1 # ‘Chaplains for Wellbeing’ in primary care: A qualitative investigation of
2 their perceived impact for patients’ health and wellbeing.

3 **Abstract**

4 Although Health Chaplaincy services are well-established in hospitals in the UK and
5 across the world, Primary Care Chaplaincy is still in its infancy and much less extensively
6 developed. This study explored the impact the introduction of a Primary Care ‘Chaplains for
7 Wellbeing’ service had upon patients’ experience and perceived health and well-being.

8 Sixteen patients participated in one-one interviews. Transcripts were analysed using
9 interpretative phenomenological analysis (IPA). Patients reported circumstances that had
10 eroded perceived self-efficacy, self-identity and security manifesting as existential
11 displacement; summarised under the superordinate theme of ‘loss’. ‘Loss’ originated from a
12 number of sources and was expressed as the loss of hope, self-confidence, self-efficacy, and
13 sense of purpose and meaning.

14 Chaplains used a wide range of strategies enabling patients to rebuild self-confidence
15 and self-esteem. Person-centred, dignified and responsive care offered in a supportive
16 environment enabled patients to adapt and cope with existential displacement.

17 **Keywords:** Chaplains, well-being, phenomenology, patients, primary care

18

19 **Introduction**

20 Internationally there is a shift in emphasis in healthcare from the curative, treatment model of
21 disease to a more preventative, public health model. In the United Kingdom (UK) this
22 refocusing has allowed the development of innovative and integrated well-being services.
23 One such innovation is the development of small experiments in Primary Care Chaplaincy,
24 based in the community and integrated with other primary care services to offer early support
25 to patients living in the community.

26 An example of such a Primary Care Chaplaincy initiative is the Sandwell *'Chaplains*
27 *for Wellbeing'* (CfWB). In this model, the intention was that patients could access the
28 service through their General Practitioner (family doctor); through the 'Sandwell Wellbeing
29 Hub' or by self-referral as appropriate. There has never been a precisely articulated version
30 of the role of a chaplain or, therefore, what the service could offer, although a list of 8 key
31 functions has emerged: "listening, compassionate presence, facilitating the search for
32 meaning, discerning the signs of life, offering appropriate ritual, offering prayer, providing
33 support in death and dying, and pastoral care of staff" (Bryson et al., 2012, p. 20).

34 Within the 'Sandwell Wellbeing Hub', CfWB was one of a range of group/individual
35 talking therapies used to support patients' emotional health/well-being. Unlike other forms
36 of healthcare chaplaincy, the Chaplains were not restricted to a single institution but offer
37 their services to all residents of the area covered by the relevant Clinical Commissioning
38 Groups (CCG's). The service comprised of five chaplains and received referrals from 134
39 primary care centres (Bryson et al., 2012). The purpose of the study, of which this paper
40 represents a part, was to seek to analyse and evaluate the service from three distinct
41 perspectives: by the use of quantitative data gathered through a measurement of patient well-
42 being (the Warwick and Edinburgh Wellbeing Scale, WEMWBS [Tennant et al., 2007]);

43 through the chaplains' own accounts of their role and its value; and (in this paper) through
44 qualitative interviews with service users.

45 ***Background***

46 *Chaplaincy in the UK context*

47 Within the UK, the term 'Chaplain' has a particular set of associations deriving from the
48 unique constellation of political and social conditions:

49 - the historical association between church and state, which perpetuates a shared
50 assumption that 'matters of ultimate concern' for the individual may also be matters
51 of shared social and religious concern.
52 - within church-state collaboration, the existence of public institutions (of which the
53 NHS is perhaps the most influential example) whose legitimacy rests in part on their
54 secular credentials. This confers on chaplains an ambiguous status 'in but not of' the
55 institution.
56 - high levels of religious diversity within the population as a whole, which precludes
57 any definition of chaplaincy in terms of the religious values of any one particular
58 group.

59 Perhaps because of these conditions, chaplaincy practice in the UK has tended not to
60 follow the Clinical Pastoral Education model favoured in the United States but has moved
61 towards a "thin, vague and useful" definition of spirituality and spiritual care (Swinton &
62 Pattison, 2012, p. 226). Thus, the most recent edition of the NHS Chaplaincy Guidelines
63 (NHS, 2015, p. 5) uses the term 'Chaplaincy': "to include the pastoral and spiritual care
64 provided to patients, family and staff, whatever it is called in practice, and to include
65 religious care provided by and to religious people. The term 'chaplain' is intended to also

66 refer to non-religious pastoral and spiritual care providers who provide care to patients,
67 family and staff."

68 In the first phase of the study represented here, a quantitative retrospective analysis of
69 patient data found evidence for a significant improvement in patient well-being scores
70 (Kevern & Hill, 2014). However, the mechanisms or sources of this improvement were not
71 immediately explicit, indicating the need to interview patients who had accessed the service.

