

WHAT DO PEOPLE TALK TO CHAPLAINS ABOUT?

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Abstract: An inpatient stay in an acute hospital setting often causes distress, confusion and in many cases the desire to explore existential issues. For health care chaplains there is no debate about the efficacy of the role they play in these existential explorations however there is an increasing need to provide evidence-based research to verify this. As a profession chaplaincy is well versed in anecdote but it needs to move beyond that to evidence of a more robust kind. This research project was an in-depth review of the dialogues held with thirty-four different adults in an acute hospital over a period of three months in 2007 to determine what people talk to chaplains about. The project involved 12 different chaplains having an encounter with a patient and then writing it up as a verbatim. At the same time a literature search was carried out to determine any other research projects of a similar nature. The texts of the encounters were analysed by two chaplains independently – they determined themes raised in the discussions and manually scored these according to the frequency of their occurrence. Results were then compared and areas of discrepancy discussed. Qualitative software was used to verify the findings. The results showed that conversations appeared to fit into four main topics: spiritual themes; life stories; hospital experiences and emotional expression.

Keywords: chaplaincy, spiritual care, efficacy, verbatim, spiritual conversations, hospital experiences, life stories, emotional language

Introduction

Chaplains in the NHS - Caring for the spirit

Chaplains in acute health care are employed by the NHS to care for the religious and spiritual needs of all those using the hospital whether patients, families or staff. Their contacts come in a variety of ways through specific requests for visits, through casual meetings on the ward or in the corridors or from the records obtained from hospital admission databases. However they are initiated, the conversations appear to be relevant and productive for those involved in them (1).

In chaplaincy encounters the set 'agenda' for any discussion is that of the person receiving the visit which means one can never determine the direction of a conversation. It had seemed to the team involved in this research that there were some themes that repeated over again in their encounters. Before the research began chaplains on the team thought

that issues around loss were probably the most spoken about in their pastoral visits. They thought most patients appreciated the time to tell 'their story' and to express any concerns or emotions about their current situation and to explore spiritual issues.

The work of chaplaincy in an acute setting can be classified as providing pastoral visits where time is spent initially in general conversation before proceeding to deeper levels. The deeper conversations have sometimes been named as pastoral counselling. The aim of such conversations is to help the patient make sense of what is going on in relation to themselves and their understanding of the world and to find sources of hope and strength. The confusion around pastoral care and counselling has been helpfully delineated by Lynch (1999) and chaplains would argue for the fluid nature of pastoral care that best suits chaplaincy in the acute setting.

Clinical Governance

As NHS employees, chaplains are subject to all that is expected of NHS staff and that includes clinical

governance. This means that just thinking the needs of patients are being met is not good enough – services are intended to be audited, researched and reviewed continuously.

Ten years ago some work in Leeds, replicated in Cambridge (Fraser 2006) and copied in Sheffield, identified staff and patient perceptions about chaplaincy.

Mowatt produced a descriptive piece entitled, “What do chaplains do?” based on chaplains’ self-reporting. Its summary concluded,

“The data suggest that the core task for chaplaincy involves an active process of finding people who need spiritual care, identifying the nature of the need and responding to the need through theological reflection and the sharing of spiritual practices. This core process is achieved in a variety of ways. These methods of meeting need throw up challenges around the idea of offering a needs led service.” (Mowatt and Swinton, 2005)

In her research into the efficacy of healthcare chaplaincy Mowatt (2008; 20) states:

‘During the 1990’s the concept of evidence based medicine and practice evolved... The problem for healthcare chaplaincy and spiritual care is that outcomes may not:

- a) be visible
- b) be measurable
- c) be available in the timescale of the “typical” research project
- d) be agreed by all parties
- e) be static over time’ (Mowatt, 2008)

She discovered that chaplains, particularly in the acute setting, have not been particularly proactive in auditing, researching and revising their services and, although she admits that measuring spiritual outcomes could be problematic, she suggests that chaplains should at least attempt to measure the efficacy of what they are doing, of what kind of service they are providing in order to give evidence to promote the continued provision of chaplaincy services in healthcare settings.

There is a considerable lack of clarity about roles and models of chaplaincy. Some literature has

highlighted the lack of clarity among chaplains as to their role and this has yet to be addressed. Practitioners anecdotally and theoreticians traditionally have suggested the task is one of accompanying people through times of transition and difficulty. Wilson (1971) describes the chaplain as one who “explores the dangerous territory of man’s making and breaking”. Macritchie (1999) in his model of chaplain as translator describes the chaplain as occupying the “uncomfortable space between” with the task of the chaplain as being alongside “those in translation”.

