2018

'What's on your mind?' The only necessary question in spiritual care

Austyn Snowden

Elizabeth Anne Lobb
The University of Notre Dame Australia, Elizabeth.Lobb@nd.edu.au

Susanne Schmidt

Ashley M. Swing

Pamela Logan

See next page for additional authors

This article was originally published as:
Snowden, A., Lobb, E. A., Schmidt, S., Swing, A. M., Logan, P., & Macfarlane, C. (2018). 'What's on your mind?' The only necessary question in spiritual care. *Journal for the Study of Spirituality, 8* (1), 19-33.

Original article available here:
https://dx.doi.org/10.1080/20440243.2018.1431031

This is an Accepted Manuscript of an article published in the *Journal for the Study of Spirituality* on *25 February 2018* available online:

https://dx.doi.org/10.1080/20440243.2018.1431031

Snowden, A., Lobb, E.A., Schmidt, S., Swing, A.M., Logan, P., and Macfarlane, C. (2018) 'What's on your mind?' The only necessary question in spiritual care. *Journal for the Study of Spirituality, 8*(1), 19-33. doi: 10.1080/20440243.2018.1431031

What's on your mind? The only necessary question

SNOWDEN, Austyn BA(hons) BSc(hons) RMN PhD FHEA
Professor in Mental Health
School of Health and Social Care
Edinburgh Napier University
Edinburgh EH11 4BN
a.snowden@napier.ac.uk

LOBB, Elizabeth Anne
Professor of Palliative Care
Calvary Health Care Kogarah
School of Medicine, the University of Notre Dame,
Sydney, New South Wales, 2010. Australia

SCHMIDT, Susanne
Pastoral Care Manager
Calvary John James Hospital
Deakin West, ACT, Australia. 2600

SWING, Ashley
Statistician
Calvary Health Care Kogarah
91 – 111 Rocky Point Road,
Kogarah, New SouthWales, 2217. Australia

LOGAN, Pamela
Lecturer in Mental Health
School of Health and Social Care
Edinburgh Napier University
Edinburgh EH11 4BN

McFARLANE, Catherine
Lecturer
School of Health and Social Care
Edinburgh Napier University
Edinburgh EH11 4BN

Abstract

The best multidisciplinary health and social care teams around the world include chaplains and pastoral care workers to support people in spiritual distress. It is important for all health and social care professionals to understand what they do. This knowledge would help other members of the team enhance their own skills and know when to refer to their specialist colleagues.

Studies undertaken by a team in Scotland showed that chaplains support people primarily by enabling them to talk freely. Enabling people to talk was shown to be more important than listening, or helping them understand themselves for example. However, these results were only obtained from small samples, and so a larger, international study was constructed to see if this relationship would hold.. Between 2015 and 2017, 2556 surveys including the Scottish Patient Reported Outcome Measure (Scottish PROM©), a valid measure of the outcome of spiritual care interventions, were sent to people who had seen a healthcare chaplain/pastoral care worker in Scotland and Australia, and 609 surveys returned. There was a highly significant moderate positive correlation between '*being able to talk about what was on my mind*' and the Scottish PROM ($r_s(452) = .451$, $p < .0005$). The more times people saw the chaplain, the better the outcome. People who described themselves as spiritual or religious did better than those who were not. As in previous research, being able to talk about what is on your mind was more important than being listened to, having your faith valued or being understood. The paper concludes that this simple finding could be generalizable to all health and social care practitioners, but only under certain conditions. For now it is essential that chaplains are employed around the world to ask people in distress: 'what is on your mind?'

Key words: Chaplain, pastoral care, outcome measures, psychometrics, therapeutic relationship, spirituality.

What is known about this topic

Healthcare chaplains offer unique spiritual support to people in distress around the world.

The impact of chaplaincy can now be measured.

What this paper adds

‘Being able to talk about what was on my mind’ was the most important element of chaplaincy encounters, more important than being listened to, having faith/beliefs valued or being understood.

This finding may be transferable to other professionals working in health and social care, but this would need to be tested.

It could be that only chaplains have the training, space and neutrality to offer the presence required to listen to the results.