72 ***Aims***

73 The aims of this study were to:

74 (1) Explore the impact the introduction of the CfWB service had upon patients'
75 experience and perceived health and well-being.
76 (2) Identify the range of skills and strategies CfWB used to respond to presenting issues.

77 **Methods**

78 ***Ethics, sampling and recruitment***

79 University Independent Peer Review (IPR) and Research Ethics Committee (REC) approval
80 were gained (REC 13/WM/0309). The Chaplains themselves compiled the list of all patients
81 who had accessed and been discharged from the service in the period from January 2011-
82 October 2013. All of these were contacted directly by the Chaplains. The sampling frame
83 CfWB used was non-random but purposive. CfWB distributed a total of 108 information
84 packs, comprising a letter, information sheet, and reply slip, to patients from multiple GP
85 surgeries across the three CCGs. Volunteer participants then contacted the research team
86 directly, and the Chaplains had no further involvement in the study. Recruitment took place
87 over 3 months (March-May, 2014).

88 ***Data collection***

89 Of the 108 patients invited to participate, the research team received 20 reply slips; a
90 response rate of 18.5 per cent. Sixteen of these patients participated in a semi-structured one-
91 one interview to explore their perspectives and experiences of the CfWB service. Two
92 members of the research team (WM and AJB), conducting the patient interviews, were
93 experienced Registered Adult Nurses and health researchers. WM is a Professor of Nursing
94 with a PhD and AJB a Trainee Health Psychologist. Both were qualified and experienced to
95 interview patients and utilise the IPA methodology. Nine prompts were utilised to help guide
96 the interview and determine the patient's evaluation of the CfWB service. Interviews were
97 digitally audio-recorded, independently professionally transcribed, and qualitatively
98 analysed.

99 ***Interpretative phenomenological analysis (IPA)***

100 IPA, developed by Smith (1995, 1996) is a seven-phase (Table 1) analytical method that
101 examines human lived experience, expressed in its own terms rather than from the
102 perspective of pre-defined categories (Smith, Flowers, & Larkin, 2009); essentially
103 committed to understanding the first-person perspective (Larkin, 2012).
104 *Insert Table 1*
105 IPA was utilised as a qualitative method to facilitate interpretation and analysis of
106 patients' lived experience of the CfWB service. However, it was recognised CfWB
107 themselves would regularly utilise phenomenological ways of working with patients to
108 enable patients to find meaning and purpose in their struggles, although not necessarily term
109 their work 'IPA'. Essentially, the spiritual care offered to patients by CfWB comprised a
110 "psychotherapy based on philosophical-phenomenology of using the human self as a
111 therapeutic tool" (Ramakrishnan, 2015, p. 7). Parameshwaran (2015) suggests chaplains

112 work to provide spiritual care by remaining mindful in their interactions with patients;
113 specifically being non-judgemental, not focusing on psychological treatment, and
114 maintaining empathy with the patient to bring about transcendence from suffering.

115 *Development of superordinate themes*

116 Loss: Patients were asked to describe their involvement with the CfWB service along with
117 the main situation/concern that led them to seek support. This led to the disclosure of a
118 variety of presenting issues, including: 31 per cent of patients (5) reporting bereavement; 25
119 per cent (4) relationship breakdown; 19 per cent (3) family breakdown; 13 per cent (2)
120 depression; and 12 per cent (2) loss of self-confidence and identity. The commonality
121 between all patients suggested many had experienced a significant number of life events,
122 which collectively 'knocked them sideways', and displaced them, existentially, in their
123 world. There was one patient, 'Beatrice', who referred to being "lost" in the stress of her
124 situation, which captured the essence of 'loss' for every other patient who participated.

125 General Practitioner (GP)/family doctor care: For the 16 participants, referral into the CfWB
126 service was initiated in 75 per cent (12) cases by GPs. Fifteen participants referred to the
127 care offered by their GP, particularly in relation to pharmaceutical treatment and healthcare
128 communication.

129 CfWB care: Reflective of this work as a service evaluation, participants were asked
130 numerous questions regarding the CfWB service. Specifically, what participants felt were
131 the main benefits to their own health and well-being; how the CfWB helped them address
132 concerns and issues; and in what ways the CfWB service differed compared to other services,
133 for example, counselling. Eight sub-themes were developed from participants' narratives.

134 **Results**

135 Due to the extensive amount of data collected and analysis, three superordinate themes along
136 with subordinate themes are presented (Table 2).

