi/URN:ISBN:978-952-493-149-6

Juntunen, E., & Saarela, T. (2009). Seurakuntadiakonian perustehtävä ja terveyden kysymykset. In K. Kinnunen (Ed.), *Sairas köyhyys, tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä*. Kirkkohallitus.

Kinnunen, K. (2009). Terveyteen ja sairauteen liittyvän auttamisen muodot diakoniatyössä. In K. Kinnunen (Ed.), *Sairas köyhyys, tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä*. Kirkkohallitus.

Kotisalo, H. (2002). *Diakoniatyön ja diakonisen hoitotyön toteutuminen Kuopion hiippakunnan diakonissojen arvioimana*, [Master Thesis, University of Kuopio].

Kotisalo, H. (2005). Diakonisen hoitotyön toteutuminen. *Diakonian tutkimus*, (1), 5–18. https://journal.fi/dt/issue/view/7863/1285

Kotisalo, H., & Rättyä, L. (2014). *Diakonissat terveyden edistäjinä.* (Diakonia-ammattikorkeakoulun julkaisuja. B, Raportteja, 58). Diakonia-ammattikorkeakoulu. http://www.urn.fi/URN:ISBN:978-952-493-220-2

Kreutzer, S. (2010). Nursing Body and Soul in the Parish: Lutheran Deaconess Motherhouses in Germany and the United States. *Nursing History Review* 18 (2010).

Lachen Diakonissen-Mutterhaus. Retrieved February 12, 2020, from https://www.lachen-diakonissen.de/.

Lehmuspuu, L. (2012). *Kaksikymmentäneljä tuntia. Novelleja diakonissan työstä 1960-luvulla.* VES-LINE.

Louheranta, O., Lähteenvuo, M., & Kangasniemi, M. (2016). Henkinen ja hengellinen tuki terveydenhuollossa – kenen vastuulla?. *Sosiaalilääketieteellinen Aikakauslehti*, *53*(4). Noudettu osoitteesta https://journal.fi/sla/article/view/59668

Lutheran Church of Australia. LCA Parish Nurse News. In *Touch Newsletter*. Retrieved January 16, 2020, from https://www.lca.org.au/departments/ministry-support/church-worker-support/lay-ministry/parish-nursing/

Lutheran Parish Nurses International. Retrieved January16, 2020, from http://www.lpni.org/

Macmath, T. H. (May 5, 2017)). Interview: Helen Wordsworth, founder director of Parish Nursing Ministries UK. *Church Times* https://www.churchtimes.co.uk/articles/2017/5-may/features/interviews/interview-helen-wordsworth-founder-director-of-parish-nursing-ministries-uk

McDermott, M. A., Solari-Twadell, P. A., & Matheus, R. (1999). Educational Preparation. In P. A. Solari-Twadell, & M. A. McDermot (edited), *Parish Nursing. Promoting whole person health within faith communities*. Sage Publications.

Miller, L.W. (2000), Continuing Professional Education: A Spiritually Based Program. New Directions for Adult and Continuing Education, 2000. 49–57. https://doi.org/10.1002/ace.8505

Mosack, V., Medvene, L. J., & Wescott, J. (2006). Differences between parish nurses and parish nurse associates: results of a statewide survey of an ecumenical network. *Public health nursing (Boston, Mass.)*, *23*(4), 347–353. https://doi.org/10.1111/j.1525-1446.2006.00571.x

Muurinen, S. (2015). Henkisen paluu. *Kirkonkello*. Retrieved October 14, 2019, from https://www.kirkonkello.fi/henkisen-paluu/

Myllylä, M. (2000). *Näkökulmia diakoniasta ja hoitotyöstä, kohti diakoninen hoitotyö -käsitettä* [Licentiate Thesis, University of Oulu].

Myllylä, M. (2002). Kohti diakonisen hoitotyön käsitettä. In M. Lahtinen, & T. Toikkanen (Eds.), *Anno Domino 2002. Diakoniatieteen vuosikirja.* Lahden Diakoniasäätiö.

Myllylä, M. (2004) Diakonisen hoitotyön mallin rakentaminen. (Doctoral Dissertation, University of Oulu). http://urn.fi/urn:isbn:9514273567

Möttönen, S. (1994). *Diakoninen hoitotyö diakonissakoulutuksessa*. [Master Thesis, University of Kuopio].

O´Brien, M. E. (2003). *Parish Nursing: Healthcare Ministry within the Church*. Jones and Bartlett Publishers.

Parish nursing ministries UK. (n.d.). What is Parish Nursing? Retrieved October 17, 2019, from https://parishnursing.org.uk/what-is-parish-nursing/.

Parish Nursing Ministries UK. (n.d.). History. Retrieved October 16, 2019, from https://parishnursing.org.uk/about-us/history/.

Preston, P. (2018). Faith Community Nursing in Community/Public Health Education: A Positive Student Nursing Experience. *International Journal of Faith Community Nursing. 4*(2). https://digitalcommons.wku.edu/ijfcn/vol4/iss2/2

Reporter. Official Newspaper of the Lutheran Church – Missouri synod. Lutheran Church Missouri Synod. Retrieved October 23, 2019. https://files.lcms.org/wl/?id=D4LzzBJdiefUmBXjeBcl51Yag01Fteb1

Rieg, L. S., Newbanks, S., & Sprunger, S. (2018). Caring from a Christian. *Journal of Christian Nursing*, *6*(3), 168–173. http://doi: 10.1097/CNJ.0000000000000474

Rättyä, L. (1998). *Diakoniatoimistojen asiakkaiden kokemukset avun ja tuen saamisesta*. (Master Thesis, University of Oulu).

Rättyä, L. (2009a) *Diakoniatyö yksilöllisenä ja yhteisöllisenä auttamisena yhteiskunnallisessa muutoksessa*. (Doctoral Dissertation, University of Oulu). Retrieved http://urn.fi/URN:ISBN:978-951-27-1309-7

Rättyä, L. (2009b) Katsaus diakonisen hoitotyön tutkimukseen. *Diakonian tutkimus*, (2), 159–165. https://journal.fi/dt/issue/view/7863/1310

Rättyä, L. (2010) *Diakoniatyöntekijöiden kuvauksia työstään ja siinä jaksamisestaan* [Licentiate Thesis, University of Oulu]. (Diakonia-ammattikorkeakoulun julkaisuja. A Tutkimuksia, 24). Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-083-3

Rättyä, L. (2012). Diakoniatyö yksilöiden ja perheiden parissa. In R. Gothoni, R. Helosvuori, K. Kuusimäki, & K. Puuska (Eds.), *Kantakaa toistenne kuormia. Diakoniatyön perusteet ja käytäntö*. Kirjapaja.

Rättyä, L. (2016). *Diakonisen spiritualiteetin tiellä. Diakoniatyöntekijöiden ja pappien käsitykset spiritualiteetin muotoutumisesta, sisällöstä ja yhteydestä diakoniaan Oulun hiippakunnassa* [Master Thesis, University of Helsinki].

Rättyä, L., & Kotisalo, H. (2015). Diakonissat terveyden edistäjinä diakoniatyössä. *Diakonian tutkimus,* (2), 129-142. https://journal.fi/dt/issue/view/7863/1306

Seppä, E. (2012). *Diakoniatyön erityispiirteitä saamelaiskulttuurissa*. [Master Thesis, Universitys of Helsinki].

Solari-Twadell, P. A., & McDermott, M. A. (eds.) (1999). *Parish nursing: Promoting whole persons health within faith communities*. Sage Publications.

Spiritual Care Association. Perspectives. *A newsletter for Faith Community Nurses*. Retrieved October 16, 2019, from https://www.spiritualcareassociation.org/nursing/perspectives.html

Swinney, J., Anson-Wonkka C., Maki, E., & Corneau, J. (2001). Community ssessment: A Church Community and the Parish Nurse. *Public Health Nursing, 18*(1), 40–44. http://www.10.1111/j.1525-1446.2001.00040.x.

Tuck, I., Pullen, L., & Wallace, D. (2001). A comparative study of the spiritual perspectives and interventions of mental health nursing and parish nurses. *Mental Health Nursing, 22*(6), 593–605. https://doi.org/10.1080/01612840121450

van Dover, L., & Pfeiffer, J. B. (2007). Spiritual care in Christian parish nursing. *Journal of advanced nursing, 57*(2), 213–221. https://doi.org/10.1111/j.1365-2648.2006.04081.x

Vis-à-vis Christlicher Dienst an Kranken und Gesunden. Retrieved February 5, 2020, from http://visavis-gemeindediakonie.de/?page_id=460

Vuoti, M. (2005). *Sairaanhoidosta eheyttävään kohtaamiseen. Elämänkertatutkimus diakonissan työn muotoutumisesta vuonna 1972 voimaan tulleen kansanterveyslain jälkeen* [Master Theses, University of Oulu].

Weaver, A. J., Flannely, L. T., Flannely, K. J., Koenig, H. G., & Larson, D. B. (1998). An analysis of research on religious and spiritual variables in three major mental health nursing journals, 1991–1995. *Mental Health Nursing, 19*(3), 263–276. https://doi.org/10.1080/016128498249060

Weis, D. M., Schank, M. J., Coenen, A., & Matheus, R. (2002). Parish Nurse Practice with Client Aggregates. *Journal of Community Health Nursing, 19*(2), 105–113. http://www.jstor.org/stable/3427667

Westberg Institute. International Parish/Faith Community Nursing. History. Retrieved October 16, 2019, from https://westberginstitute.org/international-faith-community-nursing/

Westberg Institute for Faith Community Nursing.2020 Westberg Symposium. Retrieved October 16, 2019, from https://westberginstitute.org/symposium2020/

Westberg Institute for Faith Community Nursing. FCN Knowledge Sharing Platform. Retrieved October 16, 2019, from https://westberginstitute.org/fcn-knowledge-sharing-platform/

Westberg, G. (1999) A Personal Historical Perspective of Whole Person Health and the Congregation. In P. A. Solari-Twadell, & M. A. McDermot (edited), *Parish Nursing. Promoting whole person health within faith communities*. Sage Publications.

Westberg G. (2006). A Personal Historical Perspective of Whole Person Health and the Congregation. In P. A. Solari-Twadell, & M. A. McDermott (edited), *Parish Nursing, Development Education and Administration*. Elsevier/Mosby.

Wordsworth H. (2014). Health ministry through local faith communities: a European perspective. *Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association, 87*(1), 24–27.

Wordsworth, H. A. (2016). An educational model for preparing Christian nurses and church congregations to offer local whole-person health programmes. *Christian Journal for Global Health, 3*, 107-112.

Ziebarth, D. Evolutionary Conceptual Analysis: Faith Community Nursing. *Journal of Religion and Health,* 53, 1817–1835. https://doi.org/10.1007/s10943-014-9918-z

Ziebarth, D. J., & Campbell, K. (2019). Describing Transitional Care Using the Nursing Intervention Classification: Faith Community Nursing. *International Journal of Faith Community Nursing*, *5*(1). https://digitalcommons.wku.edu/ijfcn/vol5/iss1/3

Minna Valtonen

4 THEOLOGY OF ENCOUNTER — THE BLESSING OF DIALOGUE

This article's premise is that professional encounter in both diaconal work and nursing is based on love of neighbour — whether in diaconal financial assistance or clinical measures in nursing. Encounter always entails a dialogue that should be built on respect for the uniqueness of the other person. At its best an encounter of dialogue empowers resources and creates hope. It embodies the loving presence of God in the world.

Introduction

Encounter and interaction are central to nursing and diaconal work — one might even say that they are their deepest essence. The situations of encounter and their related objectives and methods vary, but the relationship between people, and the interaction that takes place within it, is always at its heart. One of the premises of this article in examining encounter is the idea of neighbourly love as the core of both diaconal work and nursing. An encounter that values, cares for and helps another person is always based on neighbourly love.

Love of neighbour is perhaps easier to identify and explain as a premise of diaconal work than it is as the core of nursing, for loving and helping one's neighbour have played a central role in the life and work of the Christian church throughout its history. All encounters and interactions in the church begin with the love of neighbour. Putting this into practice is one of the church's basic tasks. According to the Church Act, the legislation which governs the Finnish Evangelical Lutheran Church, "...the church proclaims the word of God and administers the sacraments, and otherwise works to spread the Christian message and realize neighbourly love" (L 1054/1993). A couple of sections later the current definition of diaconal work is also associated with the idea that it is based on the Christian love of neighbour (L 1054/1993).

The recent debate concerning the concept of diaconal work questions whether its current form can be justified by New Testament texts or other key writings

of the early church, or if diaconal work as a biblical concept would have meant helping one's neighbour to the early Christian as the term has been subsequently used (e.g. Latvus, 2017; Koet, Murphy & Ryökäs, 2018; Ryökäs, 2020). However, at the same time there is a common view that love of neighbour, helping others and fellowship have been hallmarks and tasks of the church from the earliest times. In the early church the task of charity was one for the entire Christian congregation.

New research findings mainly concern who was responsible for charitable relief work in congregations, and the definitions that were attached to the deacon's office. It would seem that the deacon's early role included that of mediator rather than charitable relief work (Ryökäs, 2020). The bishop was responsible for the congregation as a whole, including its poor and sick members. However, it seems the deacons, as the bishop's assistants, ensured he was aware of those members of the congregation who had any difficulty attending the congregation's assemblies because of illness or other reasons. The bishop ensured that these members were prayed for in worship and were visited, and that they received their share of the eucharistic meal (Nordstokke, 2019 30–31).

The current Finnish conception of the diaconal office is derived from interpretations stemming largely from both the Reformation period — mainly the thinking of John Calvin — and the nineteenth-century diaconal revival. In his writings Calvin took the view that caring for the poor was part of the deacon's job description. He interpreted certain epistles of Paul (1 Tim. 5:3–10 and Rom., 16) as mentioning widows who were good examples of deaconesses (Latvus, 2007, pp. 74–75). For his part Theodor Fliedner played a key role in the nineteenth-century diaconal revival. He began training deacons in his hometown of Kaiserswerth. The educational innovation quickly resonated elsewhere, and several institutions modelled on Kaiserswerth's were established throughout Europe. The Deaconess Institute was established in Helsinki in 1867 (Latvus, 2007, pp. 76–77, Malkavaara, 2007, pp. 83—92).

The concept of diaconal work has gradually become established in Finland to describe relief work based on the Christian faith, to the extent that it is primarily associated with the work undertaken by the diaconal workers (Elenius & Latvus, 2007, pp. 272–275). Research and discussion on the various interpretations of diaconal work continue to be required to establish how professional diaconal work can be strengthened and expanded while recognizing that diaconal work is the common task of the whole parish. Diaconal work remains a question of social responsibility for the church as a whole.

However, although there are many questions about the understanding of the diaconal office, it is clear that a central element of the church's mission through the ages has been to listen to and encounter people, and to seek out human distress and strengthen inclusion (Malkavaara, 2015, p. 5, p. 16). Listening and encounter, and helping those in need, exemplify Jesus and his love, which are the core of the Christian faith. The building of fellowship and the enabling of inclusion are signs of the work of the Holy Spirit.

Elenius and Latvus (2007, pp. 275–282) have suggested that there is a problem with the theological examination of diaconal work if love of neighbour is too clearly associated with the work of diaconal officeholders. They therefore speak of a theology of helping and state that it can also be understood in a secular context. Less attention is paid to the helper's intrinsic motivation and its rationale than to the event of the encounter. "The coming together of two people brings creation, redemption and sanctification to light. Human encounters always take place before the face of God" (Elenius & Latvus, 2007, p. 275).

Although love of neighbour is at the heart of the church's life, it is not the preserve of the Christian church, nor is it especially that of any office. Many studies of nursing also connect love of one's neighbour to nursing and its professional premises (see e.g. Haho, 2006, p. 137). In Finland the researcher and teacher of nursing Katie Eriksson (1989, pp. 26–44) defined love of neighbour as one of nursing's core concepts. According to her, "Care is based on love. It entails respect for human beings, life and eternity" (Eriksson, 1989, p. 26). She described this core premise or ethos of nursing as the idea of Caritas (later as that of karitas), that is, the idea of love and compassion (Eriksson, 1989). The theory of a nursing based on caritas was built on this idea (see e.g. Haho, 2006, pp. 39–40).

Eriksson's conception of love was based largely on Christian thinking (Eriksson, 1989, pp. 37–41; see also Henttonen, 1997, pp. 307–312 and Paldanius, 2002, p.13). For example, in examining the premises of the idea of caritas, she stated that "the idea of love is the cornerstone of Christian doctrine and is described throughout the Bible" (Eriksson, 1989, p. 35). At the same time, however, she also separated the doctrine of the Christian faith from the individual's personal belief or experience, averring that love was central to all religions and concretized in the human relationship with God "regardless of how an individual defines their God or religion" (Eriksson, 1989, p. 35; see also Henttonen, 1997, pp. 330–331).

The American nursing researcher Jean Watson (1979, 2008) also sees love as a central concept in nursing. She created a human theory of care which associated it

with broader universal values such as kindness, caring, and loving oneself and one another. The encounter between the nurse and the patient is always at the heart of human caring (see also Haho, 2006, p. 133).

However, some researchers maintain that the concept of neighbourly love has long been downplayed, especially in health science research. Harri Kankare and Hanna Lintula (2004, p. 35), who have written on the ethics of work among the elderly, suggest that love should be restored as a central element of the scientific debate, as "this gives the practice of nursing its basic ethical value". The act of listening to people is defined by this basic value. In the conclusions of her dissertation on the nature of nursing, Annu Haho (2006) contends that love is a moral characteristic of nursing: "Love is an opportunity in nursing that creates human dignity in the encounter between the nurse and the patient. Its goal is the welfare of another person (Haho, 2006, p. 162).

This article's premise is that the professional encounter in relief work is based on love of neighbour. Encounter and interaction are viewed primarily from a theological perspective. The aim is not to describe the methods and practice of encounter and interaction, but the theological structuring of the background thinking concerning them.

The article's approach resembles the structure of the theology of helping of Elenius and Latvus described above: the event of the encounter is central, and less the basis of the motivations of the individuals involved. However, according to the title of the article, the premise for this review is the theology of encounter. The word choice underscores a certain neutrality: although in both diaconal and nursing encounters it is often the case that a professional helps another person, the premise is an equal partnership in which one person encounters another.

Creation: Love calls for dialogue

According to the Christian faith, the human being is created by God in God's image (Lat. imago Dei). According to the creation account, human existence is based on the will of God. The first chapter of Genesis recounts that at the beginning of God's creative work God seems to involve God's self in a discussion and makes the decision to create the human being: "Let us make humankind in our image, according to our likeness" (Gen. 1:26). The creation account does not so much provide answers to the scientific questions concerning the origin and development of the human being as it explains the uniqueness and value of the human person and their place and relationships in the world.

The likeness of the image of God is found in every human being and encompasses the whole of the human being: soul, body and spirit (Pihkala, 2009, p. 134). This is the foundation of the principle that the human being should always be viewed as a whole. The act of creation also places all people on an equal footing regardless of their gender, nationality, age, beliefs or race. Being in the image of God extends to all of humanity. It can be conceived that together, people form the image of God. The Hebrew word "Adam" used in the creation account is both a proper name and a reference to an individual or all humanity.

So what kind of image of God is the human being, and what does it mean to be in the image of God? According to the classical understanding of Christianity, God is Triune, one substance and three persons: Father, Son and Holy Spirit. This doctrine of the Triune God was formulated during the first Christian centuries and is witnessed to by the early Christian creeds, the Nicene Creed (more precisely, the creed of Nicaea-Constantinople) and the Athanasian Creed (Pihkala, 2009, pp. 90–91, 110–111). However, there is no clearly formulated doctrine of the Trinity in the Bible, though there are several references to it. An important example is the divine commission, in which Jesus exhorts: "Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit" (Matt. 28:19).

Describing God as three persons emphasizes that "relationship" is central to God's nature. The persons of the Holy Trinity, the Father, Son and Holy Spirit, are interdependent and live in a relationship of sharing.

The concept of personality has its roots in the Roman theatrical world, where it originally meant an actor's mask. It thus referred to a role or part played by somebody. In describing the nature of God, the concept of personality was probably first introduced by the Church Father Tertullian. Alister McGrath (2012, pp.281–282) avers that Tertullian may have wanted to interpret the concept of one substance and three persons of God so that God manifested three distinct but cohesive roles in the salvation of humankind.

The doctrine of the Trinity describes God's dynamism and love. It is in God's nature to call and long for interaction and fellowship with God's creatures. The interaction inherent in the essence of God is filled with love — or rather, it is love in its entirety (see e.g. John 3:16 and 1 John 4:7–10).

The likeness of the image of God means that the human being is created to live in an interactive relationship. In creating humankind, God created a being with whom God can speak and who listens to him. The human being is thus not called to live in the role of a passive recipient but in an active dialogue with their Crea-

tor (Sainio, 1989, pp. 26–27). Dialogue determines humanity's relationship with God, but also with others and creation.

While the Christian conception of God emphasizes the likeness of the human being with God, it also recognizes human sinfulness. The reality of sin is part of what it is to live as a human being and applies to all people. The account of the Fall (Gen. 3) describes how the human being breaks the relationship of trust. Although God continues to invite human beings into a relationship, the Fall has introduced the human desire to hide from God's gaze.

As a result of the Fall human relationships are also fractured. According to Martin Luther, sin entails more than the evil deeds of human beings; it is also an attitude that is seen in selfishness and indifference to one's neighbour (Kopperi, 2015, p. 83).

St John's Gospel speaks of Jesus as the Word of God (logos), through whose power everything has its being (John 1:1–13), and which is made flesh (John 1:14). God creates the universe through God's Word. The act of God's love in saving humanity also happens through the Word. God's love for humanity is consummated in Christ and in his life and death. Jesus, born as a human and living a human life, is at the same time the embodiment of the perfect image of God. How God's love is manifested in the birth, life and crucifixion of Christ is also a matter of dialogue.

According to Christian theology, a person always encounters Christ in another. For example, chapter 25 of St Matthew's Gospel tells us that in helping their neighbours, people help Christ. In serving their neighbours, humans serves God. Encountering Christ in one's neighbour is as real as his presence in the gospel or in the sacrament of the eucharist (Huttunen, 2009, p. 95).

In light of the above, dialogue is a theological concept that profoundly embodies both the nature of God and the human being's role and place in the world. At the same time the concept of dialogue is used in many disciplines and can also be defined as a very practical work method (see e.g. Valtonen, 2017, pp. 53–57).

Relationship, power and responsibility in dialogue

In recent decades the dialogue approach and dialogue as a method have been of interest in social care, healthcare and education. The driver of interest has been the need to strengthen the voices of clients and patients. For example, *Open Dialogue* is a model developed in psychiatric nursing in the 1980s and 1990s that is also applied in social work with clients (Seikkula & Alakare, 2004; Seikkula &

Arnkil, 2014). In turn, *Foresight Dialogue* has been particularly developed in the context of multidisciplinary work with children, young people and families (Seikkula & Arnkil, 2009, pp. 19–32). The basic idea of both models is that the client and their immediate circle are viewed as active, rather than being treated as passive recipients of aid.

Dialogue methods have also been used in the church's diaconal work (see e.g. Aalto, 2009). A dialogue approach is also necessary when church workers act as experts in multidisciplinary networks or when different beliefs and religions meet (see e.g. World Council of Churches, 2016; Kirkkohallitus, 2018, p. 14, p. 25).

Dialogue and the dialogue approach, as well as various dialogue methods, share many roots and traits. The premises of the philosophy of dialogue are traced to ancient Greece and the radical teaching style of Socrates, as well as in texts written by Plato in dialogue form (Alhanen, 2017, pp. 24–26). The modern philosophy of dialogue is represented by figures like the Austrian-Israeli Martin Buber, the Russian Mikhail Bakhtin and the Lithuanian-French Emmanuel Levinas (see e.g. Värri, 2002 and Mönkkönen, 2007). In the field of philosophy and education the Brazilian Paolo Freire's pedagogy of the oppressed is also based on a dialogue approach (Freire, 2005).

Martin Buber was a Jewish theologian and philosopher who analysed the concepts of dialogue and personality, especially in his principal work *I and Thou* (*Ich und Du*, in Finnish translation, 1999). According to Buber, human relationships are twofold: I–It relationships always entail categorization and objectification, as well as a calculating and possessive attitude. I–Thou relationships represent in turn an authentic encounter in which another person is encountered as they are. (McGrath, 2012, pp.283–284; Nivala & Ryynänen, 2019, p. 112). Encounters between people, including professional ones, should always entail an I–Thou relationship.

An attitude of non-knowledge is central to interaction in dialogue. A person can never know with certainty about another's life and issues, but they can ask about them and try to understand. The only way to come close to know something about another's journey in the world is to be present, give space and listen. Nevertheless, the other ultimately always remains a mystery. The idea of mystery approaches the concept of otherness in the philosophy of dialogue. For example, Levinas emphasizes that everyone should function in human interaction to ensure that the other can maintain their otherness as another. Every human encounter thus entails an ethical responsibility for the other (Tuohimaa, 2001).

Both nursing and diaconal work encounter vulnerable people experiencing suffering and illness. Nurses must make decisions on the patient's behalf. In crises

professionals often need to find solutions based on the information available and their own interpretation. It is important for the professional to be aware of the power their job gives them, as well as their motives (see e.g. Haho, 2006, p. 47, p. 161, p. 167).

Ulla Jokela (2011) has studied the experiences of clients of diaconal work and the underlying management practices. The study highlighted three levels of management relationship that defined relationships between clients, workers and other stakeholders. The first is the exchange-based encounter between a diaconal worker and client. A relationship of exchange often extends to other stakeholders like family members or partners in diaconal work (Jokela, 2011, p. 184). The help offered in diaconal work is a selfless gift to the client that does not need to be repaid. Although selflessness is considered a Christian virtue, it also entails tensions if, for example, the worker has unconscious expectations of a gift in return, such as the client's rehabilitation (Jokela, 2011, pp. 185–186).

The second level consists of the relationships of control that are inherent in diaconal work, which include power. In people's everyday lives power manifests itself in management practices that can include the valuing of spiritual and emotional issues above the physical, humiliation concealed in helping, client selection, limited freedom of choice and randomness. At the same time the power inherent in diaconal work includes positive elements such as the opportunity for an unrushed encounter and to offer concrete help (Jokela, 2011, pp. 184–185).

The third level concerns the social dimension of diaconal work. Diaconal work often plugs and fills gaps in public services. From the private person's perspective help is usually welcome, but at the same time it also allows for the continuing dismantling of the welfare state (Jokela, 2011, p. 185). Diaconal work plays an important role as an advocate for the most vulnerable and as a service-provider (Jokela, 2011, pp. 190–191). Thus, social advocacy, such as drawing attention to unfair and discriminatory structures and practices and finding solutions that promote equality, also plays a key role in diaconal work.

The blessing of dialogue

As has previously been stated, the basic premise of a dialogue of encounter lies in the idea that another person is always "the other". The other person should not be understood only as an extension of one's own self, but as a distinct, different human. Saarinen (2008, pp. 11–12) states that it is difficult to understand the distinctiveness of another person, because people often place themselves in others'

shoes. Understanding the other more deeply is possible only when the encounter also entails an understanding of their distinctiveness. Levinas writes that human interaction should include the opportunity for the other person to maintain their otherness (Jokinen, 1997, pp. 7–8). The aim of dialogue is not to achieve like-mindedness or similarity, but the coexistence of different experiences, stories, and understandings.

Päivi Thitz (2013) has researched community and inclusion in parishes. The study identified a variety of ways of speaking that enhanced inclusion, from worker-centred language to dialogue based on partnership and as competitive or negotiatory discussion of boundaries. When people disclose their own views without knowing how others will react to them, the new and unknown is encountered. Then, disagreements and charged understandings are also possible (Thitz, 2013, pp. 195–210).

In examining the state of interaction when two or more people meet, Veli-Matti Värri (2002, pp.64–65) refers to Buber. Buber uses the German term *Zwischen*, which means a state in between, to describe this state (Värri, 2002, pp.64–65). The theologians Juha Luodeslampi (2013, pp. 53–57) and Risto Saarinen (2008, p. 12) use the concept of the Trinity to describe the state or atmosphere that is created by interaction. The encounter between two people creates a mood, atmosphere, or spirit whose nature is very special, entering almost as a third party into the relationship. The nature of this trinity in the encounter is important for the interaction's continuation. Is it distressing and repressive, or a positive entity that supports the freedom of diverging opinions? However, when there is room for different "others", as well as conflicting or contentious opinions, in conversation or coexistence, a state of trust can also emerge that is very special in nature.

For example, in a camp led by a parish diaconal worker and a coordinator for early Christian education and care, an especially enjoyable and relaxed atmosphere can be built in which previously unacquainted people are encouraged to share their experiences. Alternatively, a deaconess may encounter a patient in the psychiatric ward with whom a conversation about cooking ensues. Although the conversation concerns everyday matters, an atmosphere of trust and hope emerges.

Saarinen (2008, p. 13) states that as something surprising and new, the positive trinity that emerges in human encounters is like a blessing or reward that almost mysteriously enriches the human world. A Christian interpretation might be that God is present in God's love in such encounters and shares their inherent good.

Pastoral care encounters can be described as a triangle whose points are the pastor, the pastored, and God (Kiiski, 2009, p. 11). Even if the matter to be dealt with

in a pastoral care situation — that is, the centre of the triangle — is unconnected with the human relationship with God, God is present in the event as in all other encounters with God's creatures. The Holy Spirit is the person of the Trinity who is present in encounters as an encouraging and hopeful bond of love.

Dialogue as a holistic encounter

In professional encounters the concept of dialogue is usually primarily associated with verbal interaction, but it is about much more. Building a dialogue is especially challenging in situations where a person's ability to communicate is limited because of an injury or illness, for example.

As a theological concept, dialogue encompasses the idea of holistic human encounter. In the Bible the concepts of body, soul, spirit, and heart are often associated with the essence of what it is to be human. These concepts are ambiguous and bear various nuances. For example, soul can mean mood, emotion, life, or personality (Sainio, 1989, pp. 15–51). The texts of the Bible present a multidimensional description of the human being, taking into account the many dimensions of human life.

In social care, healthcare and education, holistic encounter means a consideration of the mental, physical, social and spiritual dimension of the person. Lauri Rauhala (1983/2014) has especially highlighted the importance in these fields of a holistic conception of people. According to Rauhala, human existence is realized in three basic forms: Corporeality signifies existence as an organic event. Consciousness describes existence as psycho-spiritual, and this includes a spiritual dimension. Situationality describes a person's different relationships – for example, their relationships with different situations and other people (Rauhala, 2014).

An approach has been developed in the church's diaconal work in which a diaconal or holistic encounter is built on six dimensions (Juntunen, Mäkelä & Saarela, 2013). These dimensions are meaning, a loving attitude, an atmosphere that creates hope, genuine human interaction, actions that support inclusion and respect for confidentiality (Juntunen, Mäkelä & Saarela, 2013). The holistic encounter approach crystallizes the previously described themes of Christian love of neighbour and dialogue.

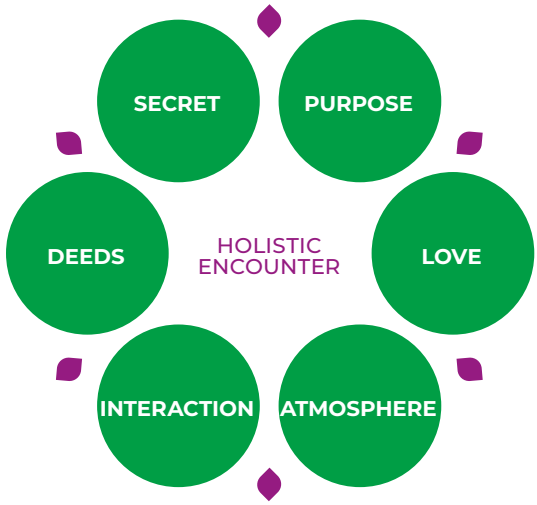

Figure 1: Holistic encounter (Juntunen, Mäkelä & Saarela, 2013; Gävert & Thitz, 2013, p. 220).

Encounter usually has a *purpose*. In a holistic encounter the meeting's content is not limited to the meeting's intended purpose (Juntunen et al., 2013; Gävert & Thitz, 2018, p. 227). A genuinely holistic encounter is possible when there are sufficient time and resources to deal with various aspects of life. For example, in diaconal work it has been found that it can be very important for the client that the worker is interested in their life story (Gävert & Thitz, 2018, pp. 226–227).

The *love* that is the premise of a holistic encounter enables the uniqueness and specificity of the other person and their inalienable dignity to be seen and accepted (Juntunen et al., 2013). A loving approach supports people in contemplating challenging issues. It creates a space where brokenness, incompleteness, dependency and vulnerability can be faced. Love is manifested as an accepting gaze. The experience of acceptance can help a person find the motivation for change in their own lives and a responsible attitude (Gävert & Thitz, 2018, pp. 220–221).

A confidential *atmosphere* is also associated with a good encounter (Juntunen et al., 2013). The encounter creates a space characterized by equality and the renunciation of positions of power. In a peaceful and unrushed encounter trust can be built (Gävert & Thitz, 2018, pp. 221–222).

In a holistic encounter *interaction* is based on partnership, hospitality and the sharing of life stories (Juntunen et al., 2013). Partnership is founded on mutual responsibility and commitment. The client or patient is not seen as the object of work, but as an active and responsible person. The approach requires the worker to surrender to interaction, and at the same time to become aware of and re-

flect on the meaning of their own roots and life story (Gävert & Thitz, 2018, pp. 222–223). In his book *Auttajan varjo* ("the shadow of the helper") Martti Lindqvist described how the life history of a person involved in relief work affected encounters either consciously or unconsciously. A key element of ethical professionalism is reflection on and acquainting oneself with one's own motives and starting points (Lindqvist, 2006).

A holistic encounter also requires the *actions* necessary to assist the client or patient (Juntunen et al., 2013). It also concerns how the worker becomes acquainted with the client's or patient's situation and arranges the meeting place. Occasionally the worker must also strike a balance between the client's agency and their own action (Gävert & Thitz, 2018, p. 223). Doing this requires the professional to update and develop their own professional skills.

The *secret* perspective is a reminder that not everything in an encounter becomes visible, but that new meanings can be disclosed in it (Juntunen et al., 2013). It is important for the worker to allow the experience of being seen and heard, while ensuring that the right to remain silent on certain issues is also maintained. Although encounters seek a holistic view of life, including its weaknesses and strengths, secrets always remain in the encounter, and this is permitted (Gävert & Thitz, 2018, pp. 224–225).

According to the Christian tradition, encounters always take place on holy ground. The secret of the encounter or the mystery of the dialogue lies in Christ's promise that wherever two or three gather in his name he is in their midst (Juntunen et al., 2013). The questions and life situation that arise in the encounter, as well as its location, can be left in God's hands.

The aim of this article was to outline the theological premises for encounter in diaconal nursing work. The theological dimensions related to diaconal nursing have also been examined from various perspectives in the publication's other articles. Malkavaara, for example, deals with diaconal nursing from the perspective of the diaconal office, and Gothóni considers the theology of corporeality. However, we remain in the early stages of the examination of the theology of diaconal nursing, and it is clear that the debate about the concept must continue. It must be hoped that a systematic presentation of a theology of diaconal nursing will be the vision and challenge of the future.

Sources and literature

Aalto, K. (2009). *Sielunhoidon aikakauskirja 21: Dialogi.* Kirkon koulutuskeskus, Kirkon sairaalasielunhoito, Kirkon perheasiat.

Alhanen, K. (2016). *Dialogi demokratiassa*. Gaudeamus.

Buber, M. (1999). *Minä ja sinä*. Wsoy.

Eriksson, K. (1989). *Caritas-idea.* Karisto.

Freire, P. (2005). *Sorrettujen pedagogiikka.* Vastapaino.

Gävert, T., & Thitz, P. (2018). Nähdyksi ja kuulluksi tulemisen mahdollistaminen diakoniatyön kohtaamisissa. In H. Kostilainen, & A. Nieminen (Eds.) *Sosiaalisen kuntoutuksen näkökulmia ja mahdollisuuksia* (pp. 215–230). (Diak Työelämä 13). https://urn.fi/URN:ISBN:978-952-493-307-0

Haho, A. (2006.) *Hoitamisen olemus. Hoitotyön historiasta, teoriasta ja tulkinnasta hoitamista kuvaaviin teoreettisiin väittämiin* [Doctoral Dissertation, University of Oulu]. (Acta Universitatis Ouluensis D Medica 898). Oulun yliopisto. http://urn.fi/urn:isbn:9514282590

Hautala-Jylhä, P., Kankare, H., & Munnukka, T. (2004). *Lähimmäisenrakkauden puolustus: uusvanha näkökulma hoitotyöhön.* Tammi.

Henttonen, K. (1997). *Voiko sen sanoa toisinkin? Diakoniatieteen lähtökohdat ja valinnat*. (Lahden ammattikorkeakoulun julkaisusarja C 1997:1). Lahden ammattikorkeakoulu.

Huttunen, H. (2009). *Kristuksen kasvot kärsivässä lähimmäisessä.* (Anno Domini 2009. Diakoniatieteen vuosikirja.) (pp. 93–103). Lahden Diakoniasäätiö, Lahden diakonian instituutti.

Jokela, U. (2011). *Diakoniatyön paikka ihmisten arjessa.* [Doctoral Dissertation, University of Helsinki). (Diakonia-ammattikorkeakoulua A Tutkimuksia 34). https://urn.fi/URN:ISBN:978-952-493-149-6

Juntunen, E., Mäkelä, M., & Saarela, T. (2013). Diakonisen kohtaamisen huoneentaulu. *Diakonia* (5), 8.

Kankare, H. & Lintula, H. (2004). Lähmmäisen rakkauden idea. In H. Lintula, & H. Kankare (eds.) Vanhuksen äänen kuuleminen (pp. 35-49). Tammi.

Kirkkohallitus. (2012). *Saavu. Kirkon saavutettavuusohjelma*. (Suomen ev.lut. kirkon kirkkohallituksen julkaisuja 2012:2). https://evl.fi/documents/1327140/39227522/Kirkon+saavutettavuusohjelma.pdf/6179e385-77b4-3382-3cd1-710651ae36c1?t=1620279620249

Kirkkohallitus (2018). *Raportti: Missiologian tuntemus ja osaaminen kirkon työssä.* Retrieved March 26, 2020, from https://evl.fi/documents/1327140/34119626/missiologian-tuntemus-ja-osaaminen-kirkon-tyossa.pdf

Koivisto, K. (2019). Ohjaus ja dialogi hoitotyössä. *ePooki.* http://www.oamk.fi/epooki/2019/ohjaus-ja-dialoginen-vuorovaikutus-hoitotyossa/

Koet, B. J., Murphy, E., & Ryökäs, E. (Eds.) (2018). *Deacons and Diakonia in Early Christianity. the First Two Centuries.* (Wissenschaftliche Untersuchungen zum Neuen Testament 2. Reihe. 479). Mohr Siebeck.

Kopperi, K. (2007). Miksi rakastaa lähimmäistä? Luterilaisen diakonian teologian lähtökohtia. In Elenius, A., & Latvus, K. (Eds.) *Auttamisen teologia.* (pp. 143–157). Kirjapaja.

Kopperi, K. (2014). *Ristin rakkaus: Matka Lutherista suomalaiseen seurakuntaelämään.* Kirjapaja.

L 1054/1993. Kirkkolaki 26.11.1994/1054. https://www.finlex.fi/fi/laki/ajantasa/1993/19931054

Latvus, K. (2007). Auttajan viran alkuperän uusi tulkinta. In A. Elenius, & K. Latvus (Eds.) *Auttamisen teologia.* (pp. 52−82.) Kirjapaja.

Latvus, K. (2017). *Diaconia as care of the poor. Critical Perspectives on the Development of the Caritative Diaconia.* (Kirkon tutkimuskeskuksen verkkojulkaisuja 53). Retrieved

Lindqvist, M. (2006). *Auttajan varjo. Pahuuden ja haavoittuvuuden ongelma ihmistyön etiikassa.* Otava

Malkavaara, M. (2007). Suomalaisen diakoniatyön taustat ja nykytilanne. In A. Elenius, & K. Latvus (Eds.) *Auttamisen teologia.* (pp. 83−121.) Kirjapaja.

Malkavaara, M. (2015). *Diakonia ja diakonivirka.* (Suomen ev.lut. kirkon julkaisuja 26. Kirkko ja toiminta). Kirkkohallitus.

McGrath, A. E. (2012). *Kristillisen uskon perusteet. Johdatus teologiaan.* Kirjapaja.

Myllylä, M. (2004) Diakonisen hoitotyön mallin rakentaminen [Doctoral Dissertation, University of Oulu]. Oulun yliopisto. http://urn.fi/urn:isbn:9514273567

Nivala, E., & Ryynänen, S. (2019). *Sosiaalipedagogiikka. Kohti inhimillisempää yhteiskuntaa.* Gaudeamus

Nordstokke, K. (2019). Diakonia as a Mark of the Church. In S. Dietrich, K. Jørgensen, K. Karsrud Korslien, & K. Norstokke (Eds.) (p. 27–40.) *The Diaconal Church.* Oxford: Regnum.

Paldanius, A. (2002). *Lähimmäisenrakkaus hoitotyön koulutuksessa. Miten hoitotyön opiskelijat kuvaavat lähimmäisenrakkautta koulutuksen ja työkokemuksen edetessä?* (Acta Universitatis Lappoensis 45) (Doctoral Dissertation, Lapin yliopisto).

Pihkala, J. (2009). *Uskoa tiedosta ja tietoa uskosta.* Johdatus dogmatiikkaan. Edita

Rauhala, L. (2014). Ihmiskäsitys ihmistyössä. Gaudeamus.

Ryökäs, E. (2020). *Aikaan sidottu diakonian käsite. Tiedekriittinen yritys ymmärtää suomalaista diakoniakeskustelua.* (Suomalaisen teologisen kirjallisuusseuran julkaisuja 289). Suomalainen Teologinen Kirjallisuusseura.

Saarinen, R. (2008). Ihmisten kohtaamisen teologiaa. *Teologinen aikakauskirja, 113*(1), 21–34. http://hdl.handle.net/10138/42068

Seikkula, J., & Alakare, B. (2004). Avoin dialogi: vaihtoehtoinen näkökulma psykiatrisessa hoitojärjestelmässä. *Duodecim, 120*(3), 289–296. https://www.duodecimlehti.fi/lehti/2004/3/duo94071

Seikkula, J., & Arnkil, T. (2009). *Dialoginen verkostotyö.* Terveyden ja hyvinvoinnin laitos. http://urn.fi/URN:NBN:fi-fe201205084999

Seikkula, J., & Arnkil, T. (2014). *Open Dialogues and Anticipations: Respecting Otherness in the Present Moment.* National Institute for Health and Welfare.

Thitz, P. (2013.) *Seurakunta osallisuuden yhteisönä*. [Doctoral Dissertation, University of Kuopio]. (Diakonia-ammattikorkeakoulun julkaisuja. Tutkimuksia A 40). Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-214-1

Tuohimaa, M. (2001.) Emmanuel Levinas ja vastuu Toisesta. *Niin & Näin* 3/2001, 35–39. https://netn.fi/node/2068

Valtonen, M. (2017). Dialogue as a Fundamental Approach in Church Work. In P. Launonen, & M. Valtonen (eds.) *Diaconia in Dialogue- The Challenges of Diversifying Contexts* p (Diak Työelämä 12). Diakonia-ammattikorkeakoulu. http://urn.fi/URN:ISBN:978-952-493-304-9

Värri, V-M. (2002). *Hyvä kasvatus – kasvatus hyvään. Dialogisen kasvatuksen tarkastelu erityisesti vanhemmuuden näkökulmasta* [Doctoral Dissertation, University of Tampere]. Tampere University Press. https://urn.fi/URN:ISBN:951-44-5558-4.

Watson, J. (1979). *Nursing: The Philosophy and Science of Caring.* Little, Brown.

Watson, J. (2008). *Nursing: The Philosophy and Science of Caring. Revised Edition.* University Press of Colorado

World Council of Churches. (2016). *Called to Dialogue. Inter-religious and Intra-Christian Dialogue in Ecumenical Conversation – A Practical Guide.* Retrieved May 15, 2021, from https://www.oikoumene.org/sites/default/files/Document/BrochureInterreligIntraChristianDialogue.pdf

Ville Päivänsalo

5 ENCOUNTERS AND ETHICS IN DIACONAL NURSING: A CROSS-CONTEXTUAL APPROACH

Whereas forms of diaconal nursing vary across contexts, some aspects in this concept and practice can be recognized as broadly shared. In this article I will assume the quest for a healing encounter with another person is a shared aspiration in the field. Furthermore, in diaconal nursing such encounters are characteristically understood as holistic and ethical — indicating openness and attention to another person's physical, economic, social and spiritual needs. Methodologically, I will nevertheless begin by asking: what sort of encounters might not be holistic and ethical in the above-mentioned aspired sense? From here on, I will proceed to discuss some of the more substantial socio-ethical and theological questions of diaconal nursing, courage and encounters in a cross-contextual manner.

Missing a Personal Encounter?

How can we properly understand the meaning of a holistic healing encounter in diaconal nursing? Professor Dr Jacob Chandy (2001, p. 13, emphasis in the source), an Indian neurosurgeon and one of the key figures in Christian health work in India in the late twentieth century and beyond, put it this way: "*Wholistic health or total 'health' is the health of a man's whole being, his body, mind and spirit*". The Lutheran World Federation (LWF) (2009) publication *Serving the Whole Person: The Practice and Understanding of Diakonia within the Lutheran Communion* similarly emphasizes the wholeness of a person. Although I will use the more standard English adjective "holistic" rather than "wholistic", I will assume that its core meaning is the same as in the above quotation from Professor Chandy.

Little by little, we can then try to understand more about the meaning of holistic healing encounters in various contexts of Christian theology and diaconal practice. In theology, for one thing, this meaning can become more vivid when examined against a background understanding of *wounded human beings* and *wounded relations* in *a wounded world*. I will return to some perspectives on the

wounded human condition towards the end of the article. In practical nursing, for another, we can clarify the significance of holistic healing encounters by considering situations in which they are absent. For example, we can contrast such encounters with relief, which is limited to material needs alone, whether in terms of financial or bodily needs.

Supporting the poor has been among the key tasks of diaconal service since the times of the early church. When deacons, nurse-deaconesses or any members of a parish have assumed this task, they have — in the language of contemporary human development paradigms — tackled the challenge of eradicating income poverty. However, the challenge has never been *only* about money. Whereas extra income may be hugely important to a poor person, an opportunity for a holistic encounter may also be deeply salient. In *Diakonia in Context*, by the LWF's Department of Mission and Development (DMD) (2009, pp. 28–29), the material aspects of diakonia come with inclusive communality and a broad theological framing as follows: "The practice of diakonia, its ethos of inclusiveness and the mutual sharing of resources, clearly imply ethical demands, but its basis is the experience of God's grace and the gift of belonging to the communion created by God's grace."

As justified as tackling income poverty is (and I do believe it is), it could often be implemented simply through bank accounts. This is indeed what public social service organizations regularly do. Nowadays, such a process usually involves filling in complex internet forms to prove one's entitlement to a particular type of monetary benefit. All this can be well-grounded and just — yet a personal encounter is missing. And for many, a faith-based framing of such encounters is also profoundly important.

A holistic healing encounter may sometimes mean virtually the same thing as a "personal encounter". For example, in the "medicine of the person" approach by the Swiss physician and author Paul Tournier (1898–1986) and his colleagues, the quest was for medial care, with attention paid "to the biological, psychological, social, and spiritual aspects of health problems" (Pfeifer & Cox, 2007, p. 42). Compared with the above quote from Professor Chandy, the social aspect here is explicit. Whereas health may sometimes be understood individually and sometimes more broadly, encounters are always somehow social. A bank transfer hardly counts as a personal encounter, but a telephone call can indeed be meaningful. We are still examining the very minimum standards of a personal or holistic encounter. However, we must be aware that achieving even this level can sometimes be difficult: a telephone ringing may be a rare event for a marginalized person.

We must surely be careful in our endeavour. Highlighting the ideal must not be interpreted as a way of diminishing other very important ideals and duties such as the eradication of income poverty. Nor should this exercise be interpreted as implying that public sector social agencies do not provide personal counselling — in addition to wired income transfers. Encounters in the public sector, in religiously non-confessional settings, can be deeply healing. Yet they cannot really cover spiritual needs and be holistic in this sense.

Furthermore, my point is not to argue that the granting of subsidies or any financial aid in person is always a better way of helping the poor or implementing justice than doing it anonymously. The latter may imply a sort of privacy that the formerly face-to-face approach to aid cannot provide. Some would certainly find telephone calls uneasy as well. But the point here is to open up the analysis: non-personal aid does not provide a holistic encounter with its healing potential — an encounter that so many poor, sick and marginalized people, among a multitude of others, lack.