These studies provide a backdrop for this study in that these are the general areas covered. The opportunity to examine in detail the patient-chaplain encounter was available by means of verbatim reporting. In placing those who use chaplaincy services at the centre of that provision, seeking to understand more of what is currently taking place seemed vital. The opportunity to analyse such recorded encounters would enable practice and pastoral education to be refined.

Therefore it was with these concerns at the forefront that this research project began – that of placing those who use chaplaincy services at the centre of that provision and endeavouring to enhance what is offered by understanding more of what is currently taking place and revising it accordingly.

The research project

There is considerable confusion about how to classify what chaplains do when they interact with patients - is it pastoral care or is it counselling?

Showing empathy and unconditional positive regard enable the quick development of trust. Skills associated with active listening allow the patient to tell their story and engage in conversation. Wolfe (2003) suggests, “through conversation we turn around our ideas and experiences with each other... and we thereby also review those ideas and experiences... conversation provides us with one way in which either to revisit our experience or to entertain possibilities of future experiences”.

It is significant that Swinton and Mowatt (2005) suggest that, “Chaplaincy is arguably one of the few roles within the hospital that could truly be needed.”

It is important to stress that we are not suggesting that medical and clinical staff are incapable of listening. It is, however, to acknowledge that by explaining treatment options or procedures they have an input into the patient narrative. In contrast the chaplain does not have that direct input but rather responds to the need of the patient as the patient themselves present it. It is argued that a chaplain is one of the few staff to whom the patient is able to tell their story of what is happening. But how do you study those interactions?

Methodology

Verbatim of patient conversations

It is the practice in this chaplaincy team that all encounters with patients are recorded and some are written up for the purposes of pastoral education. This is through either writing a case-study or by recording a verbatim account of a conversation held (all anonymised). These are then used for group reflection (pastoral reflective practice) to inform and enhance practice in a similar way to the reflective cycle designed by Gibbs, G. (1988) but incorporating theological reflection as part of the process.

During the period of the research the chaplaincy department had a number of student and trainee chaplains. These people were not aware that the verbatim of their patient encounters would form the basis of a project to determine what patients talk to chaplains - in order to eliminate any potential (deliberate or subconscious) to bias the conversations. Their consent to use such material was sought.

The verbatim accounts were collected over a three month period in 2007 and thirty-four discussions were analysed by two chaplains. The patient encounters came from random sources - either patient, family or staff requests for a visit, from a list generated by the hospital admission system which indicates a person's faith group or by simply being on a ward and striking up a conversation.

Analysis methodology

The two experienced chaplains analysed the texts separately then discussed their findings with regard to theme. They allocated the conversations to one of the themes as being the one **most discussed** since most encounters included most, if not all, of the themes. Their separately recorded results were then reviewed. Some of the encounters fitted equally into two or more separate themes and so these were recorded as being equally weighted. Following the human analysis of the texts they were analysed using NVIVO.

Analysis of data

The texts were examined in minute detail with fifty-seven initial different categories of conversation itemised. These fifty seven categories were then seen to fit into four main areas of discussion topic –

Spiritual themes/exploration
hospital experiences
life stories
emotional language

In 28 of the 34 (82%) verbatim texts the two chaplains had placed the conversation under the same category – after discussion about the 6 remaining texts these were also placed in the same group/s. It was impossible to determine with 5 (15%) of the texts one particular theme so these were placed in two or more topic groups as indicated on the chart below.

NVIVO software was also used to analyse the texts. The software is reliant upon input from the researchers – i.e. words to search for. A coding summary report was produced for each verbatim giving percentage coverage of words inputted for each of the topic areas. In 68% of cases NVIVO agreed with the category chosen by the two chaplains as being the most spoken about in a conversation.