137 *Insert Table 2*

138 ***Patient characteristics***

139 *Demographics*

140 The sample of 16 patients was heterogeneous, reflecting the extent to which the CfWB
141 service functioned to support adults of different ages, presenting issues, and walks of life.
142 Whilst patients presented with different issues a common theme amongst all was a substantial
143 degree of psychological distress, and often desperation, resulting from one or more
144 significant life events or crisis situations. Consequently, patients seemed to lack the
145 orientation, resilience or self-confidence to start 'living' again.

146 The 16 patients comprised 10 women and 6 men between the ages of 29-69 years
147 (mean = 52-53 years). A total of 12 patients identified themselves of Christian faith (9
148 "Church of England"; 2 "Christian"; 1 "Baptist"). Four patients identified according to other
149 faiths (2 "Hindu"; 1 "Humanist"; 1 "Sikh"). To maintain anonymity and to contextualise the
150 quotes, a pseudonym is used (Kaiser, 2009) (Table 3).

151 *Insert Table 3*

152 ***Superordinate Theme 1: Loss***

153 'Loss' was manifested in many ways: relationship/family breakdown, bereavement, or loss of
154 self-identity. However, these 'named' issues, fail to capture the interrelationship between
155 them and other shared features. For example, a group of patients (4) experienced relationship
156 breakdown (either divorce or separation). This subsequently created significant grief, a loss

157 of self-confidence, general distress, or loss of self-identity. Other patients (5) suffered
158 bereavement(s), leading to anxiety and guilt. What all patients appeared to have in common
159 was a set of circumstances that eroded their sense of self-efficacy, self-identity and security
160 manifesting as an existential displacement or crisis.

161 "[…] Identity had just gone and I was completely lost. […] Sitting with the chaplain
162 saying, 'I feel like I am in a waiting room. […] I don't know why I am here […] where
163 am I going'. Total sense of bewilderment […] very, very stressful. I had no sense of
164 purpose, no sense of future either." ('Beatrice', L. 10).

165 The existential concept of loss thus 'frames' and provides a key to the interpretation of all
166 superordinate and subordinate themes.

167 ***Superordinate Theme 2: GP care***

168 Several patients reported GPs provided good care and would listen well, demonstrating a
169 "caring and pastoral" (Michelle, L. 36) approach. However, patients reported inconsistency
170 (seeing different GPs) and where the GP was inhospitable:

171 "[GP] said, 'I think it is time now you come off the sleeping tablets', […] just quite cold
172 and said, 'you have got to manage that yourself'." ('Victor', L. 94).

173 Furthermore, there was evidence GPs sometimes lacked empathy, remaining rather matter of
174 fact:

175 "[GP's] response was certainly not to engage with my stress at all […] but simply to
176 offer a service. […] I don't feel [they] were particularly empathetic with me at all, 'just
177 well if you are suffering from stress, we can offer you a pill, or we can offer you a
178 Chaplaincy Service'." ('Beatrice', L. 87).

179 However, for ‘Hakim’, existing issues with his GP resulted in a degree of distrust and
180 concern:

181 “ Spoke with [GP for] a long time […] and [they] said to me, ‘just take that medication,
182 it’s going to be [fine]’. I said, ‘I don’t feel good when I take the medication […] feeling
183 down […] should be seeing psychology really […] [GP] said, ‘no you don’t need
184 [psychology] now’ […] [eventually the GP] decided to send a referral to the chaplain.”
185 (‘Hakim’, L. 120).

186 Despite this, patients’ reported no further evidence suggesting their GP failed to respond
187 adequately to their needs. Patients acknowledged that GPs were very busy with limited
188 opportunity to address issues of psychological distress.

189 Emphasis on physical care was predominant, with prescribed medication being an
190 initial treatment of choice given the degree of their psychological distress. Typical
191 medications comprised antidepressants, hypnotics, and anxiolytics. Although many patients
192 were reluctant to take psychotropic medication, they felt no option but to commence this,
193 given the severity of their distress:

194 “’OK, I will [take antidepressants], I don’t really want to but I realise that my body can’t
195 take this [distress] anymore, my mind can’t take it.” (‘Brenda’, L. 170).

196 ***Superordinate Theme 3: CfWB care***

197 All patients reported their chaplain had a positive impact on their health and well-being,
198 illustrated by ‘Margaret’:

199 “I don’t think [the chaplain] could have done anything differently, [they were]
200 wonderful. […] Like a shining light at a very dark time […].” (‘Margaret’, L. 110).

201 The methods chaplains used to help patients during their time of ‘darkness’, illustrative of the
202 depth of physical and psychological pain all patients were suffering, depended on the
203 working ‘style’ of the chaplain, according to the patient’s presenting issue(s).

204 *Environment*

205 An environment that patients considered “comfortable”, “relaxed, “safe” and “calm”
206 appeared important:

207 “[First chaplaincy experience] was really relaxing, […] comfortable, […] safe
208 environment […] absolutely felt freed up to really express and tell [the chaplain] exactly
209 how I was feeling.” (‘Michelle’, L. 10).