In diaconal nursing in particular, the work characteristically includes curing: healing physical wounds, giving a vaccination, helping an ill person take medicines and so on. Even in this field an encounter with another person cannot be taken for granted. It is possible to perform numerous physically curing actions while scarcely paying any attention to the person in question as a whole. Especially during the coronavirus pandemic, nurses must wear masks virtually all the time when meeting their patients. The nurses' facial expressions therefore remain mainly hidden. Moreover, if they do not look into the eyes of the patient and only say what is very necessary for the *physically curing* action to be correctly performed, we must say that the personal encounter has been missed.

Again, we should beware of unnecessary generalizations. Sometimes in the field of curing it may be better to have less personal encounter than more. Much depends on the personality of the patient: while some long for more social contacts, others appreciate the opportunity to just focus on physical essentials. Yet the key notion here, to start the analysis, is the openness of a nurse to a small-scale personal encounter. For quite a number of patients even very minor attentive gestures that treat them as something other than merely physically wounded or ill bodies can be healing indeed.

The challenge of such personal encounter also necessarily directs our attention to issues at the institutional level. Even in Finland, a high-income country in the global perspective, it is unfortunately common that nurses lack the time for personal encounters. The discussion has been heated at times: have at least some

of the business-sector or public-sector organizations pressed their nurses to adopt such busy schedules that their opportunities for personal encounters have shrunk? What explains the frequent alarming reports of a rushed approach, sometimes in the context of elderly care, sometimes of childcare, and so on? Is this really about the *poverty of institutions* in Finland, about the tightness of their budgets? In the hectic conditions of the nursing sector in general, it is easy to see that *insofar as the faith-based sector can provide something more* in the field of personal encounters, this can entail significant added value for many — an added personal value. Empirical studies have managed to capture aspects of such value (Selman et al., 2018), albeit often also reminding us that unprofessional and perhaps overtly spiritual approaches can be part of the problem.[1] Achieving the kind of encounter that is genuinely healing cannot be taken for granted in any sector!

Social needs and empowerment

The quest for healing encounters resonates strongly with our social needs as human beings. Beyond individual encounters, this notion leads us to think about various social events: open and closed groups, regular and special events, and the like. Nurse-deaconesses can play very important roles as leaders or coordinators of such activities, whether in parishes or other venues. Of course, hiking trips in nature and to cultural sites must be recalled, and sports as well, and taking part in Sunday services and other faith-centred events serves social needs in addition to spiritual ones.

The impact of Covid-19 is especially topical in the field of social needs. It is still too early to estimate the damage caused by the virus itself — as well as the restrictions involved, including the shutting down of an enormous number of social activities. Empirical studies will tell us more month by month. What has become clear, however, is the rapidly increasing need to alleviate the loneliness of those who have not become fully integrated with social encounters on net-based platforms. The first challenge here could be just to find the persons affected, especially those who really suffer from the isolation stemming from the restrictions involved in the response to the coronavirus.

1 Ulla Jokela (2011, 9) reports in her doctoral dissertation that the clients of the diaconal service in the Evangelical Lutheran Church of Finland have experienced "humiliation and randomness" and "valuating spirituality above bodily being", although diakonia has also appeared "to be a place for respectful encounter".

The impact of restrictive coronavirus policies, however justified, can hit hard because of the transformation of social events into net-based meetings. Holistic encounters are at the crux of the challenge. Whereas internet platforms do allow communication through sound, sight and chat, this is still less than meeting other people in person. Furthermore, in online meetings, many of us do not show our faces to the other participants for technical or other reasons. What would the philosopher and ethicist Emmanuel Lévinas (1906–1995) have said about this? For him, the ethical demand was particularly vivid in the face of the other. Indeed, the entire tradition that emphasizes the importance of I-Thou encounters from Martin Buber (1878–1965) onwards, drawing on the Jewish heritage, for example, and developed by the aforementioned Paul Tournier (Hilton & Hilton, 2007), needs to be profoundly reconsidered in the age of present communication technologies and cultures! The coronavirus era has become an almost faceless time for many, online and beyond.

Fortunately, online platforms have also provided *more* opportunities for encounters with others, especially for those who find attending live events challenging. The hope is that we will soon learn more about online encounters. My guess is that this will come with a renewed appreciation for keeping the cameras on. We are also challenged to improve our hybrid events and courses, including live meetings and online communication. Perhaps even the concept of "holistic encounter" will begin to include online or digital encounters as its integral dimension.

When addressing the issue of human sociability in the context of diaconal nursing, it is not enough to speak of social *needs*. Healing social encounters have also been envisioned as *empowering*. In other words, the question not only concerns the satisfying of one's prevailing needs to belong to a group and communicate with others, but also finding the strength to change things and grow into positions of responsibility. Philosophers have also conceptualized such issues in terms of capabilities, agency and courage. Notwithstanding the more detailed arguments involved, we can at least say that it may be very valuable for us as human beings not only to have our social needs satisfied, but also to be empowered as active agents in our own lives and well beyond.

From the perspective of social policy the focus of the discussion of social integration is often on employment. And it would certainly be good and fair if any person of working age found a way to earn their living and thereby presumably also increase their involvement in social activities. However, we know that in most societies full employment is impossible, and in many societies not even nearly. Given such broader societal fragilities, the discussion of empowering social en-

gagements should not overtly focus on work life opportunities. The "capabilities approach" (CA) to human development, for instance, has provided a much broader theoretical framework for the discussion of societal participation (Sen, 2009), and the CA approach has also been discussed broadly in the contexts of justice and faith (Päivänsalo, 2020). What we can at least say from the perspective of probably any reasonable philosophy, as well as of that of diaconal nursing, is that people can be empowered to grow in a great many types of responsibility.

The parish itself is a community that can provide a variety of options for people to use and develop their talents, and to find courage! More broadly, we all have a reason to recognize the importance of a viable civil society in any country and region.[2] No society can implement salient development goals securely through paid workers alone. The role of the voluntary sector is often paramount (Grönlund, 2021). Accordingly, it is essential that social contributions are not seen only through employment data, and not even nearly so. Diaconal nursing does very well if it manages to empower and encourage the marginalized to broadly assume responsibilities in the life of society.

Spiritual Needs 1: Openness

Let us turn to spiritual needs — first to the openness to such needs. We are now clearly moving into a field specific to diaconal nursing vis-à-vis nursing as a corresponding secular endeavour. But it is important to recall here that nurse-deaconesses generally serve people with *diverse* religious underpinnings. If someone is serving in a parish, she or he may serve mostly people who share a faith similar to their own. In a hospital, a medical centre or other organizations — whether state-based or faith-based — the variety in this respect could be much broader still. It therefore seems appropriate to first consider the mere openness to spiritual needs in this work, and thereby also to highlight the need to respect diverse religious and non-religious convictions alike.

However, openness to the patient's spiritual needs can hardly entail only willingness to listen without any capability of responding. In a holistic approach, the starting point is rather to be sensitive to what the other person may want to say or communicate. This entails an attempt to understand what she or he means. This is a person-centred and dialogical approach. A person's ideas and understanding

2 Finnish perspectives on civil society, religion, and sustainable development have been discussed intriguingly in Päivi Hasu (ed.) (2018), Kansalaisjärjestöt, uskonto ja kestävä kehitys.

(*dia-logos*), and willingness to communicate more generally as a person, are taken seriously.[3]

It is of course possible that the person in question represents a religious faith that makes it practically impossible for a nurse-deaconess to be of any real help. Perhaps the faith is strange for the nurse altogether, or it is mostly familiar but still very difficult to discuss. Certainly, for example, it may be difficult for a Protestant Christian to understand even another Protestant Christian — across the liberal-conservative divide, or other divisions or wounded relations. Kalle Kuusniemi (2015) illuminates some divisions within global Lutheranism. In any case, the professional nurse-deaconess needs to develop their capability of encountering spiritual needs through both openness and respect. Insofar as there are opportunities for healing in the spiritual realm, these are not to be dismissed. But insofar as the person in question wants to keep her or his distance, or insofar as the differences in conviction appear too sharp to be integrated in the process of healing, it is important for the request for respect to be kept clearly in mind.

Sometimes respect alone can prove healing. This may not sound a lot. However, sometimes genuine respect may emerge only after the fear of dissent, difference or failure has been overcome. As Jean Vanier (2008, pp. 69–79), the founder of the L'Arche communities, has pointed out, such a path to respect and healing may well involve walking through unknown territories.

Openness to the spiritual needs of the other may indeed lead to broad oceans of thought. The attraction of spiritual oceans may stem from a perception that we have been somehow living in a materialist, even soulless era. The author of the bestselling *Care for the Soul* (1994), psychotherapist Thomas Moore, has thereby assigned even a kind of priority to the care of souls and spirituality. While there is much that resonates with Christian theologies in this approach, the Christian holistic approach has also frequently insisted on the importance of our bodily existence. We can therefore recall that openness to spirituality does not need to mean sailing through all the seas of spirituality, and caring for souls does not need to involve uncritical acceptance of all that might attract one's soul.

Theologically speaking, openness to spiritual needs resonates with the *theology of creation*. In Christian faith it has always been believed that God created human beings with a longing for God, for the origin of all that is good in creation. Yet among all creatures human beings were created in the image of God, making

3 For more on dialogical encounters see Minna Valtonen in this book.

them sacred in a very special way. This faith also means to Yenenes Geleta (2009, p. 212) from the Mekane Yesus Management and Leadership College in Ethiopia, for example, the assigning of "equal value to men and women, poor and rich, disabled and the elderly". Most deaconess-nurses hardly have to delve deeply into the related theologies, at least not often. Nevertheless, merely a way of seeing human life as sacred can make a major difference. Whether through words or symbols like a candle, introducing the dimension of sacredness to the encounter can help all involved see themselves as highly valuable human beings rather than persons not to be treated only as things or means.

Let us here mention *narrativity* as another theological avenue to spirituality. Even if we may sometimes find it difficult to spell out what spirituality means to us here and now, we may be able to speak of something spiritually relevant from our past. Or perhaps our narrative understandings of ourselves are future-oriented, beginning with our hopes or fears. The broad heritage of the narrative theology inspired by Paul Ricoeur (1913–2005) and Stanley Hauerwas (b. 1940) among others illuminates such topics. But very practically speaking, if we rush into discussions of faith in the present, we may miss the opportunities for such healing encounters that require the processing of a troubled person's narrative from her or his childhood or youth onwards.

We must also recall here that human beings can be partly mysteries to themselves. We do not always know why it is that we feel pain, or whence our pain or fear comes — or if a spiritual aspect is involved. Sometimes providing an open and safe place for healing is already what matters (WCC & DIFAEM Study Group on Mission and Healing, 2010, pp. 30–31). Yet openness to the narrative understanding of the person as whole, including her or his spiritual struggles, wounds, discoveries and longings, can be seen as something special to diaconal nursing.

In diaconal encounters, a nurse-deaconess may thus be open to seeing other people as both sacred and narrative creatures on their spiritual journeys. Seeing a patient merely as a material physical being may go quite a long way for a surgeon. Adding the social dimension makes a huge difference to many other types of healing. But seeing human beings also as sacred and as spiritual nomads or pilgrims — more or less spiritual — can add a great deal to the encounters of each other as we are. And for a quest for holistic healing, we must indeed learn sensitivity to the richness of persons' internal lives, including the human quest for meaningfulness, while also appreciating ourselves as bodily beings.

A nurse-deaconess is also invited to recognize themselves as sacred and as a traveller somewhere on their own journey. As a professional, they are not to allow

their own wounds or struggles to occupy the space and meanings the other might need for healing. This is essential for encounters to be safe, thereby also supporting the safety and openness of the broader communities in question. Yet genuine truthful encounters cannot proceed for long without any indication of the stance of the nurse-deaconess herself or himself. In particular, for those nurse-deaconesses serving in parishes or faith-based organizations, mere openness to spirituality can hardly be a sufficiently specific determinant of such a professional's perspective on the encounters in question.

Spiritual Needs 2: This Faith

When serving as a deacon or deaconess, or in a corresponding office, a nurse-deaconess does represent a particular faith tradition. While this condition necessarily narrows the spiritual materials she or he may use, for example, when leading a devotion, it also implies opportunities. Let us start with the patient's legitimate expectations — or another person's — of being encountered. She or he can legitimately expect the nurse-deaconess to approach spiritual questions from the perspective of the faith tradition in question. Thus, if the patient regards themselves as belonging to that tradition, she or he can confidently attend the devotion to have their spirit and soul nourished. Or if the patient does not belong to or attend that tradition, she or he may in any case be aware of the overall spiritual approach of the said professional. In ethical terms, such transparency can clearly be an advantage.

In addition to healing, spiritual approaches can support coping with a disease. Harold G. Koenig (2008, p. 55) has reported on studies from the United States in support of this view, and Joey Marshall (2019) from the Pew Research Center has addressed similar issues on a global perspective. This is not to say that a nurse-deaconess or any other practising Christian needs to justify their service through such empirical studies. In many respects, matters of faith are not measurable, and no one needs to expect them to be. They may be, in some respects — these are matters for empirical scientists and perhaps philosophers of religion to debate. However, it is enough for a nurse-deaconess to join the Christian tradition of *faith* that affirms the healing power of God. Within Christianity, this aspect of faith has traditionally been more at the forefront of faith in Eastern Orthodoxy than in Western Christianity. While in the former it has been common to depict human salvation in terms of healing, in the latter the emphasis has tended to be on the juridical terms of guilt and mercy.

In both the Eastern and Western traditions, sub-traditions of miraculous healing, often connected with faith in relics and saints, have also existed. However, healing in a spiritual sense has not necessarily coincided with physical healing in either of these great currents of Christian faith. A person may grow closer to God and have their spiritual wounds healed while simultaneously deteriorating as a bodily being. And a broken spirit and a broken soul can be revived, even if there are few if any external visible signs for outside observers, at least for those who lack the mentioned sensitivity for discerning such things. Each branch of Christianity conceptualizes such insights somewhat differently (Numbers & Amundsen, 1998).

Indeed, Luther warned about assessing anyone's internal condition on the basis of their physical health or of their possession of any external good. For him Christ was not be sought in things that were high and desirable in human eyes, earthly speaking. Instead, Christ could better be found somewhere seen as low in human terms, perhaps in misery, as in Bethlehem's lowly stable or on the cross. Suffering belongs to both Christian life and human life in general. Nevertheless, Luther surely intended to avoid the ascetic path of his youth in his more mature days. In his youthful zeal he had even tortured himself to find peace for his spirit and soul. Yet having found a merciful God, he instead exhorted Christians to thank God for all that was good for the human body, soul and the spirit alike. It was therefore not human suffering either, in Lutheran terms, that was the essential way to spiritual healing — except Christ's once and for all suffering on the cross (Päivänsalo, 2020, pp. 144–151).

Little by little, the Lutheran non-ascetic and common-sense approach also paved the way for modern medicine to emerge as a reason-based and evidence-based manner of taking care of our bodies. Henceforth, the rise of the Protestant deaconess movement, not least in Kaiserswerth in Germany in the 1830s, was inspired by insights of faith, as well as the development of medicine. Indeed, Florence Nightingale, the mother of modern nursing, received part of her medical training at the Deaconess's Institute of Kaiserswerth (Päivänsalo, 2020, pp. 160–170; Porterfield, 2005, pp. 109–188; Lindberg, 1998).

Surprisingly for many, much more straightforward forms of spiritual healing have not disappeared from the scene of world religions. In many Roman Catholic regions faith in healing through the saints has mingled with similar traditions in aboriginal religions. Meanwhile, charismatic/Pentecostal Christianity has been a rapidly growing movement worldwide, projected to grow from 442,677,000 adherents in 2000 to 655,557,000 by mid-2021, and to 703,639,000 by 2025 (the

International Bulletin of Mission Research, 2021). Theological and ethical questions related to the faith in miraculous healing are therefore not about to vanish in a global perspective. Nurse-deaconesses within the Protestant Lutheran tradition, among others, will therefore need the theological prerequisites to navigate these terrains.

It is useful here to recall the above-mentioned advantage of transparency. Serving openly within a particular tradition of faith creates legitimate expectations for the patients and other people involved. They can therefore roughly anticipate the type of insights and practices the nurse-deaconess in question will employ in the field of spiritual healing. These could include reading familiar verses from the Bible and using the Lutheran hymnbook, as well as this church's handbook, and perhaps devotional literature and music that sufficiently resonates with this faith tradition. Moreover, patients often know some of their local pastors around, and probably their diocesan bishop through the media. They can thus have an overall understanding of the sort of spiritual approach the nurse-deaconess in question represents. And the trust that may well follow such transparency and familiarity may not be a minor factor in making the encounter in question a healing one.

Institutions across Contexts 1: In the West and Beyond

In the contexts of the Nordic welfare state in its most successful forms, the role of diakonia and diaconal nursing has been basically to complement strong public health and welfare institutions. Both historically and worldwide today, the baseline institutional setting for these movements has not been like this. In the German *Sozialstaat* the institutional basis has been strong, but both Protestant and Catholic diakonia institutions have played major roles in the system. In the two-thirds world — largely comprising low- and medium-income countries — diaconal nursing has often struggled amid overwhelming health and social challenges. This also used to be the case in Finland. The diakonia and diaconal nursing movement began to develop under the pressures of poverty, famine and Russian oppression, and it continued to evolve through the period of the two world wars. Finally, as Mikko Malkavaara explains in this volume, it started to find its contemporary institutional niche from the early 1970s.

A key turning point in this respect was 1972 — the year of the adoption of the Finnish Primary Health Care Act. Parish nurses who were on the payroll of the local Lutheran parish were no longer authorized to serve as nurses. It has since been

customary in Finland to regard public sector welfare institutions as the primary responsible agencies for health and social services. Such an assumption, however, can no longer be taken for granted. The emergence of the business-based sector, albeit often in the service of public institutions, has transformed the scene. It has also become painfully probable that the publicly funded services will remain deficient for a lengthy period. One of the implications of this likely scenario is that the need for the diaconal health and welfare service will remain much more than marginal. The extra pressure on public health due to the coronavirus pandemic has reinforced the assumption that the public sector will need, in addition to its business-based partners, a viable diakonia and diaconal nursing movement as its companion.

In the Anglo-American countries, in turn, not least in the United States, a broad welfare state has not been a shared ideal to begin with. The underlying model has consisted instead of a comparatively thin public sector with active business and voluntary sectors. In 2003 the Evangelical Lutheran Church in America (ELCA, 2003, p. 1) expressed its concern about this condition in *Caring for Health: Our Shared Endeavor* as follows: "Health care resources often are rationed based on ability to pay rather than need." Roger A. Willer (2010, p. 36), after reviewing the theological and practical objectives of the 2003 statement, clarified further: "The point was to look for a mix of means that would make equitable access available for all." The ambitious Obama Care or other reforms have not brought about sustainable welfare-state institutions in the United States.

Countries with dominant Roman Catholic traditions constitute a different story still. The doctrine of subsidiarity has influenced the understandings of the division of moral labour among different types of institution: in particular, the responsibilities for health and wellbeing begin from within families and smaller communities, and then, insofar as necessary, extend to broader levels and institutions. Caritas Internationalis (2021), a confederation of more than 160 members working around the world, highlights that in this approach "local groups should be given the power to carry out their own duties to work towards the common good".

Institutions across Contexts 2: Amidst Scarcity and Diversity

In a global perspective the variety among institutional arrangements is even more diverse. In low-income countries the question may be less about ideology than it

is about scarcity: an extensive public sector with quality care is not yet in sight. Around the globe, positive developments have occurred. Health and welfare institutions have grown stronger, and statistical trends have indicated rising life expectancy at birth, reduced under-five mortality, and so on. Between 1990 and 2019 the Human Development Index (HDI) figure for the entire world rose from 0.601 to 0.737 (UNDP, 2020, p. 359). Yet public health and welfare institutions remain poor in most low-income countries. The coronavirus pandemic makes it still harder for public health institutions to overcome their fragilities, and the ecological challenges highlighted by the UNDP's (2020) *Human Development Report 2020*, for example, are bound to complicate global health development as well. Amidst all this, the faith-based health sector will certainly be needed — both its institutions and its more informal neighbourly care. By its very nature this sector is also at the heart of what it means to be a church in a wounded world (LWF, 2003; Cavanaugh, 2016).

There is an urgent need for further human development in India, for example. D. Arthur Jeyakumar (2011, p. 8) points out that Christian medical work came there largely as a response to the "[t]errible inadequacy of medical facilities in India". And despite the rising average standard of living in this huge country, the inadequacy of public sector health and social services is still striking in broad areas. For example, the faith-based (Lutheran) Mohulpahari Nursing College in Dumka, Jharkhand, stemming from the heritage of the Santal mission, must still assume a kind of pioneering position in the education of nurses and sending them around India (Hodne, 1967; Päivänsalo, 2020, pp. 174–179; the Northern Evangelical Lutheran Church, 2017). In this case it is obvious that the impact of Christian nursing is bound to have its limits, for Christianity itself is clearly a minority religion in the country. However, we should note that the majority Hinduism includes a very lively health and healing tradition (Chantia & Misra, 2021), and that the Roman Catholic health sector is much broader than the Protestant one in India. A renewed Protestant attention to health-related development there would indeed seem welcome.

Meanwhile, in several African countries church-owned health institutions belong to the key infrastructure in the health and social services fields. Cooperation with the state can mean, as is common in Tanzania, that the state largely pays the salaries of the staff members of church-owned health facilities (Sundqvist & Ndaluka, 2021; ELCT Health, 2021). Much more variation can still be found in Latin America and in any region across the globe where Christianity is in a minority position, for example.

The contexts of migration have further underlined the need to rethink the roles of institutions in a cross-contextual manner. In January 2016, amidst the dramatically intensifying migration challenges in Europe, Dr Olav Fykse Tveit, the General Secretary of the World Council of Churches, was asked to give a presentation about the issues of service and advocacy as matters of faith and love. In doing so, Tveit (2019) emphatically regarded them also as matters of hope. This reminds us that, while promoting service and advocacy in changing conditions, we are also to reflect dynamically on the work's inspiration . Which teachings of faith, hope and love might be the most relevant in the transforming social conditions of our wounded world in each era? Whether there is a strong institutional backing for health work or not, and whether a unified political agenda prevails in the transforming contexts or not, the church's faith-based calling is to care for the wounded and reinforce human dignity and hope.

There is no straightforward way to infer how various institutional arrangements influence the understandings of diaconal nursing in each context. But what appears evident, first, is that diaconal nursing cannot be envisioned further, in most contexts, on the assumption of stably progressing public institutions. *Diaconal nursing, alongside diakonia more broadly, needs viable institutions of its own to foster its development*.

Second, the calling of diaconal nursing entails that *it must provide an alternative to business-based care*. However difficult it may be, the diakonia and diaconal nursing movement must adhere here to its own strengths, enshrining personal and holistic encounters at its heart, extending much further than to meeting material and bodily needs alone. The movement also needs to develop institutionally in ways that support healing encounters with the reinforcement of dignity and hope. This goes hand in hand with the quality that vindicates the competitiveness of faith-based agencies among the corresponding public and private agencies.

And finally, the cross-contextual developments at both the personal-relational and the institutional levels indicate a *further need for the theology of spirituality in diaconal nursing*. There is a need for education about spiritual openness and respectful dialogue, as well as about the roots and clarity of one's own faith tradition. Indeed, it is essential for practising nurse deaconesses, as well as their institutional superiors, to think through what cross-contextuality requires at all levels, from material to spiritual needs, and from personal encounters to institutional transformations.

Sources and literature

Caritas Internationalis (2012). Caritas and Catholic Social Teaching. Retrieved May 15, 2021, from https://www.caritas.org/who-we-are/catholic-social-teaching/

Cavanaugh, W. T. (2016). *Field Hospital: The Church's Engagement with a Wounded World.* Wm. B. Eerdmans Publishing Co.

Chandy, J. (2001). The Concepts of the Ministry of Healing (1990). The Responsibility of the Congregation in the Healing Ministry of the Church. V. Aruldas (Ed.), *The Healing Ministry of the Church of India: A Compilation of the Jakob Chandy Orations* (pp. 5–18). Christian Medical Association of India.

Chantia, A., & Preeti, M. (2021). Hinduism and Health Justice: An Indian Perspective. In V. Päivänsalo, Ayesha A., George Z., & M. Stenlund (Eds.), *Faith-Based Health Justice: Transforming Agendas of Faith Communities* (pp. 82–122). Fortress Press.

The Department of Mission and Development (DMD) (2009). *Diakonia in Context: Transformation, Reconciliation, Empowerment: An LWF Contribution to the Understanding and Practice of Diakonia.* DMD / Lutheran World Federation (LWF).

The Evangelical Lutheran Church in America (ELCA). (2003). *Caring for Health: Our Shared Endeavor.* Amended and adopted as a social statement of the ELCA by the eighth biennial Churchwide Assembly on August 15, 2003, at Milwaukee, Wisconsin. Retrieved May 15, 2021, from http://download.elca.org/ELCA%20Resource%20Repository/HealthSS.pdf

ELCT (The Evangelical Lutheran Church in Tanzania) Health (2021). Home. Retrieved May 16, 2021, from http://health.elct.org/home.html,

Geleta, Y. (2009). The Socioeconomic Perspective of the EECMY Holistic Ministry: A Brief Presentation for the LWF Global Consultation on Diakonia. In K. Nordstokke, with F. Schlagenhaft (Eds.), *Serving the Whole Person: The Practice and Understanding of Diakonia within the Lutheran Communion*, LWF Documentation 54, 207–215. Lutheran University Press.

Grönlund, H. (2021). Empirical Perspectives on Health Justice. In V. Päivänsalo, A. Ahmad, G. Zachariah, & M. Stenlund (Eds.), *Faith-Based Health Justice: Transforming Agendas of Faith Communities* (pp. 172–185). Fortress Press.

Hasu, P. (ed.) (2018). *Kansalaisjärjestöt, uskonto ja kestävä kehitys.* Fida International & Finnish Evangelical Lutheran Mission.

Hilton, C., & Hilton, M. (2007). Personhood in Health Care: Jewish Approaches." pp.J. Cox, A. V. Campbell & B. (K.W.M.) Fulford (Eds), *Medicine of the Person: Faith, Science and Values in Health Care Provision* (pp. 96–124). Jessica Kingsley Publishers.

Hodne, O.(1967). *The Seed Bore Fruit: A Short History of the Santal Mission of the Northern Churches 1867–1967.* Santal Mission of the Northern Churches.

The International Bulletin of Mission Research (2021). Status of Global Christianity, 2021, in the Context of 1900–2050. Gordon-Conwell Theological Seminary. Annual statistics. Retrieved May 6, 2021, from https://www.gordonconwell.edu/center-for-global-christianity/resources/status-of-global-christianity/

Jeyakumar, D. A. (2002). *History of Christianity in India: Selected Themes*. Indian Society for Promoting Christian Knowledge.

Jokela, U. (2011). *Diakoniatyön paikka ihmisten arjessa.* [Doctoral Dissertation, University of Helsinki). (Diakonia-ammattikorkeakoulua A Tutkimuksia 34). https://urn.fi/URN:ISBN:978-952-493-149-6

Kuusniemi, K. (2015). *The Voice of Confessionalism and Inter-Lutheran Relations: The Influence of the Missouri Synod in the Baltic and Ingrian Lutheran Churches, 1991–2001.* [Doctoral Dissertation, University of Helsinki).

Lindberg, C. (1998). The Lutheran Tradition. In Ronald L. Numbers & Darrel W. Amundsen (Eds), *Caring and Curing: Health and Medicine in the Western Religions Traditions* (pp. 173–203). The Johns Hopkins University Press.

Marshall, J. (2019). Are Religious People Happier, Healthier? Our New Global Study Explores This Question. The Pew Research Center. Home. 31 Jan 2019. Retrieved May 6, 2021, from https://www.pewresearch.org/fact-tank/2019/01/31/are-religious-people-happier-healthier-our-new-global-study-explores-this-question/

Moore, T. (1994). *Care for the Souls: A Guide for Cultivating Depth and Sacredness in Everyday Life.* Harper Perennial.

The Northern Evangelical Lutheran Church (NELC) (2017). *Panji.* NELC.

Numbers, R. L., & Darrel W. A. (Eds) (1998). *Caring and Curing: Health and Medicine in the Western Religious Traditions.* Johns Hopkins University Press.

Lutheran World Federation (LWF) (2003). *Official Report: LWF Tenth Assembly: Winnipeg, Canada, 21–31 July 2003: For the Healing of the World*. LWF.

Päivänsalo, V. (2020). *Justice with Health: Faith in Support of Progress across Contexts*. (Acta Universitatis Upsaliensis. Uppsala Studies in Social Ethics 51). http://urn:nbn:se:uu:diva-411572

Pfeifer, H.-R., & Cox, J. (2007). The Man and His Message. In J. Cox, A. . Campbell & B. (K.W.M.) Fulford (Eds), *Medicine of the Person: Faith, Science and Values in Health Care Provision* (pp. 33–45). Jessica Kingsley Publishers.

Renkert, T. 2021. Healing and Salvation: The Relation of Health and Religion in the Context of Christianity. pp. V. Päivänsalo, A. Ahmad, G. Zachariah, & M. Stenlund (Eds.), *Faith-Based Health Justice: Transforming Agendas of Faith Communities* (142–171). Fortress Press.

Selman, L. E., Brighton, L. J., Sinclair, S., Karvinen, I., Egan, R., Speck, P., Powell, R. A., Deskur-Smielecka, E., Glajchen, M., Adler, S., Puchalski, C., Hunter, J., Gikaara, N., & Hope, J. (2018). Patients' and caregivers' needs, experiences, preferences and research priorities in spiritual care: A focus group study across nine countries. *Palliative Medicine, 32*(1), 216–230. https://doi.org/10.1177/0269216317734954

Sen, A. (2009). *The Idea of Justice*. The Belknap Press of Harvard University Press.

Sulmacy, D. P. (1997). *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals*. Paulist Press.

Sundqvist, J., & Thomas N. (2021). Towards Basic Health Justice: Grassroots Challenges in Church-Related Health Services in Tanzania. In Ville Päivänsalo, Ayesha Ahmad, George Zachariah, & Mari Stenlund (Eds), *Faith-Based Health Justice: Transforming Agendas of Faith Communities* (pp. 45–64). Minneapolis, MN: Fortress Press.

Sundqvist, J., & Thomas, N. (2021). Towards Basic Health Justice: Grassroots Challenges in Church-Related Health Services in Tanzania. Teoksessa V. Päivänsalo, A. Ahmad, G. Zachariah, & M. Stenlund (Toim.), *Faith-based health justice: Transforming agendas of faith communities* (45–64). Fortress Press.

Tveit, O. F. (2019). Service and Advocacy: Matters of Faith? V. Päivänsalo, & P. Slotte (Eds), *Matters of Faith and Love: Nordic Perspectives on Transforming Social and Theological Challenges* (pp. 15–29). Luther-Agricola Society.

The United Nations Development Programme (UNPD) (2020). *Human Development Report 2020: The Next Frontier: Human development and the Anthropocene.* UNDP. Retrieved May 15, 2021, from http://hdr.undp.org/sites/default/files/hdr2020.pdf

Vanier, J. (2008). *Becoming Human*. Paulist Press.

Willer, R. A. (2010). Caring for Health: Our Shared Endeavor. *Lutheran Women Today*, 34–36. https://download.elca.org/ELCA%20Resource%20Repository/HealthSS_Introduction.pdf?_ga=2.208150932.704493922.1621062184-56844484.1621062184

World Council of Churches (WCC) & The German Institute for Medical Mission (DIFAEM) Study Group on Mission and Healing. (2010). *Witnessing to Christ Today: Promoting Health and Wholeness for All.* DIFAEM.

Raili Gothóni

6 CORPOREALITY AND TOUCH

Too many people have to live without anyone listening to them or giving them the slightest touch. One of the tasks of the pastoral carer is to listen to the body's speech. Corporeality is observed in the sacraments, in prayer, and in the combination of drama and movement in the spiritual context. The task of the nurse-deaconess is to work close to the person. The work involves touch, which takes into account considers the need for space and boundaries, and the impact culture has on persons in need. The different kinds of touch are to connect, comfort, pass on a sense of security, assist, nurse and control. The area of expertise of the nurse-deaconess is spiritual touch. Touch is always an adjunct to — not a substitute for — talking and listening.

Corporeality

Created and redeemed

The creation accounts (Gen. 1:1–2; 3 and Gen. 2:4–25) have been interpreted in various ways. One way of looking at the accounts is to view them in hierarchical terms, according to which the human being is considered higher than the other creatures and has dominion over everything that is created. Another interpretation is that it is the human being's task to protect creation. The human being is a steward and is responsible for creation. The perspective of interaction, interdependence and togetherness has been considered as a third possible interpretation (Veikkola, 2007, pp. 21–44). The last interpretation describes well the position of human beings in relation to their body, other people and creation.

When God saw everything that God had made, God found that it was beautiful. People are diverse, but in their uniqueness, they are all beautiful. People's measure for what constitutes beauty or the way they view the body as a modifiable object are unsustainable from the perspective of diaconal nursing. One of the

tasks of diaconal work is to support people in taking care of their own wellbeing. The deaconess can support people in their own corporeality and in the diversity of human bodies. Being human also involves sexuality and the longing for another person. Sometimes workers themselves, sometimes people seeking help, need support in accepting their own sexuality. In their emphasis on the sanctity of and appreciation for the whole of creation, the issues of ecotheology are part of the theology of the body.

The human being is a weave of the body and soul whose threads are inseparable. The body is not a shell or prison where the soul is detained for a lifetime. The box–content comparison should never be used in Christian theology. The Christian image of the human being should rather be seen as a blessing: *May the God of peace himself sanctify you entirely; and may your spirit and soul and body be kept sound and blameless at the coming of our Lord Jesus Christ* (1 Thess. 5:23).

Corporeality is an integral part of God's creative work. The body is no less valuable than a person's mental and spiritual welfare, as suggested by advertisements and demands for body modification (Gothóni, 2012, p. 16). Bodily needs are no less valuable than spiritual needs, as is implied by those with a dualistic conception of humanity. In her dissertation, Ulla Siirto observed that some diaconal workers spiritualized everything or appraised people's spiritual questions as more important than their questions concerning the body's welfare (Jokela, 2011).

God created the human being innocent and naked. The Fall changed the situation completely (Gen. 3:7–11). Man became aware of nakedness, guilt and disobedience. He experienced shame and wanted to cover himself with leaves and to hide. It is the task of the diaconal worker to listen to people's experiences of guilt and shame. These do not need to be covered up. In shame and guilt the person needs open discussion and forgiveness (Nissinen, 2002, p. 33).

God became human in Jesus. From the perspective of incarnational theology, God is present not only in the written word but also in human documents and in the stories and experiences of corporeal life. Touch is mentioned on several occasions in the descriptions of Jesus's actions. He touched people both with his hands and in his words, gestures of acceptance and attitudes. He touched her hand and the fever left her. He laid his hands on them for blessing, and touched (Mark 1:30–31; Matt. 9:24–25; Mark 8:22–23; Mark 1:40–42). It is the task of the diaconal worker to grasp someone's hand when they need help. Their task is to bless and touch when the one seeking help needs it.

God became human as a little child. Jesus was born and began his life as a baby. Shepherds and wise men worshipped the little new-born child. Worship did

not commence when Jesus performed miracles and spoke wise words. Worship did not commence after the resurrection. Worship commenced when he was born. This obliges all people to honour each other and care for the human dignity of all without questioning their actions, usefulness or decency.

In addition to the word the sacraments also have a concrete substance. At the eucharist there is bread and wine. In baptism there is water. The sacraments are concretely received and those who receive them know God's presence and blessing. Prayer is holistic. Corporeality is manifested in the crossing of hands and in making the sign of the cross. The human being bows down to God. Body prayer, touch hymnody, and dances of prayer and praise are expressions of the increased attention to corporeality as part of prayer and praise (Helle-Lahti, 2015).

Corporeality is a charged concept

In the history of the Christian churches there has been a strong tension between accepting and valuing the body on the one hand, and contempt for the body and denial on the other. People have feared and despised corporeality; they have denied, subjugated and suppressed it as filthy and evil. Western theologies of corporeality have sought to defuse the tension between Christianity and sexuality. They have used the dualistic conception of the separation of the body and spirit. They have contained body and sexuality negativity. The body as sexuality and negativity have often been the Western churches' ways of reflecting on corporeality (Vuola, 2008).

The theologies of liberation have emphasized issues of gender, colour, suffering, poverty and power. The following questions are topics of liberation theology: Whose bodies are being spoken of? Who is speaking? How is it spoken about? What is not spoken of and why? At the forefront of poor countries' theologies of corporeality is corporeality as suffering, hunger, thirst and torture (Vuola, 2004).

The Western theology of the body has been criticized for being too centred on sexuality. Liberation theologians have reminded us that the body has more than simply a right to food and drink, but also that all people have the right to a life in dignity and the subjectivity, corporeality and sexuality of their own lives (Vuola, 2008). A holistic view of the sacredness of the human body results in the fight against human trafficking. Nothing in nature should be an object of greedy exploitation.

Many expressions used in religious language and symbols speak of the pain and suffering of the human body, but also of the joy, gratitude and pleasure of the

body. There are, for example, texts in the psalms with which a depressed and suffering person can identify. Likewise, they contain hymns of love and expressions of joy that give voice to love, joy and gratitude.

It is ironic that those who criticize the bodily negativity of Christian norms submit themselves to torturous fitness regimes, rigorous physical exercise and the commercialization of the body. Modern society's rules and categories strongly invoke everyone's freedom in relation to their own bodies. Often this entails a submission to a biopower that determines, categorizes, manipulates, moralizes. The consideration of corporeality in diakonia is reflected in actions to eradicate poverty and hunger, as well as in action to strengthen people's right to integrity and the equal opportunity to be proud of their own body and gender.

The diaconal worker uses three different approaches to deal with corporeality. First, there are situations in which only one option is correct — the choice is either/or. For example, this arises when it is necessary to alert child protection authorities or establish the grounds for granting or denying financial assistance. In the second approach, helping a person seeking assistance requires the worker to perceive reality from different perspectives, in which case the aim of the discussion is to obtain a multifaceted picture of the situation. The third approach is to experience reality as a bodily presence that cannot be expressed in words. This dimension is always present in an encounter, but sometimes a holistic presence alone is the best way to help (Andersen, 2012, pp.81–94). How these three approaches are used in perceiving the reality of the person seeking help and in offering assistance depends on the situation and the worker.

Life has its limits

Change and ageing are inherent to corporeality. In today's debate about the care of the elderly, many are asking how one can grow old today without a loss of dignity and respect for fellow humans. This is the intersection of diakonia and corporeality, and the place to fight for human dignity.

People's awareness of their limitations forces them to consider existential questions. When a person is near death, they are faced with two types of question. On the one hand, they reflect on the meaning and purpose of their life; on the other, they reflect on its end (Virtaniemi, 2018). They need an interlocutor in these exchanges who is willing to discuss the suffering, life and death of the body, but also faith and resurrection.

Even if the body wears out, the human being is not a consumer good. Disposability in human relationships is regrettable. Instead of lasting relationships, people seek transitory and fleeting ones with few obligations and ties. They become tools and recyclable goods, and ultimately waste for disposal. However, perhaps it is also possible to learn the principles of sustainable development in relation to oneself and others. It may be good to remember that God does not have a bin for used people. Short-sightedness is not a diaconal approach (Gothóni, 2012, p. 14).

Professor Raija Julkunen (2004, pp. 19–21) states that corporeality is too often associated only with disability, illness and helplessness. In her opinion, this is because a materialist-naturalistic biological conception of the body has prevailed. The body is an object that can be observed externally. More attention should be paid in social care and healthcare to the societal meanings, symbols and power relations of corporeality. Julkunen uses the expression "constructionist body perception". Moreover, she avers that until recently the phenomenological perception of the body which is alive, bearing meanings and constructing them, has been almost completely ignored. The nurse-deaconess's special expertise lies in the ability to combine these concepts of the body in both education and work.

The body feels and remembers

Several metaphors in the Finnish language describe the intertwining of the body, mind and life situation. By listening to examples, one can understand where something is felt in the body and the meanings it communicates.

> *I can't digest (process) how he's treating me.*
>
> *It's annoying when my boss is always breathing down my neck.*
>
> *In front of the audience, I couldn't catch my breath. I couldn't give a presentation. I had to get out of there to breathe.*
>
> *I have to keep all the threads in my hands as a leader. I wouldn't have the strength for it any longer.*

The metaphors' messages are clear. Listening to the body's voice entails observing the effect of external factors, as well as assessing the impact of one's own situation.

The human being senses and feels with their body. Memories accumulate in the body. The human being bears in their body both a sense of what is good and the things that are calming, as well as heavy and traumatic events. The body remembers experiences even when the memory has already forgotten them, or when the individual has never been able to allow them to be consciously dealt with because of the pain of events. The body is a mirror of thoughts and attitudes. How a person moves and their way of being express their overall situation, wellbeing, and relationship with the people and world around them (Lindfors, 2018, pp. 141–163).

Body memory is non-linguistic. Traumatic experiences may latter be manifested as sensory and tactile sensations like convulsions, stiffness, twinges, cutting, burning, numbness or difficulty breathing. Odours, sounds and colours can be associated with body memory. It manifests itself in movements and gestures (Parviainen, 2014, pp. 179–189).

The body's memory is often better than the mind's. The mind is very capable of covering up and failing to be aware of things that are too difficult to remember and deal with. Emotions or experiences cannot be concealed from the body, because emotions live and manifest themselves in the body. Emotional experiences can be stored in the body, which may at some stage of life require awareness and reflection.

The body remembers the blows of life and speaks of the passage of time. The body's memory is often the shrine of lifelong experiences. It contains the unstable and the stable, chaos and integrity, abandonment and presence, interruption and continuity, lovelessness and love. We use many metaphors when we verbalize our story. These metaphors link the stories of the body and mind. Sometimes it is only in the language of the body that especially difficult, buried and forbidden memories arise. They can be perceived in human movements, touches, tones, how a person observes and sees, and in response to space, smells and tastes. Difficult memories are experienced as a painful or distressing feeling. The experiences of success and acceptance are also manifested in the body. That is when it is easy to smile. Joy and passion appear to invigorate the whole body (Parviainen, 2014, pp. 179–189).

Bitterness is experienced as stinging in the chest. Fear is felt in the gut. Panic arises from the area of the diaphragm and is the compulsion to find an escape from a situation. Anger raises our pulse. Unresolved feelings of anger, fear and bitterness are issues over which the individual has no sense of control and to which they cannot give expression. Anger becomes anger with oneself or is redirected at others. If this dark side is very large, energy is spent silencing forbidden emotions, preventing internal balance. It is then that a person needs a professional helper

who will allow a safe and confidential interaction to share and deal with experiences and feelings.

A cry that has not been vented or a grief that has not found mourning remains as a gnawing at the throat or settles in the chest. Only a stream of tears can dissolve it. Sometimes the prohibition on crying is so strong that a person prefers to chop wood or bark at another instead. The sorrow felt by the body is unheard. Tears melt the ice and alleviate grief. Not only do they interpret emotions; they are also lenses that afford a different perspective. A nurse-deaconess can offer a handkerchief and has the time not to rush. They can listen to the issue that caused the crying. They can then work together to consider the options for moving forward on a difficult issue.

When rejected, repressed emotional cycles and lumps tend to come to the surface, causing anxiety, fear and despair, it means we are approaching something significant waiting to enter our consciousness. If the words are found for the experience, work on the issue can begin. It is important to find the words to the emotions which are associated with an experience a person has been forced to keep out of their consciousness, sometimes for years.

The body shows the weak and needy side of a person. It defends everybody's right and possibility to be strong and weak at the same time. Embodied experiences are not always easily translated into words without distorting something, yet listening to what the body is saying is essential for increasing self-awareness (Gothóni, 2020).

We engage in dialogue with our body and in everything we do. Interaction is not merely talking; it is a physical activity. All our expressions are functions of the body. Speaking, writing, painting, and all non-verbal messages require a body (Seikkula, 2018, pp. 66–80). The body is essential in every interaction. It is sometimes good to stop and ask oneself what kind of traces there are in our own bodies, and what kind of traces one passes on to others.

Touch

Different types of touch

Touch is communication and interaction. Touch can be neutral in nature, for example, in a greeting. Touch can be comforting, safety-enhancing, helpful, therapeutic or controlling. Negative touch is a paternalistic or cold routine. Sometimes touch has a spiritual content. Every diaconal worker felt that touch was part of

their job. In their view they touch another person when the situation calls for it. Seventy-nine per cent of workers felt that they knew when touch was appropriate. Eighty-one per cent believed that they learned how to act correctly through intuition (Hautamäki, 2012). Various types of touch can overlap and have several meanings simultaneously.

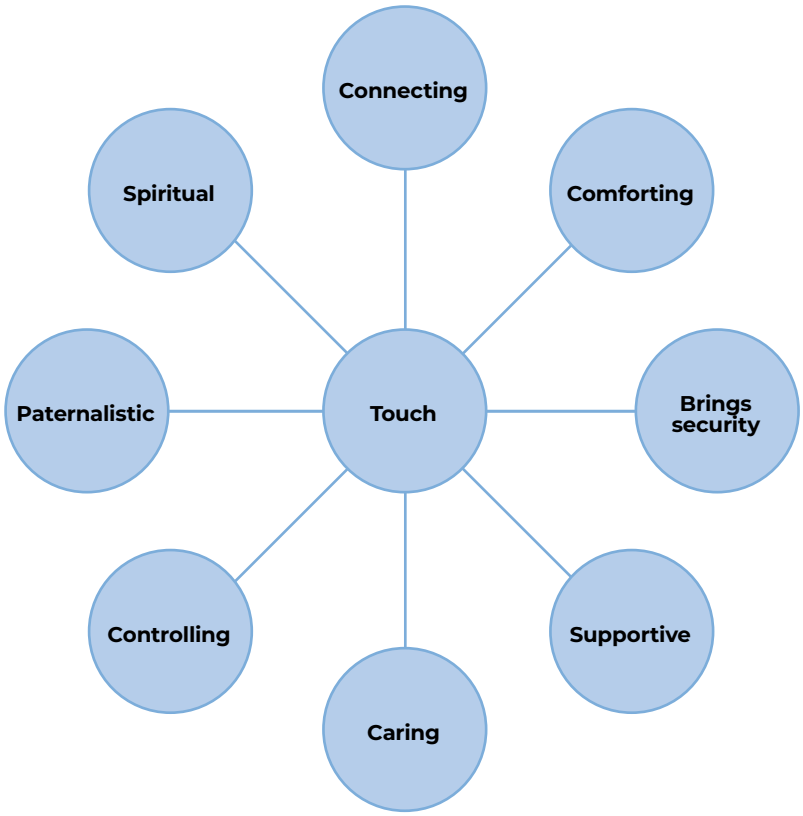

Figure 1. Different types of touch

A touch that connects entails a greeting, for example. Shaking hands is part of Finnish daily life. The deaconess offers a greeting and welcomes. A greeting and smile show friendliness. However, during epidemics shaking hands is avoided because of the risk of infection. Shaking hands is perceived in Finland as a neutral and correct way to acknowledge another person. In southern Europe it is common to kiss people on the cheek. In Asian culture one bows and places one's hands together instead of shaking hands. Some Muslims consider a handshake between women and men inappropriate.

A comforting touch shows care. It is meaningful to sit beside the seriously ill and those who are approaching death. It is a time to be present and still. Many

find it difficult to be present without doing something or making a fuss. Similarly, a touch that only lingers may feel strange. Yet such a presence and touch are sometimes the most essential care and consolation.

Most sick or otherwise vulnerable and unprotected people feel good when their hand is held. Many people hope that they will not have to die alone. Holding hands says what cannot be said in words. A hand conveys trust and consolation instead of doubt and fear, peace and security instead of flight. A warm hand provides the energy that is needed and relieves fear.

When a person is ill, pain can consume their thoughts so completely that there is only pain and its endurance. Especially when a person is near death, it is important to be able to be accepted and valued by both oneself and others. Good pain management and safe touch permit ease and comfort. They demonstrate appreciation of and care for a person (Hänninen, 2013; Aalto, 2013).

Here are two different experiences of holding hands from a time spent working as a hospital theologian:

A 76-year-old woman always grasped my hand and expressed a hope:

> *When it's my time to leave, if possible, don't leave me alone but sit here and hold my hand. Somehow it feels so safe.*

An 81-year-old man found holding hands beneath his dignity.

> *I don't want anyone to hold my hand, even if I'm already weak. It's horrible to even think about. Touch is like the last straw on a journey in which your independence is gradually stripped away, your self-determination diminishes bit by bit, and you grow dependent on others. If the nurse tries to hold my hand, I feel they think I've become helpless and dependent on others. I'll be led by the hand towards death, the last portal. I want to feel independent until the end.*

A touch that brings security is especially important for a person with a memory disorder. Touch grounds the client and provides reassurance that they are not alone. Touch can contribute to the expression of emotions, the alleviation of fear and the experience of security. Sometimes touch helps to revive past experiences (Aejmelaeus, Kan, Katajisto & Pohjola, 2007, pp. 225–231; Gothóni, 2012, pp.86–87).