Table 1: Analysis of Conversations with Chaplains

Text No	Spiritual	Life Story	Hospital	Emotional	NVIVO	1+ topics
1	yes				y	
2		yes			y	
3	yes				y	
4			yes		y	
5			Yes	yes	y	2
6	yes				n	
7	yes	yes			n	2
8				yes	y	
9	yes				n	
10		yes			n	
11		yes			n	
12			Yes		y	
13	yes				y	
14			Yes		y	
15			Yes		y	
16			Yes	yes	y	2
17		yes			y	
18			Yes		y	
19			Yes		y	
20	yes	yes		yes	n	3
21					y	
22	yes				y	
23	yes				n	
24	yes				n	
25			yes		y	
26	yes				y	
27	yes				y	
28		yes			y	
29				yes	n	
30			yes		y	
31	yes				y	
32				yes	n	
33		yes			n	
34	yes	yes			y	2
	14	6	8	6	23	5
	41%	17.6%	23.5%	17.6%	68%	15%

Spiritual conversations

As had been anticipated at the outset the largest proportion (41%) of discussions was predominantly of a spiritual nature. This category was very broad

covering spiritual journeys, experiences of church, of God, of prayer; discussions about sin and forgiveness and those questions of meaning that are often asked at crisis points in life. Sometimes there was the assumption that the chaplain wished to speak of religious/spiritual things:

‘I suppose you want us to talk about church now?’
(1)

These initiations by the patient led in many directions, text 1 (led by the patient) continues:

‘we’ve got a great vicar in the village and he’s made a big impact on the church’.

‘Is church a place where good people go? Or is it for people trying to be good but sin?’

Others spoke of the importance of their faith and the sacraments in their current journey, ‘I know our Lord’s helping’ (6) or of their own faith journeys. Then there were the patients who wanted to explore the ‘big’ questions of life:

‘I don’t want to pray anymore. There is no sense in it, is there? I have lost everything. Is there any use in living? I have suffered for the last twelve years but I don’t want to bore you with all these...what kind of God is it that allows one to suffer so much?’ (24)

Others trying to make their own sense of it:
‘we bring illness on ourselves, we are all sick as a consequence of our lifestyleto see the need for change and to sort out relationships.’ (26)

Most patients (67%) either requested prayer or did not refuse it when offered (it was not offered in all cases) and many of them wanted or spoke about other rituals or sacraments – marriage, baptisms, communion or about the accessibility/availability of the chapel.

That most encounters were of a spiritual nature did not surprise the team involved but did show some

expectation of the role of a chaplain in an increasingly secular society.

Hospital experience

29% of the conversations recorded were listed as involving hospital experiences (including medical stories, the isolation of being in hospital from home/family, pain and complaints about systems or staff). This was either considered most of the conversation or at least an equal part to other themes. Patients frequently referred to medical and nursing staff as ‘they’:

‘It’s nothing really. Just these drips. They’re supposed to come at 9 each night to change them, so that by 11 I can sleep. But they’ve been getting later and later. And then they wake me up early to

start all over again. And I don’t think there’s anything wrong with me. I just want to go home.’ (19)

The patient in encounter 5 told their medical hospital history:

‘I came in for a bladder operation and my anaesthetic was an epidural. When I came round from the op I had no feelings from the waist down. There was some talk that I might have had a stroke during or after the op...it’s so difficult to come to terms with not being able to walk again – but there’s some hope because they now think it’s a trapped nerve. That’s why I’m having this scan.’

Other texts record requests for help with physical needs - for example for pain control or the bed pan or for the pillows to be moved to make them more comfortable, whilst others link hospital experiences quite emotionally talking about being ‘down’ or ‘depressed and agitated’. Still others speak of hospital experience as being out of their control and impersonal:

‘the doctor thinks we should take her off the ventilator and turn a blind eye while she dies.’ (33) (about her baby).

Clearly the role of the chaplain here is often to act as ‘critical friend’, to listen to stories and to offer to intervene if requested to do so.

Life stories

Under this category (26%) were placed conversations relating to family, to history, interest in the chaplain’s

story, any loss issues raised and discussion about relationships. This is where the theory at the outset of the research differed since the chaplains had expected loss issues to feature more highly than they did. However, they had anticipated 'stories' being significant in encounters. One story took place over a number of days and involved the chaplain in that story as s/he listened to the original story of a desire to be married and the current terminally ill state of the partner and then helped to organise the wedding. Others record a whole life story with very many issues expressed, like the woman due for a transplant who told a difficult life story to the chaplain who was then able to explore faith issues with her, particularly relating to forgiveness (29). Some told life stories that made little sense to the chaplain (12), or at the very least they wondered what relevance they had to the here and now. Others simply told stories of their families:

'I've got a family although my wife is not very mobile and I've got two sons.' (8)

Several patients asked the chaplains to tell something of their story which led to discussions about faith, church or God (both positive and negative!)