210 An appropriate environment appeared helpful in minimising barriers preventing ‘Michelle’
211 from discussing her issues. ‘Janet’ did not consider anything particularly unique about the
212 consultation environment, however, having a designated space for CfWB, separate from the
213 GP environment appeared important:

214 “An area [in the primary care centre] set aside for [chaplaincy] specific purpose […]
215 needs to be sacrosanct. […] It might be more difficult [to consult with the chaplain] if
216 you had been to see the doctor, or the nurse practitioner, in a room where next week you
217 are going to see the chaplain.” (‘Janet’, L. 124).

218 Perhaps the most fundamental aspect of the consultation environment links to how the
219 chaplain facilitated the consultation, instilling a sense of “calm”:

220 “[The environment] was a very calm place […] [the chaplain] was always on time, and
221 always had enough time, without cramming in people, […] not like a doctor’s
222 consultation...” (‘Victor’, L. 74).

223 Chaplains had more time to consult with patients, compared to GPs, where the emphasis was
224 more towards identifying patient needs and referring on. Chaplains' time management was
225 crucial, allowing enough time per patient and respecting the patient's time (and courage) in
226 presenting before the chaplain.

227 *CfWB demeanour*

228 The way in which the chaplain presented before a patient was crucial:

229 "[The chaplain] was happy to me […] I respect [they were] kind to me, [they] respected
230 me, listened to me, when I was talking [they] respected me." ('Hakim', L. 106).
231
232 "[The feeling of comfort and friendliness manifested in] the way [the chaplain] came
233 across, a very open, trustworthy, kind, considerate person, and how [they] spoke."
234 ('Joan', L. 54).

235 For 'Hakim' and 'Joan', the way in which the chaplain communicated was important.
236 Offering patients time to talk, being completely open and considerate to their needs,
237 conveyed trustworthiness, professionalism and mutual respect. Perhaps differentiating
238 chaplains from other health professionals, patients' considered chaplains had an air of
239 wisdom about their demeanour, positively impacting upon their experience:

240 "[…] With the chaplain that perhaps […] another Christian friend or non-Christian
241 friends [would have was] a sort of wisdom. […] You might go to a friend and they talk
242 to you and often friends try to give you advice […] the chaplain didn't give you advice
243 and tell you what you should do […]." ('Michelle', L. 145).

244 Articulating the notion of wisdom was complex, but it appears linked to the chaplain actively
245 listening; avoiding the provision of advice and empowering patients to come to their own

246 solutions. However, there were times when chaplains provided advice if required:

247 "[…] Certain [problems] going on […] which I told [the chaplain] about […] [the
248 chaplain] was like an advisor to me, […] I was saying 'what shall I do about this' and
249 [the chaplain] would tell me and write it down […] not sort of running your life but
250 putting alternatives." ('Peter', L. 60).

251 For 'Peter', the provision of advice from the chaplain was enhanced in part through the
252 chaplain's experience of working with challenging issues. Some, but not all patients, did
253 have supportive networks of family/friends during their crisis. However, as helpful as family
254 and friends were, the non-judgemental and impartial support offered from chaplains was
255 welcomed. The wisdom conveyed by chaplains during their consultations appeared to
256 manifest in the way they responded non-judgementally and impartially. Chaplains were able
257 to achieve a delicate balance between befriending a patient and remaining professional:

258 "I felt really welcomed, […] warm inside […] really comforted […] the chaplain was
259 really friendly […] made me feel safe […] really nice […] a professional approach."
260 ('Katrina', L. 13, L. 102).

261 *Person-centred care*

262 Person-centred care can be illustrated by considering care that was not person-centred:

263 "[…] In the hospital I came across a doctor that was dressed in lavish clothes and [they]
264 made me feel as if I wasn't a person […] the doctor came in, grabbed the notes, said [to
265 the nurse], 'where is the patient, oh yes well can you get the patient into that room'."
266 ('Bimal', L. 144).

267 The illustration of the care 'Bimal' received lacked human dignity: respecting the 'patient' as
268 a 'person'. Conversely, chaplains made sincere efforts to care for the 'person':

269 "[CfWB] never treated me like a patient, [they] treated me more like a friend so [they]
270 were welcoming, used my first names […] more informal than I suppose the counsellor
271 might have addressed me […]." ('Sylvia', L. 134).

272 Aside from putting 'Sylvia' at ease, this informality appeared therapeutic: enabling her to
273 discuss issues openly and monitor her own progress:

274 "[The chaplain] would comment on my clothes or would [say], 'you are wearing bright
275 colours today, how does that make you feel […]?' ('Sylvia', L. 134).