It can serve as a safe bridge between two people. Touch is used to confirm a verbal expression or respond to a question that has been asked. This may mean

touching the shoulder, back or hand. Just a few words or very short sentences are needed to emphasize a verbal statement (Gothóni, 2012, p. 87).

A supportive touch is significant when the human body refuses to function. It needs help and hands. Sometimes — for example, at camps — a nurse-deaconess may help with washing and dressing. Many people enjoy having their hair brushed or a light massage that improves the blood circulation. Taking a patient for a walk also entails much needed intimacy and touch. Rehabilitative touch is part of supportive touch (Kinnunen, Parviainen, Haho & Jolkkonen, 2019, pp. 48–51). Touch can be about the sharing of joy and the experience of wellbeing and fun. It binds both the nurse and the one being cared for in a mutual presence. In such situations nursing expertise is of use.

The touch associated with care has not vanished from parish work. Sometimes nurse-deaconesses in the parish can take blood pressure and measure blood sugar levels, change a bandage on a wound, apply lotion, or rub the hands or shoulders. Nurse-deaconesses especially feel that they contribute active observation and clarify matters through questions. They assist in treatment guidance if required. Exploratory touch associated with treatment is used in checking a person's health. In such a case, the nurse confirms the situation by feeling the pulse, a swelling or bruises. Touch associated with care in parish work is very minimal, most often occurring during home visits, at camps or on excursions. If the nurse-deaconess is functioning as a nurse at a hospital, a caring touch is naturally part of their job. (Hautamäki, 2012, p. 55).

One patient's prayer reflected the importance of a nurse's respectful way of touching. She said:

> *Every morning I pray that I won't be treated by one particular firm nurse who treats me like a bag of flour and to whom no one dares complain about their pain.*

Nursing-related touch often involves technical tools, in which case the nurse's job is to create a relationship of dialogue. This prevents the interaction relationship becoming cold and distant (Kinnunen et al., 2019, pp. 93–111).

Controlling touch is associated with situations where a person is reassured, violent behaviour is prevented, or either the person themselves or another is protected. Controlling touch is appropriate if the touch of a person in need of help is unpleasant, sexually charged or violent. A sexually charged touch can be reacted to with a clear statement that the situation is uncomfortable and should not hap-

pen again. Sometimes the situation causes anger; sometimes it can be acknowledged with humour.

Punching, kicking, scratching, grabbing and biting are acts of violence. Their incidence has increased, both in diaconal work and in the social and health fields in general. A violent person may be suffering from dementia. They may be anxious about the situation, and their fear may make them angry. Violence is often associated with alcohol or other intoxicants. Verbal dialogue is paramount in both cases. A controlling touch may also be needed. Violence is never right, and the incident must be properly reported. Parishes should also check that adequate measures have been taken to ensure the safety of workers.

A paternalistic touch is a patronizing touch that is perceived as negative. It can cause anxiety and shame. For example, this means touching an elderly person as if they are a child. Patting a person on the head and speaking in a loud or patronizing tone are offensive and disrespectful.

A spiritual touch is an opportunity for the nurse-deaconess to give a blessing. The laying on of hands and the associated words of blessing "The grace of our Lord Jesus Christ, and the love of God, and the fellowship of the Holy Spirit be with you" (2 Cor. 13:14) convey God's presence and blessing through the deaconess.

Anointing with oil is also tactile. Although anointing with oil appears in the Bible, it was almost forgotten in the practice of the Evangelical Lutheran Church of Finland for a long time, until the general synod issued guidelines for the anointing of the sick in 1985. Anointing with oil in worship has increased in various parishes, especially during Lent. People may ponder existential questions with a diaconal worker when being blessed and anointed with oil. Experiences of the meaning and meaninglessness of life, as well as interpretations of a person's past and future, may emerge, depending on the individual.

Dignity and unhurriedness

Interaction means more than just a professional relationship between the deaconess and the person in need. It also concerns the relationship between two people, in which both respect the life that has received its unique expression in precisely the other person. It reflects issues of dignity and experiences of worthlessness, the relationship between the strong and the weak, the independent and dependent, and the ability to exercise power.

Problems and diseases have been compared with a lock. The lock is always a double lock. The most important keys are a person's own desire to speak about

their problem and their will for change. The second lock and key are for the diaconal worker. Their engagement in open interaction, and their willingness to listen and use their own expertise, are what is needed (Gothóni, 2020).

Touch is not measured in terms of efficiency. The meanings of touch are always subjective, and touch and intimacy cannot be replaced by anything else. No amount of money can replace love, no number of locks and guards can prevent insecurity, and wellbeing is not built with urgency and a self-important image. Open interaction with warmth and caring is needed. A sense that one is given time, is heard, seen and understood, is the best indication of the quality of touch.

Ethical reflection and ethical action seem an impossible luxury if workers are always in a hurry. Increases in efficiency are desired when cutbacks are being made. Merete Mazzarella has explored the madness of valuing efficiency, using the string quintet as an example.

> *If one now considers a piece of chamber music composed for five musicians that takes half an hour to play, I don't think it would occur to anyone to speed it up, to play it through in twenty minutes to save on musicians' salaries. It would scarcely occur to anyone to save half an hour of working time by summarily dismissing one player and then waiting for the other four to play in exactly the same way as all five did originally. Playing and listening to a piece of music takes as long as it takes (Mazzarella, 1999).*

Too often, the clock is not used by the field's specialists and professionals; it is guided by the number crunchers who control the purse strings. Genuine encounter, the commitment to help and human humility fall by the wayside. Hurry, fatigue and irritation are communicated by people through touch. Emotions are communicated through body language, touch and atmosphere. Anxiety tends to be transmitted to the patient and causes them to be insecure. Similarly, a safe and restful atmosphere can be built when the worker is calm. Touch can communicate superiority and dominance, but also acceptance, humanity and kindness.

Touch is bidirectional. Both parties give and receive. Both are present in the moment. In the best case, both consciously focus on an equal encounter with each other. In treatment the right ways to grasp and touch are important. In good interaction looking, touching, listening and acceptance are always articulated. How I look at another person tells them if I am safe and trustworthy. Touch communicates relaxation and serenity. Listening allows the client to talk, but also to be silent. Acceptance is mediated by the caring person's way of being and appreciation of the other.

The boundaries and personal space of touch

Different people interpret touching and being touched differently. Everyone functions in accordance with their own personality, life experience and culture. Learning how to touch and the sensitivity to identify the correct distance are often intuitive, evolving as skills and experience accumulate.

The effect of personality and life experience is reflected in the extent to which a person perceives touching or being touched as natural for themselves. For some people, saying good afternoon by nodding and shaking hands is the only appropriate form of contact in interacting with a stranger. They do not even want to hug their best friend. Another person wears their heart on their sleeve and is happy to hug. There is no one correct way. What is important is reading the room, sensitive listening to the other, and consideration and acceptance of their wishes.

If a person has experienced violence and an abusive touch, they may flinch when another comes close to them. If discipline was severe in the family in a person's childhood, and touch was mainly associated with punishment, and if being held in someone's arms was not customary in the family, touch will not seem natural, even to an adult. Many Finns prefer to keep a stranger at least at arm's length away from themselves. One student wrote of their own relationship with touch:

> *Arvo Ylppö's strict and systematic parenting approach prevailed in post-war childhoods: feeding your baby every four hours, avoiding holding it too much in one's arms. The traces of the war were still evident in their fathers' lives. The results of such an upbringing are seen in today's middle-aged as alienation from touch. I've tried to learn, but liking distance is natural for me. I guess it's like that for most Finns.*

Every human being is an individual who knows of their need to be touched and the boundaries of touch. Everyone expresses their boundaries in their own way. It's natural for some to say they need distance and they are not the hugging type, for example. Another will communicate by repelling or by moving formally. Sometimes violent behaviour is a statement that it has gone too far. A confused person is not always sure what is happening. An unexpected touch can be experienced as threatening. When this happens, a person confused by touch can sometimes emphasize their own boundaries very vigorously. A man who had just lost his wife said:

I find it very difficult when people hug me. I find myself crying, even though I don't want always to be in tears. But it's hard to say: leave me alone and cut out the hugging. They mean well.

Those who are grieving find comfort in touching a hand or hugging because the words feel empty and meaningless in the situation. It is usually experienced positively. However, those who are grieving do not always want a touch or a hug. The man I met said he did not want a hug from his co-workers. A hug made him cry. Emotional turmoil has its own place and time. He wanted himself to choose the space for crying and unravelling his grief. When a person suffering profound grief is touched too warmly and at the wrong time, they find it impossible to know how to react. We cannot know whether another person wants to be silent or to talk. The opportunity must be given for both.

Personal space is the space a person marks around themselves for themselves alone. They are not happy to let everyone inside. Within the individual's personal space and boundaries there are both general rules and each person's sense of the extent of their own personal space. It is good for every person to learn to respect their own body and to set boundaries in accordance with what feels good, and what does not.

The duration, place, purpose, intensity and regularity of touch affect how it is interpreted and the significance a person attaches to it. One must always remember to listen to the other person's feelings and pay attention to the extent of their personal space. Everyone has the right to say yes or no to a touch and to define the boundaries of their own personal space. It is important that a child or young person knows how to say no to the unpleasant touch of another, whether it comes from a child or an adult.

Boundaries of touch are determined by the parts of the body. The body can be divided into four zones. The social zone, which includes the hands, arms, shoulders and back, is an area that can be touched without it being perceived as intimate. The close zone, that is, the mouth, wrists and feet, is sensitive areas, and require intimacy and permission. The vulnerable zone — the face, neck and front of the torso — requires permission. The intimate zone — the genitals and buttocks — belongs only to romantic partners. Entering a person's touch zone requires their consent and permission. Sometimes, whether intentionally or inadvertently, a person can offend the other by invading their mental and personal space (Gothóni, 2012, pp.106–107).

Too much distance feels negative. People can be offended within their own community if they experience complete indifference. The exclusion of a person from the community is offensive and stigmatizing. Silence and indifference can be excluding. The touchless zone is then much wider than the person themselves would like.

Cultural customs define and regulate touch. Touch rules control touch between people of different genders, ages and socioeconomic status. There are different degrees of stringency in the requirements for the application of these norms. Moreover, norms and attitudes change. However, change happens slowly (Gothóni, 2012, pp.108–112).

The building blocks of human culture are models of touch derived from the childhood home and internalized norms of the social environment. Typically, men, parents and those of a higher social status touch women, younger people and those of a lower social status more than vice versa. The boundaries of touch are determined by cultural social acceptability.

According to internalized cultural norms and customs, the community may define a wider scope or prohibition of touch for an individual or family, as is the case, for example, in the implementation of the practice of avoidance among the Roma. This is based on the principle that everyone is morally responsible for the actions of each member of their own family. The dishonest behaviour of one family member brings shame to the entire family and requires resolution. If mediation is unsuccessful, the families are estranged, and avoidance comes into effect. Members of families involved in a dispute must avoid meeting, and especially physical contact with each other.

Touch is also regulated by various norms, depending on individuals' gender, generation, socioeconomic status and family. For example, an age- and gender-based hierarchy in the Roma family is clear. Elderly women occupy the highest place in the hierarchy; young women of childbearing age the lowest. After adolescence children and parents in the Roma family are no longer allowed to display affection for each other, at least in the presence of others. (For more on Roma culture see Mertsi Ärling's article in this publication; see also Viljanen et al., 2007.)

The position of women in their own culture and religion is reflected in dress, attitudes to the body, sexuality and touching. However, misunderstandings, prejudices and stereotypes should be avoided. Many Muslims regard a handshake between people of the opposite sex as forbidden. Eye contact, which in Finnish culture is interpreted as honesty and politeness, is readily interpreted in Islamic culture as rude and inappropriate. This may affect the selection of a helper or an

interpreter, on the basis of gender (Abdelhamid, Juntunen & Koskinen, 2009; Maiche, 2010; for encountering people of a Somali background in healthcare see Mölsä & Tiilikainen, 2007).

Various internal norms and taboos as well as prohibitions of touch are associated with corporeality and rules for touch. In her work Purity and Danger Mary Douglas describes how different communities structure and separate purity and the unclean. The unclean is always classified as external, unstructured and polluted. She regards dirt as symbolic. In distinguishing between purity and pollution, the community creates its boundaries and structures the threats to them. This helps the individual in interpreting and facilitates their actions (Douglas, 2009).

The juxtapositions support those who can count themselves normal and pure. The concept pairs, good–bad or unclean–pure, allow groups to be kept separate. Force can be deployed against the evil and unclean, and it can be set apart. Purity rules and norms govern touch. For example, in India the crude definition of a single group as polluted is manifested in the treatment of the Dalits, or those without caste. Accordingly, contempt for the human body of someone held to be unclean is considered justified. Discrimination based on caste is prohibited by law. Yet the dishonouring of Dalits and their bodies remains commonplace (Uuksulainen, 2008).

When a person is defined as another, an alien or a stranger, they can be kept at a distance, marked out, and perhaps also targeted for concrete hostility and corporal violence. In fleeing from and opposing the stranger, the human being fights their own subconscious. They deny their own frightening impurity and project it beyond themselves. The only way to avoid persecuting and hating the alien on the outside is to identify and observe the alien in oneself.

It is the right thing to ask a person in need of help what their hopes are. When touch is connected with helping, it is important to explain what is being done and why. Intuition and nonverbal expression also offer information on how close one can be and whether touching is appropriate. The other must always be approached in such a way that intimacy does not harm them, but nor should they be left alone. A person needs the distance that allows them to feel their personal space, place and identity are respected by others. A respectful touch conveys appreciation. It is honest, open, fair, equal and strives for the common good.

Conclusion

The training of a Finnish nurse-deaconess gives them the ability to pay attention to corporeality and touch. This knowledge is required in both the parish and in nursing. If the nurse-deaconess works in healthcare, they are more capable than an ordinary nurse of recognizing and responding to the desire for spiritual care and to discuss the meaning of life. If they serve in a parish, their nursing training is useful for identifying the needs and problems associated with both spiritual life and corporeality.

The consideration of corporeality requires self-knowledge and an encounter with one's own body's messages. Self-knowledge and training provide the readiness to perceive the messages of the body of the person seeking help and to be helpful. It is a good idea to reflect on how we listen to our bodies, what we convey to others with our bodies, and how we hear the messages of others' bodies. Thus, one learns from one's own way of reacting nonverbally and verbally to the story told by the client's body and words. The nurse-deaconess's special skill is the courage to approach a person but also to recognize the need for space and bodily boundaries.

Although nursing interventions and their associated touch rarely arise in the parish's diaconal work, the nurse-deaconess can use a wide range of tactile skills. They can pay attention and welcome another by their greeting. They can offer comfort and convey safety. Sometimes they need to exert control not only with words but with touch. Spiritual touch is a special skill to be used in their work. Extensive training affords the capacity for diverse interaction.

Sources and literature

Aalto, K. (2013). Surevan tukeminen. In Kirsti Aalto (Ed.), *Saattohoito kuolevan tukena.* Kirjapaja.

Abdelhamid, P., Juntunen, A., & Koskinen, L. (2009). *Monikulttuurinen hoitotyö*. WSOY Pro.

Aejmelaeus, R., Kan, S., Katajisto, K.-R., & Pohjola, L. (2007). *Erikoistu vanhustyöhön – osaamista hyvään arkeen*. WSOY.

Andersen, T. (2012). Human participating: human 'being' is the step for human 'becoming' in the next step. In H. Anderson, & D. Gehart (Ed.), *Collaborative therapy: Relationships and Conversations that make a difference*. Routledge/Taylor & Francis.

Douglas, M. (2009). *Puhtaus ja vaara. Rituaalisen rajanvedon analyysi*. (Suom. Virpi Blom ja Kaarina Hazard.) Vastapaino. (English: Douglas, M. (1966). *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*. London: Routledge & Kegan Paul)

Gothóni, R. (2012). *Kosketuksia arjessa, hoidossa ja pyhässä*. Kirjapaja.

Gothóni, R. (2020). *Kuuntelijan käsikirja.* PS-kustannus.

Hautamäki, M.-L. (2012). *Fyysinen kosketus diakoniatyössä* [Master Thesis, University of Helsinki]

Helle-Lahti, E.-L. (2015). *Liikuttava seurakunta.* Kirjapaja.

Hänninen, J. (2013). Saattohoito tänään. In K. Aalto (Ed.), *Saattohoito kuolevan tukena.* Kirjapaja.

Jokela, U. (2011). *Diakoniatyön paikka ihmisten arjessa.* [Doctoral Dissertation, University of Helsinki). (Diakonia-ammattikorkeakoulua A Tutkimuksia 34). Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-149-6

Julkunen, R. (2004). Sosiaalipolitiikan ruumis. In E. Jokinen, M. Kaskisaari, & M. Husso (Eds.), *Ruumis töihin. Käsite ja käytäntö*. Vastapaino.

Kinnunen, T., Parviainen, J., Haho, A., & Jolkkonen, M. (2019). *Ammatillinen kosketus. Kuinka tunnetyötä tehdään*. Kirjapaja.

Lindfors, B. (2018). Lintu polttaa pesänsä: trauma ja kehollinen psykoterapia (suomennos J. Ikonen). In B. Lindfors, K. C. Walderkranz-Piselli, & J. Ikonen (Eds.), *Keho ja mieli.* Johdatus psykofyysiseen psykoterapiaan. Duodecim.

Maiche, A.-G. (2010). Muslimi potilaana. Duodecim.

Mazzarella, M. (1999). *Silloin en koskaan ole yksin – kirja lukemisen taidosta*. (Translated K. Sonck.) Tammi.

Mölsä, M., & Tiilikainen, M. (2007). Potilaana somali – Auttaako kulttuurinen tieto lääkärin työssä. *Duodecim* 2007; 123(4).

Nissinen, M. (2006). Ruumiillinen ihminen Vanhassa testamentissa. In M.-R. Antikainen, M. Ahola, T. Kousa, & P. Salmesvuori (Eds.), *Taivaallista seksiä. Kristinusko ja seksuaalisuus*. Tammi.

Parviainen, J. (2014). Kehomuisti: Traumaperäisistä stressihäiriöistä kollektiivisiin traumoihin. In J. Hakkarainen, M. Hartimo, & J. Virta (Eds.), *Muisti.* Tampere University Press.

Routasalo, P., Isola, A. (1998) Touching by skilled nurses in elderly nursing care. *Scandinavian Journal of Caring Science* 12(3), p. 170–178.

Russell P. (2011) Dying, Death and Spirituality. In Hogston R, & Marjoram B (Eds.), Foundation *of*

Nursing Practice: Themes, Concepts and Frameworks (pp. 291–318). (4th ed). Palgrave Macmillan.

Seikkula, J. (2018). Dialogiset kohtaamiset luovat voimavaroja. In T. Styrman, & M. Torniainen ,s.) *Kunnioittavan kosketuksen käsikirja. Ammatillinen hoitokohtaaminen sosiaali- ja terveysalalla*. PS-kustannus.

Sharples, N. (2013) Relationship, Helping and Communication Skills. In C. Brooker, & A. Waugh

(Eds.), *Nursing Practice: Fundamentals of Holistic Care* (pp. 193-218). Mosby Elsevier.

Uuksulainen, R. (16.1.2008). Syntymästä saakka saastainen: kastittoman naisen suhde puhtauteen. *Teologia.fi.* https://teologia.fi/2008/01/syntymaakka-saastainen-kastittoman-naisen-suhde-puhtauteen/

Van Dongen, E., & Elema, R. (2001) The art of touching: The culture of 'body work' in nursing. *Anthropology & Medicine*, 2001-8-01, 8(2-3), 149–162.

Veikkola, J. (2007). Kristillisen ekoteologian kehitys. In P. Kainulainen (Ed.*), Pyhän kosketus luonnossa. Johdatus kristilliseen ekoteologiaan*. Kirjapaja.

Viljanen, A. M., Hagert, T., & Blomerus, S. (2007). Romanit suomalaisessa terveydenhuollossa: tasa-arvon ansat. *Lääketieteellinen aikakauskirja Duodecim* 4/2007: 123.

Virtaniemi, M.-P. (2018). *Elämän päätösjakson haaste – ALS-tautiin sairastuneen eksistentiaalinen prosessi ja uskonnollinen spiritualiteetti.* Helsingin Yliopisto.

Vuola, E. (2004). Ruumiillisuuden teologia. In L. Larjo (Ed.), *Teologian uudet virtaukset. STKS:n symposiumissa marraskuussa 2003 pidetyt esitelmät. (*Suomalaisen teologisen kirjallisuusseuran julkaisuja 241). Suomalainen teologinen kirjallisuusseura.

Vuola, E. (14.1.2008). Lihallinen ihmisyys ja ruumiiton jumala – ruumiillisuuden teologia koskettaa. *Teologia.fi*. https://teologia.fi/2008/01/lihallinen-ihmisyys-ja-ruumiiton-jumala/

Virpi Sipola

7 RESPECT FOR CONVICTION IN NURSING

Conviction can be defined in many different ways. Several dimensions of conviction can be identified, including experiential, ideological, intellectual and ritual. Conviction manifests itself in all the different dimensions in a nursing setting. Respect for conviction in nursing entails respect for different worldviews, values, cultural backgrounds, belief systems and traditions, as well as taking the needs associated with conviction into account.

Conviction as part of identity

As a concept, conviction is multifaceted. According to one definition, a *conviction* has a certain unity, gravity, persuasiveness and meaning. It must respect dignity and be related to human life (European Convention on Human Rights, Article 9). Several dimensions of conviction can be identified, including ideological, experiential, intellectual and ritual. Conviction manifests itself in all the different dimensions in a nursing setting.

A values world and worldview are an integral part of a person's personality and their own life history. Questions related to values and conviction cannot be separated or compartmentalized in a separate area; nor can a person be detached from their experience. Conviction affects a person's thinking, actions, and what treating their neighbour justly and well means to them.

Conviction belongs to a belief system that manifests itself differently at a practical level in different people. Doing good and volunteering can embody a person's perception of neighbourly love. People can feel that belonging to and being involved in a religious community is important. In turn, a person can enact their conviction by praying or meditating, fasting, or reading sacred texts.

Belief is associated with emotional and spiritual wellbeing. Emotional wellbeing is seen as one element of human health and a healthy lifestyle. Emotional wellbeing enhances the stability and peace of life and strengthens one's relationship with oneself, God, society and the environment. It can also enhance happiness and reinforce the experience of meaningfulness in life (Azarsa, 2015).

The importance of conviction is emphasized in life crises like illness. Issues related to existence are activated, and the individual reflects on the meaning of life and death in the light of their own belief system and conviction. Surrender is one of the basic themes of human life. It intensifies with ageing and physical decay. The acceptance of surrender and finding balance requires an ability to identify the things that are relevant and valuable to oneself in life, and to holistically integrate individual life events and mental processes. Another's support facilitates the process and, depending on the interaction relationship, enables one to endure even difficult situations safely.

Conviction as part of holistic care

Holistic care means that the patient is regarded as a whole person with their own family and cultural background, life history and life experiences that influence basic views, attitudes towards various issues and behaviour (Vainio, 2015, pp. 271–274). Culture is a way of life. Cultural norms and social rules determine how we treat illness and the sick, and how the sick feel about themselves.

The patient's and their family's ethnic background, age, gender, educational background and adaptation to a new environment affect their life, belief about illness and death, norms, language and meanings. Attitudes to pain and other symptoms, perceptions of self-determination, being truthful with the patient, and perceptions of the involvement of family and loved ones in treatment vary. Perceptions of proper nutrition and eating habits, corporeality, appropriate touch, nudity, sexuality, and what can be discussed also vary among people from different backgrounds (Vainio, 2015). Cultural competence requires sensitivity and entails knowledge of different cultural backgrounds, the acceptance of difference and otherness, respect for human dignity and the conviction of the other, subtlety and the ability to conciliate, even in challenging situations.

The patient-centricity of nursing is emphasized in palliative and end-of-life care, and especially of the fragile, vulnerable and those in need of great support. In nursing it is important to remember that differences and similarities between people are more significant than differences between cultures. Cultural sensitivity entails the caregiver's interest in the patient's personality, familiarity with their family and background, and an ability to listen with an open mind without judging different perceptions or interpretations (Vaino, 2015).

A good way to do this is to ascertain from the patient and their loved ones what is immediately important to them, and what ought to be considered in treatment.

Respecting the patient's conviction requires a similar sensitivity. From the nursing perspective it is important to consider what emotional or spiritual wellbeing means to an individual, how the related needs can be identified, and how those needs are met.

Studies show that respecting a patient's conviction increases their experience of dignity, supports hope, strengthens trust and their experience of connection with others. Conviction has a positive impact on happiness. It gives strength to everyday life and creates calm. Conviction is very important, especially when it is difficult. It gives faith that difficulties will be overcome. Conviction is comforting (Hakkarainen & Tervaniemi, 2016). The expression of religious conviction supports mental health and provides social support (Cook, 2013, p. 2; Koenig, 2011, pp, 14–15).

Conviction supports coping

The concept of coping is central to conviction. Coping serves as a tool for studying people's different solutions — their coping systems — for coping with life's adversities. The concept of coping is inextricably linked with life management. Human wellbeing entails the finding of one's own identity, a sense of inner life management and coping, and confidence in the future. The experience of life management plays an important role when a person has to deal with their own illness or death. Coping is related to the individual's resources. These resources are physical, cognitive, emotional, social or spiritual. The ability to cope is not born in a vacuum; it is a resource created as a person lives their life. Spirituality and religion are important coping mechanisms (Pargement, 1997).

In coping research in the psychology of religion, religion is viewed multidimensionally as emotions, thoughts, actions and social phenomena. The human being seeks a life purpose in religion. The goal may be physical health, self-realization and social connection, and gaining consolation (Geels and Wikström, 2009).

In his study Koenig (2009) found that the more important spirituality was in an individual's life, the less they suffered from depressive disorders (Koenig, 2009). Furthermore, according to Koenig's (2012) study, conviction has a positive effect on and accelerates rehabilitation after a cerebral infarction (Koening et al., 2012, pp.423–493). Religion may also change perceptions of disability and contribute to the progress of rehabilitation. It gives the hope of healing, supports balance and improves quality of life (Koenig et al., 2012, pp.492–493; Amoah, 2011, pp. 353–354).

According to a study conducted in a Finnish nursing environment (Rantala & Lipponen, 2019), emotional and spiritual support that respected conviction helped in times of despair at the ends of patients' lives in palliative and convalescent care. It was materialized in the patient's desire to pray together, trust in a guardian angel and reflection on the suffering caused by illness. The importance of prayer was especially strong when painkillers were of no help in the face of intense fear and hopelessness (Rantala & Lipponen, 2019).

Respect for conviction in practical nursing

In nursing that respects conviction it is important to be able to acquire and use information relevant to the patient's care. Appreciation of the patient's background and life situation, encouraging them to share their own interpretations of illness and health, and how they perceive the burden of their life situation, help in the consideration of conviction. For patients from other cultures identifying any traumatic background and raising awareness of cultural emphases are key (Reijonen, 2014). In every area of nursing, interaction and communication skills, as well as creativity, emotional skills and the ability to emphasize, are important, but especially in multicultural encounters. Figure 1 illustrates the areas of an encounter where conviction is respected.

Figure 1. Respect for conviction in practical nursing: encounter with a patient from another culture (Reijonen, 2014).

Supporting a patient's conviction in nursing may concern what calms the patient at a given moment, what comforts them, or what affords them a sense of security when life is difficult. Identifying what situations are good for a patient, and when they are good for them, can open the conversation in a deeper direction. The patient can be asked directly if they have any conviction, whether spiritual things are important to them, and whether they are somehow manifested in some way in their own life. The patient may be offered the opportunity to talk with a hospital chaplain or another representative of a spiritual community.

In his dissertation Ikali Karvinen (2009) presents Anandaraja and Hight's (2001) description of the use of HOPE. With the aid of the meter information about the person's spiritual history is provided. HOPE is derived from the terms sources of **h**ope, **o**rganized religion, **p**ersonal spirituality and practices, and **e**ffects on medical care and end-of-life issues. Using the HOPE meter, the sources of the patient's hope, strength, peace and love are identified. At the same time the patient is asked about their relationship with organized religion The patient is also asked about their characteristic ways of expressing spirituality and practising religion. Finally, the effects of the patient's spirituality on the treatment given, and especially on issues related to death, are investigated (Karvinen, 2009).

The AVAUS ("open") model developed by Karvinen operates according to the same principle. The AVAUS model has five thematic conviction areas:

The five thematic areas of the AVAUS model:

Theme 1. Values and conviction

Theme 2. Resources

Theme 3. Assessment of emotional and spiritual needs

Theme 4. External support

Theme 5. Nursing procedures that support spirituality

Figure 2. AVAUS model thematic areas (Karvinen, 2009).

The following questions can be used in discussing conviction with the patient: "What values are important to you — do you consider yourself religious? What do you resort to when you experience pain or suffering? Do you have any convictions or emotional or spiritual needs of which the nursing staff should be aware during your treatment, and for which you want the help of the nursing staff? Is there anything associated with your conviction that ought to be considered during your treatment?" (Karvinen, 2009; Karvinen et al., 2020).

Sometimes a patient wants to discuss why they have fallen ill, or what illness has brought to their life. An illness may seem unfair, and the patient may experience loneliness and separation from people. Feelings of anger, bitterness, despair and worthlessness may also manifest themselves. The opportunity to tell one's own life story and reflect on the life one has lived and one's relationships is often a positive and empowering experience. Through telling and being heard, the mean-

ing of life can become visible. Questions used in dignity therapy can be useful aids to that discussion. Dignity therapy has been found to alleviate patient's anxiety and depression (Räsänen & Matila, 2018).

1. Tell your life story. Tell me about the people and things that have been important to you. Tell me about the significant moments in your life.
2. Are there things you would like your loved ones to know and remember about you?
3. What have been the most important roles in your life? Why have they been important? What do you think you have achieved in them
4. Which of your achiecements are you most proud of?
5. Is there anything you would like to say to your loved ones, or that you would like to discuss with them?
6. What do you hope for your loved ones? Do you have any dreams for them?
7. What have you learned from life? Is there anything you would like to pass on?
8. Do you have any adbice or guidance for your loved ones or others regarding their future lives?
9. If you were to write something or make a documentary about your life, what would you want to include in it?

Figure 3. Dignity therapy questions (Martinez et al., 2017).

The method requires safe interaction, a calm space that is suitable for conversation and enough time. It is also important that the nurse can assess the patient's resources to deal with issues. Occasionally, there have been so many difficulties and adversities that processing them profoundly requires special professional skills and multiple appointments. In such situations a psychosocial support professional like a psychotherapist or hospital chaplain may be called upon to assist the patient.

A Czech study (Kisvetrová et al., 2013) investigated the forms of emotional support according to the Nursing Interventions Classification (NIC) that are used with patients diagnosed with anxiety about death. The study included 468 nurses, and the responses were gathered using a questionnaire with Likert scale questions. According to the study, the primary form of support was to treat the patient with dignity and respect (37.6%). Nurses also supported the patient by listening to their feelings (32.3%) and being available when they were suffering (25.2%). The protection of privacy and enabling a quiet environment was significant (20.9%). Empathy for the patient's emotions (22.6%), as well as openness

to patient-related concerns (22.6%) and feelings about illness and death (17.1%) were also important forms of support. Nurses supported the patient by arranging a visit to them from their own spiritual counsellor or a representative of a spiritual community (17.9%) (Kisvetrová et al., 2013).

Praying with a patient is a common form of support and a common practice for many different religions (Da Silva et al., 2015). Prayer promotes health, strengthens spirituality and supports the patient's recovery (Oliveira et al., 2015). Other means of support include eye contact, touch, a tone of voice appropriate to the situation and dialogue (Joanna Briggs Institute, 2011, p. 3).

Neo-spirituality and spirituality may also involve exploration. The patient can seek answers to existential questions without experiencing it as a spiritual or religious search. It is then that they may ask about the meaning of life, of their own relationships, experiences and the life they have lived. The experience of meaning and reflection on the meaning of life are fundamental ethical questions for human beings. Meaning involves an understanding of the dignity of one's own life. It can well up from the past, future or present. Sharing the experience of meaning and the reflection on the meaning of life can become a very important encounter between the patient and the nurse. Wondering why they fell ill or asking if there is a god or a higher power can also be part of the patient's reflection and part of their spiritual quest. The patient may feel life has treated them unfairly and be angry at something greater. Emotions are real. All of them are permitted, and room must be given for them.

The patient may also clearly express a desire for a ritual associated with their own convictions. They may wish to have the opportunity to receive holy communion or to attend a spiritual event in the ward or care home. They may wish to be put in touch with a representative of their own spiritual community.

An experience that supports conviction can arise from presence, being seen and heard, a conversation, listening to music, the visual arts, literature or interacting with nature. Many feel that they encounter the Holy or relate to a higher power in nature, in the forest or by the sea.

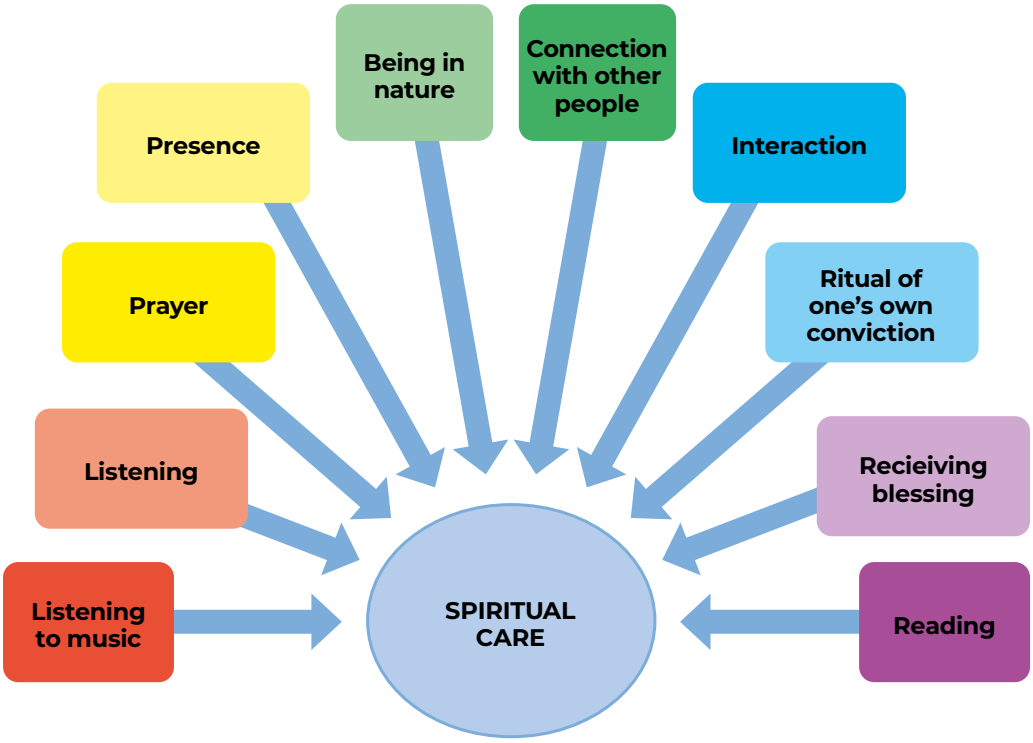

Figure 4. Spiritual care. (Sipola, 2018, p. 141, Original image published in the book Palliatiivisen hoidon hyvät käytännöt [good practices in palliative care], Figure 15.30 Means of spiritual care).

Identifying the need for conviction

Spiritual distress is a holistic state in which anxiety is caused by an impaired ability to relate to oneself and other people, and an unsatisfied need for love and serenity. Spiritual anxiety is also visible in themes associated with conviction, rituals and the experience of the meaning of life (Villagomeza, 2005; Caldeira et al., 2013). Depression has similarities with spiritual distress (Rodin et al., 2009), but it is often accompanied by mood symptoms and mood changes, which are more clearly distinguishable from each other (Huttunen, 2017). The distinction between anxiety and depression is important if the patient is to receive the help they need.

A study of the emotional wellbeing of cancer patients (Caldeira et al., 2017) used the Spiritual Well-Being Questionnaire (SWBQ). The study found that the more important religion was to the patient, the greater its impact on the patient's emotional wellbeing. The study also found that metastatic cancer especially increased emotional stress. It was found that the questionnaire was a reliable instru-

ment for assessing emotional pain, but in addition to using the meter, discussing emotional needs, listening to the patient and being present were important ways of identifying emotional pain and helping the patient (Caldeira et al., 2017).

The following cases have been used to describe the consideration of conviction-related needs in nursing met by the patient and nurse. Interest in the patient and respect for their conviction, the ability to perceive the needs of that conviction, the courage to ask, and acting in support of it are central to the work of the nurse. The nurse treats the patient with empathy.

Case 1.

Aura is a 61-year-old patient in the Department of Oncology. She has recovered well from surgery, but complains of vague symptoms: headache, stomach symptoms and insomnia. Particular attention has been paid to pain management, but the patient remains restless. Her nurse notices that Aura looks as if she may cry and ask if they can be of any help. Aura sighs deeply and says she doesn't want to be bothered, because the nurses have so much work to do as it is. Her nurse says they are not in such a hurry and asks what is wrong. Aura says she finds thinking about things difficult, and she can't get to sleep. Aura begins to cry and says she is in the middle of a divorce. Her husband couldn't cope with her illness and had left. Aura feels angry and disappointed. She is mourning the end of a long marriage and is worried about practicalities, and whether there will be enough money. Aura says she hasn't spoken with anyone about this, because she doesn't want to bother them and feels she has failed. Her nurse reassures Aura and asks if she has someone to talk to, and if there is anyone she would like to visit her. Her nurse also asks what has helped Aura in difficult situations in the past. Aura says that she prays. She believes there is a God who cares for people. Aura says that she would not have survived her illness otherwise, and that praying somehow calms her. The conversation can continue in one of the following ways:

a) Her nurse asks if she can pray with Aura.

b) The nurse tells her that a hospital chaplain will be visiting their ward and asks if Aura would like to talk to them.

c) Her nurse says that prayer certainly helps. They stroke Aura's shoulder, saying that everything will be fine and then leave.

Case 2.

Aulis, 83, lives in a service house. He suffers from moderate memory loss, and his condition varies. The days are pretty much the same. Sometimes his children and their families visit, and they drink coffee and look at photos. A club meets in the home every other week. Aulis participates in its activities. The programme varies: singing, remembering the old times and drinking coffee together. Aulis enjoys singing. He remembers each verse of the old songs from beginning to end. Last time the club discussed childhood and daily chores. During their childhood many of the elderly's fathers and brothers had died in the war and so small children also participated in housework and the family's livelihood. Aulis's father died in the war too. "Veteraanin iltahuuto" (the veteran's evening cry) is an important song for Aulis. He often wants to sing it at the Thursday club. Aulis has a good singing voice. He is often moved when he sings and gets a hug from the nurse.

Case 3.

A fifty-year-old male patient with suspected stomach cancer has been brought into the internal medicine department. He is suffering from nausea and has severe pain in the lower abdominal area. The patient refuses to take painkillers. He is cared for by a female nurse who is on her shift. The nurse goes to the patient and explains that pain medication will make him feel better and give him strength to heal. The man has a book in his hand, and the nurse notices that it is the Quran. The man does not make eye contact and says it's better this way. The nurse leaves frustrated, but she remembers at the same time that Muslims want a person of the same sex to nurse them. The nurse tells a male co-worker about the situation, and he goes to see the patient. It turns out that the patient is a devout Muslim and thinks the disease is God's will. He feels that tolerating pain reinforces faith and strengthens the soul. The patient also suspects that alcohol or ingredients of animal origin such as pig fat have been used in the painkillers, and he therefore cannot take them. The co-worker promises to find an alternative medication and asks for a male doctor. The patient seems satisfied. He reminds him that the illness must not be discussed with his children when they come to visit. He will only discuss things with the older members of his family.

Case 4.

Noora is a 29-year-old woman. She is in the hospital with her six-month-old son. Her son is undergoing corrective surgery for a congenital heart defect. He has been premedicated and is awaiting transfer to the operating theatre. Noora is scared. She is fumbling with an angel jewel and is raising a small angel figure to her son's bed. The nurse reassures Noora, telling her that the surgical team is a top one that has carried out similar operations in the past. Noora digs some angel cards out of her bag and says she can use them to get messages from angels. They calm her somehow. She says she attended an angel course where she learned the meaning of intuition, and about the tremendous power of angels, and how they support people. Noora keeps in touch with the angel community through the internet. The nurse sits down beside Noora and tells her this sounds interesting. She asks Noora to tell her more.

The importance of conviction in the life of a person with a memory disorder

With illness and ageing, life values form a basic perspective on life. The internalization of conviction affects the ability to survive and solve problems. Spirituality and religion can be an important element in how we structure life, making it possible to build a life and identity, and confront bewildering concerns. Religion can create meanings for one's own life and thus give us empowerment. Using religious language makes it possible to benefit from and recreate social resources (Spännäri, 2008).

A person's ability to experience spirituality is also preserved in advanced dementia, and conviction can serve as the key to a memory-impaired mental landscape. At its best, conviction supports a person with a memory disorder to control their life and retain an identity. The conviction and spirituality of a person with a memory disorder often entail a return to childhood beliefs and their attendant emotional world. Then, when spirituality has been a positive factor in human life, its reinforcement increases the sense of security.

In working together to support the spirituality of a person with a memory disorder, the use of elements that evoke different senses and the importance of symbols are emphasized. Performing religious rituals together strengthens the connection with the Holy and with others. Familiar texts from the Bible or another holy book from childhood, a familiar prayer and singing together transport the participant to the spiritual moments of their childhood or youth. The language

should be simple, and the tempo and rhythm of the one offering the ritual calm. An aesthetically beautiful and quiet atmosphere contributes to the experience of spirituality (Kallunki, Keskitalo, Nummela & Palosaari, 2018).

Conviction and ethical conflict

How can one function as a nurse in situations where the patient's conviction and nursing ethics conflict with each other? How should the nurse act when they identify an ethical conflict within their own profession or between a healthcare or social care organization?

Healthcare legislation (the Act on Health Care Professionals 559/1994) and ethical guidelines oblige the care worker to behave ethically. According to ETENE (the National Advisory Board on Social Welfare and Health Care Ethics), ethics describes and justifies good and right ways of living and acting in the world the person shares with others. Ethics consists of the values, ideals and principles concerning good and evil, and right and wrong. The role of ethics is to help people make choices, guide and assess their own and others' actions, and examine their rationale. Ethics does not provide ready-made solutions, but it does provide tools for thinking and reflection (ETENE, 2001).

Respect for human dignity and self-determination, the protection of human life, and the promotion of health are the key principles guiding healthcare professionals. Treatment is required based on scientifically researched data or solid clinical experience. Inhuman treatment and torture are prohibited (ETENE, 2001, Sairaanhoitajien eettiset ohjeet, 1996). In identifying ethical problems, a distinction can be made between personal and professional ethics and values (Fry & Johnstone, 2008). Personal ethics may also conflict with professional ethics (Fry et al., 2008). The nurse's own conviction can also negatively affect the care relationship. For example, this arises when a nurse seeks to influence a patient's beliefs, or when a nurse refuses to work on the basis of their own conviction (Karvinen et al., 2020).

For example, an ethical conflict may arise in the care relationship when a patient has an unwanted pregnancy, and her conviction includes an absolute ban on abortion. In such situations the patient herself may wish to have an abortion, but her family or community may oppose it. In some beliefs abortion is unacceptable, even when a pregnancy is the result of rape. The nurse may themselves find the situation conflicting and unfair from the patient's perspective. They may recognize the patient's anxiety and distress and consider the patient's right to self-

determination and its support key premises in their own work in accordance with nursing ethics.

In such situations, establishing the views that are grounded on conviction, providing information on the care and treatment situation, and risk analysis are ways to facilitate understanding between the patient and family members. The patient may place the community's interests ahead of those of the individual and voluntarily choose to "do the right thing" based on their conviction and not have an abortion. In this event the nurse should support the patient's decision, seek to empower her and refer her for support. The nurse has no right to pressurize the patient or to seek to influence their decision.

Attitudes towards patient conviction may differ among nursing staff, giving rise to ethical conflicts. It is then important to discuss the significance and professionalism of the conviction and agree how the hospital can support it. The consideration of conviction, the production of information and the analysis of support means may also be the task of an appointed specialist nurse.

The nurse's conviction and its significance in nursing

> *"I'm not a believer. I'd find it really strange to pray with someone. I don't even know any prayers" — nurse, 27.*

Identifying the needs of conviction can be difficult, especially if its associated issues and spirituality are alien to the nurse. The identification of conviction and spiritual and neo-spiritual needs is facilitated if the nurse is familiar with their own spirituality (Karvinen, 2009; Karvinen et al., 2020). This entails reflection on how one thinks about the holy, neo-spirituality and spirituality oneself. It means becoming aware of what one believes oneself and recognizing the effects of one's convictions on one's own way of thinking, attitudes, values, daily life and celebrations. The nurse can consider their own cultural background, the cultural or religious customs they have been taught and have followed in the childhood home, and how religion and spirituality are treated in the family or extended family. They can also consider whether they believe in anything themselves, and if what they believe in is an object of faith. If they believe in God, they can reflect on the kind of God in whom they believe.

Identifying their own values and principles is also important. What or what kind of values and principles are those they want to follow in their own life and

pass on to their own children, for example? What you turn to in trouble, or where you find shelter, also says something about conviction. The nurse can examine their own view of humanity and consider how conviction affects perceptions of health and illness, or what they think about life and death.

When we recognize the importance of conviction in our own lives, it is easier for us to recognize and respect the conviction of another. We can find meanings related to conviction that are shared by people from very different cultural and religious backgrounds. It facilitates the provision of support in conviction and spirituality.

The perception of spirituality can sometimes be very narrow or thought to be always tied to the practice of religion. Bad experiences can also be associated with spirituality. It is therefore important to study neo-spirituality and spirituality as a broader phenomenon with an open mind. It is one aspect of life that at its best can increase a sense of security and support hope by deepening and enriching life.

Conviction supports the wellbeing and fulfilment of patients and nursing staff, as well as their resilience at work (Azarsa et al., 2015). A study examining the relationship between a nurse's emotional wellbeing, attitudes towards spirituality and competence in the contribution of spiritual care to nursing quality found that competence in mental health was also positively related to nurses' emotional wellbeing and attitudes to mental health. Conversely, the more highly the nurse rated their own wellbeing, the more positive was their attitude towards spiritual care, and the more spiritual care they offered their patients. Spiritual wellbeing strengthened a more holistic, open and flexible approach to life, and the issues arising in it (Azarsa et al., 2015).

Experiencing the purpose and meaning of life

In holistic care the patient is encountered as a person with physical, emotional, social, mental and spiritual needs. Neo-spirituality refers to a person's interest in the basic values, purpose and meaning of life (Karvinen, 2011). Meanwhile, spirituality refers to how an individual seeks and expresses meaning, purpose, and how they experience connection to the moment, the self, others, nature and the sacred (Piderman et al., 2015). Neo-spiritual and spiritual questions concern human existence and are related to human wellbeing and balance in relation to oneself and the surrounding environment. From the perspective of the theology of nursing, the consideration of the individual's spirituality is relevant, because the various manifestations of the spiritual dimension affect their health, quality of

life, and their attitude to the experience of life's meaning, purpose and suffering (Karvinen, 2006).

The patient's right to emotional and spiritual support is based on healthcare legislation and ethics (Laki potilaan asemasta ja oikeuksista 785/1992 Finlex). By law, a patient must be treated in a way that does not violate their dignity, and that their personal conviction and privacy are respected (Louheranta et al., 2016). Spirituality is integral to quality healthcare and is realized in attitudes, compassion and practical action (Puchalski et al., 2014). Spiritual support can serve as an important resource for multidisciplinary support in life crises (Lee, 2007). Patients do not feel that emotional and spiritual issues are a separate area from other care (Hodge & Horvath, 2011, King et al., 2013), but also expect to face spiritual needs (Hodge et al., 2011).

The mental and spiritual life can be described by the term "spirituality". The term comes from the Latin word *spiritualis* (Suomen evankelis-luterilainen kirkko, i.a.). The word refers to the deepest values of human life, the quest for meaning and the experience of fellowship with God or a higher power. Spirituality is a universal experience. It is something that touches us all. Spirituality is problematic as a concept, because it is applied to very different meanings. Harri Koskela (2009) uses the concept broadly to include existential issues, the quest for purpose and meaning, social relationships, emotions, values and human identity. These are common to the spirituality of different religions or worldviews.

The spiritual life, faith, idea and relationship of God arising from Christian tradition constitute the area of Christian spirituality (Itkonen, 2017).