INTRODUCTION

Most international models of health and social care include spirituality as a key component. For example, Macmillan Cancer Support UK use the 'holistic needs assessment', a model of care focused on the whole person: —physical, emotional, mental, social, environmental and spiritual (National Cancer Survivorship Initiative, 2013). Spirituality refers to issues of meaning, purpose and connectedness:

> *''the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature and to the significant or sacred''*
>
> (Puchalski & Ferrell, 2010)

Just as physicians are specialists in physical health and psychologists specialise in psychological health, special spiritual needs are met by chaplains[1] (Mowat & Swinton, 2007). The need for chaplains in health and social care has grown in line with the recognition that illness and trauma of any nature can cause much more than physical or psychological harm (Carey et al., 2016). Patients experience better quality of life where interdisciplinary teams include chaplains (Sinclair & Chochinov, 2012). Chaplains connect deeply with their patients, a quality highly valued by patients and their families (Cramer, Tenzek, & Allen, 2015). Although some nurses feel they offer spiritual support, they also recognise that there is a need for specialist spiritual care as delivered by chaplains (Kim, Bauck, Monroe, Mallory, & Aslakson, 2017). The purpose of this paper is to better understand how chaplains improve outcomes for patients. This knowledge may enable colleagues to

[1] In some countries, e.g. Australia, pastoral care workers as well as chaplains fulfil this role

use transferable therapeutic techniques where appropriate, whilst also gaining a better understanding of unique skills of the chaplain.

BACKGROUND

Healthcare chaplains around the world are embracing research to provide evidence of their impact (Snowden et al, 2016). Much of this research has historically been qualitative. Case study research for example is a well-developed field with international chaplain practitioners and scholars leading this vital work (Fitchett, 2011; King, 2012). Quantitative research is not so well developed. There are numerous reasons for this. Chaplaincy doesn't easily reduce to measurable components. Chaplaincy is fundamentally about stories (Nolan, 2016), and so narrative analysis tends to get used more than counting, say, days off work, or hospital admissions for example. Despite this, there is a growing recognition that chaplains need to engage with measurement and there have been some notable successes. Flannelly et al., (2012) found lower death rates in hospitals that employed chaplains. Kevern & Hill, (2015) found chaplains improved the wellbeing of people in primary care, and Macdonald, (2017) found primary care chaplain to be as effective as antidepressants in a retrospective analysis. All concluded that the next step is to better understand and measure outcomes of chaplaincy interventions, and there has been recent progress in this regard (Snowden & Telfer, 2017).

A patient reported outcome measure (PROM) is a measure of health, as defined by the patient, in relation to any treatment they have received (Wolpert, 2014). PROMs are used in health setting around the world to inform planners and clinicians alike about the effectiveness of interventions. In 2010, researchers in Scotland began developing a PROM designed to measure the outcomes of spiritual care as delivered by chaplains. The Scottish PROM© was iteratively developed, tested and refined with the help of chaplains and service users. It has proved reliable and valid in a range of

studies and settings (Snowden & Telfer, 2017) and is presently in use UK and USA, as well as Australia in this study. It is also being translated and tested in six European countries (European Research Institute for Chaplains in Healthcare, 2017).

The Scottish PROM is embedded within a short survey. The survey is designed to gather basic demographic data such as age and gender and includes a question about whether people self-describe as religious, spiritual, both or neither. These demographics are important to gather because they help identify where chaplains may be more or less effective. A set of four Likert questions then ask about the patient's experience of the chaplain encounter(s). These questions are asked to explore the link between the quality of the chaplain encounter and the outcomes of them. They are primarily there to help chaplains reflect on practice. The PROM itself is next, consisting of five Likert questions. Finally, there is a free text box for participants to write anything they wish. The whole survey is shown in figure 1.

Most of the recent work on the Scottish PROM has necessarily focused on its psychometric properties (Snowden & Telfer, 2017). However, as mentioned above it was also designed to better understand the relationship between the quality of the patient encounter with the chaplain and subsequent outcomes. This is so chaplains can better reflect on their performance in a structured manner. During an early pilot study, correlations were examined between the responses to the 'during my meeting with the chaplain' items and the outcome items ('in the last two weeks I have felt…'). A noticeable finding was the striking relationship between the item '*I was able to talk about what was on my mind'* and all the outcome items (Snowden, Telfer, Kelly, Bunniss, & Mowat, 2013). There was a strong, significant positive correlation in every case. In other words, '*I was able to talk about what was on my mind*' was associated with the person feeling honest, less anxious, having a positive outlook, in control and feeling a sense of peace. None of the other items

showed this strength of relationship. In brief, '*I was able to talk about what was on my mind*' was an even better indicator of subsequent positive outcome that any of the other three statements:

- I was listened to
- My situation was understood
- My faith/beliefs were valued

If generalizable, this counterintuitive finding would be important to explore in some depth. For example, why is being able to talk more important than being listened to? However, the pilot was only based on a total of 37 responses and so the generalizability of the finding was unknown. The aim of this study was therefore to retest for this relationship in a larger cohort of respondents.