276 The provision of person-centred care honours holistic patient care. This was implicit
277 throughout chaplain consultations with practically all patients stating they received dignified
278 care.

279 *Dignified care*

280 The immense life situations patients experienced, coupled with subsequent losses in their
281 self-identity and self-confidence made patients feel very undignified. Consulting with the
282 chaplain for many patients was a significant moment – a 'light' in their 'darkness' – where
283 they had some dignity restored, illustrated by 'Victor':

284 "[The chaplain cared for my personal dignity] very highly, because I had no self-dignity
285 then at all […] was in the gutter, and no self-worth at all, no self-esteem, nothing. [The
286 chaplain] actually respected my dignity." ('Victor', L. 106).

287 The preservation of dignity essentially summed up how chaplains worked by using their
288 professional and life experience, to walk a shared journey with the patient:

289 "[The chaplain] was providing some time, I think that's the main thing that [they] had
290 and [they] were not trying to fix anything [they] just were alongside [me] and all that sort
291 of stuff." ('Margaret', L. 92).

292 *Offloading*

293 The significant distress patients were experiencing was metaphorically asphyxiating, with
294 patients not being able to "breathe":

295 "[…] I felt quite desolate and I couldn't talk, I couldn't breathe, I got quite distressed and
296 upset […]." ('Brenda', L. 166).

297 Chaplains providing time for patients to discuss their issue(s), and being with them non-
298 judgementally and impartially, facilitated a space to offload:

299 "[The chaplain] gave me that time to kind of just breathe […] I felt free with [them] I
300 could be myself with [them] [they] were not judgemental […]." ('Sylvia', L. 144).

301 What appears to differentiate chaplains from other health professionals is the way they allow
302 patients to determine the consultation, according to their needs, not the model of therapy the
303 health professional is working to:

304 "[…] Needed to sort of talk it through […] cry it out and, whilst you have people that
305 you can do that with who are friends and close to you, sometimes you need someone that
306 perhaps isn't quite as close to you […] outside of your own circle […] to see things
307 slightly differently." ('Michelle', L. 51).

308 Similarly, when patients resort to family or friends for support there is the sense of this
309 needing to be reciprocal, unlike when consulting with a chaplain where it is solely for their
310 benefit:

311 "[Seeing the chaplain] it's time for you, you can be completely self-indulgent, whereas if
312 you are chatting to your mates, you feel it has got to be 50-50." ('Beatrice', L. 44).

313 The key aspect here is having approximately one hour (a relatively long consultation) to
314 offload. However, of equal importance is that the patient feels comfortable to confide in the
315 chaplain. Central to this is the chaplain remaining independent of the patient's immediate
316 circle of family/friends, providing an objective perspective:

317 "[…] Knowing that week on week […] I was going to see someone [chaplain] who
318 would listen to me other than my family […] I felt because of what had happened I was
319 still senior in the family and it was my duty to keep everybody going […]." ('Brenda',
320 L. 30).

321 Having the chaplain, as an independent source of support helped 'Brenda' maintain her sense
322 of resilience; creating a separation between providing support for her, whilst honouring her
323 need to continue supporting her family, maintaining her self-esteem and self-identity.

324 *Active listening*

325 Chaplains not only heard what patients offloaded but they actively listened:

326 "[…] [The chaplain] wasn't sitting there just listening […] [they] were actively listening
327 […] expanding on some of my thoughts and reflecting them back to me […] a genuine
328 absorption in the discussion." ('Simon', L. 56).

329 This illustrates that listening was not simply a method of obtaining information and providing
330 advice, but rather chaplains working phenomenologically: actively encountering the patient's
331 world, journeying with them. Chaplains were attempting to attend to what was not said, in
332 addition to what was said:

333 “[…] That skill of not just listening to what [the patient] is saying, but actually what they
334 are not saying, and using an approach which you feel is best going to meet the not said,
335 rather than the said.” (‘Janet’, L. 101).

336 Ultimately, when chaplains actively listened, they asserted their presence to the patient as
337 another human being with a genuine and sincere concern for their presenting issue(s). Some
338 patients had no one else to turn to in the time of their need:

339 “[…] [The chaplain] helped me get [my issues] out of myself […] I was able to talk to
340 somebody about it, was there to listen, at a time when I hadn’t got anyone else to talk
341 to.” (‘Peter’, L. 116).

342 The processes of offloading and active listening appear to be working simultaneously,
343 representative of the interpersonal interaction between the chaplain and patient. The outcome
344 of these processes appears to be in the way a patient comes to a realisation of their presenting
345 issue(s).