People can describe a spiritual experience as sacred or transcendent, or as a feeling of depth and connection. At its best the experience of connection with something greater than oneself contributes to positive emotions, serenity, satisfaction and gratitude. It can also increase respect for life and the experience of acceptance (Beauregard & O'Leary, 2009; Pulchaski et al., 2009).

Spirituality changes over the course of life. It is influenced by life events and experiences of human relationships. Spirituality and religion contain some of the same elements, but both have their own special areas (Figure 5). The middle section of the figure is a personal experience affecting our thoughts, feelings and behaviour.

The questions associated with spirituality are: Where do I find the meaning of life? How do I feel connected and valued? Meanwhile, the questions associated with religion are: What is true and right?

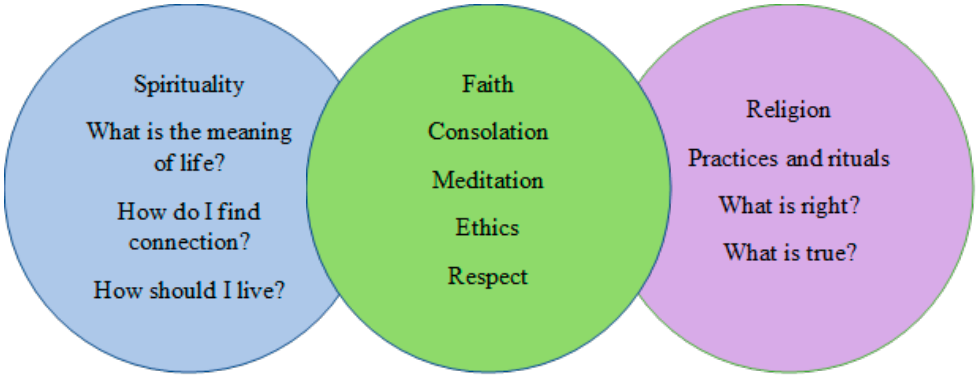

Figure 5. The relationship between spirituality and religion (Chang et al., 2019).

Emotional and spiritual support focuses on existential questions, that is, presence and listening, active and reciprocal discussion, and comfort (Tanyi et al., 2009). Spirituality is enabled by compassionate interaction (Shields et al., 2014). In healthcare cultural and religious diversity challenges the skills of professional staff, making the meeting of emotional and spiritual needs more demanding than before (Louheranta et al., 2016). Emotional and spiritual support should take better account of the historical and cultural framework, and should be effected in a way that values the individual at all levels of care (Puchalski et al., 2014).

The nursing code of ethics states that "the nurse should promote the patient's individual wellbeing and treat the patient as a valued person, taking the individual's values, conviction and customs into account. Every patient should be treated equally, taking individual nursing needs into account, regardless of the patient's health problem, culture, religion, mother tongue, age, gender, race, skin colour, political opinion or social status."

The ethical guidelines list conviction, religion and culture mentioned separately as promoters of the patient's wellbeing. Fairness in the nurse's work means each patient is treated equally well, regardless of their conviction. In everyday nursing ethical guidelines should be transformed into nursing practices that are integrated in the activities of the individual nurse and the nursing community as attitudes and operating models, and are identifiable in the nursing setting as a conviction-friendly environment.

Emotional and spiritual nursing

In Western medicine psychiatric nursing, psychological assistance, spiritual nursing and hospital chaplaincy can be understood as emotional support (Karvinen, 2009). Spiritual nursing entails being close to and helping a person as they consider questions about their life, relationships, relationship with God and their death. It is also often a quest for courage and hope with another person (Suomen Muistiasiantuntijat).

Spiritual care can be divided into religious and spiritual nursing. Music, the visual arts and literature, animals, and nature can support those who lack religious conviction, or can more generally create hope, strength and a positive mindset for the sick person. A discussion with a hospital chaplain or a person who supports conviction, watching or listening to a religious radio or television programme, or participating in a religious activity in turn supports religious conviction (Karvinen et al., 2020).

Spiritual nursing have an important place in culturally sensitive nursing. Spiritual nursing manifests itself as an interest in the patient's values and conviction. Spiritual care is not about providing ready-made answers. *It is about being on the edge and searching for things together*. It means listening to and supporting the patient as they seek the meaning of their life. It is important to consider the patient as a person with all of life's dimensions. Studies have revealed that a spiritual care space, quiet room or chapel help in calming down and in recovery. Meanwhile, the nurse's empathetic and ethical approach increases the sense of conviction (Karvinen et al., 2020).

An international study (Galek et al., 2005, pp. 66–88) maintains seven constructs can be identified that describe the patient's spiritual needs. The first, "love, belonging and respect", was the most significant. Its components were the receiving and giving of love, being shown respect and feeling close to others. The second, "the sacred and heavenly", was the second largest. It was associated, for example, with religious rituals that made it possible to experience a connection with God. The third was "positivity, gratitude, hope and peace", the fourth, "purposefulness and meaning", the fifth, "morality and ethics", and the sixth, "appreciation of beauty". The seventh category was "acceptance of dying", which was manifested in thinking about death, preparing for it and its remembrance.

A positive attitude and the possibility to be calm were important. Hope increased the desire for life. Humour and laughter made it easier to endure a difficult situation. The possibility to act morally correctly and reflection on spiritual

issues and death were manifested in spiritual needs (Galek et al., 2005). A Finnish study suggested spiritual needs also included the need for control and independence, communication and comfort, and forgiveness, reconciliation and closure (Juvonen & Lindfors, 2013).

Spiritual care helps the patient deal with their own illness, and gives hope and inner peace for the resolving of problems (Van Leeuwen et al., 2007, p. 482). It has a positive effect on health, aids in coping with adversity and improves quality of life by reducing anxiety and depression (Wasner et al., 2005, p. 99). Three key areas can be identified in spiritual care: spiritual anxiety; spiritual needs; and spiritual wellbeing. Spirituality is multidimensional and individual. The patient's feelings of failure, anxiety and guilt may be the result of spiritual suffering. The goal of spiritual care can be dealing with states of fear and the attaining of reconciliation and peace of mind. Care should always take the patient's own values, conviction and lifestyle into account (Kärpänniemi, 2008, p. 115).

The meaning of spiritual care for the patient

According to Edwards (Edwards et al., 2010, p. 761), patients need friendly and dignified care and comfort. A positive and confidential nursing relationship is important, as is the support of loved ones. Patients need to experience love, appreciation and respect. It is manifested in the nurse's activities as listening, the ability to show empathy and to discuss spiritual matters, fears and anxieties, and to take the patient's feelings on board. Discussion was a significant way to prevent the onset of spiritual anxiety. Spiritual anxiety was difficult to recognize because it was often concealed by humour or physical symptoms. In supporting patients, nurses used art and music to help them discuss spiritual matters. The study found that the positivity of the nursing environment and a lack of urgency on the part of the nursing staff, as well as the integration of spiritual care with other nursing work, supported patients' ability to express and address spiritual needs (Edwards et al., 2010).

Unhealthy traits like compulsion, fear, anxiety and guilt can also be manifested in spirituality. Spirituality can be used as a tool in the exercise of power. Healthy spirituality allows a person to be sometimes weak and sometimes strong. It is founded on trust and grace (Kettunen, 2011, p. 6, p. 19). An emotionally and spiritually healthy individual is one who experiences a dynamic individual and communal balance, in which the relationship with the afterlife and one's own conviction is considered (Karvinen 2009).

Spiritual care and patient support require the nurse to be open to spirituality. The nurse must agree that reflection on such things also leads them to reflect on their own spirituality and its meaning. Despite different frameworks or ways of expressing spirituality, what is common to spirituality is always its meaning for the person. Reflection on meaning can create as connection between those who think differently.

Sources and literature

Amoah C. F. (2011). The central importance of spirituality in palliative care. *International journal of palliative nursing*, *17*(7), 353–358. https://doi.org/10.12968/ijpn.2011.17.7.353

Azarsa, T., Davoodi, A., Khorami Markani, A., Gahramanian, A., & Vargaeei, A. (2015). Spiritual wellbeing, Attitude toward Spiritual Care and its Relationship with Spiritual Care Competence among Critical Care Nurses. *Journal of caring sciences 4*(4), 309–320. https://doi.org/10.15171/jcs.2015.031

Beauregard, M., & O'Leary, D. (2009). *The spiritual brain*. Harper Collins.

Caldeira, S., Timmins, F., de Carvalho, E. C., & Vieira, M. (2017). Spiritual Well-Being and Spiritual Distress in Cancer Patients Undergoing Chemotherapy: Utilizing the SWBQ as Component of Holistic Nursing Diagnosis. *Journal of religion and health*, *56*(4), 1489–1502. https://doi.org/10.1007/s10943-017-0390-4

Chan, W. Y. A., Akanmori, H., & Parker, C. (2019). Addressing Canada´s truth and reconciliation commission for indigenous peoples through religious literacy and spirituality: unexpected pathways to peace education. *FIRE: Forum for International Research in Education, 5* (1), 63–68.

Cheraghi, M. A., Payne, S., & Salsali, M. (2005). Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran. *International journal of palliative nursing*, *11*(9), 468–474. https://doi.org/10.12968/ijpn.2005.11.9.19781

Cook, C. C. H. (2013). *Spirituality, Theology and Mental Health*. SCM Press.

Culliford, L. (2011). *The psychology of spirituality: An introduction*. Jessica Kingsley Publishers.

Euroopan ihmisoikeussopimus (Yleissopimus ihmisoikeuksien ja perusvapauksien suojaamiseksi) sellaisena kuin se on muutettuna yhdennellätoista pöytäkirjalla). 20.5.1999. https://www.finlex.fi/fi/sopimukset/sopsteksti/1999/19990063/19990063

Edwards, A., Pang, N., Shiu, V., & Chan, C. (2010). The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research. *Palliative medicine*, *24*(8), 753–770. https://doi.org/10.1177/0269216310375860

Emblen, J. D., & Halstead, L. (1993). Spiritual needs and interventions: comparing the views of patients, nurses, and chaplains. *Clinical nurse specialist CNS*, *7*(4), 175–182.

ETENE (2009). Terveydenhuollon yhteinen arvopohja, yhteiset tavoitteet ja periaatteet 2001. https://etene.fi/ammattietiikasta

Fry, S., Johnstone, M.-J. (2008). *Ethics in Nursing Practice: A Guide to Ethical Decision Making* (3rd edition). Blackwell.

Galek, K., Flannelly, K. J., Vane, A., & Galek, R. M. (2005). Assessing a patient's spiritual needs: a comprehensive instrument. *Holistic nursing practice*, *19*(2), 62–69. https://doi.org/10.1097/00004650-200503000-00006

Geels, A., & Wikström, O. (2009). *Uskonnollinen ihminen. Johdatus uskontopsykologiaan*. Kirjapaja.

Hakkarainen, T., & Tervaniemi, J. (2016). Se on sellainen voimavara. Uskonnollinen vakaumus perheen mielenterveyden ja hyvinvoinnin tukena [Bachelor Thesis, Diaconia University of Applies Sciences]. https://urn.fi/URN:NBN:fi:amk-2016112116630

Hodge, D. R., & Horvath, V. E. (2011). Spiritual needs in health care settings: a qualitative meta-synthesis of clients' perspectives. *Social work*, *56*(4), 306–316. https://doi.org/10.1093/sw/56.4.306

Huttunen, M.O. (September 14, 2017). Mitä on masennus? https://www.terveyskirjasto.fi/terveyskirjasto/tk.koti?p_artikkeli=lam00037

Itkonen, J. (2018). Kun vauvaonni vaihtuu kuoleman suruun – Narratiivinen tutkimus kohtukuolemasta, lapsen kuoleman aiheuttamasta surusta ja selviytymisprosessista sekä kirkon tuesta. [Doctoral Dissertation, University of Helsinki]. http://urn.fi/URN:ISBN:978-951-51-4363-1

Juvonen M., & Lindfors J., (2013). Aikuisen kuolevan potilaan hengelliset tarpeet hoitotyössä. [Barchelor Thesis, The Novia University of Applied Sciences]

Joanna Briggs Instituutti (2011). Sairaanhoitajien ja syöpää sairastavien aikuispotilaiden tehokas viestintä sairaalassa. *Best Practice* 15 (1). http://docplayer.fi/5006621-Sairaanhoitajien-ja-syopaa-sairastavien-aikuispotilaiden-tehokas-viestinta-sairaalassa.html

Kallunki M., Keskitalo, M., Nummela, I., & Palosaari, M. (2018). *Hengellinen tuki muistisairaan ihmisen elämässä*. Kirkkohallitus.

Karvinen, I. (2009). *Henkinen ja hengellinen terveys. Etnografinen tutkimus Kendun sairaalan henkilökunnan ja potilaiden sekä Kendu Bayn kylän asukkaiden henkisen ja hengellisen terveyden käsityksistä*. Kuopion yliopisto.

Karvinen, I. (2010). AVAUS-mallilla selville potilaan uskon ja voiman lähteet. *Syöpäsairaanhoitaja*, *14*(3).

Karvinen, I. (2011). Henkisyys ja hengellisyys terveysalan asiantuntijuusalueena – miten käsitteitä jäsennetään? *Pro terveys* (6).

Karvinen, I., Hänninen, M., & Lipponen, V. (2016). Valmius vastata potilaiden henkisiin ja hengellisiin terveystarpeisiin – Pilottitutkimus. *Diakonian tutkimus*, (2). https://journal.fi/dt/issue/view/7863/1309

Karvinen, I., Hakkarainen, T., Tervaniemi, J., Winqvist, S., & Lipponen, V. (2016). Vakaumus on voimavara – Uudistamassa Vakaumuksen kunnioittamisen opasta. *Diakonia* (4)

Karvinen, I., Lipponen, V., & Sipola, V. (2020) *Vakaumuksen kunnioittaminen – opas vakaumuksen kunnioittamiseen sosiaali- ja terveydenhuollossa*. Kirkon sielunhoito, sairaalasielunhoito. Kirkkohallitus.

Kettunen P. (2011). *Kätketty ja vaiettu. Suomalainen hengellinen häpeä*. Kirjapaja.

King, S. D., Dimmers, M. A., Langer, S., & Murphy, P. E. (2013). Doctors' attentiveness to the spirituality/religion of their patients in pediatric and oncology settings in the Northwest USA. *Journal of health care chaplaincy*, *19*(4), 140–164. https://doi.org/10.1080/08854726.2013.829692

Kisvetrová, H., Klugar, M., & Kabelka, L. (2013). Spiritual support interventions in nursing care for patients suffering death anxiety in the final phase of life. *International journal of palliative nursing*, *19*(12), 599–605. https://doi.org/10.12968/ijpn.2013.19.12.599

Koenig, H. G. (2011). *Spirituality & Health Research*. Templeton Press.

Koenig, H. G., Carson, V., & King, D. (2012). *Handbook of religion and health*. Oxford University Press.

Koskela, H. (2009). *Miksi ja mitä varten Jumala? Lapsen menetyksen merkitys vanhemman spiritualiteetille* [Licentiate Thesis, University of Joensuu).

Kotisalo, H. (2002). *Diakoniatyön ja diakonisen hoitotyön toteutuminen Kuopion hiippakunnan diakonissojen arvioimana*. [Master Thesis, Universtity of Kuopio).

Kotisalo, H. (2005). Diakonisen hoitotyön toteutuminen. *Diakonian tutkimus*, (1). https://journal.fi/dt/issue/view/7863/1305

L 785/1992. Laki potilaan asemasta ja oikeuksista 17.8.1992/785. https://www.finlex.fi/fi/laki/ajantasa/1992/19920785

Lee, B. J. (2007). Moderating Effects of Religious/Spiritual Coping in the Relation Between Perceived Stress and Psychological Well-Being. *Pastoral Psychology,* (55), 751–759. https://doi.org/10.1007/s11089-007-0080-3

Leino-Kilpi, H., Välimäki, M. (2003). *Etiikka hoitotyössä*. WSOY.

Lipponen, V., Niemipelto, H., & Karvinen, I. (2018). Surevan läheisen vakaumuksen kunnioittaminen. Avaus-malli henkisen ja hengellisen tuen tarpeen jäsentäjänä. *Diakonia*, (4).

Lipponen, V., & Karvinen, I. (2015). Hengellisyys hoitotyössä saattohoitokodin omahoitajan silmin. *Palliatiivinen hoito*, (40).

Lipponen, V., & Karvinen, I. (2014). Lupa lähteä. Hengellisyys saattohoidossa hoitohenkilöstön kokemana. *Gerontologia* 28(1).

Louheranta, O., Lähteenvuo, M., & Kangasniemi, M. (2016). Henkinen ja hengellinen tuki terveydenhuollossa – kenen vastuulla?. *Sosiaalilääketieteellinen Aikakauslehti*, 53(4). Noudettu osoitteesta https://journal.fi/sla/article/view/59668

Martínez, M., Arantzamendi, M., Belar, A., Carrasco, J. M., Carvajal, A., Rullán, M., & Centeno, C. (2017). 'Dignity therapy', a promising intervention in palliative care: A comprehensive systematic literature review. *Palliative Medicine, 31*(6), 492–509. https://doi.org/10.1177/0269216316665562

Oliveira AMM., Lopes MEL., Evangelista CB., Gouveia EML., Costa SFG. & Alves, A. M. P. M. (2015). Spiritual dimension of care in nursing practice: student's opinion. *Journal of Nursing UFPE online, 6*(9): 2037–2044. https://doi.org/10.5205/1981-8963-v6i9a7306p2037-2044-2012

Pargament, K. I. (1997). *The Psychology of Religion and Coping. Theory, Research, Practice*. Guilford Press.

Piderman, K. M., Sytsma, T. T., Frost, M. H., Novotny, P. J., Rausch Osian, S. M., Solberg Nes, L., Patten, C. A., Sloan, J. A., Rummans, T. A., Bronars, C. A., Yang, P., & Clark, M. M. (2015). Improving Spiritual Well-Being in Patients with Lung Cancers. *Journal of Pastoral Care & Counseling, 69*(3), 156–162. https://doi.org/10.1177/1542305015602711

Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of palliative medicine, 3*(1), 129–137. https://doi.org/10.1089/jpm.2000.3.129

Puchalski, C., Ferrell, B., Virani, R., Otis-Green, S., Baird, P., Bull, J., Chochinov, H., Handzo, G., Nelson-Becker, H., Prince-Paul, M., Pugliese, K., & Sulmasy, D. (2009). Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *Journal of palliative medicine*, *12*(10), 885–904. https://doi.org/10.1089/jpm.2009.0142

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: reaching national and international consensus. *Journal of palliative medicine, 17*(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

Rantala, R., & Lipponen, V. (2019). "Elämää lasikuution sisällä". Eksistentiaalinen kärsimys sarkoomaa sairastavien potilaiden kirjoittamissa tarinoissa. *Diakonia*, (4)

Reijonen, K. (2014). *Monikulttuurisen hoitotyön kulmakivet. oppaan toteuttaminen lastenosaston hoitohenkilökunnalle* [Bachelor Thesis, Lahti University of Applied Sciences]. https://urn.fi/URN:NBN:fi:amk-201404013757

Rodin, G., Lo, C., Mikulincer, M., Donner, A., Gagliese, L., & Zimmermann, C. (2009). Pathways to distress: the multiple determinants of depression, hopelessness, and the desire for hastened death in metastatic cancer patients. *Social science & medicine (1982)*, *68*(3), 562–569. https://doi.org/10.1016/j.socscimed.2008.10.037

Räsänen, S., & Matila, A. (16.12.2018). Lääkkeettömät (psykososiaaliset) hoitokeinot saattohoitopotilaan ahdistus- ja masennusoireiden hoidossa. *Käypähoito. Duodecim*. https://www.kaypahoito.fi/nak08965

Rättyä Lea (1998). *Diakoniatoimistojen asiakkaiden kokemukset avun ja tuen saamisesta* [Master Thesis, University of Oulu].

Rättyä Lea (2009). *Diakoniatyö yksilöllisenä ja yhteisöllisenä auttamisena yhteiskunnallisessa muutoksessa* [Doctoral Dissertation, University of Kuopio]. http://urn.fi/URN:ISBN:978-951-27-1309-7

Sairaanhoitajien eettiset ohjeet. (1996). Hyväksytty Sairaanhoitajaliiton liittokokouksessa 28.9.1996. Retrieved 6.6.2019, from https://sairaanhoitajat.fi/jasenpalvelut/ammatillinen-kehittyminen/sairaanhoitajan-eettiset-ohjeet/

Shields, M., Kestenbaum, A., & Dunn, L. B. (2015). Spiritual AIM and the work of the chaplain: a model for assessing spiritual needs and outcomes in relationship. *Palliative & supportive care*, *13*(1), 75–89. https://doi.org/10.1017/S1478951513001120

Sipola, V. (2018). Vakaumuksen kunnioittaminen käytännössä. *Viesti-lehti*, (3)

Sipola, V. (2018). Hengellisen hoidon välineitä. In T. Saarto, J. Hänninen, R. Antikainen, & A. Vainio (Eds.), *Palliatiivisen hoidon hyvät käytännöt*. Duodecim.

Spännäri, J. (2008). *Rukous on perintöä suvusta sukuun: Ikääntyneet ja uskonto vuosituhannen vaihteen Suomessa*. (Käytännöllisen teologian laitoksen julkaisuja). Helsingin yliopisto.

Suomen evankelis-luterilainen kirkko. (i.a.). Spiritualiteetti. Teoksessa Aamenesta öylättiin – kirkon sanasto. https://evl.fi/sanasto/-/glossary/word/Spiritualiteetti

Suomen muistiasiantuntijat. (n.d.). http://www.muistiasiantuntijat.fi/tuemme.php?udpview=795008569&lang=fi.

Tahere, R. (2018). *Muslimipotilaan kohtaaminen hoitotyössä* [Bachelor Thesis, Lapland University of Applied Sciences]. https://urn.fi/URN:NBN:fi:amk-201804245358

Tanyi, R. A., McKenzie, M., & Chapek, C. (2009). How family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice. *Journal of the American Academy of Nurse Practitioners*, *21*(12), 690–697. https://doi.org/10.1111/j.1745-7599.2009.00459.x

Vainio, A. (2015). Saattohoito monikulttuurisena. In T. Saarto, J. Hänninen, R. Antikainen, & A. Vainio, (Eds.), *Palliatiivinen hoito* (pp. 271–274). Duodecim.

van Leeuwen, R., Tiesinga, L. J., Jochemsen, H., & Post, D. (2007). Aspects of spirituality concerning illness. *Scandinavian journal of caring sciences*, *21*(4), 482–489. https://doi.org/10.1111/j.1471-6712.2007.00502.x

Villagomeza, L. (2005). Spiritual distress in adult cancer patients. *Holistic Nursing Practice*, 19(6), Villagomeza L. R. (2005). Spiritual distress in adult cancer patients: toward conceptual clarity. *Holistic nursing practice*, *19*(6), 285–294. https://doi.org/10.1097/00004650-200511000-00010

Vuoti Maire (2005). *Sairaanhoidosta eheyttävään kohtaamiseen. Elämänkertatutkimus diakonissan työn muotoutumisesta vuonna 1972 voimaan tulleen kansanterveyslain jälkeen* [Master Thesis, University of Oulu].

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8 DEACONESSES AS PROMOTERS OF HEALTH AND WELLBEING

Competence in health promotion is part of the expertise of nurse-deaconess graduates of the Bachelor's Degree Programme in Healthcare, Diaconal Nursing. Deaconesses are healthcare professionals. They are qualified to work as health promoters in nursing positions in healthcare and social services, and in diaconal offices in the Evangelical Lutheran Church of Finland. Current health promotion emphasizes resources and health in contrast with the problem- and illness-orientation of the past. Deaconesses' work as health promoters complements public healthcare and social services.

The rationale for the promotion of health and wellbeing in Finland

The Ministry of Social Affairs and Health is responsible for the overall guidance and supervision of health promotion (Sosiaali- ja terveysministeriö, 2020). At the local level the municipality is responsible for promoting the wellbeing of its residents and the sustainable provision of services to them (L 410/2015). The municipalities organize and provide healthcare and social services with state support. In addition to municipalities, services are provided by private companies and organizations. Health promotion means actions aimed at "individuals, the population, communities, and living environments with a view to maintaining and improving health, workability and functional capacity, influencing determinants of health, preventing illnesses, accident injuries, and other health problems, strengthening mental health, and reducing health inequalities between different population groups, as well as systematic targeting of resources in a manner that promotes better public health" (L 1326/2010 3. §).

According to the Association of Finnish Local and Regional Authorities (Kuntaliitto), health promotion is a conscious influence on health and wellbeing background factors like lifestyle and life management, living conditions and the living environment, as well as the functioning and availability of services. Wellbeing and

health are promoted at the local level in cooperation with parishes, organizations and the private sector, as well as the state authorities (Kuntaliitto. Terveyden edistäminen, 2020). According to the Health Care Act (L 1326/2010 12. §), "local authorities shall cooperate with other public organizations based in the local authority as well as with private enterprises and non-profit organizations".

The European Union's (EU) responsibilities include the protection of human health, improvement of public health, prevention of disease, and elimination of physical and mental health risks. The EU Health Programme 2014–2020 aimed to promote health, prevent disease and encourage healthy lifestyles, protect EU citizens from serious cross-border health threats, promote innovative, efficient and sustainable healthcare systems, and enhance access to quality and safe healthcare in the EU (Kivelä, 2019; European Commission, 2020). The goal of a healthcare professional's work (L 559/1994 15. §) is "to maintain and promote heath, prevent disease, and relieve and alleviate the suffering of the sick".

During their studies a Finnish nurse acquires the skills described in the general nurse's competence requirements (180 credits) and content (YleSHarviointi, 2020). Health promotion is one of the competence requirements. The nurse can apply current health promotion research data and identify health risk factors, and can direct early support to those who need it. The nurse can plan and implement health and functional promotion interventions for individuals and groups with clients/patients, and if necessary, in multi-professional collaboration. They identify health threats and can incorporate them in the promotion of clients'/patients' health. Professional means of health promotion include early identification and the direction of support to those in need, health promotion education, and encouraging healthy lifestyles, self-care and commitment to care. In addition, the nurse's professional means include the assessment and promotion of functional capacity, rehabilitation and community health development (YleSHarviointi, 2020).

According to the National Church Council (Kirkkohallitus, 2009), health and illness issues are emphasized in diaconal work, especially when dealing with older people, and mental health and substance abuse clients. Nurse-deaconesses could make greater use of their expertise in the parish in areas like convalescent care, home nursing, mental health work, health promotion and work among the elderly, as well as in reducing health inequalities. Links with healthcare should also be strengthened.

The promotion of health and wellbeing

Health can be defined as a component of wellbeing, a human resource, or a life value. According to the World Health Organization (WHO, 1986), health is physical, mental, social, emotional and spiritual wellbeing, and can vary at different stages of life. In health promotion, health is described as a positive resource for everyday life. Health promotion emphasizes individual and community resources and functional capacity. The goal of health promotion is the population's good health, good quality of life and wellbeing (WHO, 1986; Pietilä, 2010, p. 10; Kivelä, 2019, p. 24).

Health can be regarded as a subjective (experiential) or objective (measurable) thing. Nursing science research has emphasized experiential health and its permutations in different cultures and populations. The philosophy of health promotion is based on a broad understanding of health. The focus is not on the disease but on the human ability to function, which health promotion can improve, regardless of the disease. This model is called the functional concept of health. A positive health model in which health is understood as vitality or a resource is considered one of the philosophical foundations of health promotion. Depending on the situation, people have more or fewer health resources, and health promotion has the potential to increase their positive health resources (Pietilä, 2010, p. 276; Kauhanen, Erkkilä, Korhonen, Myllykangas & Pekkanen, 2013, p. 102).

A health process model can be used to examine the factors underlying individual, family and community health. A health promoter can reinforce and address health determinants and identify the factors that may predispose a person to illness or trigger problems. Spirituality can also be viewed as an asset for the individual or community, and a factor in the protection of health (Figure 1).

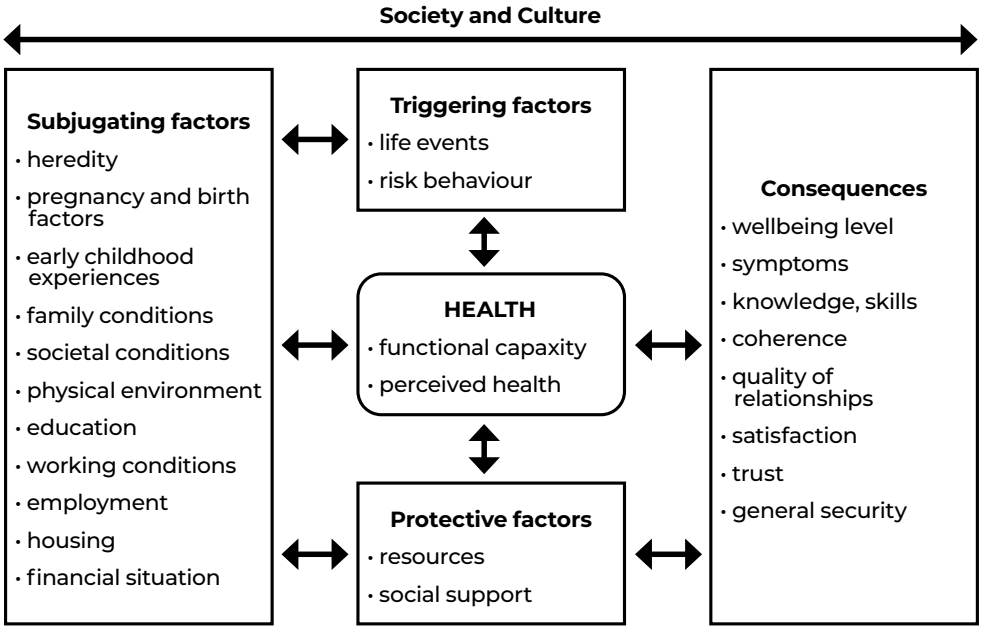

Figure 1. Health process model (adapted from Koskinen-Ollonqvist et al., 2007, p. 28)

Health promotion activities are divided into health *protection* and *promotion* activities, and disease or *prevention* activities. Health promotion is a resource- and health-driven activity that emphasizes positive health, human and community inclusion, and the quest for and discovery of untapped resources at the individual and community levels. Promotional activities maintain health, creating internal and external opportunities for people in their health and wellbeing before problems or illnesses emerge. In turn, the protection of a healthy living environment is an activity that protects the population's health (Lindström & Eriksson, 2010, p. 32; Rouvinen-Wilenius, Aalto-Kallio, Koskinen-Ollonqvist & Nikula, 2011, p. 11; Mittelmark & Bull, 2013).

Health promotion activities have been described with the aid of a health- and resource-based salutogenic model. The model's focus on health promotion has shifted from a research approach to the causes of the disease (*pathogenesis*) to the identification of factors that support and maintain health (*salutogenesis*). The salutogenic model emphasizes positive health, supports human and community inclusion, resources and opportunities (Antonovsky, 1996; Mittelmark & Bull, 2013).

The preventive approach to health promotion emphasizes preventive action that is risk-, symptom- and illness-based in nature. The goal of preventive action is to prevent the development of illnesses and problems and the maintenance of health. Health promotion measures prevent risk factors and harm while also pro-

viding treatment and rehabilitation. Preventive action is essentially illness-based, that is, pathogenic. For example, the worker identifies the risks, adversities and wellbeing deficiencies in the client's life. The preventive approach is divided into primary, secondary and tertiary prevention. Primary prevention is the prevention of illness and the reduction of its risk factors. Secondary prevention aims to prevent the illness worsening or to reduce its impact. The aim of tertiary prevention is to increase functional capacity and reduce the harm caused by illness (Laitila, 2010; Lindström & Eriksson, 2010; Mittelmark & Bull, 2013; Rättyä & Kotisalo, 2015; Huttunen 2018).

The promotion and preventive approaches to supporting health are sometimes indistinguishable. Today, instead of an illness prevention approach, more emphasis is placed on health and resource-promoting and salutogenic approaches to the promotion of health. For example, in diaconal nursing the promotion of mental health often focuses on both strengthening the protective factors in mental health and the prevention of mental health problems (Lindström & Eriksson, 2010, p. 37; Rouvinen-Wilenius ym., 2011, 11; Rättyä & Kotisalo, 2015).

The strengthening of the empowerment of individuals and communities, the experience of inclusion and coping, and the advancement of a sense of coherence and mental resilience are key in health promotion. The antithesis of empowerment is helplessness or powerlessness, which refers to the failure to achieve one's own goals, as well as limited options. The empowered person has found their own resources. A sense of coherence protects against illness and problems, reduces stress and helps healing. It is positively associated with good health, mental wellbeing, the ability to function and a healthy lifestyle (Lindström & Eriksson, 2010, p.43; Härkönen, 2012; Rautio & Husman,, 2012).

The experience of survival and life management affects a person's health and wellbeing. The stronger the patient's experience of the meaning of everyday life, the better their chances of coping with stress and problems (Häkkinen, 2019). Early identification and intervention can reduce the service need among high-use healthcare clients and contribute to their coping. In addition to symptom analysis alone, the client's overall situation should be elicited, and the means that might support coping should be discussed (Kivelä 2019, p. 93).

Resilience is associated with optimism, satisfaction with life and recovery from adversity. It supports wellbeing and protects against stress (Nuortimo & Vanhanen, 2019). Individual resilience includes mental function and the ability to adapt to changing situations. Resilience at the individual level is linked to beneficial support from the family, community and society. Community resilience

includes but is not limited to community, participation and social safety nets. In communities where people-to-people interactions are positive, meaningful shared experiences emerge. Community resilience also increases individuals' resilience (Hyvönen & Juntunen, 2018, pp. 5–6).

Inclusion entails belonging and being heard. Inclusion is built on trust and respect, livelihoods, knowledge and skill-based competences, complementary services and meaningful activities (Terveyden ja hyvinvoinnin laitos. Heikoimmassa asemassa olevien osallisuus, 2020). Inclusion, manifested as greater control over one's own life, is strengthened when the individual capacity for action increases (Koivisto, Isola & Lyytikäinen, 2018, p. 11).

Inclusion is best supported by activities that offer an experience of dignity and relevance, and promote the common good. The experience of inclusion also has therapeutic and empowering implications (Laitila, 2010; Isola, Kaartinen, Leemann, Lääperi, Schneider, Valtari & Keto-Tokoi, 2017, p. 38). According to Juntunen (2014), diaconal work can strengthen the client's inclusion and influence. For example, a person suffering from mental health problems and substance abuse can be supported to experience involvement in their own care and rehabilitation, and the development and organization of services.

Challenges to health promotion

According to Kivelä (2019, pp. 26; 93), a specific goal of health promotion is to promote the quality of life, commitment to care, clinical health status and the lifestyle of high-use healthcare clients. Finns' health has generally improved, but the health status of those belonging to the lowest income and education cohorts has deteriorated, while health inequalities have increased. It has been found that exclusion and poor health are strongly linked, as are mental health problems and heavy use of health services and medicines. High-use healthcare clients have long-term illnesses that reduce their quality of life, lower education levels and weak financial situations (Kinnunen, 2009; Rotko, Hannikainen-Ingman, Murto, Kauppinen & Mustonen, 2014; Aaltonen, Berg & Ikäheimo, 2015; Manderbacka, Aalto, Kestilä, Muuri & Häkkinen, 2017).

Poverty is often linked to health problems. For example, the perception of poor health, a weak ability to function, disability, the restriction of long-term activity, absence from work or school, a lack of support and resources, infectious diseases, or high mortality may be the result of poverty (Cone, 2015). A low socioeconomic status also predisposes people to morbidity and premature mortality, but its im-

portance as a health risk factor is insufficiently addressed (Stringhini, Carmeli, Jokela et al., 2017; Manderbacka et al., 2017).

Clients who need a lot of services often have multifaceted problems. They have somatic symptoms, illnesses, impaired mental function, fail to adhere to treatment and have financial difficulties. Substance users may also experience difficulties associated with exclusion, depression, panic disorder, functional capacity, family situation, social relationships and work capacity. These factors make it difficult to cope in everyday life. The healthcare and social services of clients who require many services should be brought together, using multi-professional working methods to tailor individual services (Ylitalo-Katajisto, 2019, pp. 79–80, p. 100; Koivisto & Tiirinki, 2020).

Recent years have seen positive changes in the health, functional capacity and wellbeing of Finns, especially in physical activity, perceived quality of life and social participation. Lifestyle changes and health behaviours can significantly affect wellbeing and health. The early identification and addressing of problems and health risks, counselling, and where necessary, referral to treatment are key instruments in health promotion (Koponen, Borodulin, Lundqvist, Sääksjärvi & Koskinen,, 2018).

Health promotion in diaconal work

The work of deaconesses in the promotion of health and wellbeing has been described as both resource-based and focused on the prevention of problems and diseases. Resource orientation refers to care grounded in health promotion. In turn, action taken to forestall problems and diseases is referred to as preventive health promotion (Rättyä & Kotisalo, 2015). (Figure 2.)

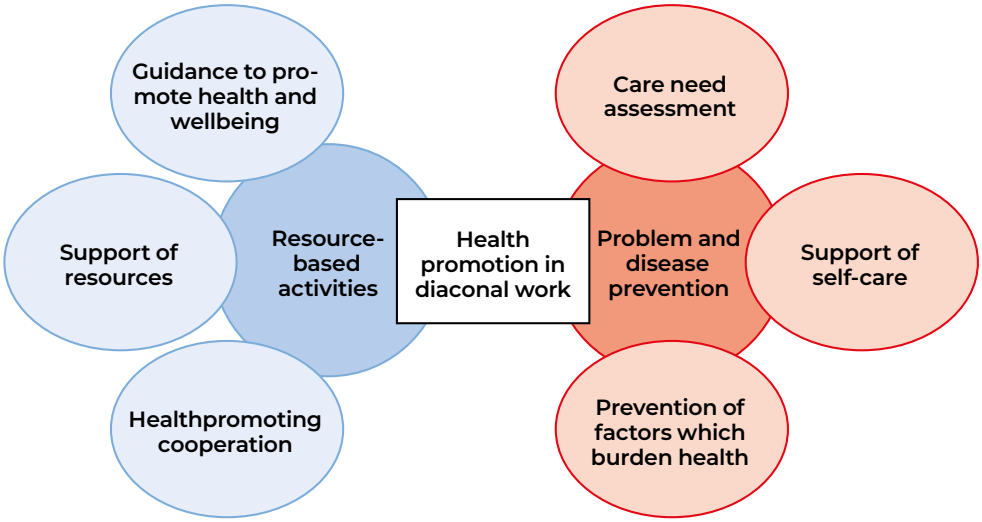

Figure 2. The promotion of health and wellbeing in diaconal work as described by deaconesses (adapted from Rättyä & Kotisalo, 2015)

In health promotion, resource-based activity emphasize the quest for and discovery of untapped resources at the individual and community levels, as well as the active role played by people in matters concerning them. Resource-based guidance which supports health and wellbeing helps the patient find opportunities for change and the adoption of a healthy lifestyle. Timely and practical expert assistance based on practical guidelines, as well as the support of relatives and peers, contributes to the implementation of a lifestyle change. What is important for the population is health literacy**,** which entails the ability to understand the available health information and actively acquire up-to-date health information (Mittelmark & Bull, 2013; Kauhanen et al., 2013, p. 103, pp. 117–118; Häkkinen, 2019).

Deaconesses describe health promotion in diaconal work as a resource-based activity. It emphasizes guidance for the health and wellbeing of individuals and families, support of resources, and health cooperation. The promotion of health and wellbeing includes guidance on health choices and parenting, as well as inclusion. The clients of diaconal work especially need guidance in relation to eating, rest, outdoor activities, exercise, maintaining health and observing a healthy lifestyle. In parenting-related guidance discussion assistance, parenting support and guidance on various peer activities, inclusion and community are essential (Rättyä & Kotisalo, 2015).

The health promoter acts as a supporter, coach and partner in the client's reflection. The client themselves evaluates the information they are given, processes

it, and may use it when the time is right for them. The worker then evaluates what the person's own goals are, and what they can commit to. The goal of health promotion is to identify and strengthen resources at the individual and community levels that give people the opportunity to play an active role in the management of their own health. Resources and living conditions determine the individual's ability to use information and exploit the available opportunities (Rouvinen-Wilenius et al., 2011, p. 11; Holmberg-Marttila, Hirsso, Mattelmäki & Koivuniemi, 2014, pp. 44–53).

Deaconesses support clients' resources, coping, mental and spiritual wellbeing and their connection with the parish. Resource-based activities come to the fore in customer-orientation and in an emphasis on hobbies, interpersonal relationships and issues related to a positive mental disposition. Clients expect support and encouragement to address their own wellbeing and ability to make choices. Themes related to the meaning and purpose of life, hope, self-esteem, dignity, spiritual wellbeing and faith often feature in discussions. Deaconesses support the people they encounter in the parish context by informing them about the parish's activities and opportunities to get involved, and helping them participate in worship (Rättyä & Kotisalo, 2015). Ziebarth and Campbell (2019) maintain that the combination of faith and health is central to nursing in religious communities. Spiritual support allows the promotion of the client's empowerment and coping.

Health promotion requires cooperation with local healthcare and social service actors, as well as communication with the client. Local cooperation with the health centres, maternity and child clinics, and other healthcare and social service actors is key. Without this cooperation the customer will not receive the required support. Deaconesses agree home visits, office visits, telephone contacts and the regularity of meetings with the client. Agreeing these things strengthens the client's commitment to cooperation and ensures its continuity (Kotisalo & Rättyä, 2014, p. 100, pp. 152–153; Rättyä & Kotisalo, 2015).

Action to prevent problems and diseases in health prevention includes the assessment of the need for treatment, support for self-care and the determinants of preventive health. Deaconesses assess the need for care by examining the client's wellbeing, discussing illnesses, and assessing the adequacy of existing care and the need for local collaboration on client care issues. Clients may have a wide range of somatic and mental symptoms, pain, insomnia, health problems and illnesses. Illnesses cause anxiety and fear. Deaconesses discuss wellbeing, symptoms and illnesses, and ask specific questions to determine mental and physical wellbeing, alertness and the overall situation (Rättyä & Kotisalo, 2015).

Deaconesses look for factors that promote wellbeing with the client and guide them in monitoring what symptoms are like. They assess changes in the client's wellbeing and encourage the client to seek treatment. They focus on changes in areas like the client's breathing, skin, medications for pain and other symptoms, as well as basic organ function and the client's orientation. Early attention to symptoms and illnesses, intervention and referral for treatment are essential. Cross-sectoral customer care cooperation with organizations and public healthcare and social service staff is central in local cooperation. Holistic support for the client requires deaconesses to be familiar with and use health promotion methods and to cooperate locally with social and health service actors (Rättyä, 2010, pp. 51–52; Rättyä, 2012, pp.97–103; Kotisalo & Rättyä, 2014, p. 101; Rättyä & Kotisalo, 2015).

Deaconesses support the client's self-care by discussing the treatment of the illness and medication, taking treatment measures and motivating self-care. Diaconal clients need to discuss how their illnesses are treated, the various examinations and procedures they face, and the associated fears. The nursing performed by deaconesses themselves involves the treatment procedure, the administering of medicines and first aid, and the measuring of blood pressure. Deaconesses motivate clients in their self-care by informing them of the effects of food, rehabilitation and adherence to medication regimens. They provide guidance in symptom monitoring, the self-care of illness, and the use of social and health services. They also discuss opportunities for support in society and social security (Rättyä & Kotisalo, 2015).

Health counselling and guidance achieve the best results when they start as soon as possible after a risk of illness has been identified or a diagnosis has been made. The result is a positive motivation on the patient's part to change their behaviour. Guidance use motivational interviews, health counselling and mini-interventions to address harmful lifestyles and promote self-care, for example (Routasalo, Airaksinen, Mäntyranta & Pitkälä, 2009; Häkkinen, 2019). Guidance can also be provided via video or the internet, using reliable web portals, a health library (www.terveyskirjasto.fi) and electronic healthcare and social services (hyvis.fi).

A motivational interview is a customer-oriented guidance method based on collaboration between a healthcare professional and a client. It helps identify and strengthen the client's/patient's motivation for a lifestyle change. The interview uses open-ended questions, reflective listening, and summarizing. Based on the motivational interview, customer-oriented health coaching has been developed,

which helps the client identify negative elements in their lifestyle and seek health-promoting behavioural changes (Motivoiva haastattelu 2014; Kivelä, 2019, pp. 85–86, pp. 90–91).

Especially in health coaching for high-maintenance health and long-term patients, customer orientation is key to achieving positive effects on health behaviour. *Health coaching* is a health promotion method that increases the client's wellbeing and promotes the achievement of health-related goals. The aim of coaching is to assist the client in finding their own means and mental resources to achieve the health goals they set for themselves (Hayes & Kalmakis, 2007; Kivelä, 2019, pp. 85–86, pp. 90–91). Deaconesses support clients' ability to function and be rehabilitated. They look for ways to survive at home, maintain functional capacity and receive adequate services with clients (Rättyä & Kotisalo, 2015).

Deaconesses encounter people in their work going through a stressful life situation. A life situation constitutes a health risk especially when it threatens coping and survival in everyday life, prolongs grief, or exposes a person to exclusion and insecurity. Grief, loneliness, serious illness, financial problems, poverty, exhaustion resulting from parenting and alcoholism cause exclusion and are an additional burden on coping. Deaconesses help by being present and giving space for the client's experiences, as well as their individual life story. They listen, discuss, support people holistically, use spiritual support and pastoral care methods, and encourage clients to participate in parish activities (Kotisalo, 2005, p. 12; Kinnunen, 2009; Rättyä, 2009, pp. 90–91; Rättyä, 2010, pp. 52–55, pp. 57–58; Rättyä & Kotisalo, 2015; Isomäki, 2018).

Summary

The promotion of health and wellbeing is part of diaconal client work. The deaconess encounters and helps people of different ages living in various life situations and people with different health problems and suffering from deprivation. Deaconesses help and support people, families, groups and communities holistically. They maintain and promote health, strengthen resources and hope, and support inclusion and connection (Kotisalo, 2005, pp. 11–14; Rättyä, 2009, pp. 74–77; Rättyä, 2010, p. 97103; Kotisalo & Rättyä, 2014). A particular challenge in diaconal work is posed by people with scarce health resources who compromise on healthcare because of deprivation, and do not receive adequate healthcare and social services (Isomäki et al., 2018, 47, p. 105). According to diaconal statistics, health and illness issues are the second most important reason people seek help

from diaconal workers. Encounters associated with both finances and health and illness have increased in diaconal work (Suomen evankelis-luterilainen kirkko, 2019).

Diaconal work differs from other Finnish social and health work because of its holistic nature. It treats people's financial, social, physical, mental and spiritual wellbeing (Isomäki et al., 2018; Rättyä, 2012, p. 87). Parishes should be more actively involved in the development of local social care and healthcare services. Deaconesses and deacons occupy roles in accordance with their own expertise in assembling customer-oriented services and coordinating multidisciplinary services (Koponen et al., 2018, pp. 191–193; Koivisto & Tiirinki, 2020).

As a result of increasing internal migration, the population is concentrated in large cities. It is largely the elderly who remain in the depopulated villages of the countryside. At the same time, the number of young people is declining nationally, and their mental health problems are expected to increase. People's inequality is reflected in their health and life expectancy, as well as in the availability of adequate and high-quality services. Solutions to the challenges can be found in preventive services and digitalization, for example (Manderbacka et al., 2017; Wallenius, 2018, pp. 67–79; Dufva, 2020, p. 22, p. 25).

From the perspective of diaconal nursing the challenges mentioned above are not new. Deaconesses are experienced in helping people and voiceless groups where disadvantage accumulates, and where they have health problems like long-term illnesses, disabilities, and deficiencies in access to support and services. Deaconesses are accustomed to acting as helpers in challenging conditions in remote areas far from services. They have acted boldly and in a client-oriented manner in their quest for solutions that maintain wellbeing and health. Deaconesses have been their era's nursing and health promotion pioneers in bringing help where other help is not forthcoming. They have provided people with holistic care, defended the vulnerable, engaged in local collaboration, and maintained the hope and supported the spirituality of the individual and the community. This competence is increasingly needed now and in the future.