Emotions

Under the emotions category (18%) were placed feelings expressed verbally or physically. These were categorised in the initial analysis stage as: anger, fear, loneliness, guilt, rejection, anxiety, hope, disappointment, denial and sadness. Interestingly only 6 texts concentrated on feelings, although most of the encounters did involve emotions or emotional language. Several verbatims record the person's eyes 'filling with tears' (e.g. 9), and there are poignant silences and tangible sadness. Some encounters contain anger or frustration either about current or past situations or about God and his part in everything.

There seems to be something about the intimate relationship formed between a chaplain and the patient that allows them to express feelings in a more overt way than often occurs with other health carers, especially with tears.

The Literature review

The search by IT database search engines in the Medical school library, using words particularly

pertinent to spiritual/religious/pastoral care produced 26 records ranging from chaplaincy in hospitals and communities, the changing nature of chaplaincy, chaplaincy about ethical decisions and in science and faith. However, only three in any way related to the question posed as to what do people talk to a chaplain about. This review was rerun in July 2009 just prior to submission for publication without any changes noted. The related articles were: 'Questions posed to hospital chaplains by palliative care patients' by Susan and Peter Strang (2002), 'Are existential questions the norm for terminally ill patients?' by Richard B. Fife (2002) and a chaplaincy survey by M. Wright (2001) looking at spiritual care in hospital and hospice.

The first project refers to the Swedish setting whilst the second is written from an American perspective; neither relates specifically to what people are talking about generally since their brief is specifically focused on end-of-life patients. However, they do demonstrate some similarities in conversation themes particularly the Strang and Strang (2002; 858) report in which the following is observed:

'Spiritual/existential questions do not cease to exist when a society is secularised. Instead the questions are expressed in other forms depending on the context, culture and traditions of that society. Spiritual/existential questions are activated in such situations as severe illness, when death becomes a real threat, regardless of whether one has an atheistic or a religious point of view.'

Strang and Strang (2002) discovered in their research, which asked hospital chaplains what questions people asked them, that the main categories related to meaning, illness, death, relationships and religion (2002;859). They also discovered that 'many patients have a need to summarise and tell the story of their lives' – this correlates well with our actual findings from the detailed conversations where 80% wanted to tell family stories and 62% wanted to tell their histories. They also discovered that one third of patients wanted to discuss the 'big' questions – this research showed 41% looking predominantly at this.

It is acknowledged that patients draw upon their spirituality in making decisions around their treatment and as a coping mechanism. King (2006) noted that

“people with no religious affiliation find it difficult to express their spiritual beliefs and experiences”.

It could be argued that in order to provide good holistic care chaplains must not be confined to meeting religious needs alone. The current change in public attitude to organised religion does not mean the chaplain as the skilled pastoral practitioner is out of a job but needs to apply those pastoral skills with increasing skill and expertise.

Many of the chaplains also stated that people wanted to speak about their illness and pain which correlates with the findings of this research. The verbatim accounts indicated that patients felt isolated and were missing their homes and families. This is different to those in Strangs’ research who wanted to discuss more about their ultimate separation – this is where the projects differ, since the Strangs’ project dealt with those facing imminent death whilst the patients in this study were possibly looking at going home.

Wright (2001) compares hospital and hospice chaplaincies in a more general way but does cite questions chaplains believe people ask them. These compare favourably with those determined by analysis of the patient encounters but are from a chaplain’s perspective rather than through detailed analysis of verbatim.

Conclusions

The National Institute for Clinical Excellence (NICE) Guidelines states that all practice should be research based and new research evaluated to see if changes in clinical practice are required. However, what has been sadly lacking in chaplaincy (particularly in this country) has been any evidence to prove what it has been doing and how effective this has been and how it can be changed. Perhaps one of the reasons there is such a reluctance to do any research is that there is a perception that the work of the chaplain is not measurable – how can one evaluate a one-to-one conversation? However in order to assess the role of the chaplain, to prove its worth as well as to meet the needs of the patients (as required by the client-centred NHS brief) there is a need for research and audit.

The current study has provided an insight into the patient–chaplain encounter in terms of thematic

analysis. It has placed the individual patient at the centre of the enquiry. It has demonstrated the focused nature of conversations around spiritual issues, life-story and the experience of hospital. While there is an inevitable bias nevertheless such classification means that chaplains are doing the job they are employed to do. Closer scrutiny of the findings and further analysis of texts is required to sift more information and provide more accurate data. A more fundamental question remains as to whether such conversations are beneficial – and, if so in what ways?

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