346 *Insight into issues*

347 Most patients acknowledged their issue(s) and accompanying feelings, however, such was the
348 severity of their suffering, some could not gain insight into their issue(s) and accept or
349 transcend suffering, as ‘Beatrice’ explains:

350 “[…] I went to [the chaplain] with a list of losses, I hadn’t realised until […] doing this
351 piece of homework […] knowing some of the theory […] no wonder I am where I am.”
352 (‘Beatrice’, L. 28).

353 The severity of the patients’ issue(s) left them paralysed with no objective detachment and
354 consequently little constructive insight:

355 “I was just numb, I couldn’t do anything, my life was suspended whilst [the problems
356 were active], I couldn’t do anything.” (‘Victor’, L. 50).

357 Psychologically, this reflects that many patients were perhaps ruminating rather than
358 reflecting on the issues, negatively reinforcing other problems such as insomnia:

359 “[The chaplain] helped with the ideas of writing things down […] try and stop this going
360 round at night where one problem was following another, was following another [et
361 cetera].” (‘Lionel’, L. 56).

362 ‘Switching’ cognitively from rumination to reflection enabled patients to determine with
363 more confidence what elements preceded psychological distress and making constructive
364 changes in daily life to manage distress:

365 “[The chaplain was] trying to make me realise why, what is actually eating me up, why
366 am I getting, feeling depressed, what is it I need to pinpoint on […] look through the day
367 at what time of day I felt down and what did I do then, just before that what did I do […]
368 [the chaplain] would try and make me realise that I can manage without [them] as well.”
369 (‘Amanjeet’, L. 157).

370 When patients gained insight into their issue(s), they gained self-confidence, empowerment,
371 and were able to moderate (or even cease) prescribed medication:

372 “[The chaplain] was instrumental in getting me off sleeping tablets. […] I just lay in bed
373 and with everything going on […] could not get to a point where you could nod off and
374 sleep.” (‘Victor’, L. 88).

375 Progress for ‘Victor’ was testament to the chaplain’s focus on imparting skills of relaxation,
376 helping him gain insight into his issues, regaining confidence. Sometimes, however, the

377 intensity of a patient's life situation was so profound that even after offloading, relaxing, and
378 developing insight into their issue(s), they were still unable to 'live' unless there was a deep
379 and felt sense of acceptance.

380 *Prayer*

381 Chaplains were unique in the way they were able to take a spiritual (and sometimes religious)
382 focus to help patients come to a sense of acceptance of their issue(s):

> 383 "[…] A big huge relief to feel that I wasn't a failure […] talking things through [the
> 384 chaplain] helped me to see that I had done everything that [was] humanly possible to do
> 385 […] accept and let things go and yes hand them over to God really, which is what [the
> 386 chaplain] helped to do." ('Michelle', L. 129).

387 In a practical sense, this "hand[ing] over to God" ('Michelle', L. 129) was initiated by the
388 chaplain through the use of prayer. Seven patients reported prayer was offered by the
389 chaplain, in such a way as the patient could comfortably decline if they wished. However,
390 one patient explained that a prayer was said at the end of the first session by the chaplain,
391 which came as a surprise:

> 392 "End of the first session […] [the chaplain] did something that really threw me. [They]
> 393 said a prayer… and I don't think I had told [them] [my personal beliefs] at that point.
> 394 […] I remember sitting there and I was quite sort of shocked, […] the whole hour had
> 395 gone tremendously well, but this somehow had sort of spoilt it for me." ('Beatrice', L.
> 396 30).

397 Perhaps the chaplain assumed that prayer was appropriate for 'Beatrice', when in fact it did
398 not appear to be. This was an isolated case, however, and in the following consultation,
399 'Beatrice' and the chaplain did resolve outstanding issues:

400 “The second time I went back [to the chaplain] […] I decided I would have to mention
401 [the issue of prayer] […] [I] had a bit of a sort of giggle with [them] over it.” (‘Beatrice’,
402 L. 30).

403 This subsequent discussion was constructive and allowed the chaplain and ‘Beatrice’ to
404 discuss in greater detail the personal beliefs she held, and how these could be explored in
405 follow-up consultations. For the remaining 15 patients their response to prayer was very
406 positive. Interestingly, even patients who had little or no faith found benefit through the use
407 of prayer:

408 “I had lost my faith […] I don’t go to church now, but I do believe, and it was quite
409 powerful when [the chaplain] suggested doing a prayer.” (‘Victor’, L. 78).

410 The conception of prayer as being “powerful” illustrates the degree of suffering patients were
411 experiencing and the divine support patients will often turn to in times of extreme turmoil.
412 For ‘Victor’, the notion of prayer being powerful was expressed eloquently through the
413 notion of forgiveness:

414 “With everything going on […] that element of forgiveness […] I was being judged left,
415 right, and centre, by people and [the chaplain] said, ‘they will do that, but ultimately
416 Jesus came and died and for the forgiveness of everything’.” (‘Victor’, L. 80). “[…] It
417 was quite sort of powerful – how can I expand upon that? Humbling really.” (‘Victor’,
418 L. 82).