Sources and literature

Aaltonen, S., Berg, P., & Ikäheimo, S. (2015). *Nuoret luukulla. Kolme näkökulmaa syrjäytymiseen ja nuorten asemaan palvelujärjestelmässä.* Nuorisotutkimusverkosto. Terveyden ja hyvinvoinnin laitos. https://www.nuorisotutkimusseura.fi/images/julkaisuja/nuoretluukulla.pdf

Antonovsky, A. (1996). The Salutogenic Model as a Theory to Quide Health Promotion. *Health Promotion International, 11*(1), 11–18. https://doi.org/10.1093/heapro/11.1.11

Cone, P. M. H. (2015). Theology of Poverty and Health Applied to Nursing Education. *Christian Higher Education, 14*(3), 158–176. https://doi.org/10.1080/15363759.2015.1033898

Dufva, M. (2020). Megatrendit 2020. (Sitran selvityksiä 162). Sitra. https://media.sitra.fi/2019/12/15143428/megatrendit-2020.pdf

European commission. (2020). EU4Health 2021-2027 – a vision for a healthier European Union. https://ec.europa.eu/health/funding/eu4health-2021-2027-vision-healthier-european-union_en

Hayes, E., & Kalmakis, K. A. (2007) Coaching as a nurse practitioner strategy for improving health outcomes. *Journal of the American Academy of Nurse Practitioners, 19*(11), 555-562. https://doi.org/10.1111/j.1745-7599.2007.00264.x

Holmberg-Marttila, D., Hirsso, P., Mattelmäki, U., & Koivuniemi, K. (2014). *Terveydenhuollon kompassi: avain asiakkuuteen*. Duodecim.

Huttunen, J. (2018). Mistä terveys syntyy? *Lääkärikirja Duodecim*. https://www.terveyskirjasto.fi/dlk00928

Hyvönen, A.-E., & Juntunen, T. (2018). *Resilienssi avaimena laaja-alaiseen kokonaisturvallisuuteen: haasteita ja mahdollisuuksia*. (Valtioneuvoston selvitys- ja tutkimustoiminnan artikkelisarja 25/2018). Valtioneuvoston kanslia. https://tietokayttoon.fi/julkaisu?pubid=28005

Härkönen, P. (2012). Elämäntyytyväisyys ja terveys – voimavarasuuntautunut ikääntyvien henkilöiden seurantatutkimus [Doctoral Dissertation, University of Oulu). Oulun yliopisto. http://urn.fi/urn:isbn:9789526200163

Häkkinen, E. (January 1, 2021). Terveyden edistäminen. *Sairaanhoitajan käsikirja.* Kustannus Oy Duodecim. https://www.terveysportti.fi/apps/dtk/shk/article/shk00489/

Isola, A-M., Kaartinen, H., Leemann, L., Lääperi, R., Schneider, T., Valtari, S., & Keto-Tokoi, A. (2017). *Mitä osallisuus on? Osallisuuden viitekehystä rakentamassa*. Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-302-917-0

Isomäki, P., Lehmusmies, J., Salojärvi, P., & Wallenius, V. (2018). *Diakoniabarometri 2018. Yksinäisyyden monet kasvot.* Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Juntunen, E. (2014). Diakoniatyöntekijöiden auttamistyö asiakkaan kansalaisuuden tukemisena. *Diakonian tutkimus*, (1). https://journal.fi/dt/issue/view/7863/1311

Juntunen, E., Grönlund, H., & Hiilamo, H. (2006). *Viimeisellä luukulla: tutkimus viimesijaisen sosiaaliturvan aukoista ja diakoniatyön kohdentumisesta*. Kirkkohallitus.

Kauhanen, J., Erkkilä, A., Korhonen, M., Myllykangas, M., & Pekkanen, J. (2013). *Kansanterveystiede*. Sanoma Pro.

Kinnunen, K. (Ed.). (2009). *Sairas köyhyys. Tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä*. Kirkkohallitus.

Kirkkohallitus (2009). *Työryhmän raportti terveyden edistämisestä diakoniatyössä* [Moniste]. Kirkkohallitus.

Kivelä, K. (2019). *Terveysvalmennuksen vaikuttavuus paljon terveyspalveluita käyttäville asiakkaille perusterveydenhuollossa* [Doctoral Dissertation, University of Oulu]. (Acta Universitatis Ouluensis, D, Medica, 1549). Oulun yliopisto.

Koivisto, J., Isola, A.-M., & Lyytikäinen, M. (2018) *Osallisuus kuuluu kaikille. Innokylän innovaatiokatsaus*. Terveyden ja hyvinvoinnin laitos https://urn.fi/URN:ISBN:978-952-343-077-8.

Koivisto, J., & Tiirinki, H. (2020). *Monialaisten palvelutarpeiden tunnistamisen ja ennakoinnin toimintamallit ja työkalut -väliraportti*. Terveyden ja hyvinvoinnin laitos.

Koponen, P., Borodulin, K., Lundqvist, A., Sääksjärvi, K., & Koskinen, S. (Eds.) (2018). *Terveys, toimintakyky ja hyvinvointi Suomessa. FinTerveys 2017 -tutkimus.* Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-343-105-8

Koskinen-Ollonqvist, P., Aalto-Kallio, M., Mikkonen, N., Nykyri, P., Parviainen, H., Saikkonen, P., & Tamminiemi, K. (2007). *Rajoilla ja ytimessä. Terveyden edistämisen näyttäytyminen väitöskirjatutkimuksissa*. Terveyden edistämisen keskus.

Kotisalo, H. (2005). Diakonisen hoitotyön toteutuminen. *Diakonian tutkimus,* (1). https://journal.fi/dt/issue/view/7863/1285

Kotisalo, H., & Rättyä, L. (2014). *Diakonissat terveyden edistäjinä*. (Diakonia-ammattikorkeakoulun julkaisuja. B, Raportteja, 58). Diakonia-ammattikorkeakoulu. http://www.urn.fi/URN:ISBN:978-952-493-220-2

Kuntaliitto. Terveyden edistäminen. Retrieved February 21, 2020, from https://www.kuntaliitto.fi/sosiaali-ja-terveysasiat/terveydenhuolto/terveyden-edistaminen.

Laitila, M. (2010). *Asiakkaan osallisuus mielenterveys- ja päihdetyössä* [Doctoral Dissertation, University of Kuopio)Hoitotieteen laitos. Kuopio: Itä-Suomen yliopisto. http://urn.fi/URN:ISBN:978-952-61-0224-5

L 559/1994. Laki terveydenhuollon ammattihenkilöistä 28.6.1994/559. https://www.finlex.fi/fi/laki/ajantasa/1994/19940559.

L 1326/2010. Terveydenhuoltolaki 30.12.2010/1326. https://www.finlex.fi/fi/laki/ajantasa/2010/20101326.

L 410/2015. Kuntalaki 10.4.2015/410. https://www.finlex.fi/fi/laki/ajantasa/2015/20150410

Lindström, B., & Eriksson, M. (2010). Salutogeeninen lähestymistapa terveyteen – teoria terveyden resursseista. In A.-M. Pietilä (Ed.), *Terveyden edistäminen. Teorioista toimintaan* (pp. 32–48). Wsoy.

Manderbacka, K., Aalto, A.-M., Kestilä, L., Muuri, A., & Häkkinen, U. (2017). Eriarvoisuus somaattisissa terveyspalveluissa. *Suomen sosiaalinen tila 2/2017.* Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-302-853-1

Mittelmark, M. B., & Bull, T. (2013). The salutogenic model of health in health promotion research. *Global Health Promotion, 20(*2), 30–38. https://doi.org/10.1177/1757975913486684

Motivoiva haastattelu. (18.6.2014). Käypä hoito -suositus Duodecim. https://www.kaypahoito.fi/nix02109

Nuortimo, O., & Vanhanen, H. (2019). *Tietoisen läsnäolon yhteys elämäntyytyväisyyteen, koettuun stressiin ja optimismiin resilienssin välittämänä* [Master Thesis, University of East Finland]. http://urn.fi/urn:nbn:fi:uef-20190335

Pietilä, A.-M. (2010). Terveyden edistämisen lähtökohtia – katsaus kirjan ydinsisältöön. In A.-M. Pietilä (Ed.), *Terveyden edistäminen. Teorioista toimintaan* (pp. 10–14). Wsoy.

Rautio, M., & Husman, P. (2012). Työikäisten terveyden edistäminen – esimerkkejä työmenetelmistä ja toimintamalleista. In A.-M. Pietilä (Ed.), *Terveyden edistäminen. Teorioista toimintaan (pp.* 165–190). Sanoma Pro,

Rotko, T., Hannikainen-Ingman, K., Murto, J., Kauppinen, T., & Mustonen, N. (2014). Terveyserojen kaventaminen käytännössä – alueellinen yhteistyö avuksi. *Yhteiskuntapolitiikka,* 79(1), 92–99. https://urn.fi/URN:NBN:fi-fe2014060526279

Routasalo, P., Airaksinen, M., Mäntyranta, T., & Pitkälä, K. (2009). Potilaan omahoidon tukeminen. *Duodecim* 125, 2351–2359.

Rouvinen-Wilenius, P., Aalto-Kallio, M., Koskinen-Ollonqvist, P., & Nikula, T. (2011). Osallisuus osana tasa-arvoa. In P. Rouvinen-Wilenius, & P. Koskinen-Ollonqvist (Eds.), *Tasa-arvo ja osallisuus väylä terveyteen. Järjestöt suunnannäyttäjinä*. Terveyden edistämisen keskus.

Rättyä, L. (2009) *Diakoniatyö yksilöllisenä ja yhteisöllisenä auttamisena yhteiskunnallisessa muutoksessa*. Kuopio: Kuopion yliopisto [Doctoral Dissertation, University of Kuopio]. http://urn.fi/URN:ISBN:978-951-27-1309-7

Rättyä, L. (2010) *Diakoniatyöntekijöiden kuvauksia työstään ja siinä jaksamisestaan* [Licentiate Thesis, University of Oulu]. (Diakonia-ammattikorkeakoulun julkaisuja. A Tutkimuksia, 24). Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-083-3

Rättyä, L. (2012). Diakoniatyö yksilöiden ja perheiden parissa. In R. Gothoni, R. Helosvuori, K. Kuusimäki, & K. Puuska (Eds.), *Kantakaa toistenne kuormia. Diakoniatyön perusteet ja käytäntö* (pp. 80–110). Kirjapaja.

Rättyä, L., & Kotisalo, H. (2015). Diakonissat terveyden edistäjinä diakoniatyössä. *Diakonian tutkimus*, (2). https://journal.fi/dt/issue/view/7863/1286

Sosiaali- ja terveysministeriö. Terveyden edistäminen. Retrieved 21.2.2020 https://stm.fi/terveyden-edistaminen

Stringhini, S., Carmeli, C., Jokela, M., Avendano, M., Muennig, P., & Guida, F. ym. (2017) Socioeconomic Status and the 25 x 25 Risk Factors as Determinants of Premature Mortality: a Multicohort Study and Meta-analysis of 1,7 million Men and Women. *The Lancet, 389*(10075), 1229–1237. https://doi.org/10.1016/S0140-6736(16)32380-7

Suomen evankelis-luterilainen kirkko. Tilastotietoa 2018 ja 2019. Diakonia. Retrieved February 2, 2020, from https://evl.fi/documents/1327140/0/Tilastotietoa+2018-2019.pdf/3b96ce86-8239-cd41-fca3-18d5a7cce68e

Terveyden ja hyvinvoinnin laitos. Hyvinvoinnin ja terveyden edistämisen johtaminen. Heikoimmassa asemassa olevien osallisuus. Retrieved Fervruary 21, 2020, from https://thl.fi/fi/web/hyvinvoinnin-ja-terveyden-edistamisen-johtaminen/osallisuuden-edistaminen/heikoimmassa-asemassa-olevien-osallisuus

Wallenius, V. (2018). Diakoniatyön viestintä, vaikuttaminen ja digitalisaatio. In P. Isomäki, J. Lehmusmies, P. Salojärvi, & V. Wallenius, *Diakoniabarometri 2018. Yksinäisyyden monet kasvot*. Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

WHO. World Health Organization (1986). *Ottawa charter for health promotion: An International Conference on Health Promotion, the move towards a new Public Health*, November 17-2. WHO, Geneva.

YleSHarviointi. (January 7, 2020). Osaamisvaatimusten muutokset kommenttien perusteella. https://blogi.savonia.fi/ylesharviointi/2020/01/07/osaamisvaatimusten-muutokset-kommenttien-perusteella/

Ylitalo-Katajisto, K. (2019). Paljon palveluja tarvitsevien asiakkaiden yksilöity sosiaali- ja terveyspalvelujen yhteen kokoaminen [Doctoral Dissertation, University of Oulu]. http://urn.fi/urn:isbn:9789526224084

Ziebarth, D. J., & Campbell, K. (2019). Describing Transitional Care Using the Nursing Intervention Classification: Faith Community Nursing. *International Journal of Faith Community Nursing*, *5*(1). https://digitalcommons.wku.edu/ijfcn/vol5/iss1/3

III
DIACONAL NURSING IN DIFFERENT ENVIRONMENTS

Päivi Thitz and Minna Valtonen

9 A DEACONESS'S PROFESSIONAL IDENTITY AND CAREERS

The deaconess's training results in a qualification for both nursing and diaconal work. The nursing professionalism entails a willingness to undertake spiritual work and an understanding of the complex field of the church's diaconal work. This multidisciplinary qualification and competence require a flexible and extensive professional identity. Changes in the field and career advancement require professionals to maintain and develop their competence. The identities of the nurse and church worker are in a constant dialogue, and they sometimes challenge each other. The deaconess career stories reveal that the same training allows for very different multi-stage career paths.

Professional identity and its career development

Professional identity can be defined as a person's individual perception of their own professionalism and role as a member of a profession. Professional identity encompasses many elements and is influenced by an individual's life story, situation, perceptions and experiences of work, and professional development. Values and beliefs also influence the formation of professional identity.

Professional identity is not a permanent state of being; it is a dynamic process in which a person's life story and situation, vocational training, work experience and social context are in constant interaction (Valtonen, 2015, pp. 93–94). Professional identity is part of the individual's identity and is linked to both personal and social identity. In constructing a professional identity, the individual's personal growth is involved, as is socialization in a professional group (Valtonen, 2009, pp. 38–43). A person can have several professional identities that are sometimes in tension with each other.

Professional identity is formed during one's own career by working in various positions and by professional development, as well as through additional training. The traditional concept of a career describes the individual's ascent to a more responsible and hierarchically higher position, and goal-oriented professional ad-

vancement. In this case the career is seen as a linear path along which working life progresses. In recent decades the clear and linearly progressing career model has been accompanied by more flexible career models better suited to today's working life. Uncertainty in working life, intermittent and project-like employment relationships, as well as individuals' own expectations and the diversification of their lives are reflected in the individualization of careers. Careers today frequently involve various stages and tasks that sometimes include work, unemployment, and periods of study and training (Marttila, 2015, pp. 19–21; Ojala, 2019).

Because professional identity is constantly changing, its core is difficult to define unambiguously. The storytelling approach is one way to examine identity and its construction. It approaches identity through narratives. A story helps one link one's own life story, present and thoughts about the desired, desirable and future self (Mahlakaarto, 2010, p. 178). As the narrator shares their experiences of professional identity and relates them to events in their own life, they also construct their own identity. This allows room for individual experiences and different voices to be heard (Valtonen, 2015, pp. p. 95).

In this article we examine the career paths of deaconess graduates. We sought career path stories from deaconesses from different parts of Finland working in different positions for the article. We received texts from seven deaconesses who had graduated at different times and had worked in various roles in their careers. The following career path accounts are summaries. In every account the deaconess's identity has supported them in their career.

Deaconesses' accounts of their career paths

Kirsti Kirjavainen — promoter of holistic health in international assignments

Having come to faith when I was 18, I set out to study to be a deaconess. I worked in parish work for two years. I then took Felm's mission course, a one-year midwifery course in London and a tropical diseases course. In 1977 I entered into service with Nepaliin Yhdistyneen Lähetys (the United Mission to Nepal) and Felm. I first worked as a midwife at a nursing school and then as a maternity and child healthcare developer. In practice, the work included the training of fieldworkers, dozens of clinics, working with witch doctors to treat diarrhoeal diseases, toilets, waterpipes, kitchen gardens, nurseries and veterinary medicine.

Deaconess training was a good foundation for mission work, but holistic work among people required continuous learning. I took refresher courses in England on children's health, peace work, adult education, rural development, and leadership and quality improvement. The additional training was a huge help in new jobs in adult literacy, rural development, and peace and reconciliation during the civil war. The promotion of health is more than the elimination of disease; it is also about supporting community, peace and human rights. I did everything as consultant and educator as part of a team with the Nepalese, involving local people from design to evaluation.

My career in Nepal lasted just over thirty years. I started as a director of community healthcare; I finished as a Nepal country representative. The most important and meaningful work happened between the two. I learned the country's language and about its culture, and I did pioneer work in the most far-flung regions in the midst of civil war, famine, earthquakes and floods. I learned to trust in God and teamwork, and to listen to local people, who know their own context best. Change happens slowly in small steps, through encouragement, training and companionship. The salvation the gospel offers is not only spiritual salvation; it is also salvation from discrimination, inequality, poverty, fear and oppression.

My biggest task was to bring hope wherever I went. Our work involved the strengthening of human dignity and self-esteem, making dreams come true, and catalysing change. It involved the education of low-caste Dalit girls and reducing discrimination based on caste. It involved securing citizenship papers for landless people, birth and disability certificates for the disabled, bringing childbirth in stone cottages and barns to an end, educating girls, and establishing women's savings groups and banks. It involved finding, educating and activating the disabled, and meaningful activities and livelihoods for them through education.

I have trusted in God's guidance through all these changes. A relationship with God and human relationships have been important when my own life, responsibility and commitment to a task have been challenged. My extensive training and spiritual background have facilitated holistic work in international environments. Now I'm retired, but I continue to volunteer by visiting Nepal every year to photograph success stories in Nepal and report on them at photographic exhibitions in Finland. I still find my inspiration in the words from my ordination service: I can do all things through him who strengthens me (Phil. 4:13).

Sirkka Jakonen — all-round influencer in managerial and administrative positions

I was actively involved in the parish in my youth, but I had no clear goal of becoming a deaconess — somehow the door opened for me. Underlying this was a strong Christian conviction, as well as an idealistic and black-and-white worldview. I wanted to find a way to help people and make a difference. I started with nursing training, going on to become a deaconess. Having graduated in 1976, I was experiencing an identity crisis of some sort and didn't want to work in a parish. I have since held various parish positions, but not in a diaconal office.

Since graduating, I've mostly worked in healthcare positions as a hospital nurse and a community health nurse. I continued my studies by first completing a degree in community healthcare, followed by a master's degree in the same field. My training as a deaconess has served as a strong foundation in all my roles in community healthcare. I was a community healthcare supervisor. I then worked in the university as a researcher in the Schools for Health in Europe network. Alongside my work I did a doctorate in health sciences in 2005. I started as a community healthcare inspector in the provincial government, after which I became the director of the Health and Social Services, Legality and Licensing area of responsibility of the Regional State Administrative Agency for Eastern Finland, which was established in 2010. I became the director general of the Agency in 2017.

The task of the Regional State Administrative Agency is to guide, approve and supervise the implementation of legislation. The aim is to promote an equal and just society, the realization of a healthy and safe working and living environment, and equality between regional and demographic groups. The Agency ensures the realization of citizens' fundamental rights and legal protection, as well as access to basic services. As the Agency's highest official, the director general's role is to lead its operations to achieve performance targets, as well as being productive, efficient and effective.

I've drifted between expert, managerial and leadership positions in my career. I've been guided by prayer and faith in my journey; I haven't consciously pursued positions. I've been guided by a strong desire to make an impact and to perform well in the roles I've been given. Diaconal work is part of my Christian identity. My training as a deaconess has been one of the highlights of my life, both in terms of growing as a person and professionalism. Human encounter and interaction skills have also always been of interest in my subsequent supplementary studies. In patient and client work, encounter with a person in a particular life situation

and the resources they have are at the centre. The same interaction skills also apply in managerial and leadership work.

My experience has been that my Christian vocation has been enacted wherever I've been led. In recent years I've approached the diaconal field quite tangibly in my service as chair of the diaconal advisory board of the Diocese of Kuopio. I retired from my official post at the end of 2019. I look forward to seeing what the next steps will be, and where they will lead. My inner deaconess will not be retiring,

Jaana Rannikko — provider of a broad range of diaconal relief

I've experienced God leading me throughout my life, even to places I might not have wanted to go and to encounter people I didn't think I would. I came to faith at confirmation camp. I realized early on that my special skill lay in the ability to meet and listen to people. I graduated as a deaconess in 1984 from Helsinki, initially working as a nurse in various hospitals. I remember an older male patient holding me by the hand: "Never change." I then worked for a year and a half in parish diaconal work in Vantaa, where the main emphasis was on home visits and groups for older people.

I was asked to do mission work in Bangladesh. Although I wasn't interested at first, I gradually grew to the idea, ending up in Bangladesh for three years as a health project manager. Some twenty-five local people worked under me, most of them Muslim men. I learned how to wear saris and speak Bengali. I came to realize that there were many ways to do things "properly". Having worked in Finland for less than a year in a nursing home as a nurse and sister, I continued with development cooperation work in Zambia. The focus of my job was on the empowerment of women, training and supporting women's groups, as well as working in the local social office. I drove a pickup truck through the bush, ate maize porridge with my fingers and danced with the women.

On my return to Finland, I found myself sometimes unemployed, sometimes working in a psychiatric ward. I learned what it was like to feel I didn't belong, and that I wasn't valuable without work. Finally, I returned to Vantaa to do basic diaconal work. From parish diaconal work I moved to the Finnish Seamen's Mission, where I worked for thirteen years. During that time I sailed on Swedish ships and cargo vessels to support the crew as a ship's counsellor, a social counsellor in Greece and a port counsellor in the port of Hamina-Kotka. I ended up painting the gunwale, changing the filters in the engine room, sounding the foghorn, serving as waitress and making the beds. At times I was on leave, working as a work-

place deacon in Kotka, where traditional smokestack industries were undergoing redundancy negotiations. Eventually, I myself lost my job at the Finnish Seamen's Mission as a result of redundancy negotiations. The experience was tough, and I felt the work I'd done with all my heart was set at naught.

I'm currently the director of services in the parish of Tuusula. Five deacons and two priests work under me. Among other things, I'm responsible for the work area and its development, as well as human resource management, crisis management, work supervision, bereavement groups, diaconal client work, camps, excursions and events. During my career I've completed long-term pastoral training, supervisor training and church leadership training, for example. The focus of diaconal work has shifted from home visiting and work among the elderly to financial assistance and holistic support. Networking has increased. The role of diaconal work in worshipping life is more prominent, and serving as an assistant at mass has deepened my identity as a church worker.

My nursing qualifications have also enabled me to work outside the parish. Qualification as a deaconess is automatically associated with Christian conviction. I've never had to vocalize them as separate. Over time my identity and skills have strengthened. I'm now clearly a church worker rather than a nurse. Today, my skillset is varied. I can encounter and help a wide variety of people. Nothing really startles me. I know everyone is valuable — everyone has their own story. God continues to lead me.

Elisa Linkola — developer and leader of changing diaconal work

As a young person in the parish I got to know a young diaconal worker and became interested in the deaconess's profession. I wanted a profession that would allow me to communicate the gospel more in deeds than in words. In my training as a deaconess nursing played a stronger role, and most of my trajectory since my graduation has involved nursing. However, I continued my diaconal studies, because I didn't find the hospital an attractive working environment. On graduating, I did short work placements in the parish and in the hospital After that I got a job in the parish where I still work, but of course, the tasks and the world have changed.

Ten years after my graduation I studied for a bachelor's degree in community healthcare. However, I was won over by the freedom and diversity of diaconal work, and I returned to my position. A desire to develop the work and find justification for what I was doing was awakened. Responsibility for diaconal work was taken by the theologian, but with my colleagues I began to agitate for a diaconal

worker being the immediate supervisor of diaconal workers. First, I was given the task of acting as a "rapporteur for diaconal matters". Ultimately, my role as the immediate supervisor of the diaconal workers was formalized. With a training in church administration, I focused on creating structures for our shared work, in which practices would be smooth and job descriptions clear. The development of work processes has involved both the integration of computer and electronic information systems with diaconal work and the development of volunteering in the Suurella Sydämellä (big heart) project.

In our parish union, I'm currently the local parish's senior diaconal worker. In addition to my leadership role, my duties include basic diaconal work: client work, groups, excursions and camps. I work as a supervisor and am responsible in the parish union for training in the client information system for diaconal work, and matters related to maintenance and development.

The development of diaconal work and the construction of one's own professional identity have gone hand in hand. Diaconal work sought its place in the welfare state of the 1980s, when, with the Primary Health Care act, clear nursing tasks were no longer part of diaconal work. However, a very strong view of holistic care that included a consideration of physical, mental, social and spiritual needs was at the heart of my own identity. The fact that people were encountered a lot in their homes required a broader consideration of issues than certain patterns of action implemented within the hospital walls.

The recession of the 1990s shifted the work's emphasis strongly in the direction of social work. I remember asking myself why a nursing degree was needed for this. However, it is in the midst of life's surprising difficulties and the accumulation of many problems that a holistic understanding and care are needed. Stress erupted for many in physical, mental and social problems. Although I can't solve problems as a deaconess, my job is to listen and understand, walk alongside, guide towards the sources of the right aid and to support. My long pastoral training deepened my client work skills.

The nurse-deaconess's identity is strongly associated with everyday matters and is present in all my work, whether in leadership, development, encounter or the supervision of work. I increasingly need the skills and identity a training in nursing brings as a support person or advocate for my clients in the bureaucratic jungle, in which tasks are very strictly defined and a single wound is treated, even though many "traumas" underlie it and multi-professional dialogue is difficult to obtain. It's difficult to find solutions to profound issues and problems if the presenting issues are not peeled off first. It can also be the other way around: deep wounds pre-

vent people from doing the things that would advance them in life. What I try to do is to introduce enough security to afford an opportunity for change.

Kirsti Rinta-Panttila — called as a link in the chain of generations of deaconesses

I graduated as a receptionist when I was twenty. I then worked in the men's reception department at a psychiatric hospital. I came from a very different world; my life as a farmer's daughter had been safe and carefree. Everyday Christianity was a feature of my home life. It gave me a strong belief in the equality of people, regardless of their status. My workplace was an eye-opener, and I had a great time. However, after a few years I left for the garment business, where I held various positions. I also worked in Southern Europe as a receptionist and on-call guide.

As the recession of the 1990s began, I wanted to find more permanent work. I got into a course to become an internal medicine surgical nurse at Helsinki's Diakonia College. I found the work busy and clinical. It didn't give me enough opportunity to encounter people. Having specialized as a deaconess, I felt I wanted to commit to that type of work. I graduated while engaged in part-time work. I worked as a deputy in the Helsinki Parish Union's special diaconal work among the homeless and as a ship's counsellor at the Finnish Seamen's Mission. I then continued by working in a women's hostel, and I started the Housing Assistance project for homeless women.

My career at the Helsinki Deaconess Institute (HDL) began as a project manager in the women's work project group. The work included the housing unit, support point, education, employment, art and culture. I then worked as a specialist in community development as well. In cooperation with Diak, we developed Cable Community Coaching for the needs of the Deaconess Institute. I've since worked as a coach all over Finland. My duties have included the coordination of artistic and cultural activities. I've trained as a work supervisor and completed a variety of shorter training courses on both the healthcare and commercial sides.

In 2018 I was surprised to be invited to serve as HDL's senior deaconess. The role of lead deaconess is more than 150 years old, and the job description has varied over the decades and the Institute's various phases. My areas at the moment are the sisterhood tradition, the history of the institute and cultural activities in the church. I'm the executive director of Dikonissalaitoksen Ystävät ry (the friends of the Deaconess Institute), and I support the sisters who belonged to the sister home system, who are now very old, as well as care institutions and relatives.

My deaconess training is the thread that has connected my previous training and work path. The psychiatric hospital was a significant milestone in my career. It tangibly exposed me to human vulnerability. My training as a supervisor strengthened my identity as a deaconess, and it's been integral in each of my work assignments, though I've had little time to be engaged in the actual supervision. Each of my duties as a deaconess has strengthened my skills — working with the homeless, coaching professionals, coordinating art and culture in the healthcare and social service context, as well as my work in the Deaconess Institute's history and tradition of sisterhood.

I feel I'm realizing the everyday Christianity I inherited, on which all this is built. I strive to meet everyone equally and with respect. I believe in bold diaconal work that ventures into unfamiliar terrains, listens to the heart of society, works with people and opens the way for hope. My identity as a deaconess is strong. It means continuing the long legacy I've inherited from previous generations of deaconesses. They were courageous and active people, whose trust in God led them to go when they were sent or called. It's an honour to be a small link in a long chain.

Elina Turunen — expert, researcher and teacher of holistic encounter

I was interested in religion when I was at upper secondary school, and I considered studying theology. However, in the end I applied for training as an optician, but was put on the waiting list. I first chanced on training as a nurse-deaconess in my quest for other options. I felt strongly that it was the career I was looking for. The nurse-deaconess degree combines perspectives from theology and health. As an intern, I encountered people in need of special support. My studies were a time of strong professional and personal growth for me.

When I graduated in the spring of 2008, I ended up working in the cardiovascular surgery ward. In my work on the ward I had to introduce myself as a nurse-deaconess. It was surprising how the word "deaconess" served as a key for opening up new dimensions of the care relationship. Patients expressed their fears, desires and reflections about their surgery, and occasionally someone would also want me to pray for their future. Encounters with patients reinforced my understanding of the foundation of the holistic diaconal nursing of the person: physical, mental, social, emotional and spiritual. I gained an experience of diaconal nursing expertise alongside other nursing expertise areas.

During my university of applied sciences studies, I had already decided to continue my nursing studies at university. In my bachelor's thesis I dealt with spir-

itual nursing in a somatic hospital setting. After graduation I worked as a project coordinator and in university research work and in the business world to develop a health application. Meanwhile, continuing studies in the doctoral programme seemed natural. My own way of doing development work in direct collaboration with various professionals and experts strongly influenced my deaconess's heart. The theory of caring led both my development work and dissertation research. My dissertation deals with a preoperative planning model based on holistic encounter with and accompaniment and support of the surgical patient and loved ones through the treatment process.

In 2017 I received new challenges. I was appointed health lecturer at Diak. As a teacher, it has been a privilege to accompany students, supporting them in the progress of studies and the development of a professional identity. I feel I can influence how people in need are encountered, treated and cared for in healthcare settings. My deaconess's heart beats strongly in everything I do, whether it be my own activities, the content of teaching, or research and development.

My identity as a nurse-deaconess means everything to me. It has laid the foundation of my professional identity and has played a key role in shaping my own worldview in relation to humanity, a higher power, the universe and from a significant perspective my own self. My nurse-deaconess's studies probably began a lifelong personal universal reflection.

Mertsi Ärling — developer and activist in diaconal and Roma work

After graduation I studied to be a licensed nurse. During my community nurse training I became enthusiastic about emergency care. I continued my university of applied sciences studies to become a paramedic, but I didn't complete my thesis at the time because of my work and family situation.

In the midst of my challenges at the time, I was able to renew my childhood faith in my God, and an entirely new page in my life was turned. At the same time, I received a strong diaconal call to spiritual work to help especially the poorest and all who could not find their place in this society or make their voices heard. I began my diaconal work as a parish volunteer in a free parish by establishing a weekly food distribution encounter for several hundred people. At the same time, God awakened an even bigger dream within me to establish a deaconess social organization, Operation Shopping Bag, the mission of which was to unite diaconal resources in Southwest Finland. The idea then arose of completing my nursing studies while obtaining the tools for diaconal relief work. I graduated as a deaconess-nurse from Pori in 2010.

During my studies I was invited by the vicar of St Michael's parish in Turku to undertake diaconal work for them. My duties included outreach and social diaconal work, and working with asylum seekers. I was the first deaconess with a Roma background to be ordained in the Lutheran church. I soon moved into the position of senior diaconal worker, where I worked for four years. Alongside this, I continued as executive director to work on the development of Operation Shopping Bag. While doing both jobs I felt I needed new skills, especially in management and organization, so I started studying in these areas alongside my job. I'm continuing my leadership studies, because I see it as an equally important element of my social diaconal work. I believe the essence of leadership lies in service, for which Jesus gives us the best teaching.

My work, which required a strong development and organization approach, gradually found its way, and I knew it was time for me to leave it in the hands of my successors and await a new call from God. So we received a call as a family to move to the countryside, where I was called to undertake pastoral responsibilities in the Pentecostal congregation in addition to my theological studies. After my days spent helping the local congregation grow and organize a new form of diaconal work, I felt it was again time to fold up my tent and await a new commission.

In 2016 Diak called. They asked me if I was interested in being a project manager for a nationwide project to promote Roma inclusion and employment. Although I hadn't actually done any Roma work, it sounded both challenging and interesting. I approached the project humbly and perhaps with some trepidation, because I had to prove myself alongside some top experts. In the middle of the project I again felt I needed more theory and tools for my skills and development work. I found myself studying again as a result. This time it meant a master's degree in social care and healthcare management at Diak. I completed my studies quickly, continuing directly to vocational pedagogical studies.

As a nurse-deaconess, I've been able to have an influence on socially, communally and individually significant issues. So I've fulfilled my original calling from God, growing within myself through my calling. I see a strong faith in Jesus and his Word in everyday life as the most important element of my diaconal calling, as well as the courage to be generous and at the same time humble at heart. I feel I've been able to use God's gifts of grace bestowed on me and the knowledge gained from education and work experience holistically for the benefit of the marginalized. My big dream of doing wondrous social diaconal work has come true before my eyes.

The professional identity of the deaconess

The career path stories of deaconesses this article has compiled highlight the processual nature of the development of professional identity. The building of the deaconess's professional identity already starts when a career and education choices are being considered. The starting point of the career choice seems to have been the desire to help or influence people's wellbeing. Alongside this, the starting points are Christian conviction, conversion or the experience of being called to the work of the church. For many, involvement in a parish's youth work has also awakened interest in deaconess training.

> *As a young person in the parish I got to know a young diaconal worker and became interested in the deaconess's profession. Nursing was a familiar field for me because of my parents' professions, and parish work also seemed inviting. I wanted a profession that would allow me to communicate the gospel more in deeds than in words. EL*

The deaconesses say they wanted to work in a field in which they could serve people or work in roles that combined Christianity and healthcare. Some career path accounts also highlight the encouragement and support of individuals as important factors in strengthening career decisions. Those who had previously worked as a nurse or in another field of care were also influenced in applying for deaconess training by experiences of nursing internships or work experience that led them to want to help even more holistically and effectively.

Identity-defining narratives can vary and evolve during studies. For example, Elina Ora-Hyytiäinen (2005) found stages in nursing students' professional growth in which they described their own professional orientation and role in slightly different ways. Initially, the students' perception of the work was still secular and practical, and how they worked was externally guided. However, during their studies they developed into responsible and independent, self-directed actors. The whole of the work was also outlined more broadly at the end of studies (Ora-Hyytiäinen, 2004, pp. 106–107). In their own account of their career path, a narrator outlines their time of study and practice not only as professional development but also as a significant stage in their personal growth.

> *In addition to accumulating theoretical and evidence-based knowledge, I experience deaconess studies as a time of significant personal growth. My studies*

> *challenged me to undergo self-reflection and reflection on life's big questions. … A work placement in the parish has been of great importance for my perceptions of humanity, humaneness and God. ET*

Deaconess training results in a qualification for the duties of a nurse and a deaconess. The interaction of the related content is examined in an article by Valtonen, Kotisalo, and Kajunen-Unkuri elsewhere in this volume. The professional identity of the nurse-deaconess is formed in one way or another from the perspective of both these professions. In deaconesses' accounts of their career paths, the multifaceted nature of their professional identity is manifested in weighing the decision to direct their own career at the parish or the health sector.

> *I didn't go into parish work because I didn't want to work in a "glass cabinet". I felt I wouldn't make the grade, and there was too much monitoring and evaluation in parish work. SJ*

> *On my [nursing] placement I felt the work was very busy and clinical. I also wanted to encounter people mentally. I specialized as a deaconess and finally felt it was a job I wanted to commit to. KRP*

The experience of those working in the parish appears to be that there is a strong demand for nursing expertise in diaconal work. This is also reflected in Sainio's article about the importance of nursing skills in diaconal work elsewhere in this publication. The diversity of deaconesses' professional identity allows for a holistic encounter and a broad understanding of people's needs.

> *Although the assignments were not nursing assignments, my own identity was based on a very strong view of holistic care, including physical, mental, social and spiritual needs, in the training of a deaconess. The fact that people were encountered a lot in their homes required a broader consideration of issues than certain patterns of action implemented within the hospital walls. EL*

However, there may also have been career situations in which the significance of nursing education has not been self-evident. The possibilities of utilizing expertise in diaconal work requires some consideration when work focuses entirely on financial assistance, for example.

> *The recession of the 1990s saw the work shift very quickly and strongly in the direction of social work. I remember asking myself sometimes why a nursing degree was needed for this. I soon realized that holistic understanding and care was needed precisely now. EL*

A survey conducted in a thesis at Diak (Vainonen, 2015) examined the professional identity of deaconesses working in nursing and parish work. Four nurses and four deaconesses responded to the survey. Professional identity was a key resource for all the respondents, and the support of the work community was felt necessary for building their professional identity, regardless of the work environment. The strong significance of professional identity was also highlighted in the accounts of career paths.

> *My identity as a nurse-deaconess has been an asset. it has evolved and endured in different situations at different stages of my career. KK*

> *I've always been proud to be a deaconess. I feel myself to be a deaconess, a representative of the church, wherever I am. I feel I'm part of a long chain of history, continuing the work of the deaconesses who have left us. JR*

According to the traditional Lutheran view, a vocation is a task received from God that a person accomplishes in their life. In its content vocation is seen as the fulfilment of everyday life and in relation to work, family or pastimes. It can also be seen as a way of life, the taking of responsibility, doing good and the values we choose (Hytönen, 2018). In the deaconesses' accounts of their career paths, vocation is strongly felt as a call from God, especially to the ministry of the church. Those working in positions outside the church also say that vocation has driven their career — whether in work as a clinical nurse, in development, teaching or leading.

> *My experience has been that my Christian vocation has been enacted wherever I've been led. The principles of diaconal work underlie all my tasks. SJ*

> *I think the most important factor is a generous and simultaneously humble heart and loyalty to God. I feel I'm in the middle of a dream doing wonderful diaconal work. MÄ*

The deaconess has been trained for spiritual work. For example, the common section of core competence descriptions for certain church positions was previously entitled "core competences for the church's spiritual workers" (Kirkkohallitus, 2020). However, defining which work is spiritual and which is not is problematic. In the new descriptions of core competences, which entered into force in 2020, the section containing common core competences has been called "common core competences for the church's professions". The idea of spiritual work is thus not restricted to the tasks of proclamation and liturgy.

In many of the career path accounts, work is described as spiritual, whether it entails diaconal work, nursing, training, direction or organizing food aid.

> *I learned that the gospel, salvation, is not only spiritual salvation; it is also salvation from discrimination, inequality and poverty, fear and oppression. Actually, my biggest task in the team was to bring hope wherever it was most needed. In practice, this was the training of low caste Dalit girls and the resulting reduction of caste discrimination. KK*

What the career paths have in common is a strong experience that spiritual work focuses on helping others and doing good. The spiritual professional identity, or the professional identity of the spiritual worker, is very close to the concept of vocation.

> *I received a strong call to spiritual work to help the poor and all who could not find their place in this society. I volunteered in the Free Church congregation and established the deaconess organization Operation Shopping Bag. MÄ*

In Valtonen's (2009) research on Church youth work leader students, spirituality manifested itself as personal faith, communal faith, and a reflection on values, ethics and existential issues. These dimensions of spirituality can also be observed in the career path accounts.

> *I've drifted into expert, managerial and leadership roles in my career. I've walked in prayer and in faith in guidance, not consciously seeking positions. The desire to influence and do good in the positions I've held has always been a strong driver in my career. Diaconal work is part of me, my Christian identity. SJ*

Building the career of deaconesses through training and various assignments

On the one hand, the career accounts describe the individual's relationship with society and social institutions; on the other, this always happens in tandem with the personal process of finding meaning and interpretation. A career path can be viewed objectively as the transition from one position to another, as a succession of professional titles. On the other hand, a subjective examination emphasizes one's own interpretation of one's career situation, values, and relationship with work (Marttila, 2015, pp. 19–23). Päivi Vuorinen-Lampila's (2018) study shows that higher education institutions often see the content of satisfying and meaningful work as more important than pay.

> *Personally, I'm not more interested in big jobs, but in challenging and varied tasks with a focus on Nepal. KK*

A career can include a wide range of stages and tasks, from work and unemployment to study and training. A strong commitment to work and the nurse-deaconess's internalized identity may also be reflected in the fact that exclusion from working life is associated with a loss of esteem. For example, becoming unemployed or being dismissed is a severe blow, perceived as the cancellation of one's work.

As working life diversifies, the individual must increasingly tailor their own path and identify possible ways of progressing. Although the experience of insecurity in working life has increased, full-time and open-ended employment relationships have remained the main form of working life participation (Vuorinen-Lampila, 2018).

> *When the recession began, I thought I should get into something more permanent, so I started studying to become an internal medicine surgical nurse at Helsinki's Deaconess Institute. KRP*

In addition to horizontal career advancement, careers can also be seen as developing vertically, expanding expertise through training and various positions. For example, employer-provided training can allow a person to invest in developing their own work and the workplace.

I participated in church work management training when teamwork and "middle management" — as it was then called — were in their infancy. I had long served in a team in my own parish driven by shared goals. I noticed in my training that we'd already left many reflections of others behind. I focused on creating structures for our shared work, in which practices would be smooth and job descriptions clear. EL

The extensive expertise offered by deaconess training provides a good foundation for developing and directing one's own expertise. The career path accounts also highlight the important role postgraduate education has played in the building of a career. There are many postgraduate study and in-service training options.

Some of the respondents have expanded their nursing skills by training to become a midwife or community health nurse. Because the writers graduated at very different stages, three held advanced degrees at a previous college level. One of the respondents wished to update and expand her previous college-level training and had applied for a bachelor's degree in community health nursing at a university of applied sciences.

With a bachelor's degree from a university of applied sciences (UAS) and two years' work experience, a person can apply for a master's degree (UAS). In her career path account one of the writers felt she needed more theory and tools for demanding project work. She decided to continue her studies at master's level. The 90-credit master's degrees (UAS) were established in Finland in 2005. They produce the same qualifications for public office as a university master's degree.

Deaconesses who focus on research, training or public administration have continued their studies in master's and doctoral programmes in health sciences, administrative sciences or theology at universities. It has also been possible in these studies to include the basic theory of diaconal nursing as part of scientific research.

The Finnish education system's description (Opetus- ja kulttuuriministeriö. Koulutusjärjestelmä) states that university of applied sciences studies should provide a direct path to master's studies. In practice, universities often require a university bachelor's degree or additional studies. Different universities have slightly different practices for how a bachelor's degree from a university of applied sciences is considered in the application process for master's programmes.

All those who wrote their accounts of their career paths had also educated themselves in non-degree training, either at home or abroad. The career path accounts display a very extensive range of in-service training, from mission courses

to training in the field. In-service church training is coordinated and provided by the Church Education Centre. The career path accounts reveal that deaconesses in the parish or in the service of a Christian organization have supplemented their skills, especially in pastoral care, leadership and supervisor training.

The nurse-deaconess's extensive training seems to provide a good starting point for a wide range of careers. All the writers describe the identity and vocation of the deaconess as a core of some kind, although their career stages and tasks all differ. A vocation has led some to other cultures and challenging situations; others have been led to Finnish parish diaconal work or to the third sector for the development of diaconal work; still others' paths have led them into leadership or higher education. The pursuit of the defence of the inalienable values of the human being, seeing and doing good, and trusting in God's care seem central to the core identity.

Sources and literature

Hytönen, M. (2018). *Kutsumus ja elämäntehtävä*. Kirkon tutkimuskeskus.

Kirkkohallitus (2020Yhteinen ydinosaaminen. In *Kirkon ammattien ydinosaamiskuvaukset* (hyväksytty kirkkohallituksen täysistunnossa 21.4.2020). http://kirkonydinosaaminen.fi/yhteinen-ydinosaaminen.html

Kirkon hengellisen työn työntekijän ydinosaaminen 2010. Retrieved February 27, 2020 from https://evl.fi/plus/koulutus-ja-tyoelama/kirkon-ammatit/kirkon-tyontekijan-ydinosaaminen

Launonen, P. (2009). *Kasvu kirkon työntekijäksi: diakoni-, diakonissa- ja nuorisotyönohjaajaopiskelijoiden ammatillinen motivaatio, osaaminen ja identiteetti vuosina 2004-2008.* (Diakonia-ammattikorkeakoulun julkaisuja A Tutkimuksia 22). Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-075-8

Marttila, L. (2015). *Ura kerronnallisena työnä. Ammattikorkeakoulun opettajat kertojina.* Tampereen yliopisto. https://urn.fi/URN:ISBN:978-951-44-9809-1

Ojala, K. (2017). *Ylemmät ammattikorkeakoulututkinnot työmarkkinoilla ja koulutusjärjestelmässä* [Doctoral Dissertation, University of Turku]. www.urn.fi/URN:ISBN:978-951-29-6823-7

Opetus- ja kulttuuriministeriö. Koulutusjärjestelmä. Retrieved January, 13, 2020, from https://minedu.fi/koulutusjarjestelma

Ora-Hyytiäinen, E. (2004). *Auttajasta reflektiiviseksi sairaanhoitajaksi. Ammattikorkeakouluopiskelijan kasvu ja kehittyminen ammattiin* [Doctoral Dissertation, University of Tampere]. https://urn.fi/urn:isbn:951-44-6076-6

Stenström, M-L. (1993). Ammatillisen identiteetin kehittyminen. In A. Eteläpelto, & R. Miettinen, (Eds.), *Ammattitaito ja ammatillinen kasvu.* Kasvatustieteiden tutkimuslaitos.

Vainonen, L. (2015). *”Ammatillinen identiteetti muistuttaa minua miksi teen tätä työtä”. Sairaanhoitaja-diakonissojen ammatti-identiteetti seurakunta- ja hoitotyössä* [Bachelor Thesis, Diaconia University of Applied Sciences]. https://urn.fi/URN:NBN:fi:amk-201503193360

Valtonen, M. (2009). Kertomuksia kirkon työntekijäksi kasvamisesta. Kirkon nuorisotyönohjaajaksi opiskelevien spiritualiteetin ja ammatillisen identiteetin rakentuminen [Doctoral Dissertation, Helsinki University]. (Diakonia-ammattikorkeakoulun julkaisuja, A Tutkimuksia 23]. Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-079-6

Valtonen, M. (2015). Ammatti-identiteetti ja sen rakentuminen. In J. Helminen (Ed.), *Osaamiseksi kokemus jokainen* (pp. 93–107.) Tallinna: United Press Global.

Vuorinen-Lampila, P. (2018). *Korkeakoulutuksen eriytyvät työelämämuutokset.* Jyväskylän yliopisto, Koulutuksen tutkimuslaitos. http://urn.fi/URN:ISBN:978-951-39-7529-6

Eila Sainio

10 THE IMPORTANCE OF DIACONAL NURSING COMPETENCE IN THE PARISH

The nurse-deaconess is a specialist in both nursing and diaconal work. The significance of nursing in the diaconal work of the Evangelical Lutheran Church of Finland has varied at different times. Changes have been influenced by both legislation and the social situation. Financial assistance has been emphasized in times of economic difficulty, although dwindling resources also affect people's health and health services.

Introduction

There is a strong tradition of nursing in diaconal work. From the outset professional diaconal training has been based on nursing work. In Finland deaconesses have also worked for a long time in nursing: in diaconal institutes, hospitals and home nursing, as well as working as rural district nurses, hired jointly by parishes and municipalities. The Primary Health Care Act, which entered into force in 1972, did not recognize deaconesses working in the parish as nursing professionals. This fundamentally changed the nature of parish diaconal work. Diaconal work began to focus on the issues and recreational activities of many special groups. From the nursing perspective the measures were somewhat limited. They included the measuring of blood pressure (see Paaskoski, 2017).

After the economic boom ended in dramatic decline and recession in the early 1990s, diaconal work was faced with many new challenges. Diaconal workers were contacted by those in financial difficulty, those who found themselves unexpectedly unemployed, and those seeking assistance for themselves or volunteering their skills. After society cut social and health services, many found themselves outside their net (Rättyä, 2012).

Over the last 25 years food aid and other forms of financial assistance have been more emphasized in diaconal work. However, financial and health problems seem to be more tightly intertwined (Kinnunen, 2009). In 2019 help from the church was sought for financial issues in 222,587 cases; issues related to illness

and health accounted for 167,285 cases, the second largest reason (Evangelical Lutheran Church of Finland: Diaconal Statistics. Statistics 2018–2019). Will the special skills of deaconesses remain invisible in the church's work, or will it be utilized? Is it time to reconsider the nursing perspective in parishes' diaconal work?

In this article I examine the importance of nursing skills in the work orientation of nurse-deaconesses working in parish diaconal work. The article is based on interview material. The importance of nursing education and competence for both one's approach to work and one's professional identity was strongly underlined. The quotations in the article are from deaconesses.

The diversity of diaconal work

The Evangelical Lutheran Church of Finland defines the task of diaconal work as the seeking out, alleviation and elimination of human distress. According to the Church Order, every parish must have at least one diaconal post (KJ 1055/1993). The aim is to help and support the most vulnerable and those excluded from other aid. The role of diaconal work also encompasses social and international responsibility (Aamenesta öylättiin. Kirkon sanasto). Professional diaconal work is undertaken in Finland by people who have received training as a deacon or deaconess.

The diaconal worker's core competence areas have been defined as theological and values competence, interaction competence, operating environment and community competence, working life and development competence, and competence in the work of diaconal officeholders (National Church Council, 2020). In addition, the work is guided by the diaconal worker's professional guidelines (Diakoniatyötekijöiden liitto and Diak, 2016).

Practical diaconal work is also regulated by each parish's own diaconal worker regulations. Each parish's implementation of diaconal work is influenced by its own strategies, action plans and goals. In most cases, diaconal work is carried out as individual work such as work in client reception and home visiting, as well as varied group activities. In customer reception and home visiting one of the major issues is clients' financial worries. However, there are many health and illness issues as well. Other topics include interpersonal issues, loneliness, unemployment and spiritual issues.

Open and closed groups are realized as group activities. They can be recreational or designed to address a life situation or personal theme: growth groups; bereavement groups; divorce groups; and groups of those suffering from depression or other serious illnesses. Groups are often based on a peer support principle.

Other forms of group activity include excursions and camps, as well as various theme days.

Diaconal workers collaborate extensively, both in parishes with various professional groups and with societal social care and healthcare actors, and with the third sector. Alongside professionals, a significant number of volunteers are engaged in diaconal work.

Diaconal nursing is the special skill of deaconesses. The importance of human encounter is underlined in diaconal nursing. Marjatta Myllylä (2004, p. 62) identifies a close professional relationship as one of the hallmarks of diaconal nursing. Spiritual work and chaplaincy are also key skills in diaconal nursing (Gothóni & Jantunen 2010, p. 64).

In their thesis (2019) nurse-deaconess students Mirja Jalo, Johanna Lehtonen and Marjo Suorsa investigate the diaconal reception exercised in the parish of Korso. In their study's conclusions they describe the deaconess's health promotion skills and consider how they are maintained. They aver that the role of a deaconess in health promotion is based on their training. They hope that the parish as a working environment will also provide deaconesses with the opportunity to maintain their nursing skills.

Deaconesses talk about their work

This article is based on material gathered in the spring of 2019. It was obtained in interviews with thirteen parish deaconesses working throughout Finland. The interviewees had graduated in different decades, from the 1970s to the 2000s. The interviewees' work experience ranged from three to more than thirty years. Some had long experience of nursing; some had long experience of parish diaconal work. When they were interviewed, all the interviewees were working in parish diaconal work. Most worked in cities, and only some in rural areas.

Among them were some deaconesses working as supervisors and one project worker, and others working in general diaconal work. Some also had a specialist nursing degree.

Most interviews reported that they undertook reception work, either by appointment or in on-call diaconal work, as well as doing home visiting, sharing meals, and organizing groups, excursions, camps, celebrations, events, prayers services and masses. In addition, many had specific responsibilities like organizing voluntary work, food distribution, family work, partnership work, coordinating

the Responsibility Campaign,1 organizing a church spiritual care group,2 work with the disabled, cooperating with healthcare facilities, twinning work, or work with undocumented immigrants. The interviews spoke in detail about the diversity of diaconal work. The picture they painted of the work corresponded well with the Deaconess Barometer's3 descriptions of narrow and fragmented job descriptions (Isomäki, Lehmusmies, Salojärvi & Wallenius, 2018). Work is undertaken for every age group, and there appears to be a wide spectrum of human life worries.

> *There's very diverse work with people of all ages, from babies to grandparents.*
>
> *I still really enjoy my work — it's variable and varied.*
>
> *The whole spectrum and life of a person is quite broad. Very differing and surprising things may surface in such situations.*

People of working age, as well as the elderly and families with children, emerged as the primary client group. One of the interviewees was responsible for work among immigrants. The motivations revealed for speaking with diaconal workers are multifaceted. Financial concerns are often to the fore, but they are intertwined with various health- and illness-related causes such as the high cost of medication and the difficulty of seeking treatment, or the mental strain an illness causes. In addition, problems with mental health, substance abuse and other addictions, unemployment, relationship problems, loneliness, caring and bereavement were mentioned separately.

Diaconal workers belong to the parishes' spiritual workers. The need for spiritual support usually only surfaced in more advanced client relationships, or when a worker raised spiritual issues. However, there was a strongly spiritual dimension

1 The Responsibility Campaign is the Evangelical Lutheran Church of Finalnd's major annual fundraiser. It helps people in need in Finland and abroad. Every parish participates in the collection, and diaconal workers play a key role in its organization. https://www.yhteisvastuu.fi/en/the-common-responsibility-campaign/

2 The church's spiritual care group is a local or regional readiness group of parish officers that provides support in the event of a major accident or crisis. It works as a partner of the other rescue authorities.

3 The Deaconess Barometer is a biennial survey that investigates the views and experiences of diaconal workers of current phenomena, Finnish deprivation and parishes' diaconal work. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/4236/viewmode=infoview

in the approach to work, and some interviewees said the client expected to receive spiritual help, because they were raising matters in a parish.

The importance of nursing training

Diak, the Diaconia University of Applied Sciences, describes the nurse's competence requirements in nine areas: client orientation; ethics and professionalism in nursing; management and entrepreneurship; clinical nursing; evidence-based skills and decision making; guidance and teaching skills; health and functional promotion; and social care and healthcare, and health services quality (Diakonia-ammattikorkeakoulu. Osaamisvaatimukset. Sairaanhoitaja (AMK)).

With the exception of clinical nursing most areas are also directly transferrable to the parish operating environment. It is neither possible nor even necessary for a deaconess in the parish to perform clinical nursing work. However, the reference framework for nursing clearly emerged in the data. A nurse's training brings a nursing perspective to the deaconess's work. The deaconess looks at people holistically, and observes issues associated with physical wellbeing. The deaconess meets their clients at reception and in home visiting, as well as bumping into them occasionally at the supermarket checkout or in the village. Clients are also encountered in group activities.

Individual work

The deaconess's nursing orientation is evinced in the fact that the main methods employed in work with individuals seemed to be health counselling, guidance in the use of services and — as a concrete measure — measuring blood pressure. Table 1 summarizes the client support needs that emerged in interviews with deaconesses, and how to respond to them from a nursing perspective.

Table 1. Individual work

Work form	Need for client support	Worker's means of support	Significance of nursing
Reception Diaconal emergency Home visits Random encounters	Medical expenses: e.g. insufficient funds for medicines.	Discussing the importance of medication Financial investigation Financial support if required	Can evaluate important primary medication and care
	Health and illness issues Illness of a loved one Mental health problems Depression Psychoticism Intoxicants Dependencies Fatigue Developmental disability	Discussion Mental support Finding information Explaining documents about health and illness in plain language Health advice Service control Ergonomics	Understands the history and causes of illnesses Can assess the client's situation Identifies symptoms Holistic perspective Can explain what it's about Can measure blood pressure Can check a medication dose Attention inherently paid to wellbeing Information about illness is reassuring Can ask for help according to the situation
	Serious illness Existential questions Bereavement	Encounter Support Prayer Hymns Peer support	Understands existential questions posed by serious illness Knows the signs of grief Spiritual nursing Offering hope
	Loneliness Relationships	Encounter Invitation to be included	Understands the importance of inclusion for human wellbeing
	Lack of documentation	Can refer to special services	Identifies the need for treatment

Clients often wish to discuss and ask about their medication. Some interviewees searched for information about a medication with their client. Sometimes the deaconess had to assess the order of priority of medicines if the client lacked the money to purchase everything they had been prescribed. In such situations the parish diaconal work unit can offer temporary assistance and guidance to the client in applying for income support, for example. The cost of medical care emerged as a real problem in the interviews. The same phenomenon was addressed in the study *Sairas köyhyys* (sick poverty, 2009) by Kaisa Kinnunen, and the situation appears not to have changed.

Many clients needed support in understanding laboratory results or the treatment instructions they received from the hospital or doctor. The seriously or chronically ill received support and discussion assistance from the diaconal work unit.

Deaconesses also discussed how lifestyles might become healthier with their clients. Many may have had problems with eating and sleeping, as well as addiction. Discussions also highlighted the illnesses of a loved one, various life crises, loneliness and bereavement.

> *Financial issues like medical expenses and hospital fees may result in an illness being a source of change or stress for a low-income person.*

> *Blood pressure management, checking laboratory results, what's ok and what isn't, mental health issues, depression.*

> *I think nursing care goes really deep. It affects a lot… I think it's a really big deal, nursing in this job.*

When the interviewees were asked for an example of where nursing skills were especially important, everyone immediately recalled one or more occasion. Many interviewees described situations in which their nurse's eyes saw something affecting their client's wellbeing, and they knew how to approach seeking symptomatic help from healthcare services.

I met an old woman who had very swollen legs, reddish, and somehow she looked pale and anaemic. I discovered she wasn't on medication, so I said right, let's get you to the health centre.

During the deaconess's home visits they might find a situation urgently requiring a doctor or hospital. Some cases were those requiring all the deaconess's professionalism. For example, a frequently arising situation was one in which a sick client had had their electricity cut off, and the food in their freezer had been spoiled. The client was sick at home, without electricity and food. The home help had visited, but hadn't noticed the situation. The client's issues were rectified by various measures. Dealing with the issue began with understanding the need for care, but required the knowledge of both the health and social services system. Other examples included the identification of hypoglycaemia, the onset of a miscarriage, and the identification of cardiac or stroke symptoms and hip fractures requiring medical attention. Many interviewees were also adept at recognizing mental health issues, from depression to delusions.

Group activities

Communality in diaconal work is created by a variety of group activities. Groups afford a good opportunity to explore various themes. Groups can also focus on life crises, bereavement, or one's own emotional and spiritual growth. The goal is the person's holistic wellbeing.

Table 2. Group activities

Work form	Client's perspective	Worker's means of support	Significance of nursing
Group activities Club activities Activity days	Need for recreation Social needs Need for information Emotional and spiritual growth	Provides a variety of group functions Opportunity to share information about health and wellbeing Devotions	Understands the importance of holistic human wellbeing
Excursions Camps	Need for recreation Anxiety about coping Challenges to medication and functional capacity	Can look after medication with the client Can support functional capacity First aid skills Can request precise health forms, e.g. for a confirmation camp	Understands the importance of medication and can assist if necessary, e.g. with washing and feeding Knowledge of first aid Can assess the need for sudden treatment

The interviews showed that nursing skills were emphasized in camping and excursion activities, in which situations requiring health expertise had been unexpectedly encountered. In principle, all those working in a camp should be prepared to administer first aid. However, nursing training was important when assessing the need for medication, or follow-up or emergency care, for example.

When discussing confirmation camp work, the importance of various illnesses, allergies and medications was also underlined. It is important for the safety of camps that at least one member of the camp staff has the necessary information about the participants' illnesses and medication.

It would be difficult for a camp for the mentally disabled to be without the training of a nurse.

When I was at my first camp last year, I got all the health information, so I made an Excel chart of all the medications and migraines...

Well, in camping conditions perhaps the most important thing is that there's also a nurse involved when you're away from everything, and first aid and medications and other things.

Organized retirement coaching as a nurse can introduce various physical, mental and social dimensions.

There are no circumstances in which a deaconess will independently dispense medication. This must be agreed with the client or the minor's parents and caregiver.

Spiritual work

All the interviewees reported that they participated in the church's spiritual work in many ways. Involvement in the provision of worship varied. All reported that they held devotions. Devotions are held in connection with group activities and departments. All the interviewees reported that they discussed clients' spiritual issues and prayed with or for the client if asked. Deaconesses might also actively enquire about a client's spiritual needs or wishes. The need for pastoral care became more apparent during home visits. Some of the interviewees were also involved in confirmation camp work. However, this was not referred to in connection with spiritual work.

Table 3. Spiritual work

Need for client support	Worker's means of support	Nursing perspective
Need to speak about spiritual matters	Confidential relationship Knows what to say Devotions at the beginning of group activities, for example. Prayer Hymn singing	Understands spirituality as part of holistic human wellbeing
Various questions about faith and life Multiculturalism	Pastoral care Respect for conviction	Spiritual care Confronting existential questions Offering hope
Parish connection	Organizing mass Hymns, home communions	Inclusion

When I suggest that I read the Aaronic Blessing or say the Lord's Prayer, or if I ask if the client has a favourite hymn or what they would like to sing, it opens up the spiritual side of things.

In this context, we simply discussed the fact that religion was no consolation to them, whether they belonged to a religious community, that they were Muslim and what hope meant to them, stuff like that.

I like these different occasions, like, I've organized Bible and prayer nights, and I've run a prayer service.

You can even ask a parish worker to go to the hospital if you're in a situation where you're seriously ill, but most of the time it's easier to talk about it... and prayer is something like... it has many meaning for people.

All the interviewees considered spiritual work to be part of their work, however it manifested itself. They pointed out that progression in spiritual issues often only happened after the client relationship had lasted a long time and trust had been built. If the diaconal worker was themselves active in offering spiritual support, it was gladly seized. The concept of pastoral care arose rarely in the material, although discussions that appeared pastoral by their nature were mentioned several times.

Cooperation with various actors

Cooperation with other actors in the social care and healthcare sectors was mixed. Collaboration with care facilities and home nursing could be organized or sporadic. Some interviewees' job descriptions included close cooperation in the municipal health sector. The tasks of some interviewees included multi-professional crisis work. Several reported their collaboration with a psychiatric nurse. One was involved in project planning for the future care of the elderly. Cooperation associated with various illnesses with various patient organizations also took place. It was felt that nursing competence brought understanding to common issues and appreciation from other actors.

Table 4. Cooperation with various actors

Work form	**Client's perspective**	**Worker's means of support**	**Significance of nursing**
Local networking Home care Services provided by organizations Encouraging healthy living End of life care	Need for support for wellbeing and health Existential questions Support for the dying	Information about the situations and wishes of the residents of their area Addressing the client's overall situation Supporting hope Service control Acting as an educator Work development Job seeking Cooperation	Nursing training facilitates involvement in cooperation Identifies the need for treatment Appreciation of co-workers Understands what is said
Family work with the city Wellness Centre, Cooperation with a community health nurse	Need for support, e.g. with postpartum depression	Listening, support and understanding Group activities Service control	Understanding what it's all about
Crisis work Maintenance of the church's spiritual service	Need for support in a crisis	Provision of support	Competence in crisis work Identifying the stages of a crisis
Advocacy work	Exclusion	Giving voice to the excluded	Understanding socioeconomic health inequalities
Volunteers	Need to act meaningfully	Provision of meaningful volunteering and offering support	Significance of the meaning of life for wellbeing

Hospice care is currently being developed. It will include diaconal work and workers, and it will be especially useful if a nurse-deaconess is among them.

What if undocumented children belong or are directed to a global clinic with primary information about the issue?

You somehow know how to speak for those alone at home, about all their needs.

Getting someone released from prison back into this society is really hard. But multi-professional cooperation is really important here too.

The interviewees suggest cooperation with other health actors and organizations should be done increasingly systematically. Health events can be arranged, as can health-related courses and lectures. This has been done, but more may be necessary.
Social impact did not feature especially prominently in this material, though the interviewees clearly identified social grievances and supported their clients in coping with difficult situations.

The significance of diaconal nursing in diaconal work

The interviewees highly valued their education. Nursing is a self-evident and integral part of professional identity. The nurse-deaconess's training was also considered beneficial for the parish's diaconal work. Almost without exception, the interviewees described diaconal nursing as holistic aid for the person. Work orientation is based on a Christian and holistic conception of the human being that takes the physical, mental, social and spiritual dimension of the person into account. More than merely one problem is scrutinized, but an attempt is made to gain an overall view of the customer's situation. Some also felt that holistic nursing could not be carried out in the same way as diaconal work. One interviewee described diaconal nursing as the lodestar of her work.

I'd feel half as able to do my work if I hadn't had a nurse's training.

The nursing perspective is an excellent tool in diaconal work.

The idea is that diaconal work is everyone's work, but there's also a need for diaconal workers.

However many possibilities there are, that's probably the thinking behind such a health promotion project.

It was also felt that cooperation between the deacon and those trained as deaconesses was beneficial. This was when issues arose with a broad shared perspective and expertise. An example was given that described how a deacon worked with a social worker during a home visit, and the deacon assessed the client's health status and possible need of care.

A deaconess's training was seen as important for camp and excursion activities. A deaconess's training could also be utilized more in home visiting, and especially in convalescent care. The deaconess's work orientation was also seen as proactive: they were prepared for the unexpected. The training provided an understanding of the encounter with those undergoing substance abuse and mental health rehabilitation.

The material revealed how professionals were appreciated: it was excellent when the church had well-trained diaconal professionals. Some also expressed the hope that nurse-deaconess training would not disappear. Clients face many illness and health issues that require professional competence, ethics and tact. Some of the interviewees wanted in-service nursing training; others were concerned they would be unable to advise the client properly with regard to medication, for example.

The interviews highlighted the value of nursing education and its importance for one's own work and approach. Nursing skills are part of professional skills and were manifested in many different ways in daily work. Several interviewees stated that nursing went hand in hand, was part of their own professional identity, and that the nurse neither could nor should hide this. Such expertise was greatly needed in parish work.

Do we need deaconesses?

Occasionally we hear it asked: are deaconesses needed, or does the church need deaconesses? Based on the material in this article, we can unequivocally answer: yes, they are needed, and yes, the church needs them. The other articles in this volume examine the importance of nurse-deaconess training in clinical nursing,

and I believe the answer is the same: deaconesses are needed. In today's diaconal work it is important to know about the social care and healthcare system, the client's rights, and how to guide and support them in a variety of life situations.

The nurse-deaconess's training offers extensive knowledge of clinical nursing and holistic human encounter. People are encountered not only because of their illness, but because of their humanity. The training includes many exercises that develop a person's encounter skills, as well as familiarizing them with their frailty, physicality, and mortality. The training also includes teaching on pastoral care and facing bereavement.

The deaconess brings the eyes of a nurse to parish diaconal work. They recognize changes and warning signs in a person's physical and mental wellbeing. They sometimes have to sound the alarm quickly. Nursing competence is especially emphasized among those involved in mental health and substance abuse rehabilitation and the elderly population. None of the interviewees really wanted clinical work in their job, but a wide range of health service guidance and counselling and support for a healthy lifestyle was perceived as meaningful. It was also considered important to coexist in the face of a serious illness.

Several spoke of cooperation with municipal services and patient organizations. for example. The deaconess could arrange training in health and illness, and health-related events. Support was also offered to loved ones. Some speculated that the need for services for the elderly in diaconal work would increase in the future. The elderly population was growing, and society lacked the resources to meet the demand for services.

Encounter with spiritual matters also plays a significant role in deaconesses' work. There is permission to discuss spiritual matters in the parish, and the deaconess can be proactive in asking about a person's conviction and its meaning. The interviewed deaconesses spoke less of pastoral care, though the concept did sometimes come up in the material. However, spiritual matters are strongly present in their work. They are discussed either at the client's initiative or that of the worker. Yet they are seldom the primary motivation for a person to seek to speak with a deaconess.

In 2017 the Helsinki Deaconess Institute celebrated its 150th anniversary. The Vyborg (now Lahti) Deaconess Instituted celebrated it in 2019. Significant professional training was celebrated at the same time. Deaconesses are still needed today, and they will be needed in the future.

Sources and literature

Diakoniatyöntekijöiden liitto ja Diak (22.9.2016). *Diakoniatyöntekijän eettiset ohjeet.* Saatavilla https://www.dtl.fi/media/dtl_eettisetohjeet_2016.pdf

Gothóni R. & Jantunen E. (2010). *Käsitteitä ja käsityksiä diakoniatyöstä ja diakonisesta työstä*. Diakonia-ammattikorkeakoulu.

Isomäki, P., Lehmusmies, J., Salojärvi, P., & Wallenius, V. (2018). *Diakoniabarometri. Yksinäisyyden monet kasvot.* Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Jalo M., Lehtonen, J., & Suorsa M. (2019). *Diakonissan vastanotto Korson seurakunnassa. Asiakkaiden odotuksia ja kokemuksia.* Opinnäytetyö, Diakonia-ammattikorkeakoulu, hoitotyön koulutusohjelma. Saatavilla https://www.theseus.fi/bitstream/handle/10024/264414/Jalo_Lehtonen_Suorsa_Diakonissan_vastaanotto_Korson_seurakunnassa.pdf?sequence=2&isAllowed=y

Kinnunen, K. (Eds.) (2009). *Sairas köyhyys: Tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä*. Kirkkohallitus.

Kirkkohallitus (2020) Diakonian viranhaltijan ydinosaamiskuvaus. Saatavilla 6.8.2020 https://evl.fi/plus/koulutus-ja-tyoelama/kirkon-ammatit/kirkon-tyontekijan-ydinosaaminen/ydinosaamiskuvaukset-pdf-muodossa

KJ 1055/1993. Kirkkojärjestys. Saatavilla https://www.finlex.fi/fi/laki/ajantasa/1993/19931055

Myllylä M. (11.6.2004). *Diakonisen hoitotyön mallin rakentamien*. (Doctoral dissertation, Oulun yliopisto). Saatavilla http://jultika.oulu.fi/files/isbn9514273567.pdf

Paaskoski, J. (2017). *Ihmisen arvo: Helsingin Diakonissalaitos 150 v*. Edita.

Rättyä, L. (2012). Diakoniatyö yksilöiden ja perheiden parissa. In Gothoni, Helosvuori, Kuusimäki, & Puuska (Eds.) *Kantakaa toistenne kuormia* (pp. 80-110). Kirjapaja.

Suomen ev. lut. kirkko. Aamenesta öylättiin. Kirkon sanasto. Saatavilla 27.9.2019 https://evl.fi/sanasto/-/glossary/word/Diakonia#Diakonian_teht.C3.A4v.C3.A4t

Suomen ev. lut. kirkko. Diakonian tilastot. Tilastotietoa 2018-2019. Saatavilla 28.3.2020 https://evl.fi/plus/seurakuntaelama/diakonia/diakoniatutkimus/diakonian-tilastot

Elina Turunen and Tiina Ervelius

11 THE NURSE-DEACONESS IN THE NURSING OF CRITICALLY ILL PATIENTS

For the purposes of this article, a critically ill patient is defined as one being treated in a specialist inpatient ward, an accident and emergency department, an intensive care unit or equivalent. The article discusses the significance and opportunities of spiritual nursing and diaconal nursing in the care of critically ill acute patients in Finland. The ideas and experiences presented have been gathered in writing from five nurse-deaconesses working in a university hospital.

The spiritual distress of a critically ill patient

Nursing a critically ill patient consists of close collaboration between the patient, family members and the nurse. Nursing often presents a range of ethical situations. A patient's condition may fluctuate rapidly, and he or she may be supported by relatives and other close people. Health-threatening crises enable deep conversations at the same time as the nurse ensures the patient's vital functions through a range of treatments, drugs and equipment. Patients and their relatives may ask about their outlook and for care prognoses. Crises open the door to patient-centric conversations about the life's big existential questions.

Critically ill acute patients often suffer from spiritual distress while in hospital. For example, one in three surgical patients experiences significant treatment-related fear and anxiety (Sanson et al., 2018). Spirituality is a personal dimension of the self, and spiritual distress may be defined as an emotion of loneliness or isolation. A person may experience insecurity, desperation, guilt, fear about the future, death and loss, or ponder the meaning of life (Ramezani et al., 2014; Fitch, 2018). For the patient, these emotions and ideas may be new and surprising, making verbalizing and discussing them difficult. Patients and their relatives should be actively offered opportunities to discuss their spiritual needs (Fitch, 2018).

Seriously disabled and ill patients often experience a spiritual activation. I try to notice their need for spiritual support. (Nurse-deaconess, surgical ward)

In my job I meet people with fear of varying degrees. These fears often relate to disease, death or continuing their lives after diagnosis. Some people can come to terms with their fears easily, but some conceal it, with humour, for example. (Nurse-deaconess, intensive care ward)

A significant share of hospital patients also experiences "professional caring loneliness" while being treated, which may present as experiences of abandonment and being forgotten. Professional caring loneliness can concern a patient's relationship with the world, God, the physical environment, nursing staff, family and friends, social network or his or her own self (Karhe, 2017). Existential loneliness means a loss of connection with other people and the universe, which may present as feelings of isolation, alienation, emptiness and abandonment. Nurses have an ethical obligation to identify patients' existential loneliness and encounter patients at an emotional level (Bolmsjö et al., 2019).

Spiritual nursing and diaconal nursing in nursing studies

Diaconal nursing is based on theology, and on nursing studies grounded in the theory of caring. A person is seen as a holistic existential unit. Diaconal nursing can be defined as professional service which uses, in addition to nursing assistance methods, caritative and liturgical methods (Myllylä, 2004). The theory of caring is associated with perspectives of care and neighbourly love, and a person is seen as a holistic being uniting the physical, mental, social and spiritual dimensions. The theory of caring strongly recognizes the immediate mutual effects of the dimensions on each other, such as between the patient's spiritual distress and the pain she experiences, or the connection of an surgical patient's fear to the success of anaesthesia and his recovery (Eriksson, 1988; Watson, 2012).

Most people are unfamiliar with diaconal nursing. When you start explaining it to people, they realize that it's something quite ordinary. It involves unselfish helping, equal encounters, walking alongside the patient and relatives, instruc-

> *tion, giving hope, encountering and allaying fear, and silent presence. These same things are part of every nurse's work. For some reason, it seems patients want to unload their most painful questions and musings about life and existence to the hospital chaplain. (Nurse-deaconess, surgical ward.)*

Spiritual nursing involves active presence, creating connection, using the nurse's own personality in nursing, sensitive permission and examination of emotions, a focus on patients, and the search for meanings. Spiritual nursing may involve the facilitation of religious or other traditions in line with the patient's background, their support and professional participation. Spiritual nursing helping methods such as active listening and presence may be used to prevent spiritual distress and professional nursing loneliness experienced by patients. Spiritual nursing supports the patients' spiritual welfare, mental integrity and care satisfaction. From the nurses' perspective, providing spiritual nursing may strengthen their awareness of a person's spirituality and increase their job satisfaction (Ramezani et al., 2014).

When the nurse and patient encounter each other, their realities momentarily intersect and shape both their futures (Watson, 2012). Encounter requires an understanding of culturally sensitive nursing and challenges nurses to be aware of and consider their own prior concepts and prejudices. Encountering the patient at a personal and spiritual level is part of the nurse's professional skill. Spiritual nursing requires emotional intelligence and empathy, which may be developed through continual reflection (Beauvais et al., 2014).

Nursing intervention methods of spiritual nursing and diaconal nursing

A critically ill patient may be seen as an expression of his or her illnesses or sicknesses; this emphasizes the professional skill to see and hear the patient as a spiritual unit. The treatment and nursing intervention methods used with a critically ill patient are chosen in accordance with the treatment guidelines and individual situations. The same nursing intervention methods do not necessarily suit all patients. Critically ill patients' physical health problems are often easily observed, and such patients are systematically monitored with regard to needs. Patients' and relatives' distress and anxiety must also be considered and encountered as part of holistic, high-quality nursing (Pyykkö, 2004).

> *There are disabilities, both difficult and easier, but the person comes through. I am present as myself, present alongside the person and always try to encounter beneath the service the person who has had to hide under the injury and to survive. (Nurse-deaconess, surgical ward.)*

Spiritual nursing and diaconal nursing methods can be used to respond to patients' and relatives' spiritual stress during hospitalization. For example, a healing touch can be used to affect a patient's blood pressure, oxygen level, pain, mood and restlessness, as well as enhancing the patient's sleep quality. Touch can also have positive emotional effects on the nurse's coping at work (Anderson et al., 2017). The significance of touch is discussed at greater length in Raili Gothóni's article elsewhere in the present volume.

> *Touch is the most important thing of all, and I know that many young nurses don't dare to touch patients — really touch them. I don't touch either if I can see it would be inappropriate, but I dare to hug or stroke a patient's hand or cheek. (Nurse-deaconess, surgical ward.)*

> *Touch is important to me and a natural part of nursing. When there are no words, presence and empathetic listening are enough. A hug is also important, and I hug colleagues a lot, and sometimes rehabilitation patients. (Nurse-deaconess, surgical ward.)*

Presence is a multidimensional phenomenon that is broader than physical presence, one that consists of encounter at the emotional level, and support and dignified treatment of the patient (Hosseini et al., 2019). In the wake of a serious illness the patient and relatives need a companion and honest and supportive conversation in the hospital, during discharge and at home. Silent presence, encountering the patients' and relatives' fears, listening to them and allaying them are part of the challenges a professional faces.

> *The nursing of every patient happens at that patient's pace. This is not always possible in acute nursing. A hasty instruction might ruin the patient's sense that they're coping. In general, patients need moments when they're being listened to. When a patient is listened to, they often calm down and feel more at ease. (Nurse-deaconess, intensive care ward.)*

> *You should always be there for a patient and listen to them just as you'd want to be listened to. There are situations where the patient is scared, and they don't know what's going to happen to them. In those situations it's natural to be a companion for the patient, give them hope, and tell them how things are as truthfully as possible. I'm not afraid to touch a patient. It's horrible to think we'd only consider the physical condition, usually a broken bone, when it's the person suffering from the fracture who needs to be encountered. (Nurse-deaconess, surgical ward.)*

Several spiritual nursing approaches and talking tools unrelated to religion have been developed for healthcare needs. They include the Avaus model (Karvinen, 2017), the Four-Leg Model (Itkonen, 2017) and SPIKES (Laaksovirta, 2017). The Finnish care classification system, which aims to harmonize entries to patient data systems, includes a "need for support with coping" classification (5074), which can be specified further with "grief" (5077), "need for emotional support" (5078) or "emotion of guilt" (5079) (Finnish Care Classification System FinCC 4.0). Nurses may be unable to provide spiritual nursing because of a lack of training, instruction or time, or because of emotional fatigue or organizational culture (Rushton, 2014).

Deaconesses are experts in spiritual nursing and advocates for vulnerable people. Deaconesses provide nursing based on Christian values and see their nursing as service. However, diaconal nursing does not require the nursed to have any specific conviction (Myllylä, 2004).

> *In my nursing, I put my Christian view of people into practice. For me, a person is a complete package, with all their needs and traits. I treat people equally and with respect, regardless of their background. In my breast pocket I carry a deaconess's badge and a crucifix, which give me "permission" to talk about spiritual matters too. (Nurse-deaconess, surgical ward.)*

> *The quality of care and the encounter do not change, no matter what beliefs about people the patient has. Everyone is equal and just as important; their needs, whatever they are, are just as important. (Nurse-deaconess, surgical ward.)*

I come across a lot of prejudice. For some reason people think diaconal nursing is just about the church and faith. In reality, diaconal nursing encompasses all forms of spirituality and support for them, from atheism to devout Christianity or abstract spirituality. Taking other faiths into account is part of diaconal nursing. What's essential is the person, their own story, and how they put it into words. Every one of us needs to be heard and seen. We look for hope, and we try to understand things as part of something bigger. (Nurse-deaconess, surgical ward.)

In diaconal nursing, interaction with patients and their relatives is seen as a professional neighbourly relationship which always involves a higher force. This higher force casts emotions of hope, strength and love into interactions. The tools of diaconal nursing support the other spiritual nursing methods from the religious perspective (Myllylä, 2004).

For me, Christ is someone I work and talk with, and prayer is a constant, daily discussion with the world above about all kinds of things. In challenging situations, faith creates security and the trust that we're not alone, and that someone is with me as a colleague and a fellow traveller. We are in bigger hands, and with time we may notice that events have had their purpose in someone's life.

I like to speak to rehabilitation patients using the informal "you", as it emphasizes that we're equals. (Nurse-deaconess, surgical ward.)

Treating patients equally and accepting diversity is an obvious fact. (Nurse-deaconess, surgical ward.)

I speak to patients using the informal "you". This makes the nurse-patient relationship equal. (Nurse-deaconess, intensive care ward.)

It's difficult to explain the triangular relationship, but I feel it's the kind where I draw the strength to nurse. It's also the courage to be myself in my work and to use myself as an instrument in nursing. I don't just nurse through some roles (patient versus nurse) — people are there as humans.

Encountering desperation and injustice is challenging, as is a situation where a patient has lost family members in an accident. Life throws these awful situations at us sometimes, and I've noticed that we, the nurses who can adapt to those situations, are the ones who are deployed to care for patients in those cases. This suits me, because I feel that by encountering them I can help them, at least for a brief moment to help them cope just a little. I don't find these situations challenging or hard. I forget myself in them. I make full use of my skills as a tool and to support the patient so they can cope. (Nurse-deaconess, surgical ward.)

Pastoral care is a key helping method in diaconal nursing. Pastoral care means listening to the patient's and relatives' problems, as well as comforting and supporting them. It can be used to help process experiences of anxiety and fear of death. It can reinforce a sense of security, tackle feelings of guilt and respond to religious needs. Other helping methods include prayer with or on behalf of the patient, spiritual songs, anointment with oil and reading the Bible and other spiritual texts (Myllylä, 2004).

Religious views of people come up from time to time when I'm talking to patients. I'm ready to talk to patients about these things too. Religious conversations do not just come up as death approaches — they can happen in other situations too. I think that nurses should be ready to listen and take part in religious conversations. Our education as deaconesses prepares us well for that.

I've used prayer and pastoral care when the patient's asked for it. It's good to know or look up, even online, the basic Lutheran prayers. You can even pray in your own words if you're asked to. Often, pastoral care conversations don't get beyond a superficial level, because the nurse's work is so hectic, or because the patient's condition is so weak. In that case, active listening plays an important role. (Nurse-deaconess, intensive care ward.)

I've prayed with a patient when asked to. When I do, I make use of Christian vocabulary in a natural way, but with a sense for the atmosphere. (Nurse-deaconess, surgical ward.)

I once sang the hymn "Maa on niin kaunis" in the presence of a dying patient, accompanying him during his last moments. He was very old, and I knew that he was lonely. We didn't know whether he was spiritual during his life, but everyone has the right to depart this life with dignity. I told a relative of his that I'd sung, and she was delighted that in a university hospital someone had sung to the deceased on his final journey. (Nurse-deaconess, surgical ward.)

I often encounter the following questions at work: Why me? What evil have I done to deserve this? What about when I die? Why haven't I died yet? Why do people care about me so much? It's questions like these that diaconal nursing tries to answer and provide tools for.

There is a demand in hospital for spiritual nursing tools such as prayer, the Bible, the hymnal, spiritual music and pastoral care conversations. If I hadn't studied to be a deaconess, I probably wouldn't have had the courage to pray for a patient when she earnestly asked me to. I thought I'd said the prayer clumsily and not at all in the way I'd wanted to. However, it provided great comfort and ease to that patient. Later I realized that for her it wasn't about how I chose my words: it was about a deeper need to be seen, heard and helped. When medicine had done all it could, she wanted to pass her hopes to the world above, even though she was a "sworn atheist" in her own words. She was incredibly comforted to know that a spiritual office holder could also be a kind of messenger. (Nurse-deaconess, surgical ward.)

Competence produced by the dual deaconess degree becomes part of the development of nursing in the workplace

Nursing managers play a key role in promoting the provision of evidence-based spiritual nursing (Draper, 2012). As spiritual nursing experts, deaconesses have an obligation to employ their specialist skills when encountering patients, but also to share information and their skills with other professionals. The obligation of healthcare institutions is to promote the formation of a strong organizational culture in which specialist skills are recognized, acknowledged and used holistically.

Specialist nursing employs a lot of nurse-deaconesses with specialist skills in using diaconal nursing and its methods. The hospital units would be able to create models and train others. There could even be cooperation between units. However, that doesn't happen often. Deaconesses blend in with the "normal" nurses, and their valuable further education doesn't go beyond credit on our degrees or a personal way of nursing in practice. Not even all the bosses know they have skills like that in their units.

You can compare the specialist skills of diaconal nursing with any equally valuable skill, just as you could compare any other further education, be that wound, diabetes or heart treatment, to a valuable skill, and why not to a midwife or public healthcare nurse. Every one of them has some additional skills on top of their nursing education. For some reason it doesn't feel like "deaconess" sits alongside those other skills in hospital. (Nurse-deaconess, surgical ward.)

Nursing staff work with patients in crisis and their relatives daily. These encounters may be ethically and emotionally burdensome. For their part, healthcare organizations should support their employees' emotional coping. They can do this by creating more effective welfare-enhancing structures, which is in turn possible by arranging sufficient opportunities for professionals to process burdensome experiences to support their coping and welfare.

Ethics are important in my job, and I always stand behind my words and actions. I'm able to discuss anything. (Nurse-deaconess, surgical ward.)

The power of diaconal nursing lies in the fact that I don't find the work itself tough when I use diaconal nursing methods to care for a patient. I draw immense strength from it and don't at all feel I'm in a challenging role. (Nurse-deaconess, surgical ward.)

When I began working on the wards, I realized I was often being assigned patients who'd received bad news like a poor diagnosis. We nurses talked about this, and what came up was that some of us found situations like that too difficult and distressing. But I think I can be at my best when I get to help patients and their relatives in a crisis.

> *I once looked after a patient whose spouse was waiting for the doctor to come on their rounds. The doctor had crushing news, and this couple were simply devastated. That morning I also had a student of mine with me. The student was really shocked by the situation and left the room during the doctor's visit. I gave the couple the support they needed and then went to find my student. We talked about the situation that day and the following morning. The student said the situation was shocking but not traumatizing. For me personally it's important that we can talk about and process situations that also shock the staff. (Nurse-deaconess, surgical ward.)*

Hospital organizations have spent a great deal of resources in recent years on developing patient- and family-centric models. There is already competition in Finland for the first hospital to achieve Magnet Hospital status. Patients are aware of their rights, they have certain opportunities to choose their treatment location, and there are now more private hospitals. Organizations have aimed to involve Experts by Experience (EbE) in developing functions and services, as well as making various service promises.

Patients have become clients who use hospital services which are readily provided where the patient is. In line with the national recommendation, patients are encouraged to give feedback to healthcare organizations. Research shows that patients encountered in a spiritual way are more satisfied with their treatment (Ramezani et al., 2014). The question is: are fluid, smooth patient processes enough to guarantee good quality of care? Understanding and encounter of a person's spiritual dimension may yet become a significant pull factor as patients select their treatment locations.

Diaconal nursing expertise meets modern healthcare needs and creates new opportunities for development. Nurse-deaconess graduates of the university of applied sciences who master spiritual nursing and diaconal nursing methods work in a broad range of healthcare settings. Diaconal healthcare expertise and the opportunities it provides ought to be used in the round for the benefit of patients, their relatives and staff.

Diaconal nursing education should also be developed systematically. It should be based on research and the best evidence available. More systematic information is needed about diaconal nursing as a phenomenon and about its effects. High-quality research into diaconal nursing should be reinforced by developing education structures, and strengthening cooperation between universities and universities of applied sciences.

Sources and literature

Anderson, J. G., Friesen, M. A., Swengros, D., Herbst, A., & Mangione, L. (2017). Examination of the Use of Healing Touch by Registered Nurses in the Acute Care Setting. *Journal of holistic nursing : official journal of the American Holistic Nurses' Association*, *35*(1), 97–107. https://doi.org/10.1177/0898010116644834

Beauvais, A., Stewart, J. G., & DeNisco, S. (2014). Emotional intelligence and spiritual well-being: implications for spiritual care. *Journal of Christian nursing : a quarterly publication of Nurses Christian Fellowship*, *31*(3), 166–171. https://doi.org/10.1097/cnj.0000000000000074

Bolmsjö, I., Tengland, P. A., & Rämgård, M. (2019). Existential loneliness: An attempt at an analysis of the concept and the phenomenon. *Nursing ethics*, *26*(5), 1310–1325. https://doi.org/10.1177/0969733017748480

Diakonia ammattikorkeakoulu (n.d.). Retrieved January, 16, 2020, from https://www.diak.fi/hakeminen/koulutukset/amk/sairaanhoitaja-diakoninen-hoitotyo/

Draper P. (2012). An integrative review of spiritual assessment: implications for nursing management. *Journal of nursing management, 20*(8), 970–980. https://doi.org/10.1111/jonm.12005

Eriksson K. (1988). *Hoito tieteenä*. Sairaanhoitajien koulutussäätiö.

Fitch, M. I., & Bartlett, R. (2019). Patient Perspectives about Spirituality and Spiritual Care. *Asia-Pacific journal of oncology nursing, 6*(2), 111–121. https://doi.org/10.4103/apjon.apjon_62_18

Hosseini, F. A., Momennasab, M., Yektatalab, S., & Zareiyan, A. (2019). Presence: the cornerstone of spiritual needs among hospitalised patients. *Scandinavian journal of caring sciences, 33*(1), 67–76. https://doi.org/10.1111/scs.12602

Itkonen J. (2017). Lapsen menettäminen ja suru. Duodecim 133 (22), 2110–2115.

Karhe L. (2017). *Potilaan hoitoyksinäisyys: käsitteellinen malli potilaan yksinäisyydestä hoitosuhteessa ja hoitoyksinäisyyteen yhteydessä olevista tekijöistä* (Doctoral Dissertation, University of Tampere (Acta Universitatis Tamperensis 2251). http://urn.fi/URN:ISBN:978-952-03-0329-7

Karvinen I. (2019). Potilaan henkinen ja hengellinen tukeminen hoitotyössä. In M. Mustajoki (Ed.) *Sairaanhoitajan käsikirja.* Duodecim. https://www.terveysportti.fi/apps/dtk/shk/article/shk04307/

Laaksovirta H. (2017). Vakavasta sairaudesta keskusteleminen potilaan ja omaisten kanssa. *Duodecim 133*, 1076−1080.

Martikainen, M., & Ala-Kokko, T. (2018). Kriittisesti sairaan potilaan tunnistaminen ja hoitoperiaatteet. In M. Mäkijärvi, V-P. Harjola, H. Päivä, J. Valli, & E. Vaula (Eds.) *Akuuttihoito-opas*. Duodecim

Myllylä M. (2004). *Diakonisen hoitotyön mallin rakentaminen*. [Doctoral Dissertation, University of Oulu]. http://urn.fi/urn:isbn:9514273567

Pearce, M. J., Coan, A. D., Herndon, J. E., 2nd, Koenig, H. G., & Abernethy, A. P. (2012). Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients. *Supportive care in cancer : official journal of the Multinational Association of Supportive Care in Cancer, 20*(10), 2269–2276. https://doi.org/10.1007/s00520-011-1335-1

Pyykkö, A. (2004). *Tehohoitotyön mallin kehittäminen ja arviointi*. (Doctoral Dissertation: University of Oulu]. http://urn.fi/urn:isbn:9514273141

Ramezani, M., Ahmadi, F., Mohammadi, E., & Kazemnejad, A. (2014). Spiritual care in nursing: a concept analysis. *International nursing review, 61*(2), 211–219. https://doi.org/10.1111/inr.12099.

Rushton L. (2014). What are the barriers to spiritual care in a hospital setting?. *British journal of nursing (Mark Allen Publishing), 23*(7), 370–374. https://doi.org/10.12968/bjon.2014.23.7.370

Sanson, G., Perrone, A., Fascì, A., & D'Agostino, F. (2018). Prevalence, Defining Characteristics, and Related Factors of the Nursing Diagnosis of Anxiety in Hospitalized Medical-Surgical Patients. *Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing, 50*(2), 181–190. https://doi.org/10.1111/jnu.12370

Watson J. (2012). *Human caring science A Theory of Nursing*. Jones & Bartlett Learning cop.

IV
DIACONAL NURSING AND CULTURAL DIVERSITY

Mertsi Ärling

12 THE ROMA: AN UNKNOWN MINORITY IN HEALTHCARE AND THE PARISH

The Roma continue to be a relatively unknown minority in Finland. Understanding of Roma people's history is important for understanding the Roma and their culture. In both healthcare and diaconal work, the most important thing is to encounter the person first. The Roma population is gradually moving from subject to independent actor in the church and society.

Introduction

Differences arising from culture are commonplace in the healthcare and social services sector, and in parish work. In diverse Finland the expertise and skills of every worker in these sectors include competence for respecting various ethnic cultures.

For many professionals in healthcare, social services and the parishes, the Roma may be a relatively unknown minority. The word "Roma" has various connotations for every reader. For some, it is a mental image of a freely wandering child of nature, while for others it is linked to strong or even rigid prejudices about perpetual problems. All other mental images probably fall between these two extremes. Every mental image has a kernel of truth. But what is really at issue when Finland's Roma are spoken of, and what is meant by discussion of their culture and encounter, either in the hospital or the parish?

The first two sections of the article present the common Roma historical and cultural framework. Professionals can internalize this framework and thus ease their realization of background cause-and-effect factors. The final two sections of the article present tried and tested practices proven to promote encounter and collaboration, both in healthcare and in parish work.

The Roma story is Finland's story

Knowledge of history is essential for understanding Finland's Roma. As a minority of approximately 10,000, the Roma have lived amid Finnish society for 460 years and adapted the main traits of Finnish peasant culture as part of their own Eastern customs. The Finnish language has largely displaced the Roma language in everyday life, although the latter's traits may still be observed in Roma speech (Rekola, 2012, pp.18–26; Hedman, 2014, p. 265; Rajala & Blomerus, 2015, p. 8).

The endonym Roma (or Romani) comes from the Roma-language word *rom*, meaning a man or person. The struggle between the words "romani" and "mustalainen" (the equivalent of "gypsy") in Finnish can be compared to the struggle of the Black population of the United States against the N-word slur (Heire, 2000, pp. 7–34; Puuronen & Välimaa, 2001, pp. 54–60).

Most Finnish Roma live in the Helsinki region, and their share of the population is highest in Kauhajoki. The Roma have the status of a linguistic and cultural minority under the Finnish Constitution, and as Finnish citizens they have the same equal civil rights and obligations as any Finn (Rekola, 2012, pp.18–26; Rajala & Blomerus, 2015, p. 8).

This status notwithstanding, the Roma encounter a broad range of problems related to discrimination and exclusion in daily life (Ärling, 2018, p. 14, p. 27). The Roma continue to be less employed and educated than the Finnish population on average, although participation in education has expanded rapidly in the last five years. The reasons for the challenges in participation, education and employment can be found in both history and the present, both within and without the community (Ärling, 2018; Jauhola & Ärling, 2019, pp. 12–17).

The Roma arrived in Finland from other Nordic countries in 1559 (Rekola, 2012, p. 18). During the Second World War, the Roma shared the fate of persecution, the Holocaust, with the Jews. By rough estimates, up to two million Roma perished in gas chambers, concentration camps and cruel Nazi medical studies (Bruchfeld & Levine, 1998, pp. 38–45).

The attitude of the Catholic and Lutheran churches to Roma in the sixteenth to nineteenth centuries was shaped by the discriminatory, exclusionary attitude of the rulers and authorities of the time (Rekola, 2012, p. 20, 32–33, pp. 45–47). The Finnish church long considered the Roma a problem and excluded them entirely, denying them all sacraments and services (Mäkinen, 2014, pp. 37–38). The "Roma problem", in the eyes of society and the church, came to a head only in 1958 with dedicated legislation, after which parish clergy were instructed to con-

duct the Roma towards social acceptability. The response to this was low due to poor cultural knowledge and an attitude of assimilation (Friman-Korpela et al., 2005, pp. 9–10, 24; Hedman et al., 2019, pp. 8–9).

By slow steps, the Finnish church and society began to appreciate their real responsibility for the country's Roma. Roma people's position gradually changed to one of a cultural minority. This was influenced by international human rights treaties and the strong advocacy of the Gypsy Committee (Mustalaisasiainneuvottelukunta) and the Gypsy Mission (now: Romano Missio) for the Roma people's position. The activation of Finland's indigenous people, the Sámi, at the same time also supported the conversation about minority rights. However, the reforms began to bear tangible fruit only in the 1980s, when a report entitled "Kirkko ja mustalaisväestö" ("The church and the gypsy population") was published, proposing the establishment of a working group in the church to coordinate spiritual work with the Roma. The working group was established in 1994 and called the Roma and Church Working Group. It was placed under the auspices of the Church Diakonia and Public Affairs Centre (KDY) (Friman-Korpela et al., 2005, pp. 9–10, 24–25; Friman-Korpela, 2014, pp. 114–115).

A particular step of progress in the shared history of the Church and the Roma was taken in Maaria Church in Turku in 1995. The then Archbishop John Vikström officially apologized for the Church's mistreatment of the Roma (Stenback, 1995; Hedman, 2012, p. 255). The apology was a significant contribution to fruitful collaboration and served as an example for other Nordic countries such as Norway and Sweden.

Although Finnish society continues to present barriers to participation and non-discrimination, in the twenty-first century the Roma population is moving from passive subject to independent social and Christian actor (Lindberg, 2012, pp.143–163; Tervonen, 2012, pp.166–168; Mäkinen, 2014, pp. 37–38).