419 For ‘Victor’, prayer was certainly beneficial and perhaps manifested as forgiveness bestowed
420 upon them. However, an esoteric quality remains with the use of prayer in primary care
421 chaplaincy being “humbling”. Some patients also appeared to be deriving safety from
422 prayer:

423 “[The chaplain gave] a card to me, with a prayer on, which made me feel really safe […]
424 I take it home, I have got maybe a little hope in my life, because I felt so low, like I
425 didn’t want to be here […].” (‘Katrina’, L. 249).

426 In addition to having a prayer card, chaplains worked adaptively with prayer, with ‘Janet’ and
427 ‘Bimal’ considering that prayer flowed well during the general conversation:

428 “[Prayer was not a separate independent part of the consultation] no, it was something
429 that came […] quite naturally.” (‘Janet’, L. 47).
430
431 “[Prayer] came about [as a] result of all the talking.” (‘Bimal’, L. 88).

432 For patients who felt rather ambiguous regarding prayer, chaplains offered an approach
433 which respected the patient’s wishes, as ‘Lionel’ explains:

434 “[Prayer] wasn’t upfront [or] pushed down my throat […] [but I would have] never [have
435 used prayer previously] […] I am not a religious person much at all. […] [But] it was
436 nice to think that more or less a stranger [chaplain] is turning round and saying I will
437 pray for you…” (‘Lionel’, L. 98, 102, 108, 112).

438 In this scenario, the chaplain was actively praying for ‘Lionel’ outside of the consultation,
439 given his unease with prayer during the consultation. Clearly, prayer is one small but
440 important aspect, which differentiates chaplains from other health professionals, who may be
441 working in similar ways, for example, counsellors.

442 Chaplains are working within a secular organisation – the NHS – and have challenges
443 in meeting the needs of patients who, when they hear the word ‘chaplain’, may consider
444 notions of religiousness and expect more theologically-orientated therapy:

445 "[…] You would assume that it would be something that would be part and parcel, and
446 obviously chaplains again have got some sort of religious background training […]
447 theological-type training." ('Janet', L. 56).

448 However, chaplains have to balance this with the expectations of patients who just want an
449 alternative to counselling: a listening service as such. The comfort and peace patients derived
450 from the use of prayer, especially for patients of little or no faith has been quite
451 unprecedented.

452 **Discussion**

453 A perceived benefit of the CfWB service was that patients felt their dignity was preserved by
454 the chaplain. The chaplains may not have been drawing intentionally upon any specific
455 dignity preservation model, but analysis of the transcripts illustrates how their attitudes,
456 behaviours, compassion and dialogue (Chochinov, 2007) created a space and environment in
457 which patients felt validated, safe and supported. From within this affirming relationship,
458 patients acquired the courage and strength to face the existential crisis or threat that had
459 impacted so negatively upon their own sense of worth and identity (Nordenfelt & Edgar,
460 2005).

461 All the patients encountered significant loss, destabilising their existence, negatively
462 impacting their self-worth, self-confidence and identity. Some described this using words
463 like 'loss', 'bewilderment' and 'waiting'; that they had been existentially displaced after
464 encountering significant life events such as bereavement or relationship breakdown. The
465 CfWB, by adopting a person-centred approach in conjunction with the development of a
466 nurturing safe, calm environment, enabled the patient to explore and develop strategies to
467 face and rebuild self-confidence and resilience. These strategies enabled the patient to
468 readjust and re-engage in life with meaning and purpose.

469 One observation that relates to the theme of existential loss is the part that spirituality
470 played in patients' lives and how this was addressed by the CfWB. Interestingly very few
471 patients made direct reference to the word 'spiritual' or 'spirituality'. However, it was clear
472 that many patients had encountered situations and life events that had challenged them
473 existentially having a dramatic impact upon their sense of meaning and purpose in life.
474 While some patients spoke about aspects of personal faith, religion and God, they did not
475 relate this specifically to spirituality. This raises questions about the language of spirituality
476 being developed in healthcare practice, the appropriateness of this for use with patients
477 (McSherry & Cash, 2004), and how chaplains operationalise notions of spirituality in
478 practice.

479 The offer of prayer deserves a special mention, because of its distinctive association
480 with the chaplain's role, and because of its awkward place in secular healthcare provision
481 (Holloway, Adamson, McSherry, & Swinton, 2010). Prayer was offered to most of the
482 interviewees, and most reported positively on the experience whether or not they had a
483 formal religious allegiance. However, this is a reflection of the tact, sensitivity and careful
484 timing of the chaplain's intervention. It is difficult to imagine how universal 'ground rules'
485 might be determined for such an intervention, and the discretion of individual chaplains will
486 therefore be the main control on possible misuse. This is not in any way to denigrate an
487 intervention that was clearly very valuable for patients, but indicates the need for careful
488 selection and supervision of chaplains.