Roma culture in a nutshell

Cultures are ambiguous, consisting of a community's spiritual, social and physical functions. The impact of cultures on people's thoughts, ideas or daily functioning is not always as direct or even as obvious as we might think. Most of a person's functions and ideas arise from human nature or are expressed as the action or view of an individual person, family or village; they are thus distinct from a person's ethnic culture (Viita, 1965, pp. 13–42; Myyryläinen, 2010; Viljanen, 2012, pp.375–387).

Finnish Roma culture is easier to envision through its sister culture, the Asian culture of respect. Roma culture stands on three pillars, a fact of which all Finnish Roma are aware and to which all are in principle expected to commit. These unwritten basic conventions are internalized at the heart of upbringing and communal life. Every extended family, family and individual living as Roma in various locations actualizes this universal culture individually and with slightly different nuances.

Respect is emphasized with regard to age, but also social standing, and extends all the way to equal interaction between men and women. Respect is seen in all actions, speech, clothing and relations towards another person, and is emphasized more strongly the higher the position of respect one person occupies regarding another.

Morality, also known as modesty, steers interpersonal interactions. Morality is a mutual guideline for respect, particularly when a younger and older Roma interact. It defines appropriate topics for discussion, acceptable clothing or overall behaviour between generations and the sexes. Indeed, mutual speech, particularly in topics which may not be spoken of directly, paraphrases and refers to a higher context to ensure the interlocutors retain "face" or esteem, a concept familiar from Asian culture (Frisk & Tulkki, 2005, p. 21).

Cleanliness is both concrete and symbolic in Roma culture. It is seen tangibly in general cleanliness of the home and clothing. Time is spent on this, and it is a matter of honour for both women and men. Symbolically, cleanliness is expressed as such things as home maintenance and the role played by the kitchen, its contents and food in the home. An extremely rigorous attitude to cleanliness has often been the only and simultaneously most important way to protect against epidemics during Roma people's migratory history.

To Western perception, the Roma social customs may sound and feel stringent. However, in everyday life these customs often adapt to new and various situations, as well as to social interactions, when the situation demands it. In their encounters with healthcare professionals, Roma people try to solve culturally problematic conflicts flexibly by bypassing or avoiding them, as if they could not see or hear the matter.

Although it would be sensible to expect understanding of the chief traits of Roma culture from healthcare and church workers, Roma do not expect actions or customs in line with their own culture from others. Every Roma person expects to be treated as a person along with the needs of his or her culture, not as his or her culture or a representative of that culture. Action from a person to a person is

a good premise for productive encounter and is the core competence in all service professions (Hänninen & Poikela, 2016, pp. 148–164).

Roma people's health and welfare

In many countries, it has been observed that Roma people's morbidity appears to be higher than that of the predominant population. Reduction of health inequality is one of the most important health policy aims in Finland (Koskinen et al., 2018, pp. 178–186). Because of the Finnish Roma policy programme (Rompo), the Finnish Institute for Health and Welfare (THL) conducted the first national health and welfare study of the Finnish Roma (the ROOSA study) as part of the Diaconal University of Applied Sciences' ESR-funded "Nevo tiija" project between 2016 and 2018 (Weiste-Paakkanen et al., 2018, p. 140, p. 144).

The prevalence of unhealthy habits, such as low leisure exercise and smoking, as well as factors detrimental to welfare, such as discrimination and insecurity, appear as significant risk factors. Many chronic diseases such as diabetes, coronary artery disease and asthma, as well as near- and farsightedness, rather commonly present health challenges. Regarding physical capacity, Roma women's weak general condition and motion difficulties are cause for particular concern. This is considered to stem from obesity, low leisure exercise and the rather heavy (8–10 kg) skirts and high-heeled shoes worn by Roma women (Weiste-Paakkanen et al., 2018, pp. 56–63, p. 70, 77, p. 141).

Several reports show the undeniable effect of experiences of discrimination on health (Malin, 2011, pp. 201–213; Kauppinen & Casteneda, 2013). The prevalence and diversity of the discrimination experienced by Roma have a significant impact, particularly in the lives of young people. Discrimination is experienced as initiated by individuals, but also when dealing with the authorities such as the police, the social insurance institution (Kela) or social welfare services (Castaneda et al., 2015).

Food plays a significant sociocultural role in Roma culture. Greater attention has been paid to the health effects of food, but knowledge and understanding of recommended dietary choices may still be lacking. Dietary and other lifestyle habits may be linked to values and attitudes which are no longer in line with current health recommendations (Weiste-Paakkanen et al., 2018, p. 90).

The latest study shows that abstention from alcohol is more common among the Roma than in the Finnish population in general. Religiosity is considered a strong factor operating in the background of this surprising result (Härkönen et al., 2017; Weiste-Paakkanen et al., 2018, p. 128). However, at the same time the

Roma population itself is particularly concerned with the increased use of various drugs by Roma youths. The deaths of several dozen under-29-year-olds due to overdoses in the last five to eight years has caused concern.

As recently as the first decade of the century the Roma were over-represented among basic social assistance recipients but markedly under-represented as users of substance abuse treatment, senior care and early childhood education services compared to the entire Finnish population. This is seen, for example, in elderly Roma people's economy in drug expenses, delaying doctor's visits, and not always being able to pay for the rehabilitation they need (Majaniemi & Viljanen, 2008; Hirvilammi & Laatu, 2008, pp. 183–195; Heinonen, 2019, pp. 10–11).

Support is needed for Roma people's overall welfare. In public health projects targeted at the entire Finnish population, the Roma population should be better considered. There is a particular need for low-threshold culturally sensitive health promotion which stresses dietary habits, exercise and other lifestyle factors. Attention must be paid to the accessibility and coverage of various services. Further education of healthcare professionals must invest in the provision of advice targeted at Roma families to ensure information reaches the Roma, and that their needs are considered. Roma employees are needed in senior care to increase elderly residents' sense of security in residential service units. The success, provision and results of these endeavours would be enabled by the involvement of the Roma themselves in the design, delivery and development (Weiste-Paakkanen et al., 2018, pp. 145–147).

Being a patient as a Roma

Diaconal nursing is based on the premise that encounter always occurs holistically, with consideration for the physical, mental, social and spiritual aspects. Every person, regardless of national or ethnic background, expects his or her cultural context to be considered in good nursing insofar as is possible. Roma people also expect this.

To deliver good care, healthcare staff can already use small methods to improve and simultaneously ease difficult situations which arise, particularly regarding privacy, between Roma patients and their relatives of different ages and sexes. Protection of privacy is obvious to healthcare staff, but in practice abundant exposure to nudity and related matters may trivialize and weaken that protection. For the patient, however, it is rarely trivial, even at the level of speech. For a patient of Roma background, the body and particularly its excretive and secretive functions are from a cultural perspective almost wholly private matters.

When performing various functions on (Roma) patients, those present and privacy protection must always be remembered. This can be done by asking relatives or guests to leave the patient's room for the lounge or a special relatives' room. This also applies to situations in which staff intend to ask patients about their condition in greater detail. It is important that nurses do not ask about toilet visits or other excretive functions, for example, in the presence of other Roma. An exception is of course when the patient or a named contact person wishes guests to remain. Here, however, the nurse or doctor may act as he or she sees best (Ärling, 2010, p. 36).

Roma culture does not present any factors which would prohibit the use of any drugs or blood products, nor does it require a nurse or doctor to be a man or a woman. Individual Roma patients may, however, have personal views or attitudes regarding certain drugs or blood products (Ärling, 2010, p. 38).

Roma people's communal spirit and ethos of mutual care are seen in accident and emergency departments or hospitals when large numbers of people accompany patients, for example. Visitors travel long distances to see seriously ill patients in hospital. It is also often customary for Roma in a town to visit local Roma who are in hospital or seriously ill, be they related or just acquaintances. Even though not everyone can visit the patient, good Roma manners dictate participation in the family's and relatives' sorrow through displays of compassion. A diaconal nurse can approach both the patient and relatives in particularly these situations and offer practical help or spiritual support as necessary, such as via refreshments or devotion.

If a corridor fills up with a Roma patient's relatives, a nurse may approach the visually oldest woman of the group and politely inform her of the need to consider other patients and changing situations in the hospital. As a practical measure, he or she can suggest choosing a contact person to liaise between the hospital and relatives. Where possible, it is a good idea to confer with the patient on the selection of a person acting as next of kin or contact person. This helps relieve the pressure on the ward and promotes good care experience. Regarding relatives, nurses should remember that patients have a subjective right to relative visits, meaning the relatives should be included in the patient's care process where possible (Ärling, 2010, p. 37).

Relatives will often want to participate in the basic care of a chronically ill patient, for example by washing or feeding the patient, changing bedclothes and cleaning the bedside table as a display of love and compassion (Ärling, 2010, p. 37). A diaconal nurse may introduce spiritual songs, Bible reading and devotion to the patient's basic care and thus promote, rehabilitate and provide succour through holistic nursing.

The death of a patient is honoured and relatives comforted at other times than on the day of the funeral itself. Relatives of patients in palliative care may often want to spend the night, as at the moment of death they want to tell the patient — whether he or she is conscious or not — that he or she is not alone. To ease the daily running of the hospital and other professionals' work, it is generally a good idea to accommodate such a patient in a single or twin room and as close as possible to the entrance to the ward. The nurse may also ask the relatives for their wishes regarding the presence of a hospital chaplain or diaconal worker. Conversation with a priest, particularly with the oldest extended family members, or with relatives, is almost without exception considered important. The relatives may also invite pastors and deacons of their own congregations (Pentecostal, Free Church, etc.) to lead devotions or share communion. This ought to be facilitated, as faith and spirituality are very important elements of Roma people's everyday lives. Upon the death of a patient relatives want to participate in some way in preparing the deceased for burial by bringing clothes owned by the deceased or bought for laying him or her out in (Ärling, 2010, pp. 38–39).

Spirituality in Roma culture

Roma have generally adopted the dominant faith of the countries in which they live. European Roma are Catholics, Protestants, Orthodox, Muslims and Jews. Finnish Roma chiefly adhere to the Evangelical Lutheran Church, but in practice, however, Roma people's spiritual activities tend towards free churches such as the Pentecostal, Free and Baptist churches. Christianity has had a similar influence on Roma culture as on the other cultures it has touched. In general, it may be stated that the influence has been decidedly positive and continues to be so (Kopsa-Schön, 1996, 168, pp. 177–179; Markkanen, 2003, p. 190, p. 193, p. 195; Mäkinen, 2014, p. 37; Åkerlund, 2014, pp. 280–281).

In Roma everyday life, Christianity and spirituality are present in many ways, even though an individual or family may not be considered religious in the usual sense. Presentation or discussion of spiritual matters is not considered intrusive or private among Roma; on the contrary, in fact. This openness is a fine opportunity for diaconal nurses and the provision of holistic nursing. Atheism is extremely rare among Roma (Friman-Korpela et al., 2005, p. 34).

Roma funerals with their traditions are the largest and most visible cultural event known even to the wider public. They may be attended by several hundred mourners with imposing wreaths. Mourners travel long distances to funerals. Fu-

neral attendance is a significant part of communal life and inter-familial respect, consideration and good behaviour. Each family or extended family adheres to its own preferences when arranging a funeral, but in general Roma funerals conform to the old Finnish Christian funeral culture. In funeral matters Roma people may turn to parish diaconal workers for financial assistance. In such situations the bereaved should naturally be encountered appropriately and a financial assessment made if necessary, with discretion applied in line with the parish's practices.

Most frequently, a bereaved family or extended family will know experienced funeral organizers, who will support and help in practical arrangements and even act as trustees. The church's priest and cantor are often asked to commend the deceased and sing the funeral hymns, but individual families may also invite other denominations' pastors and use musicians. The funeral service itself is complemented with music performed by song groups on agreement between the next of kin and the funeral organizers. The deceased is generally buried in a coffin. Only a few individual Roma opt for cremation. The old tradition of two-day funerals has changed to funerals held on a single day. Better transport connections have influenced this change.

Before the funeral, a small wake is held, accompanied by refreshments. Close relatives and local Roma generally attend. A separate memorial event is held after the funeral service and the burial. This is most frequently held in the parish hall whose facilities best support it. The opportunity to deliver a eulogy in the parish hall, due to the large numbers alone, is considered extremely important. The attendance of a priest and diaconal worker at the memorial event is also considered important and welcome, particularly if the parish workers had known either the deceased or the next of kin. Attending a Roma funeral is an honour for the guests and provides an excellent opportunity to learn about the heart of the culture and its conventions (Friman-Korpela et al., 2005, 9–10, 33–34).

The departure of a deceased person is honoured, and relatives are comforted at other times than on the day of the funeral itself. Upon a death or receipt of information about the terminal phase of an illness or a sudden accident, a large group of relatives, friends and acquaintances often arrives to sympathize with the next of kin. In this case, the hospital chaplain's or diaconal worker's role as a sympathizer, for example through devotion, is key. Discussion with the oldest members of the extended family or relatives is considered sensible and important (Friman-Korpela et al., 2005, pp. 9–10, 33–34).

Music plays an important role in Roma life and spirituality. The influence of Roma music and Roma performers on various musical genres, from classical to

rap, has been significant. In Finland, however, this influence is particularly seen in spiritual and schlager music. Roma people have started several popular spiritual groups whose music has significantly changed Finnish spiritual musical culture and left a legacy of many new spiritual songs. They are still played and sung daily, particularly in Free Church congregations.

The work of parishes with Roma appears in various forms in different localities. Generally, however, it falls within the job description of a single parish diaconal worker or the aegis of a priest or diaconal worker of parish unions' diaconal centres. It thus appears as either basic diaconal work or specialized diaconal work and collaboration between different bodies. The popularity of diaconal office hours or the frequency of discussions or meetings with priests can vary in the same way as with other parishioners. Diaconal or other spiritual work with Roma people does not especially differ in any way from work with the population at large. Differences may be seen in greater openness or acceptance of Roma to spiritual discussion. The challenges which arise are individual and are related to specialized situations.

Roma are met and encountered in parishes today in various contexts and roles. It is therefore important to devote attention to Roma people's participation, engagement and especially agency. In the design, delivery and development of actions concerning Roma, Roma themselves should be included as equal actors to ensure availability of the content and purpose, as well as correct targeting. A parish worker will get off to a good start by contacting the local Roma society or national Roma associations such as the Finnish Roma Forum (Suomen Romanifoorumi), Romano Missio or Elämä ja Valo. They can provide information on regional or local active and trusted contact people.

Encounter the person, not the culture

Finland's diversification has brought people's cultural needs and the importance of the existence of those needs to the fore. In a multicultural society different people live cheek by jowl, together striving for non-discrimination and equality in life.

Although the Roma have lived in Finland for almost half a millennium, they are still an unknown minority to many. This sense of the unknown is potentially influenced by mutual prejudice, if not some sort of fear, which a separate and shared history has created. However, behind prejudices and fears on both sides there is always a person who expects and hopes for humanity and encounter. In both healthcare and parish work, it is important and worthwhile to know vari-

ous cultures, but ultimately in both contexts what is important is the skill of encountering a person. This is the basis for everything. So, dare to get to know the person in front of you and give his or her culture the opportunity to come forward.

Sources and literature

Bruchfeld, S., & Levine, P.A. (1998). *Kertokaa siitä lapsillenne… Kirja juutalaisten joukkotuhosta Euroopassa 1933–1945.* Opetushallitus.

Castaneda A, Larja L, Nieminen T, Jokela S, Suvisaari J, Rask S. Koponen, P, & Koskinen S. (2015). *Ulkomaalaistaustaisten psyykkinen hyvinvointi, turvallisuus ja osallisuus. Ulkomaista syntyperää olevien työ ja hyvinvointi -tutkimus 2014* (UTH). (Työpaperi 18/2015). Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-302-535-6

Friman-Korpela, S., Hedman, H., Jääskeläinen, K., Puumala, S., & Åkerlund, T. (2005). *Romanit ja kirkko - Opas seurakuntien työntekijöille ja luottamushenkilöille.* (Suomen ev.lut. kirkon kirkkohallituksen julkaisuja 2005:2). Kirkkohallitus / Diakonia ja yhteiskuntatyö.

Friman-Korpela, S. (2014). *Romanipolitiikasta romanien politiikkaan - Poliittisen asialistan ja toimijakonseption muutos 1900-luvun jälkipuoliskon Suomessa* [Doctoral Dissertation, University of Jyväskylä). http://urn.fi/URN:ISBN:978-951-39-6012-4

Frisk, O., & Tulkki, H. (2005). *Kulttuuriavain.* Otava.

Hedman, H. (2012). Romanit ja kirkko. In P. Pulma, (Ed.), *Suomen romanien historia.* Suomen Kirjallisuuden seura.

Hedman, H. (2014). Romanikieli ja sen asema tänään. In J. Mäkinen, *Elämää ja Valoa 50 vuotta.* Elämä ja Valo ry.

Hedman, H., Åkerlund, T., & Siirto, U. (2019) *Romanit kirkossa – Opas seurakuntien työntekijöille ja luottamushenkilöille.* (Suomen ev.-lut. kirkon julkaisuja 80). Kirkkohallitus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/4212

Heinonen, J. (2019). *Suomen romanien kohtaama syrjintä ja rasismi. Kokemuksia, mielipiteitä ja sosiaalityön ratkaisumalleja.* Helsingin yliopisto. http://urn.fi/URN:NBN:fi:hulib-201904181703

Heire, H. (2000). *Lähihoitajiksi opiskelevien romanien käsityksiä terveydestä.* [Master Thesis, University of Kuopio].

Hirvilammi, T., & Laatu, M. (2008) Epäoikeudenmukainen kohtelu on romaniasiakkaiden arkea. In Hirvilammi, T., & Laatu, M. (Eds.) *Toinen vääryyskirja: lähikuvia sosiaalisista epäkohdista.* Kelan tutkimusosasto.

Huttu, H. (Ed.) (2018). *Suomen romanipoliittinen ohjelma (ROMPO) 2018–2022.* (Sosiaali- ja terveysministeriön julkaisuja 3/2018). http://urn.fi/URN:ISBN:978-952-00-3916-5

Hänninen, K., & Poikela, R. (2016). Toimintalähtöinen, dialoginen ja kohtaava vuorovaikutus. In M. Törrönen, K. Hänninen., P. Jottimäki, P., T. Lehto-Lunden, P. Salovaara, & M. Vestilä, (Eds.) *Vastavuoroinen sosiaalityö.* Gaudeamus.

Härkönen J, Savonen J, Virtala E, & Mäkelä, P. (2017) *Suomalaisten alkoholinkäyttötavat 1968-2016: Juomatapatutkimusten tuloksia.* (Raportti 3/2017). Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-302-873-9

Jauhola, L., Ärling, M., Karinen, R., Luukkonen, T., & Oosi, O. (2019). *Romanien työllisyys, yrittäjyys ja työmarkkinoille integroituminen.* (Työ- ja elinkeinoministeriön julkaisuja. Työelämä 2019:58). Työ- ja elinkeinoministeriö. http://urn.fi/URN:ISBN:978-952-327-469-3

Kauppinen, T. M., & Casteneda, A. E. (2013). Maahanmuuttajaryhmien elinoloissa on eroja. *Hyvin-*

vointikatsaus (3). https://www.stat.fi/artikkelit/2013/art_2013-09-23_007.html

Kopsa-Schön, T. (1996). *Kulttuuri-identiteetin jäljillä – Suomen romanien kulttuuri-identiteettistä 1980-luvun alussa.* Suomalaisen Kirjallisuuden Seura.

Koskinen S, Martelin T, Borodulin K, Lundqvist A, Sääksjärvi K., & Koponen P. (2018) Terveyden, toimintakyvyn ja niihin vaikuttavien tekijöiden vaihtelu koulutuksen ja asuinalueen mukaan. In P. Koponen, K. Borodulin, A. Lundqvist, K. Sääksjärvi, S. Koskinen (Eds.), *Terveys, toimintakyky ja hyvinvointi Suomessa - FinTerveys 2017 -tutkimus.* (Raportti 4/2018). Terveyden ja hyvinvoinnin laitos. http://urn.fi/URN:ISBN:978-952-343-105-8

Lindberg, V. (2012). Suomen romanien uskonnollinen herääminen. In P. Pulma, (Ed.), *Suomen romanien historia.* Suomen Kirjallisuuden seura.

Majaniemi, P. & Viljanen, A. M. (2008). *Romanivanhusten palvelutarvekartoitus: De patti phuuridenge - douva hin godjiba = anna kunnia vanhuksille - se on viisautta*. Suomen romaniyhdistys.Malin, M. (2011). Maahanmuuttajien terveyteen ja hyvinvointiin vaikuttavat tekijät. *Yhteiskuntapolitiikka, 76*(2). https://urn.fi/URN:NBN:fi-fe201209117822

Markkanen, A. (2003). *Luonnollisesti – etnografinen tutkimus romaninaisten elämänkulusta.* (Joensuun yliopiston humanistisia julkaisuja 33). Joensuun yliopisto

Myyryläinen, H. (2010). *Mitä on kulttuuri.* Retrieved July 3, 2019, from http://materiaalit.internetix.fi/fi/opintojaksot/9historia/euroopankulttuurihistoria/mita_on_kulttuuri

Mäkinen, J. (2014). *Elämää ja Valoa 50 vuotta.* Elämä ja Valo.

Puuronen, A., & Välimaa, R. (Eds.) (2001). *Nuori ruumis.* Gaudeamus.

Rajala, S., & Blomerus, S. (2015). *Katsaus aikuisten romanien koulutustaustoihin.* (Raportit ja selvitykset 2015:8). Opetushallitus.

Rekola, T. (2012). Romanien varhaisvaiheet Suomessa: 1500-luvulta 1800-luvun puoliväliin. In P. Pulma, (Ed.), *Suomen romanien historia.* Suomen Kirjallisuuden seura.

Stenbäck, I. (1995). Kirkko ja romanit yhteistyöhön - Romanien kaksi päivää kestäviä hautajaisia ei tunneta. *Helsingin Sanomat.* Retrieved 10.7.2019 https://www.hs.fi/kotimaa/art-2000003433762.html

Tervonen, M. (2012). Romanit ja suuri muutos. In P. Pulma, (Ed.), *Suomen romanien historia.* Suomen Kirjallisuuden seura.

Weiste-Paakkanen, A., Lämsä, R., & Kuusio, H. (Eds.). (2018). *Suomen romaniväestön osallisuus ja hyvinvointi Romanien hyvinvointitutkimus Roosan perustulokset 2017–2018.* (Raportti 15). Terveyden ja hyvinvoinnin laitos. https://urn.fi/URN:ISBN:978-952-343-246-8

Viita, A. (1967). *Mustalaisväestön hyväksi: Mustalaislähetystyö Suomessa v 1904–1966.* Mustalaislähetys.

Viljanen, A. M. (2012). Romanikulttuurin muuttuvat muodot ja pysyvät rakenteet. In P. Pulma, (Ed.), *Suomen romanien historia.* Suomen Kirjallisuuden seura.

Åkerlund, T. (2014). Romanikulttuuri. In Mäkinen, J. (2014). *Elämää ja Valoa 50 vuotta.* Elämä ja Valo.

Ärling, M. (2010). *Romanit terveyspalveluiden käyttäjinä: Romanipotilas vuodeosastolla -opas* [Bachelor Thesis, Diaconia University of Applied Sciences]. https://urn.fi/URN:NBN:fi:amk-2010120717332

Ärling, M. (2018). *Romanien työllistyminen - kompastuskivi vai ponnahduslauta? : Tuumasta töihin -koulutusmalli ponnahduslautana työllistymiseen* [Master Thesis, Diaconia University of Applied Sciences]. https://urn.fi/URN:NBN:fi:amk-201805026065

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13 NURSE-DEACONESSES IN THE SÁMI REGION

A nurse-deaconess in the Sámi region encounters exceptional professional challenges because of the cultural traits of the region. This article discusses the features of Sámi culture, such as the relationship with nature, reindeer herding, language, dress culture and lifestyle with respect to the work of nurse-deaconesses in Finland. Knowledge of specific cultural traits is necessary to create a trusting relationship with the local Sámi population.

Cultural sensitivity in diaconal nursing is expressed as a culturally oriented approach, even if the worker comes from outside Sámi culture. This includes the sensitivity of noticing the significance of cultural customs, language and local conditions. Cultural sensitivity and respectful and equal interactions create a good ground for working in the Sámi region. This article discusses these matters from the perspectives of various healthcare units, as well as that of diaconal work. The direct quotations describe our experiences of our work in the Sámi region.

The total global Sámi population is estimated at between 75,000 and 100,000. The Sámi have traditionally lived in Finnish, Norwegian and Swedish Lapland, and on the shores of the Varangerfjord in Russia. There are about 10,000 Sámi in Finland, of whom around 4,000 live in an area designated as the Sámi Homeland. This Homeland covers the municipalities of Inari, Utsjoki, Enontekiö and the Vuotso area in the municipality of Sodankylä.

Three Sámi languages are spoken in Finland: Northern, Inari and Skolt Sámi. The traditional Sámi livelihoods of reindeer herding, fishing, crafts, hunting and gathering are part of Sámi culture. Most Sámi now work in non-traditional professions, but the traditional livelihoods still shape the Sámi relationship with nature, culture and the Sámi way of life.

Specific traits of the Sámi region

Fell landscapes, high uplands, green river valleys, the beautiful and sometimes harsh banks of Lake Inari — these are the broad features of the Sámi region in Inari and Sodankylä. Long distances, the diversity of Lapland's cultures and a survival ethos are all things with which a nurse-deaconess working in the Sámi region is familiar. The beautiful and alluring landscapes of Lapland are simultaneously an opportunity and a challenge in both diaconal work and healthcare.

The traditional lifestyle, which includes a firm relationship with nature, is an essential part of Sámi culture. The Sámi relationship with nature is described as a special connection between human and nature. It places the person not above nature, but as part of it (Helander, 2000, 171–174). The relationship between person and nature is based on balance and maintenance of harmony, not exploitation. A close relationship with nature is also based on the fact that nature must be respected and reckoned with if one is to survive. For example, in reindeer herding reading natural signs and acting according to changing weather and seasons is still the order of the day, modern technology and aids notwithstanding.

The relationship with nature is also sometimes seen as an independent lifestyle in the midst of nature, from which people do not want to move to towns and cities, even when their functional capacity declines. Even the presence of a stranger can be considered a burdensome factor in this way of life. On the other hand, a diaconal worker may be a much anticipated visitor once a trusting relationship has been allowed to form naturally. Meetings can proceed more naturally in an environment familiar to the client than in the office, and a conversation could even be held outside by an open fire.

Life in the harsh climate of the north has been tough, but people have always tried to make ends meet independently. This can be seen in diaconal assistance. People have a high threshold for seeking financial support: in spite of want, they try to survive by their own means, and the support of their immediate circle and the bounty of nature. Nature has traditionally been a supplier of nutrition, and hospitality and caring for others have always been considered important.

The *gákti*, a traditional Sámi garment previously worn in the Sámi region, is gradually becoming a festive garment. It has been used down the years to say many things about the wearer, such as sex, marital status and geographical origin. This Sámi garment is an important symbol of being Sámi and an essential part of a Sámi person's identity. For a member of Sámi culture, the message conveyed by clothing is rich and multifaceted. This Sámi garment can even be compared to a

personal identity number, as each one is always made for a certain person. A headdress alone can reveal the wearer's home locality, age or marital status (Ruotsala, 2011, pp. 362–365).

> *An older female Sámi patient had, as was her habit, put on her traditional Sámi hat as she got ready to go to the day lounge to eat. The nurse who came to get the patient took the hat off the patient's head, saying a hat was no attire to be eating in. This small act, which the nurse felt was harmless, led to the patient refusing to go to the day lounge when others were present.*

Removing a hat against the wearer's will offends the person's identity, and limits his or her right of self-determination over his or her own clothing. For older Sámi women, a hat is an important garment without which they do not participate in public interactions such as eating with strangers. Appearing in public without one's hat carries the same significance as doing so half-naked. The patient in question may even have considered the removal of her hat degrading. Sámi dress is not worn without a hat, as the wearer would then feel half-dressed. Wearing traditional garments on a ward is difficult, but particularly in a situation where all the garments cannot be worn, wearing a hat is even more important, as it is the only visible part of the person's background and identity (Bigga-Helena Magga, personal informant, 20.10.2019).

For Sámi people, their own language is an extremely important expression of cultural identity. Language is not just an informational tool; it is also an expression of emotions and contains key cultural elements. Language reveals an entirely different way of thinking and imagining the world (Lehtola, 2015, p. 13, p. 18). A native language is in particular the language of emotion, one strongly linked with childhood and youth. Hearing it arouses a feeling of familiarity. The significance of a native language lies deeply in a person, and hearing one's own language stimulates and restores emotional memories of the childhood home (Bigga-Helena Magga, personal informant 20.10.2019).

> *I remember one older Sámi person with a memory disease that those of us working on the ward weren't able to establish any kind of contact with. A student intern, who knew a few words of Sámi, came to work the evening shift. The student greeted the patient in the patient's native language. To everyone's great surprise, the patient's eyes opened and the patient, who had previously been silent, began chatting in Sámi.*

For patients with dementia in particular, hearing their native language is a return to a familiar world. A dementia patient whose first language was Sámi may forget the Finnish he or she learned later. Finnish may have become a foreign language, one the patient does not recognize or no longer has the energy to respond to. In such a situation, the dementia patient may feel they are in a foreign country and withdraw from the context. Learning a few words of Sámi can help the nursing staff connect with the patient and reinforce a sense of security (Bigga-Helena Magga, personal informant 20.10.2019).

Local cultural knowledge builds bridges

For newcomers to the Sámi community from elsewhere, adapting to its way of life and earning trust are not automatic. They require the sensitivity to observe and appreciate cultural traits, and the desire and ability to adjust both to local customs and conditions. This is part of the culturally sensitive form of diaconal encounter (Huhtamella, 2018, pp. 18–20). Cultural diversity consists of the various influences people have internalized during life, and which they express in their individual ways of life. Nor is Sámi culture uniformly definable; it consists of various cultural and geographical factors (Lehtola, 2015, p. 29). This should be considered in cultural encounters. Generalizations ought to be avoided, as the Sámi way of life can also be individually formed according to each person's individual and family history.

Family, extended family and the immediate community have traditionally played a large role in Sámi culture, and the community's conception of the family and extended family affect the individual's status in the community (Ruotsala, 2016, p. 4). Someone who marries into a Sámi family is often asked where he or she comes from, and who his or her parents are. The person is also asked what extended family he or she has married into, which village his or her spouse comes from, and who his or her parents-in-law are. The answers make it easier to approve the newcomer as part of the community. Traditional livelihoods are often practised with the family and immediate community; for example, in a reindeer herder family the whole family takes part in reindeer sorting. In Utsjoki, the reindeer sorting may be incorporated into children's school day. As the adults work, the children learn traditional ways of working in the correct environment; the reindeer herding culture thus passes from one generation to the next.

In the Sámi region, life is lived in a rich cultural and linguistic environment. The era of Fennicization has left its mark, but fortunately Sámi culture and lan-

guage are now appreciated and cherished. It is also worth remembering that people from different backgrounds have generally striven to coexist well, and the meeting of different cultures has also had positive effects on the development of mutual activities and understanding (Lettinen, 2016, pp. 125–130, 178–185).

The understanding that many things may be learned with an open mind, as well as the acceptance of the fact that "latent knowledge" is an essential part of being Sámi, make adjustment easier. Such knowledge can only be adapted through birth in this culture and may never be totally entered into by newcomers from elsewhere. An understanding of one's own background and culture, as well as experience of the uniqueness of cultural heritage for every one of its heirs, can ease occasional feelings of foreignness. That cannot be explained; it is felt in the heart, and at its deepest can only be shared by someone bearing the same heritage. Appreciation of individual cultural identity is a prerequisite when living in the midst of various cultural influences. Nevertheless, differing cultural backgrounds do not prevent true encounter, as humanity is common everywhere.

Holistic encounter

In sparsely populated Finnish Lapland, several matters are dealt with on a single house call. Trust is built over a long period, during which acquaintance is made, with people asking where their interlocutors are from and which families they belong to. In diaconal work, the client is encountered holistically. It is natural to talk about other matters in addition to spiritual matters: personal relationships, finances and health concerns. The nursing degree provides skills and competence to advise and guide in health matters, such as monitoring a client's health and drug treatment.

Distances are long in the north. The villages in a nurse-deaconess's closest working area may be 40 km away. Journeys to other villages are considerably longer, up to 200 km in each direction. Weather conditions mean leaving and arriving are not always a given. Snow ploughing of roads leading to remote houses during snowfall is never immediate, as the closest tractor may be dozens of kilometres away. Thus, if there is heavy snowfall today, some houses will only be accessible by car in about two days. An alternative to rescheduling is, naturally, walking one or two kilometres. In this situation the client may come to meet the visitor on a kick sled so the heavy EU food package can be carried to the destination. A few years ago there were houses that were totally inaccessible by car; they were reached on skis in the winter and on foot in the summer.

In addition to weather conditions, planning of work and activities should consider the annual cycle and related matters. The reindeer herding year begins with calving in May–June, and the summer involves calf tagging in June–July, when the reindeer calves have their owners' marks carved in their ears. Then, in early winter, the reindeer sorting begins. Berry-picking and fishing take their own time in the summer and autumn. At these times, it is not worth planning any events or visits, particularly to villages where reindeer herding is practised. More or less the entire village is present for the reindeer sorting. The precise dates of the reindeer sorting cannot be known in advance; it begins when the reindeer are gathered into the enclosure. Lapin Radio may announce: "The Christmas carol service has been cancelled due to reindeer sorting". Some reindeer sorting locations have accommodation used by several families, where people may eat, drink coffee and rest. This is also a fine place for the deaconess to meet people.

The long distances and sparse habitation also challenge municipal healthcare, and clients make use of cooperation with home nurses and deaconesses (Seppä, 2012, p. 73). People previously considered the professions of health sister and parish sister the same thing in questions of illness.

> *It has always felt like the people of the north have especially appreciated a deaconess's nursing education, and the long distances have by their nature increased the share of nursing work.*

A diaconal worker is one of the only officials who can make a house call without prior arrangement. A tip from a neighbour or relative is often a good reason to go and check on a person's or family's situation on the spur of the moment. "Especially in the Sámi community, people do not easily seek or accept help from outside the family. A parish worker is often the one who may cross the threshold. Not necessarily anyone else. A parish worker is allowed to be in touch and offer help. This is precisely what highlights the holistic encounter and noticing of others enabled by a deaconess's education" (Magga, 2019).

In the Inari–Sodankylä Sámi region, there were previously three border region sister offices, administratively subject to the Oulu diocesan chapter, which in practice were deaconess offices from the perspective of the nursing content of the work. The diocesan chapter had a specific border region work fund, thanks to which the deaconesses had supplies such as a medicine bag, the contents of which were supplemented: it contained drugs, wound treatment supplies, injection equipment and a blood pressure monitor. As late as the 1990s a border region

sister would sometimes hold office hours in the Vuotso health centre. When the border region sister office was abolished in 1998, the three border sister offices of the Inari–Sodankylä area were merged into one Sámi region office.

> *The medicine bag still travels with me in my car. It has fewer contents, and we do fewer treatments. Instead, we counsel and advise. Of course, we still measure blood pressure. My work involves a lot of house calls, and on those visits I see a lot: illnesses, spiritual issues, interpersonal relationships, death… I often also get phone calls where a person describes their symptoms and situation and expects me to advise on what to do next. Whether they should go see a doctor or wait and try something else. People don't easily travel a couple of hundred kilometres to see the doctor. They don't go for no reason at all.*

Medical knowledge learnt during studies, practical nursing placements and learning of manual skills in real situations on various wards, in health centres and in community-based care have been necessary. A deaconess's skills are still widely used, even though they perform fewer concrete actions. A blood pressure monitor is still as useful a tool as the hymnal when the deaconess encounters people and their many needs. To quote one mother: "It's good to talk to a deaconess, as they understand medicine and diseases, they can stand talking about death, and don't label you the way you might be in a mental health clinic. And what's more, you can pray with them."

Diaconal nursing in the various operating environments of the Sámi region

For a Sámi client, the quality of social services and healthcare is made tangible in three significant matters: how the client is encountered, behaviour towards the client, and the content of the work. In encounters, what is important is showing respect, considering culture, and language and communication. Behaviour towards the client should be grounded in non-discrimination, respect and human dignity. In the content of the work, it is important to consider the client's own language and culture, and the content of the work should be based on the person's view, as well as the need for help or support (Magga 2019).

Whether a deaconess works in a parish or a healthcare unit, it is important to encounter each client with consideration for the individual situation. Deaconesses are equipped to create an unhurried, accepting and trusting environment in which

the client can feel listened to and understood. This also makes it easier for the client to bring up difficult matters and emotions.

On a health centre ward, the diaconal nursing professional is the person sent to a dying patient or a patient considered difficult. The nurse-deaconess degree equips the professional to broach matters of death and spirituality while nursing. Particularly when the patient is in palliative care, it is important for the nursing staff to be able to create a calm environment in which even difficult matters and emotions may be spoken about. Encountering grieving relatives is also natural for the nurse-deaconess.

Some nursing staff do not want to or cannot speak about matters related to death. This may be due to fear or uncertainty of how to act in mentally or spiritually challenging situations. It is easier to claim one is too busy, or simply check the intravenous drip is working. However, when a person is seriously ill, the need for psychosocial support is great, and it is precisely here that a deaconess may help. A deaconess does not care for the illness, but for the whole person, and considers the patient's various support needs.

In the northernmost unit of Finland which trains conscripts, the Lapland Border Guard Border Private Company in Ivalo, the worker serving as nurse holds a nurse-deaconess degree. Diaconal nursing prepares this professional for supporting young conscripts' mental coping and overall welfare. The nurse requires the skill and courage to be able to discuss the matters that arise, be they life difficulties or spiritual matters. For the nurse-deaconess, encountering these matters is natural. A good interactive situation should always be created and mutual trust achieved with the focus on the patient. Such a discussion can arise when the nurse is treating abrasions or a headache, for example.

> *A young man came to my office and said he had a headache. As we talked, the headache became less important, and he raised the bigger concerns of close interpersonal relationships and his own coping. I let him take his time to cry and tell me about his situation. A little while later he felt better, meaning there was no need to refer him to the doctor. Someone who's crying doesn't always need a doctor, but a listener.*

Time constraints, physical and mental burdens, and homesickness make young people less sure about their coping skills. Changing circumstances in military and alternative service conscripts' lives also arouse strong feelings at times (Mielenterveysopas, 2014, pp. 14–18). Welfare consists of knowing oneself and consid-

eration for others. Good relationships and a sense of control over daily life help a person cope (Ollikainen, 2016, p. 34). Conscripts are supported in their coping by their fellow conscripts, which is coloured by a good group morale. Although conscripts are generally satisfied with the support provided by healthcare staff, they also feel a need for the deeper conversations conducted with a nurse which help support their mental welfare (Rantakeisu 2018, p. 8, p. 10).

> *In my opinion, a key goal as a barracks nurse is, on top of health promotion, giving hope and support, particularly when a young person is at the end of their tether.*

When a young person is listened to and engaged in conversation, matters are placed in the correct perspective. Both physical and mental fatigue may transform small concerns into large challenges. In turn, they can lead to dropping out and thus exclusion. Support for coping can help avoid untimely cessation of service and reduce the risk of exclusion.

In all this, diaconal nursing is a kind of undercurrent which offers a strong, human frame of reference and Christian value world for many kinds of encounters and nursing tasks, as well as relationship skills for demanding challenges. It provides a holistic perspective for the Sámi region when getting to know its cultural traits and helps act in various environments and tasks appropriately and respectfully. Diaconal nursing has created a fine basis and taught perception of people, matters, phenomena and life both more deeply and more broadly. A person, the unit as part of his or her own community and a valuable creation in God's image, is the core of diaconal encounter, and diaconal work is in turn an essential part of the core of the church's work. This is particularly the case in the Sámi region, where people still live a strongly communal life in a multicultural environment.

An open and excepting attitude is of assistance when forming mutual trust. In diaconal work this is seen as cross-border collaboration with representatives of municipalities, the third sector and other religious communities, and particularly in multicultural client encounters. The neighbourly love at the core of diaconal work does not differentiate between people in any way: the doors to encounter are open to all.

> *Whether I am working as a nurse or a diaconal worker, my view of diaconal nursing is always the basic premise for working and orienting myself towards*

another person. In everyday work this shows best as the courage to enter difficult situations, and the trust that in this job you don't need to act on your own strength alone.

Sources and literature

Helander, E. (2000). Saamelainen maailmankuva ja luontosuhde. In I. Seurujärvi-Kari (Ed.), *Beaivvi Manat. Saamelaisten juuret ja nykyaika* (pp. 171–182). (Tietolipas 164). Suomalaisen kirjallisuuden seura.

Huhtamella, A. (2018). *Kahden maailman rajalla. Kulttuurisensitiivisyys hengellisessä kohtaamisessa saamelaisalueella.* [Master Thesis, University of Helsinki].

Lehtola, V. (2015). *Saamelaiset. Historia, yhteiskunta, taide*. Puntsi.

Lettinen, E. (2016). Lantalainen tekee suuren tulen ja menee kauaksi lämmittelemään. In Samuli Aikio, Marjut Huuskonen, & Eva Lettinen. *Sukelluksia saamelaisten ja suomalaisten suhteisiin* (pp. 125–249). Raakku.

Magga, R. (20.10.2019). *Saamelaisen vanhuksen kohtaamisesta.* Lecture in Sámi Education Institute.

Ollikainen, A. (2016). *Hyvinvoinnin ulottuvuudet aikuisuuden näkökulmasta.* [Master Thesis, University of Tampere]. http://urn.fi/URN:NBN:fi:uta-201602231243

Pääesikunta ja Sotilaslääketieteen keskus. (11.4.2014). *Mielenterveysopas mielenterveystyötä tekeville puolustusvoimissa.* Retrieved October 22, 2019, from https://puolustusvoimat.fi/documents/1948673/2015558/Mielenterveysopas/b459af96-8b33-4c13-bef0-d93283efa233/Mielenterveysopas.pdf

Rantakeisu, M. (2018). *Katse eteenpäin. Lapin rajavartioston voimavarat ja jaksamista kuormittavat tekijät varusmieskoulutuksessa.* [Bachelor Thesis, Diaconia University of Applies Sciences]. http://urn.fi/URN:NBN:fi:amk-201801291751

Ruotsala, H. (2011). Kaunista ja toimivaa – saamelaisten aineellinen kulttuuri. In: I. Seurujärvi-Kari, P. Halinen, & R. Pulkkinen (Eds.) *Saamentutkimus tänään.* Suomalainen Kirjallisuuden Seura.

Ruotsala, P. (2016). *Saamelainen perhepalveluiden asiakkaana: kulttuurinen konteksti ja hyvät käytännöt.* Saamelaiskäräjät.

Saamelaiskäräjät (n.d.). Saamelaiset Suomessa. Retrieved October, 22, 2019, from https://www.samediggi.fi/saamelaiset-info/

Seppä, E. (2012). *Diakoniatyön erityispiirteitä saamelaiskulttuurissa* [Master Thesis, University of Helsinki]

Sormunen S., Eloniemi-Sulkava U., Finne-Soveri H., Mäki-Petäjä-Leinonen A., & Andersson S. (2008). Dementiaoireisen asuminen tehostetussa palveluasumisessa ja ympärivuorokautisessa pitkäaikaishoidossa. In S. Sormunen, & P. Topo (Eds.) *Laadukkaat dementiapalvelut: opas kunnille*. Stakes.

V
THE FUTURE OF DIACONAL NURSING

Mikko Malkavaara

14 DIACONAL NURSING AND THE DIACONAL OFFICE

The development of diaconal nursing has been strongly linked to vocational education and the emphasis on professionalism which is an essential part of it. Diaconal nursing has developed alongside diaconal social work, and in the parishes' diaconal work holders of degrees in both disciplines serve in the same diaconal offices and largely perform the same duties. The Church's ordination practices have been harmonized and led to the restriction of ordination to ecclesiastical duties. Thus, entrants to the nursing profession are not ordained for the diaconal office as they once were. This is bound to increase the significance of education in the formation of identity. Diaconal work in the parishes is becoming more multidisciplinary and diverse, but the specialized skills learned in the diaconal nursing degree are still valued. Because of the church's internal development, the special development of diaconal nursing draws most strength, in addition to clients' and colleagues' appreciation, from the international disciplines of spiritual nursing and parish nursing.

Defence of the deaconess's education and profession

The articles in the present book form a solid body of material which sheds light on how strongly Finnish diaconal and diaconal nursing professionals defend the diaconal education and profession. In the authors' opinion, healthcare training is necessary to fulfil parish diaconal tasks, and deaconesses have much to give in nursing due to their skills in spiritual and mental encounter.

Simply put, there are two reasons opinions are voiced on the subject, or for this discussion continuing year after year. The first concerns the significance of nursing in parish work and the place of a worker with nursing education among a parish's key workers.

The second concerns the cost of educating deaconesses. The Bachelor's Degree Programme in Healthcare, Diaconal Nursing, is currently worth 240 cred-

its, while the Bachelor's Degree Programme in Nursing is worth 210 credits. The groups are generally relatively small. Both the breadth of the education and the small group size create costs. Third-level education in Finland is free for the students, with the education ministry carrying the costs. The cost of deaconess education was under discussion before the formation of universities of applied sciences in Finland in the 1990s. Providers of deaconess education have long been used to taking a defensive position.

The deaconesses themselves prove through their interaction with numerous parishioners and parish workers the usefulness of their nursing education to the parishes. The diaconal nursing experts in various roles who have contributed to the present book have demonstrated the same.

Deaconesses and deacons

After deacons' education reincorporated social work in the 1950s following a long hiatus, the first graduates faced many barriers when they sought work in the parishes. The parishes wished only to employ parish sisters, that is, deaconesses. A long time would pass before the parishes would begin also to employ deacons for diaconal work.

When the National Board of Health harmonized nursing education in the late 1920s, graduates of the deaconess institutes no longer received full nursing rights without further education. They could be earned in the new state nursing institutes. The deaconess institutes faced time pressures to arrange the necessary additional education for their deaconesses working in the most critical roles, as well as to apply for licences for their nursing institutes operating under the new education regulations (Kansanaho, 1964, p. 282, pp.284–285; Kansanaho, 1967, p. 229; Erkamo, 1969, pp. 158–161; Paaskoski, 2017, pp. 183–186).

Between 1930 and 1934 a discussion took place in the deaconess institutes and their shared body, the Diaconal Work Central Committee, on the need to prevent deaconess education from becoming wholly nursing education on the state's terms. There was a desire to complement it with a special "care sister" (see the "Nursing diaconal work section" in Chapter 1) course whose graduates would also be deaconesses, but primarily for parish diaconal duties. This was considered justified by the place of diaconal work in encountering all manner of distress, which gave diaconal work the tools for spiritual direction and social support. There was an urge to divert diaconal work away from pure nursing. The Sortavala deaconess institute emphasized parish diaconal work the most, but the Helsinki and Vy-

borg institutes also launched care sister courses. Nurse-deaconesses were educated alongside it on a dedicated course (Kansanaho, 1964, pp. 232–283, pp. 291–294; Kansanaho, 1967, pp. 225–226; Erkamo, 1969, pp. 161–164, p. 166; Paaskoski, 2017, pp. 185–189).

The care sister courses scarcely had time to form properly, as they were closed after a few years' trial. They attracted insufficient numbers, and the parishes were not interested in employing their graduates. The parishes received state aid for employing deaconesses with nursing degrees. Thus, the clergy and parishioners chiefly expected the deaconesses to provide nursing. Deaconesses supplemented municipal health services and were part of the public health system (Kansanaho, 1964, pp. 290–299; Kansanaho, 1967, pp. 230–231; Pyykkö, 2004, pp. 120–121; Paaskoski, 2017, pp. 188–190).

Nowadays, diaconal nursing and diaconal social work, the latter of which refers to the education of deacons, are developed harmoniously alongside each other. Diak, the Diaconia University of Applied Sciences, is responsible for almost all third-level vocational education in these areas. The church has not taken a stance on either educational avenue; instead, it has supported both courses. Individual voices of dissent have, however, been heard from time to time.

In truth, the diaconal work of the Finnish Lutheran church differs from that of all other comparable large churches in that its worker structure includes the office of diaconal worker, obligatory for every parish. This notable solution with its diaconal focus is furthermore statutory. Far from all countries have ecclesiastical legislation in the same manner as Finland and the other Nordic countries.

In many other countries in which deaconesses work, the deaconesses are still in direct contact with their home institutes and act on their authority in various roles.

Factors common to deaconesses and deacons

Parish diaconal work has several structural factors which the roles of deaconesses and deacons are closely connected by, and which they even share.