489 Patients valued highly the environment in which the service took place. The value of
490 the service may depend on the provision of appropriate physical spaces. It also depends upon
491 the perceived demeanour of the chaplain as calm, caring and capable which should be
492 considered in the recruitment and training.

493 The single most important contribution offered by the chaplain was the gift of time:
494 long appointments repeated over months or years if necessary. This implies that any attempt
495 to make the service more efficient by employing more highly-trained (and so highly-paid)
496 staff for fewer hours would be counter-productive.
497 The other very important contribution by the chaplains was active listening, in which
498 the act of attending to the patient is itself a validation of their experience and identity;
499 supporting findings from the *Community Chaplaincy Listening* service in Scotland (Mowat &
500 Bunniss, 2013). In addition to active listening, CfWB also utilised relaxation and
501 visualisation techniques, where appropriate. Patients reported the importance of simple
502 reassurance, but also of 'offloading', and integration of a new life-narrative.

503 **Conclusions**

504 IPA led to the development of pertinent themes in relation to the patients' experience of
505 primary care chaplaincy. All patients reported significant benefit from accessing the CfWB
506 service for many reasons.
507 The key-presenting theme seemed to be one of 'loss' derived from bereavement,
508 unemployment, or family breakdown. This was expressed through loss of hope, self-
509 confidence, self-efficacy, and sense of purpose and meaning. In essence, it represents the
510 antithesis of well-being, and so helps to define the role and contribution of the CfWB service.
511 Patients appreciated the role of GPs and other health professionals in maintaining
512 their well-being, but also understood the limitations of time and abilities with which they
513 were confronted. Patients understood that a busy GP cannot always spend time on an
514 individual's complex psychological needs, or have the appropriate range of competencies to
515 address them. Supplementary services such as the CfWB are not in competition with other

516 Primary Care services but offer another resource to complement and enhance the existing

517 portfolio of care.

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573 Table 1. IPA as a seven-stage process.

	IPA Phase	Generic Process	Specific Process
Repeat phases 1-5 for each transcript	1	Reading and re-reading	Each transcript reviewed to aid familiarisation; record pertinent issues; and help 'bracket' off interviewers' preconceptions of the patient's experience.
	2	Initial coding: Specifically within IPA the use of descriptive, linguistic, and conceptual codings.	Each transcript explored further: what the patient said (descriptive); their use of particular language to describe their world (linguistic); and the (analyst's) interpretation/questioning of narrative.
	3	Developing emergent themes	Applying themes to reduce volume of detail but retain essence of the patient's lived experience: both of their presenting issue(s) and of the CfWB service.
	4	Searching for connections across emergent themes	*Abstraction* used to develop superordinate themes from patients' common issues. For example, loss of identity, bereavement, relationship breakdown all termed 'loss'. *Subsumption* used to create superordinate themes based on related themes. For example, 'CfWB care' representing the ways of how CfWB worked with patients. *Polarisation* used to illustrate contrasting interpretations. For example, 'prayer' as a subordinate theme illustrating catharsis for some patients and provoking discomfort for others.
	5	Collation of themes	Listing of all emergent themes.
	6	Moving to the next case	Continuing to 'bracket' off preconceptions and development of emergent themes for each preceding patient to enable idiographic focus on new patient's information.
	7	Looking for patterns across cases and final reporting	Listing of all emergent themes for each patient in table and examining connections (similarities, differences) between patients.

574

575 Table 2. Superordinate and subordinate themes identified from IPA.

1	**Loss**
2	**GP care**
3	**CfWB care**
a	Environment
b	CfWB demeanour
c	Person-centred care
d	Dignified care
e	Offloading
f	Active listening
g	Insight into issues
h	Prayer

576

577 Table 3. Pseudonymous patient names and presenting issue.

Interview Number	Pseudonymous Patient Name	Presenting Issue
1	Beatrice	Loss of identity
2	Joan	Bereavement
3	Simon	Depression
4	Janet	Bereavement
5	Michelle	Relationship breakdown
6	Amanjeet	Depression
7	Peter	Family breakdown
8	Bimal	Loss of self-confidence
9	Brenda	Family breakdown
10	Victor	Relationship breakdown
11	Hakim	Bereavement
12	Fearn	Bereavement
13	Katrina	Relationship breakdown
14	Lionel	Family breakdown
15	Sylvia	Relationship breakdown
16	Margaret	Bereavement

578