Deaconesses were initially and for a long time ordained in the deaconess institutes, and the ordainer was the director of the institute, even if a bishop was present. The first ordination by a bishop in a deaconess institute was in 1948. It was at that time that ordinations generally became the responsibility of bishops, and churches were established as the ordination venues. The church manual contained no formula for the ordination of deaconesses or deacons, in the absence of which

the bishops applied a formula like that used by the Swedish Lutheran church. The format for ordaining deacons and deaconesses first entered the manual of the Finnish Lutheran church in 1964, following its approval by general synod (Malkavaara, 2015, pp. 113–116).

The office of deacon was not a complete novelty in the Finnish language and Finnish ecclesiastical parlance. It had been used in the discussion in the 1910s about diaconal work, at least. An expanded bishops' conference established a committee in 1963 to "study the direction of diakonia and the education of diaconal workers". In its report in 1969, the committee used the still rare phrase "diaconal office" (Finnish: "diakonian virka"), which it viewed as part of Christ's ministry. It was deployed by Bishop John Vikström, whose research article on the theology of office, "Diaconal work and the diaconal office from the theological perspective" ("Diakonia ja diakonian virka teologian näkökulmasta"), was one of the studies on the topic commissioned by the committee. In Vikström's view the distinguishing feature of diaconal work was not the quality of service but its place in connection with salvation and the gospel. The difference between diaconal and other care work did not depend on the worker, or on the efficacy or spirit of the work, but on the different contexts in which the two types of work were performed. Social workers and nurses performed a statutory office, one of an earthly society. Here, Vikström employed the Lutheran theological distinction between law and gospel, or between the earthly and spiritual (Malkavaara, 2015, pp. 133–135).

The term, which referred to both deaconesses and deacons, gained firmer ground when the Church Diaconal Work Committee established a working group in 1973 to consider the diaconal office and ordination to it. Its report, "The diaconal office and ordination to it", was published in March 1975. In the working group's opinion, the offices of deacon and deaconess ought to be returned to the richness to which the church's tradition testified, and in which the liturgy and both caritative and catechetical service were combined. The definition of such a broad range of duties should also be seen in the ordination formula. The Church Diaconal Work Committee did not support the working group it had appointed. Nevertheless, the significance of the working group was still great, as it saw the duties of the diaconal office of service as being much broader than had been habitually thought (Malkavaara, 2015, pp. 144–145).

The offices of deaconess and deacon were kept separate until the approval of the church manual in 1984, which included an ordination formula entitled "Ordination to diaconal office". "Diaconal office" was the term used to equate deaconesses and deacons. At the time, the title of the office was considered an advantage be-

cause it did not distinguish between the nursing and social welfare areas of diaconal work. It was also completely gender-neutral (Malkavaara, 2015, pp. 148–151).

One justification for the reform of the ordination and the title of the office was that deaconesses and deacons, despite their different educational backgrounds, had become eligible to apply for the same parish offices. This reform took place gradually, but the separate offices of deaconess and deacon were only replaced with the diaconal office in 1982. Both deacons and deaconesses were eligible for the office (Jääskeläinen, 2008, p. 90).

The creation of a new trade union in 1991 also emphasized the commonality of deaconesses and deacons. The Finnish Church Sister Federation (Suomen Kirkon Sisarliitto) and the Finnish Deacons' Federation (Suomen Diakonien Liitto) ceased operations (Salmesvuori, 2008, pp. 53–61).

Despite deaconesses' and deacons' different educational backgrounds, their duties in parish work became to a large extent harmonized. However, the pace of the change was not uniform in all localities and in all parishes. Until the 2010s, deaconesses formed the majority of diaconal workers in the parishes, meaning the deaconesses in many parishes defined duties and continued working as before. The great recession of the 1990s, however, nudged the nature and methods of diaconal work further in the direction of social work, particularly in cities and large towns.

Signs of deaconesses' emancipation

So many signs of change in diaconal work were visible that increasing questions began to be asked about deaconesses' special skills and identity. In her doctoral dissertation of 1998, Lea Henriksson asked why the role of diaconal work in the history of nursing and social work had been so little described. She considered the reason to lie in a perception of the deaconess's profession as the most "familial" one in social care and healthcare. By this she meant that the deaconess's profession was the least specialized, and that it included duties done in the home. It was as such the broadest of the care professions. Deaconesses were worse paid than nurses and other healthcare staff, which created tensions with other care workers. The vocation of deaconess was in contradiction with an orientation towards salaried work and professional education and the striving for status. Salaried work and vocation were poorly compatible (Henriksson, 1998; Kauppinen-Perttula, 2004, p. 24).

A significant boost to the visibility, identity and new identity of deaconesses' work was Marjatta Myllylä's doctoral thesis of 2004, in which she defined diaconal nursing (Myllylä, 2004). The work was of value to the entire profession. It sup-

ported teaching in Diak and served as an example for later dissertations about the deaconess's profession or diaconal nursing.

Deaconesses' role as healthcare professions and the nursing competence necessary in parish diaconal work were discussed in a research project conducted by the church council, on which a report edited by Kaisa Kinnunen entitled "Sick poverty" ("Sairas köyhyys") was published in 2009 (Kinnunen, 2009). A research project conducted at Diak by Helena Kotisalo and Lea Rättyä emphasized deaconesses' role as health promoters. The research report was published in 2014 (Kotisalo & Rättyä, 2014).

The long developmental curve which had in the last decades of the twentieth century reinforced the commonality of the two degrees leading to the diaconal office began to acquire a new direction. Deaconesses began to reinforce their own profile and strengthen the image of the necessity of their professional skill and educational orientation in parish work. At the same time, the significance of the specialized skills in diaconal nursing was emphasized.

Social change and diaconal work

In truth, deaconesses' professional identity received a blow as early as the initial years of the welfare state, when the stress on deaconesses' professionalism was only beginning to be made. When the Primary Health Care Act was being prepared, the important public health and social contribution of deaconesses until that time was completely side-lined. When the Act entered into force in 1972, deaconesses were no longer home nurses working under the direction of municipal doctors, but only parish workers. Health services were provided by health centres built in the municipalities. Legislation made the boundary between the worldly and the spiritual clear. Healthcare services were the concern of lay society.

Naturally, at issue in the first instance was not the church's role or the fulfilment of the Lutheran two kingdoms doctrine but the streamlined construction of the welfare state, the ideology of which included the state's responsibility for all key services. The aim was the equal treatment of all citizens and availability of primary services to all. The focus of the system behind the welfare state was income redistribution. The welfare state model in Finland was primarily developed by assigning more responsibilities for welfare services to the municipalities.

The welfare state model has since been reformed many times. These changes have been caused by both societal crises and ideological shifts.

In an article in 2009, Anne Birgitta Pessi and Juho Saari described the pre-

1960 period as the moral economy era, drawing on a concept from the sociologist Pertti Alasuutari. Pessi and Saari wrote that in that era the welfare state focused on older people, children and the sick, and diaconal work had an established position in work with alcoholics, criminals, disabled people and in healthcare. Only deaconesses then worked in diaconal work. The period between the 1960s and 1990 was a time of the planned economy, when the welfare state expanded into the areas of unemployment, housing, higher education and work-life balance. Simultaneously, diaconal work reduced its role in healthcare and focused on older and disabled people. From 1990, the era of the competitive society began, when both the welfare state and diaconal work expanded into working with immigrants, the excluded and people with debt problems (Pessi & Saari, 2009, p. 80).

The changes to the welfare state since the 1990s have been based on a slight shift of voters to the right. Market-based models of healthcare and social service provision and the possibilities of civil society, also known as the third sector, have gained favour. Complementary pension and health insurance systems with tax benefits, as well as to individuals' freedom to choose among various services, have been supported (Pessi & Saari, 2009, p. 79).

Deaconesses' withdrawal from the health service area occurred when the equal treatment of citizens was believed to be only possible through the provision of services by the public sector. Social justice was the key value of the planned economy. During the golden age of the construction and reinforcement of the welfare state, it was common to consider the services provided by the church and various associations charity, which had a bad reputation. These services were neither statutory nor based on any norms. Therefore, the work of the church and associations merely supplemented public services.

Before the change at the start of the 1990s, the Finnish welfare state project had driven the diaconal work of the parishes and associations into an even narrower area. The public sector removed diaconal work from the agenda one duty at a time. Correspondingly, the gradual shift in the political wind in the 1990s to market-led right-wing policies gave diaconal work a permanent, and even growing, agenda in Finnish society (Latvus, 2009, p. 73).

According to Pessi and Saari, the societal change opened up a new market niche for the church and its diaconal work as a defender of the weakest, an opening the church exploited. Diaconal work began to engage with the long-term unemployed, the over-indebted and immigrants, partly filling the gaps left by core public services. The church also took a clearer role in the media as a defender of the poor and proponent of justice. Pessi and Saari called this the new diaconal pol-

icy and the new church policy, which was also reflected in people's esteem: trust in the church grew strongly in the 1990s and after. The researchers also noticed a peculiar trait in the trend: as religious attachment to the church had constantly weakened, people had begun to see the church as a an increasingly sociopolitical actor (Pessi & Saari, 2009, pp. 81–82).

However, the attitude of government to the church's new policy has been contradictory. The church has faced many problems and challenges at the same time as its operating methods have changed, its client base has grown, and its target groups have expanded. One problem was Section 19 of the Constitution, which entered into force in 1995, which assigned the public sector responsibility for a sufficient level of social security. The church's work could not be considered part of public-sector welfare policy (Pessi & Saari, 2009, pp. 82–83). However, diaconal work has found ways to work, even though the parishes have had significant difficulties in making the transition to third-sector actors.

Emphasis on community

The third turn in diaconal work was the name given to a more societal way of working, reminiscent of social work, which was adopted during the recession of the 1990s. Following in the footsteps of experts, Jaakko Ripatti analysed in 2014 that the confrontation of the challenges of a postmodern society would lead diaconal work to a fourth turn. He saw signs of this which, however, were strongly reminiscent of competitive society: a reduced public-sector responsibility for citizens' basic security, a harsher atmosphere, the idea that the poor must earn their assistance, and the pricing of assistance. Ripatti stated pessimistically that the church and its diaconal work would be forgotten in the public space (Ripatti, 2014, p. 156).

According to Ripatti, a new development direction had been noted in diaconal work, shaped by a reinforced community responsibility, the growth of social networks, the increased role of local communities, the importance of family and other social ties, and advocacy on behalf of the excluded. There was a desire in the parishes or parts of them to be seen as communities which were concerned about helping the needy. In the observations of diaconal researchers, a sense of community was widely seen as a goal, but the parishes' worker-centric culture had, however, become so deeply rooted that it was delaying the achievement of a culture in which parishioners were agents rather than subjects (Thitz, 2013; Ripatti, 2014, pp. 156–157).

According to Ripatti, new diaconal plans emphasized a transition from office-based work to community-centric diakonia. Its focus was service-minded provision, which is what the community meant to its members and environment. He contributed to the diaconal discussion with an idea from the Seurakunta 2000 ("parish 2000") of the 1990s, rehashed: *Let the subject of diaconal work be a small parish community, a regional divine service community or an inter-regional personal community.* Parish life occurring in communities was the rule, not the exception, in Christianity. Ripatti's vision was one of a community deriving its vital force from worship and which opens up to neighbourly responsibility (Ripatti, 2014, p. 157).

The stress on community has been a significant new development vector in diaconal work and diaconal education since the 2010s. This sense of community is seen in parishioners' voluntary contributions and projects begun when many people and helping hands are available. Ripatti's vision is too idealistic to describe the general reality of Finnish Lutheran parishes, but in some situations and briefly it has corresponded to reality. (On community-centric work models and pilots in recent Finnish parish life, see e.g. Malkavaara & Valtonen, 2019.)

Professionalism

The development lines of diaconal work are quite well known. There has been considerably more research in diaconal work in recent decades. Neither the establishment of Diak in 1996 nor the foundation of the Finnish Association for Research on Diaconia (Diakonian tutkimuksen seura) in 2002 is the only reason for this. Rather, both belong to the wave in which diaconal work was recognized as part of the essence of the church and the church as a diaconal community.

Modern diaconal work began in the nineteenth century with education of deaconesses, for which special institutes were founded, containing at least dormitories, teaching hospitals and schools. It was precisely deaconesses who began to popularize diaconal work, and the deaconess's profession may be considered the cornerstone of diaconal work. It is the oldest of the specialized diaconal professions.

The new prominence of deaconesses and the emphasis on their identity are chiefly phenomena of the developments in the twenty-first century described above. They are not, however, part of the mainstream of diaconal development, which is probably one reason for the emphasis on deaconess education and professional skill.

Although deaconesses perform a fundamental diaconal profession, the discussion of deaconesses' work and its necessity is dominated by professional rather

than diaconal justifications. A deaconesses' identity would appear to be formed based on education, and the discussion emphasizes the professional skill formed in that education, skill which ought to be deployed in a wide range of roles, particularly in nursing and healthcare more widely.

Such thinking about the deaconess's identity, competence and value is strongly supported by international, particularly Anglo-Saxon, phenomena, called *parish nursing* or *spiritual nursing*. The former refers directly to nursing occurring in parish work, the latter to nursing which sees the person holistically and with spiritual needs which may be met through approaches like pastoral care. Lea Rättyä's article in the present volume discusses these areas.

Naturally, the discussion on deaconesses' identity and competence also stresses necessity. The parishes particularly value workers with nursing competence in mental health and related to older people, and there is a clear need for it. Young and working-age people's increased mental health problems, as well as older people's substance abuse and loneliness, are questions that cannot be resolved with public-sector resources alone. In clinical work, too, staff competence and capacity to encounter the patient from the perspective of spiritual needs has also been considered important. The present volume contains specialized articles about these topics.

The aforementioned justifications point to professionalism. The key frames of reference for diaconal nursing have been the professional development of welfare work and care studies. A significant emphasis on professionalism has been placed on these areas in recent decades (Henriksson & Wrede, 2004, pp. 10–15). An emphasis on professionalism is also natural in the university of applied sciences environment, which constantly stresses the profession and the significance of professional competence. In Finland, Diak alone has provided deaconess education since 1996. In turn, Diak is clearly the institute in Finland offering the largest number of places in the social work sector. Healthcare studies are also reasonably strong in numbers at Diak, but it is not one of the largest providers. Vocational healthcare education is strictly regulated, which is why the inclusion of diaconal content in nursing education has been a demanding task. In the present volume, the article by Minna Valtonen, Helena Kotisalo and Satu Kajander-Unkuri describes this. Vocational deaconess education is quite different from vocational deacon education, whereas the education of deacons and the parish coordinators for youth work is quite similar, with both receiving the equivalent of a BA in healthcare and a professional qualification.

The emphasis on deaconesses' work, professionalism and competence is therefore a very understandable process. Deaconesses' profession and particular profes-

sional quality have had to be given prominence in both parish work and in various healthcare professional contexts.

Development in the church

Although the developments in deaconess and deacon vocational education could not fail to influence the parishes' diaconal work, the main trends in the development of diaconal work have, however, gone in a totally different direction to the emphasis of professions.

In terms of theological research and the general development of Christianity, the twentieth century has been called the "century of the church". This phrase highlights the effect of the ecumenical movement, as well as an emphasis on the church, ecclesiology, the confession of the church, its sacraments, ministry and missionary task in research and interdenominational conversations (Teinonen, 1972, pp.47–48). In ecumenical affairs, developments in the unification of churches have not progressed as quickly as optimistically predicted in the early twentieth century, but theological work has been particularly significant in the area of the sacraments and the church's office (Saarinen, 1994, pp. 64–65, pp. 113–122, pp.162–178).

As a result of years or rather decades of preparation, the Faith and Order commission of the World Council of Churches issued a wide-ranging, detailed paper in 1982: "Baptism, Eucharist and Ministry". The paper is important because of both its assiduous preparation and its broad reception in the churches. Between 1982 and 1990 most churches in the world made official statements on the document (Saarinen, 1994, p. 162).

I discuss developments from this point on in my article at the start of the present volume. The discussion of the theology of office first focused on the ordination of women and then, from the late 1980s, on the diaconate, which general synod tried to bring to a conclusion in 2019, as the church was unable to reach a solution.

In its response to "Baptism, Eucharist and Ministry" in 1985, the Finnish Evangelical Lutheran Church wrote: "the questions raised by the paper, and its description of the diaconal office, present to our church a challenge to assess fundamentally the service nature and the duties of the church's ministry". According to general synod, the confessional books divided ministry into three, bishop, priest and deacon (or diaconal work), because of which it could be accepted as a "human order". Many leading Finnish theologians, most visibly Bishop of Mikkeli

Kalevi Toiviainen, have stressed that signature of the declaration meant approval of the tripartite ministry (Malkavaara, 2015, pp. 165–167). Later developments showed that general synod was unable to achieve sufficient unanimity about this interpretation.

In the development of the diaconal office (or the office of deacon), a clear direction has been its ecclesiastical nature, or its binding to the church. As late as 2015, when the church council proposed adding regulations on the new office of deacon to the Church Act and Church Order (Kirkkohallitus, 2015), the ordination practices in different dioceses were declared incongruent and confusing. In practice, this meant that the dioceses had chiefly begun only ordaining to diaconal office those with a vocation; in other words, the selection for church office was mostly being made in the parishes. Some dioceses, however, retained the old practice, inherited from the era of the sister homes, in which ordination followed education and almost all graduates of deaconess education were ordained upon graduation.

This practice has changed. Since 2016, ordination practices in the entire church have been uniform, and people are ordained to diaconal office on the basis of vocation and other ordination requirements (Piispainkokouksen pöytäkirja, 2016). In principle, people transferring to hospital work or other healthcare roles are therefore not automatically ordained. Nevertheless, they hold degrees as nurse-deaconesses issued by a university of applied sciences. The church's practices have diverged from those of education, and a deaconess's education is built more on education than vocation.

Theological investigations have stated that a third office can be recognized alongside that of bishop and priest, one which does not, however, have a strongly established set of duties. Instead, the diaconal office is the most contextually and missionally adaptive and flexible of the church's offices (Hietamäki, 2019).

Diaconal work has strongly diversified in recent years. Its core is caritative and in social work, but parish diaconal work now includes many liturgical and catechetical tasks. The biennial diaconal barometer surveys have proven the continual diversification of tasks and fragmentation of job descriptions (Kiiski, 2013; Gävert, 2016; Isomäki, Lehmusmies, Salojärvi & Wallenius, 2018).

When one adds to this the research direction arising from conceptual New Testament study by which diaconal work is not nursing or care in the first instance or even partly, the developmental directions of diaconal work compared to deaconesses' professionalism-centric self-image are even less clear. The docent Esko Ryökäs has stated that since the nineteenth century the habit has been to state that a "deacon (or deaconess) is a humble helper of his or her neighbour", whereas

from the 1990s a new "correct" interpretation appeared: "the deacon (or deaconess) is one of the assistant leaders of the parish". (Ryökäs, 2019, p. 21). This view continues to startle, as it would change a great deal were it universally adopted.

The results of the new approach to New Testament research have been adopted rather slowly and cautiously in Finland. They have chiefly been considered an academic discussion which need not have large effects on practical diaconal work. The rejection of the new, broad interpretation of diaconal work was a motive and argument used in discussions at general synod and statements by committees in 2015 to object to the proposal on diaconal office, the last occasion on which approval was sought for reform of the diaconate.

In Sweden, by contrast, the Lutheran church has adopted new research quickly and universally. Since 2014, graduation from the church's own education system has been the only avenue to diaconal work roles in Sweden. Appropriate higher education is a condition for entry to it. In 2015, a paper by the Swedish church's bishops' conference, in which the church's bishops jointly discussed diaconal work, presented the church's diaconal work fully in the light of new research, while still retaining the caritative and social dimension, that is nursing and care, in connection with diaconal work (Ett biskopsbrev om diakoni, 2015).

Even the Finnish conceptual history of diaconal work shows that it has long been understood as broader than nursing and social care. At present, there is tension between the broadening and diversification of the diaconal work done in the parishes and the clear boundaries of the professions set by the degree programmes.

Although the parishes view matters in terms of practical feasibility and necessity in general, it is difficult to anticipate the development at the entire church level in the near future taking a different direction to the general one prevailing in recent decades. From the perspective of a theological mindset, the church is primarily interested in ministry and ordination, not professions, education or skills.

Predictions and possible developments

The declining membership of the Finnish Evangelical Lutheran Church inevitably creates the assumption that the number of workers will also decline. Duties in the parishes must be reorganized. The division of labour among a shrinking workforce must in general terms be reformed either to have specialized duties performed over wider areas, or by merging job descriptions to give individual workers responsibility for duties in several areas. The latter scenario would naturally and without burdensome definitions produce the kind of parish work model envisaged in di-

aconal conceptual analysis as matching the early church's manner of understanding diaconal work. That was also the aim of the 2015 diaconal office proposal.

All in all, there is reason to ask whether the field of diaconal tasks will expand, and whether the content significance of diaconal work will grow further. Both are likely developments. The tasks of parish diaconal work could extend so far as gradually to produce diaconal thinking or the expansion of the content of the diaconal concept.

If development thus proceeds, it could have two main avenues. The first is the understanding of diaconal work as contextual, that is situation-dependent, easily subject to shifts in focus, and a flexible ecclesiastical service. In that case, it would correspond to the definition under which diaconal work does not have a well-established field of duties, with diaconal office rather being contextually and missionally adaptive and flexible, and diaconal work being understandable as a service in a very diverse fashion. The old Finnish definition of diaconal work, as assistance of those in the greatest need and who are not helped in other ways, would in such a case cover only part of the field of duties of diaconal work. It would instead speak of the priorities of Christian neighbourly love.

The other avenue of the substantive expansion of diaconal thinking could be the understanding of diaconal work as doing good and defence of justice, as well as the defence of those in difficulties and distress regardless of faith. In this case, diaconal work would seek its content in the broadest possible definitions, such as the Swedish author Erik Blennberger's idea that diaconal work is all works aimed at the good throughout history, and all helping is understood as spiritual, as Antti Elenius has proposed based on Luther's theology. This would also open the closed circuit of diaconal work to other helping work occurring in society (Blennberger, 1989 and, 2002; Henttonen, 1997 130–133; Ryökäs, 2006, pp. 25–26; Elenius, 2007, pp. 162–165). However, the problem remains of the difficulty of the concept of diaconal work, as it links Christian neighbourly love too clearly to one professional group, diaconal workers. Elenius and Latvus have proposed speaking of the theology of helping instead of diaconal theology as a solution (Elenius & Latvus, 2007, pp. 275–276).

The expansion of the concept of diaconal work would barely solve anything in this case; at most it would lead to its no longer being used. Bearing social responsibility for people and society, that is, organized neighbourly love, is in any event part of the church's basic task (Elenius & Latvus, 2007, p. 281).

Diaconal nursing occurring as work in society outside the parishes falls under the latter scenario of expansion of diaconal thought, as it falls outside the church's

diaconal office. The main problems of diaconal nursing are thus connected with the understanding of the diaconal content, as well as the development of the diaconal office in the church. An entirely different matter in the expansion of diaconal work is if service being done in society could also be an approved element of the diaconal ordained office when the service is recognized as diaconal, or the ordinand participates in the church's work in an otherwise acceptable way as a representative of the diaconal office.

According to a recommendation issued by the bishops' conference in May 2016, there is no formal barrier to this. Thus: "a person who has been called to discharge diaconal duties (Church Order 4:3 §) in the service of a parish, Christian association, the state, a municipality, foundation, private association or other community, and who specifically participates in an acceptable way for the deliverance of the church's task (Church Act 4:1 §) may also be ordained".

These have not entirely remained mere words on paper. The Diocese of Oulu, at least, has based on this recommendation been able to make diaconal ordination specifically voluntary, without employment by the parish (Rauhan Tervehdys 29.5.2019). If the parishes are less able to pay wages, this is potentially also the model of the future elsewhere. The conversation will also undoubtedly expand to include the church's approval of work outside the immediate church environment, primarily care of mental and spiritual distress in clinical nursing, as a vocation.

The church's understanding of a parish has from the early Middle Ages been territorial. A bishop was once the leader of a parish. When the number of parishes grew, the episcopal office was placed in cities, and the bishop monitored and led the operations of the adjacent parishes. A parish continues to be thought of as a geographical unit in the church. This kind of parish model is known as "parochial". However, the reality of the parish is also partly "congregational", meaning it has a sense of community not necessarily based in a place. A single large modern parish can be the site of many communities which are like parishes, even if they are not so called. Large regional parishes and the "little parishes" functioning in them ought to have different names.

As the diversification of parish life is recognized, the current diversification and broadening of duties necessary in parishes should also be recognized. This would give new opportunities to the deaconesses among the nurse-deaconesses recognized and authorized by the church performing the duties of ordained office, which could be of a diverse nature, perhaps even also part-time and voluntary.

Diaconal work means service, and as such it may also be understood as an attitude. Diaconal work is thus the task of the entire parish and all Christians, which

is why graduate nurse-deaconesses are a cause for joy, as they can serve in hospitals and other healthcare settings in their roles.

If diaconal work is thought of broadly in accordance with the research avenue created by Collins, service is any service, nor is it limited to nursing and care. In that case, it may be thought that the church has a mission, a greater task, which is divided into various parts, diaconal work. The content of the concept of diaconal work is thus something completely different to the customary thought of more than the last 150 years.

On the other hand, if diaconal nursing separates from the Christian conceptual world and seeks its identity from the world of broadly interpreted spirituality and spiritual nursing, it may proceed and develop in that direction, as has been seen in recent decades.

We may assume that the field of diaconal duties and their content will expand. At present they are expanding in several directions. A silent conversation is being conducted between them; nor are clear mutual links evident.

Sources and literature

Blennberger, E. (1989). Diakoni och dess teologi. In H.-E. Lindström (Ed.), *Handbok för diakoni och samhällansvar* (pp. 40–57). Verbum.

Blennberger, E. (2002). Diakonia ja diakonian teologia. In M. Lahtinen, & T. Toikkanen (Eds.), *Anno Domini 2002. Diakoniatieteen vuosikirja* (pp. 165–178). Lahden Diakoniasäätiö.

Ett biskopsbrev om diakoni. Biskopsmötet 2015 (2015). Svenska kyrkan, Biskopsmötet.

Elenius, A. (2007). Avaran diakonian puolustus. In K. Latvus, & A. Elenius (Eds.), *Auttamisen teologia* (pp. 158–176). Kirjapaja.

Elenius, A., & Latvus, K. (2007). Diakonian teologia – auttamisen teologia. In K. Latvus, & A. Elenius (Eds.), *Auttamisen teologia* (pp. 271–282). Kirjapaja.

Erkamo, P. (1969). *Vuosisata diakoniaa Viipurissa ja Lahdessa. Viipurin–Lahden Diakonissalaitos 1869–1969*. Lahden Diakonissalaitoksen Säätiö.

Gävert, T. (2016). *Diakoniabarometri 2016*. Kirkon tutkimuskeskus. https://evl.fi/documents/1327140/45386794/Diakoniabarometri+2016_netti.pdf/1e030b26-9f43-ebf6-251e-dc857859a11f

Henriksson, L. (1998). *Naisten terveystyö ja ammatillistumisen politiikka* [Doctoral Dissertation, University of Tampere]. (Tutkimuksia 88.) Stakes.

Henriksson, L., & Wrede, S. (Eds.). (2004). *Hyvinvointityön ammatit.* Gaudeamus.

Henttonen, K. (1997). *Voiko sen tehdä toisinkin? Diakoniatieteen lähtökohdat ja valinnat*. Lahden ammattikorkeakoulu.

Hietamäki, M. (2019). *Selvitys diakonian viran uudistusprosessin tilasta 2019. Raportti kirkkohallitukselle*. Kirkkohallitus.

Hiilamo, H., Raunio A., & Yeung, A. B. (2007). Lähimmäinen hyvinvointivaltiossa. In J. Saari, & A. B. Yeung (Eds.), *Oikeudenmukaisuus hyvinvointivaltiossa* (pp. 220–236). Gaudeamus.

Isomäki, P., Lehmusmies, J., Salojärvi, P., & Wallenius, V. (2018). *Diakoniabarometri 2018. Yksinäisyyden monet kasvot*. Kirkon tutkimuskeskus. https://www.dtl.fi/media/diakoniabarometri_2018.pdf

Jääskeläinen, I. (2008). Sisar- ja veljesyhteisöistä avoimiin oppimisympäristöihin – Diakoniatyöntekijäkoulutuksen vaiheet Suomessa. In S. Korpela (Ed.) *Rakkauden virassa. Diakonian ammattilaisten viisi vuosikymmentä* (pp. 81–96). Minerva.

Kansanaho, E. (1964). *Suomen Kirkon Sisälähetysseuran historia. Sortavalan aika 1905–1944*. Suomen Kirkon Sisälähetysseura.

Kansanaho, E. (1967). *Sata vuotta kristillistä palvelutyötä. Helsingin Diakonissalaitos 1867–1967*. Wsoy.

Kauppinen-Perttula, U.-M. (2004). *Kutsumus, palvelustyö, jaksaminen : sisaret Oriveden leprasairaalassa (1904-1953)* [Doctoral Dissertation. University of Tampere]. (Acta electronica Universitatis Tamperensis 355). Tampereen yliopisto. http://www.urn.fi/urn:isbn:951-44-5995-4

Kiiski, J. (2013). *Diakoniatyöntekijä – rinnallakulkija ja kaatopaikka. Diakoniabarometri 2013*. Kirkon tutkimuskeskus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/1588

Kinnunen K. (2009) (Ed.), *Sairas köyhyys, tutkimus sairauteen liittyvästä huono-osaisuudesta diakoniatyössä*. (Suomen ev.lut. kirkon kirkkohallituksen julkaisuja 2009:7.) Kirkkohallitus.

Kirkkohallituksen esitys (2015). Kirkkohallituksen esitys kirkolliskokoukselle. Asianro 2015-00012. Uutta diakonivirkaa koskevien säännösten lisääminen kirkkolakiin ja kirkkojärjestykseen. http://kappeli.evl.fi/kkoweb.nsf/8055b7c73c38f56dc22571540045bfe2/e271961250ebcea1c2257ddc00451c90?OpenDocument.

Kotisalo, H., & Rättyä, L. (2014) *Diakonissat terveyden edistäjinä. Raportti tutkimus- ja kehittämishankkeesta (1.3.2011–28.2.2014) Terve sielu terveessä ruumiissa – diakonissat terveyden edistämisen toimijoina.* (Diakonia-ammattikorkeakoulun julkaisuja. B, Raportteja, 58.) Diakonia-ammat-

tikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-220-0

Kuivalainen, S., & Niemelä, M. (2009). Universalismista selektivismiin? – Miten köyhyyspolitiikka vakiintui 1990- ja 2000-luvun alun Suomessa? In J. Kananen, & J. Saari (Eds.) *Ajatuksen voima – Ideat hyvinvointivaltion uudistamisessa* (pp. 187–218). Jyväskylä: SoPhi/Minerva,

Latvus, K. (2009). Diakonian tutkimus vuonna 2009. *Diakonian tutkimus*, (2), 71–75. https://journal.fi/dt/issue/view/7863/1310

Malkavaara, M. (2002). Sodasta laman kynnykselle – Köyhyys ja diakonia hyvinvointivaltiota rakennettaessa. In V. Mäkinen, (Ed.), *Lasaruksesta leipäjonoihin – Köyhyys kirkon kysymyksenä* (pp. 221–261). Atena.

Malkavaara, M. (2015). *Diakonia ja diakonivirka.* Suomen ev.lut. kirkon julkaisuja 26. Kirkko ja toiminta. Kirkkohallitus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/4215

Malkavaara, M., & Valtonen, M. (Eds.). (2019). *Uusi elämisen kulttuuri – muutos Tampereella.* (Kirkon tutkimuskeskuksen verkkojulkaisuja 61). Kirkon tutkimuskeskus. https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/4215

Myllylä, M. (2004) *Diakonisen hoitotyön mallin rakentaminen.* (Doctoral dissertation, University of Oulu. http://urn.fi/urn:isbn:9514273567

Paaskoski, J. (2017). *Ihmisen arvo. Helsingin Diakonissalaitos 150 vuotta*. Edita.

Pessi, A. B., & Saari, J. (2009). Kollektiiviset muistot ja hyvinvointipolitiikan tulevaisuus – hyvinvointivaltion ja diakoniatyön muuttuvat suhteet ja tulkinnat. *Diakonian tutkimus*, (2), 77–96. https://journal.fi/dt/issue/view/7863/1310

Piispainkokous. (24.5.2016). Piispainkokouksen pöytäkirja 24.5.2016 § 5. Suositus diakonian virkaan vihkimisestä. http://domus.evl.fi/ktwebscr/pk_asil_tweb.htm?bid=2112

Pyykkö, R. (2004). Valtion ja kirkon välissä: ammatillisen seurakuntadiakonian muotoutuminen. In L. Henriksson, & S. Wrede (Eds.), *Hyvinvointityön ammatit*. Gaudeamus.

Karhu, E. (2019, May 29). Diakoniatyötä voi tehdä kaikkialla. *Rauhantervehdys.* https://rauhantervehdys.fi/2019/05/diakoniatyota-voi-tehda-kaikkialla/

Ripatti, J. (2014). Diakonian neljäs käänne. *Diakonian tutkimus*, (2), 155–157. https://journal.fi/dt/issue/view/7863/1303

Ryökäs, E. (2006). *Kokonaisdiakonia. Diakoniakäsityksien opilliset liittymät.* (Diakonia-ammattikorkeakoulu. (Diakonia-ammattikorkeakoulun julkaisuja, A, Tutkimuksia, 14). Diakonia-ammattikorkeakoulu.

Ryökäs, E. (2019). *Aikaan sidottu diakonia-käsite. Tiedekriittinen yritys ymmärtää suomalaista diakoniakeskustelua*. Suomalainen Teologinen Kirjallisuusseura.

Saarinen, R. (1994). *Johdatus ekumeniikkaan.* Kirjaneliö.

Salmesvuori, P. (2008). Sisarliitosta Diakoniatyöntekijöiden Liitoksi – 50 vuotta liiton historiaa. In S. Korpela (Ed.), *Rakkauden virassa. Diakonian ammattilaisten viisi vuosikymmentä* (pp. 11–78.) Minerva.

Teinonen, S. (1972). *Uudistuva kirkko. Johdatus ekumeniaan.* Kirjaneliö.

Thitz, P. (2013). *Seurakunta osallisuuden yhteisönä*. Diakonia-ammattikorkeakoulu [Doctoral dissertation, University of East Finland]. (Diakonia-ammattikorkeakoulun julkaisuja. A, Tutkimuksia, 40). http://urn.fi/URN:ISBN:978-952-493-214-1.

Vikström, John (1970): Diakonia ja diakonian virka teologian näkökulmasta. In P. I. Hissa (Ed.), *Diakonia ja muuttuva yhteiskunta*. Kirkon diakoniatoimikunta.

Lea Rättyä, Päivi Thitz and Minna Valtonen

15 VIEWS ON THE FUTURE OF DIACONAL NURSING

There is insufficient awareness about the diverse competence earned in the dual nurse-deaconess degree. The opportunities of this broad-based expertise therefore remain partly unrealized, both in the church and in healthcare. A barrier to the use of this expertise in parish work may be an excessively narrow understanding of nurses' competence, while in nursing, there may be biases against the Christian content of the degree. However, the encounter, sharing of hope, and holistic health promotion all based on neighbourly love at the core of diaconal nursing would appear to be increasingly significant skills in the future.

Identification and recognition of diaconal nursing competence

The concept of diaconal nursing has been used for about forty years. Although the roots of Finnish nurse-deaconess education and the field of their duties was visible in the late nineteenth century, the conceptual definition of the work is only now acquiring greater definition. This book has attempted to provide materials for the analysis of the premises, specialist skills and practical working methods of diaconal nursing. This final article reflects on the significance of diaconal nursing competence and the opportunities for using it in a changing society.

When examining a nurse-deaconess's competence, it is important to observe that nursing and diaconal competence are not areas totally separate from each other. They overlap with each other and combine to build holistic diaconal nursing expertise. The knowledge basis, skills and experience in the sector, as well as personal professional development paths, form rounded competence and a professional identity. In addition to the accrual of knowledge and skills, it is important for students to grow as people, which is then expressed in professional values, attitudes, motivation and commitment.

It is important for diaconal nursing professionals themselves to recognize the

dimensions of their broad competence and be able to verbalize their specialist skills so all the aspects of their competence can be seen and recognized when they evaluate their career needs or are recruited by employers.

The identification and recognition of diaconal nursing expertise in healthcare settings may be hindered by a lack of knowledge about the content and principles of diaconal nursing, as well as biases about Christian education. The diaconal nursing qualification and skills do not have the same status as other healthcare qualifications such as those for a diabetes or wound nurse.

Of the articles in the present volume, that by Elina Turunen and Tiina Ervelius incisively reveals the thoughts and experiences of nurses working in hospitals on diaconal nursing expertise. Nurse-deaconesses could, for example, spend some working time on promoting and developing spiritual health and welfare. They could also focus in their work on encountering patients' friends and family, considering the entire situation of and coordinating services for vulnerable patient and client groups, promoting successful discharge from hospital or institutions, reinforcing community spirit, and on the conversation on ethics and values in the workplace.

In some cases, an excellent solution could be the hospital chaplain working permanently in a team with a nurse-deaconess employed by the hospital. In the ecclesiastical conversation, the parish is mostly thought of as a local parish with a known geographical area. A report by the church council examining the knowledge and competence of missiology presented the idea that the parish was where its members or people in general were: in hospitals, schools and workplaces (Kirkkohallitus, 2018). Could it be possible to think of the parish being where the nurse-deaconess works?

The era of the Covid-19 pandemic has shown that communities of worship can gather people across parish boundaries and that virtual communities can bear the hallmarks of parishes. Parishes are diversifying, and nurse-deaconesses' work done in hospitals and other healthcare units can therefore in many ways be understood as diaconal work authorized by the church.

One scenario could be the adoption of the view that clinical nursing is also the site for the care of mental and spiritual distress or specialized faith-related tasks that belong to the ordained diaconal office. This would require dialogue and recognition of the broad-based nature of competence between the church and society.

Deaconesses do not necessarily have sufficient opportunities for fully exploiting their competence in nursing roles, but the same kind of situation could also arise when a deaconess with a nursing degree works in a parish's diaconal work. More

discussion and research are needed on what diaconia is in a hospital, and what nursing is in a parish. The articles in the present volume present the view that a deaconess helps and works with a diaconal approach, regardless of the operating or working environment.

From the perspective of parish diaconal work, placing the spotlight on diaconal nursing and speaking about the significance of diaconal nursing may be sensitive subjects. Deacons and deaconesses have different educational backgrounds, but the content of their work is largely the same. The question must indeed be asked of the extent to which diaconal work experts can fully exploit their competence in parish work. In her article in the present volume, Eila Sainio writes that nursing competence also has an important significance in parish work. Graduates of deaconess degrees have a strong professional identity.

One barrier in parish work to the full use of deaconesses' broad competence may be a lack of knowledge among church decision makers of the multidimensional nature of deaconesses' competence and the significance of the holistic promotion of human welfare and health. The skills taught in nursing degrees may be seen as too narrow from the perspective of treatment, even though clinical nursing is but one area of a nurse's education. Further, the church's task of encountering people may be thought of as relating only to spiritual questions; however, diaconal work encounters a person holistically and is based on his or her needs. It is professionally tough if deaconesses need to defend and justify the significance of their own competence to gain the opportunities to deploy it in diverse ways.

Spirituality as part of quality nursing and respectful encountering of people

In the nursing field, the traditional Finnish thinking of faith as a private matter needs to be disrupted. The understanding of spirituality, both spiritually and mentally, could help this change in attitudes. Even a person without religion may be spiritual and need support with pondering the meaning and significance of life. The cultural and religious backgrounds and religious questions encountered in hospitals are increasingly diverse. The skill of religious literacy is therefore needed. Many other countries have made more advanced progress in encountering these matters than in Finland.

In recent years, the international discussion of the integration of spirituality as a natural part of healthcare has grown. As healthcare and social services strive for more seamless integration, they should also consider the perspective of clients'

or patients' spiritual needs. In a nursing setting, this could mean the systematic analysis of a person's mental and spiritual needs and harmonized rights to spiritual care for everyone who needs it (Karvinen, 2018).

The consideration of mental and spiritual questions in nursing is part of ethically good patient care. Mental and spiritual matters are often intertwined with life's other questions; nor do they necessarily present themselves on the first encounters. They may come to the fore gradually as trust is built during various nursing encounters. The worker must therefore have the spiritual sensitivity to identify, and the courage to respond to, a person's spiritual needs.

Spiritual health and welfare bolster overall welfare, particularly during changes in life. They support coping and facilitate adjustment, while also providing security, balance, hope and succour. Spirituality may be significant in strengthening a patient's resilience.

Responding to a patient's mental and spiritual support needs may include presence and listening, or dialogue and comforting with the inclusion of faith elements. In her article, Virpi Sipola presented tangible models for the support of belief. Crucially, the patient and his or her needs must be the premise for mental and spiritual care and consideration of the patient's own beliefs. A nurse must therefore be capable of supporting a patient, regardless of personal beliefs.

Several articles in the present volume describe spirituality and spiritual helping methods as the key content in diaconal nursing. Nurse-deaconesses' specialized competence in spiritual care is seen as knowledge of faith matters and an ability to encounter various worldviews, and questions of God and unseen reality. It is the courage to remain alongside, to be present in difficult situations, and to discuss death and the limited nature of life. Sometimes, the ability to pause next to a person merely to be quietly present is also needed.

The spirituality in diaconal nursing is delicate and respectful of others' beliefs. It does not involve forcing religion on people or showing off with theological concepts. It may be of an everyday nature, contextual, occurring with and alongside people, and often more concerned with asking questions than knowing on behalf of someone else. The principles of spiritual safety guiding church workers stress sensitive encounter which should avoid all kinds of speech that could sound like rejection, judgement or exclusion (Turvallinen seurakunta, 2018).

Personal belief and vocation as part of professional development

The professional helping work done in diaconal nursing is governed by regulations and instructions, but the worker's own personal values and belief also operate in the background. The motive for entering the nursing and diaconal profession is often the desire to help and the need to do significant work. Among many deaconess graduates, the attraction to neighbourliness and diaconal thinking began in childhood with the observation of their parents' activities, rebellion against perceived injustices, or defence of the weak. Few entrants to nursing or diaconal work come to the professional by complete happenstance. More frequently, training for the profession and career progress are seen as a vocation and Providence (Rättyä, 2010; 2016).

However, not all student deaconesses are necessarily clearly motivated to work in the church, meaning the search for their own place may cause pain and conflicting emotions. Students may question whether they are spiritual enough, or whether their religious conviction is acceptable. They may be confused by how contradictory the church's operations seem in media coverage. They may also question their motivation and commitment to church work.

A vocation can be built in many ways and gradually as part of professional development. Professional interest, following a vocation and career progress do not necessarily lead straightforwardly to working either with the church or in nursing. People may move between the two sectors in both directions, both while studying and later during their careers.

A trust in Providence may provide the feeling that one may be and work in one's own place. A vocation, for its part, may help orientation towards the sector, coping in it, and renewed motivation for the work. A person may serve in work in the place to which vocation has led. A vocation and Providence may support a worker in particularly difficult and challenging duties. They may provide calm for various encounters and the courage to take on work outside one's own comfort zone. Personal faith and spiritual life may be a significant resource for coping at work.

Deaconesses' expertise in the service of the future

The articles by Mikko Malkavaara, Minna Valtonen, Helena Kotisalo and Satu Kajander-Unkuri describe how both deaconesses' work and the education for it have been in constant dialogue throughout history with social reality and the changing needs for change in working life. When the first institute training deaconesses was founded in Finland more than 150 years ago, the country was beleaguered by famine and the resulting epidemics and social problems. The deaconesses it prepared were equipped to respond to human distress. They worked in hospitals and homes, and especially to improve the conditions of the most vulnerable (Helsingin Diakonissalaitos, 1929, pp. 19–26).

The nurse-deaconess degree arms graduates for working in emergencies, helping in crises and catastrophes, as well as encountering serious illness and death. Depending on the situation, the conditions for contextual and flexible helping are met with this kind of work approach.

The present discussions of the visions for Finnish higher education emphasize that the task of vocational higher education is to respond to the needs of working life and to social change. Professionals are required to be able to encounter not only constant changes, but also to search for new solutions. Situations in professional life may change rapidly and unpredictably, as the Covid-19 pandemic has shown.

Throughout its history, the education of deaconesses in Finland has equipped graduates to encounter change and search for solutions which support human welfare. The diaconal approach considers the most vulnerable, promotes humanity, mercy and hope, and proceeds boldly towards the unknown. At the same time as society and the church are developing new digital applications to encounter people and support helping, thought is also being given to those with insufficient digital skills or without digital tools.

According to the results of a forecasting survey conducted by the Ministry of Education and Culture, the most important skill needs in the next fifteen years will include: multiculturalism and tolerance; cooperation; interaction, public relations and dialogue; client-centric service development; ethics; emotional intelligence; and knowledge of the principles of sustainable development (Opetushallitus. Palvelut. Tietopalvelut. Ennakointi. Ennakointituloksia). All these topics are included in the current deaconess degree curriculum. Because some of the studies transcend disciplinary boundaries and are grounded in working life,

they give a strong grounding for working at intersectoral interfaces and engaging with networking, partnerships and stakeholders. Such competence also emerged in the results of the forecasting survey.

Both the nurse-deaconess degree and any personal belief in the background reinforce the workers' spiritual sensitivity. It helps the person see deeper meanings and be open to questions of spirituality, religion and the meaning of life. Even when spiritual questions are not discussed, being helped can mean experiencing God's presence, blessing and the significance of life.

According to Professor Arto O. Salonen (2020), the next challenge to be faced by Finnish society is finding a life with a purpose. Instead of the pursuit of wealth, a meaningful life becomes central, one in which everyone can feel valuable and significant. Diaconal encounter aims for the person to be seen and heard — to be loved. Such encounter can even create the experience of having meaning when a person is wounded and fragile.

Sources and literature

Helsingin Diakonissalaitos. (1929). *Sisarillemme. Helsingin diakonissalaitoksesta*.

Karvinen, I. (2018, December 13). Hengellisen hoitotyön kehittäminen liikkeessä. *Diakonia+*. https://www.diakoniaplus.fi/hengellisen-hoitotyon-kehittaminen-liikkeessa/

Kirkkohallitus (2018). Kirkkohallitus. *Kaikkialta kaikkialle – kirkon missio nyt. Missiologian tuntemus ja osaaminen kirkon työssä.* https://julkaisut.evl.fi/catalog/Tutkimukset%20ja%20julkaisut/r/1486

Opetushallitus. Palvelut. Tietopalvelut. Ennakointi. Ennakointituloksia. Retrieved May 22, 2020, from https://www.oph.fi/fi/palvelut/ennakointituloksia

Rättyä, L. (2010) *Diakoniatyöntekijöiden kuvauksia työstään ja siinä jaksamisestaan*. [Licentiate Thesis, University of Oulu]. (Diakonia-ammattikorkeakoulun julkaisuja. A Tutkimuksia, 24). Diakonia-ammattikorkeakoulu. https://urn.fi/URN:ISBN:978-952-493-083-3

Rättyä, L. (2016). *Diakonisen spiritualiteetin tiellä. Diakoniatyöntekijöiden ja pappien käsitykset spiritualiteetin muotoutumisesta, sisällöstä ja yhteydestä diakoniaan Oulun hiippakunnassa* [Master Thesis, University of Helsinki].

Salonen, A. (2020, May 14). Suomalaiset heräsimme kysymään, miksi elämme – vaurauden tavoittelu on kääntynyt ihmistä vastaan, väittää professori Arto O. Salonen. *Kirkko ja kaupunki.* https://www.kirkkojakaupunki.fi/-/vaurauden-tavoittelu-on-kaantynyt-ihmista-vastaan-vaittaa-professori-arto-o-salonen-#40329bad

Turvallinen seurakunta (2018). Suomen evankelis-luterilaisen kirkon julkaisuja. https://evl.fi/plus/seurakuntaelama/kasvatus/turvallinen-seurakunta

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DIAKONIA-AMMATTIKORKEAKOULU
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DIACONAL NURSING holistically promotes health and welfare, while bolstering hope and a person's resources. This publication describes the theory of diaconal nursing and the practice of Finnish diaconal nursing in healthcare and the church's work. It is intended for both student and professional readers.

The book covers the history, definition of concepts, education and various career paths of diaconal nursing, proceeding to a practical description of diaconal nursing and the environments and encounters in which diaconal work is performed.

The authors consider the dual qualification provided by nurse-deaconess education: its meaning; the opportunities it affords graduates; and future prospects. How is diaconal nursing competence identified and recognized? How can this competence be used in healthcare and parishes in the best possible way? This publication seeks answers to those questions.

The book's authors are Finnish specialists in diaconal work, and particularly diaconal nursing, in the Evangelical Lutheran Church, parishes, society, nursing and education.

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