Age		*How would you describe yourself?*	
Male	◯	Religious	◯
Female	◯	Spiritual	◯
Other	◯	Both	◯
		Neither	◯

During my meeting(s) with the listener I felt...

	None of the time	**Rarely**	**Some of the time**	**Often**	**All of the time**
I was listened to	◯	◯	◯	◯	◯
I was able to talk about what was on my mind	◯	◯	◯	◯	◯
My situation was understood	◯	◯	◯	◯	◯
My faith/beliefs were valued	◯	◯	◯	◯	◯

In the last two weeks I have felt:

	None of the	**Rarely**	**Some of the time**	**Often**	**All of the time**
I could be honest with myself about how I was really feeling	◯	◯	◯	◯	◯
Anxious	◯	◯	◯	◯	◯
I had a positive outlook on my situation	◯	◯	◯	◯	◯
In control of my life	◯	◯	◯	◯	◯
A sense of peace	◯	◯	◯	◯	◯

Thank you. If you want to add any other relevant information, please do so in this text box/overleaf:

This box is much larger in the paper version. It is only condensed here to save space.

Figure 1. The survey containing the Scottish PRO

METHOD

Design: Cross-sectional survey, correlational study.

Participants: People in UK and Australia who had been seen by a chaplain/pastoral care worker and subsequently discharged from the service.

Process: In UK, participants came from the Community Chaplaincy Listening (CCL) service. CCL is a free service held within GP surgeries in Scotland (Bunniss, Mowat, & Snowden, 2013). If the GP thinks a patient would benefit then they discuss a referral to CCL. Participants then either agree or disagree. If they agree the GP explains that the study is also happening. Patients then see the chaplain for as many sessions as they need to, to resolve the issues they presented with. Following discharge those that had also agreed to take part in the study (N = 206) were then sent the questionnaire in figure 1, with a stamped addressed envelope back to the study team.

In Australia, a separate study aimed to establish whether pastoral care provided by pastoral care practitioners was deemed by patients and their families to be an effective component of their overall health experience at a network of Catholic hospital sites in Australia. In total, 2,351 surveys were mailed to patients and family members at 7 clinical sites (acute, rehabilitation and palliative care). The survey was an earlier iteration of the one used in Scotland (Snowden, A. et al., 2012). The main difference was that it contained more questions, but crucially included all the items in the Scottish study. The surveys were mailed by Pastoral Care Managers of each site between December 2015 and June 2016.

Analytic plan

To combine datasets some of the demographic data were amended to construct comparable groups. For example, Australia obtained age data in groups, so the UK scale data was transformed into the same groupings. In UK, the demographic question pertaining to religion was as figure 2: 'are you: religious, spiritual, both or neither'. In Australia this information was obtained in the body of the survey. These two questions about religion and spirituality were re-coded in SPSS in order to obtain the same data. All data were imported into SPSS version 23. Likert categories for all measures were coded as follows:

Not at all = 0

Seldom = 1

Some of the time = 2

Most of the time = 3

All of the time = 4

Responses containing more than one item of missing data were excluded from analysis. Total PROM score was calculated by adding the value of each outcome item, except for the anxiety item, which was reversed in the UK version. Depending on the outcome of normality tests and treatment of outliers, either parametric or non-parametric tests were then used to examine individual associations between the four items from the section 'during my visit(s) with the chaplain' and the total PROM score (Lund & Lund, 2017).

Secondary analyses were also performed to explore relationships between the various demographics and the survey responses. In particular, the data were tested for mean differences in PROM scores according to age, gender, number of consultations, and faith/religion. Again, depending on the outcome of normality tests, homogeneity of variance

and treatment of outliers, either parametric or non-parametric tests were then used to compare mean PROM scores.

Ethics

Ethics permissions to conduct the study were granted from Bristol ethics committee in UK (13/SW/0178) and the Human Research & Ethics Committees in New South Wales, South Australia, Victoria and Tasmania in Australia.

The primary study hypothesis is:

'The statement '*I was able to talk about what was on my mind'* will demonstrate the strongest correlation between any statement and total PROM scores.'

Secondary hypotheses:

1. There will be no difference in mean Scottish PROM scores between men and women
2. There will be no difference in mean Scottish PROM scores between people of faith and people of none
3. There will be no difference in mean Scottish PROM scores between age groups
4. There will be no difference in mean Scottish PROM scores according to number of consultations

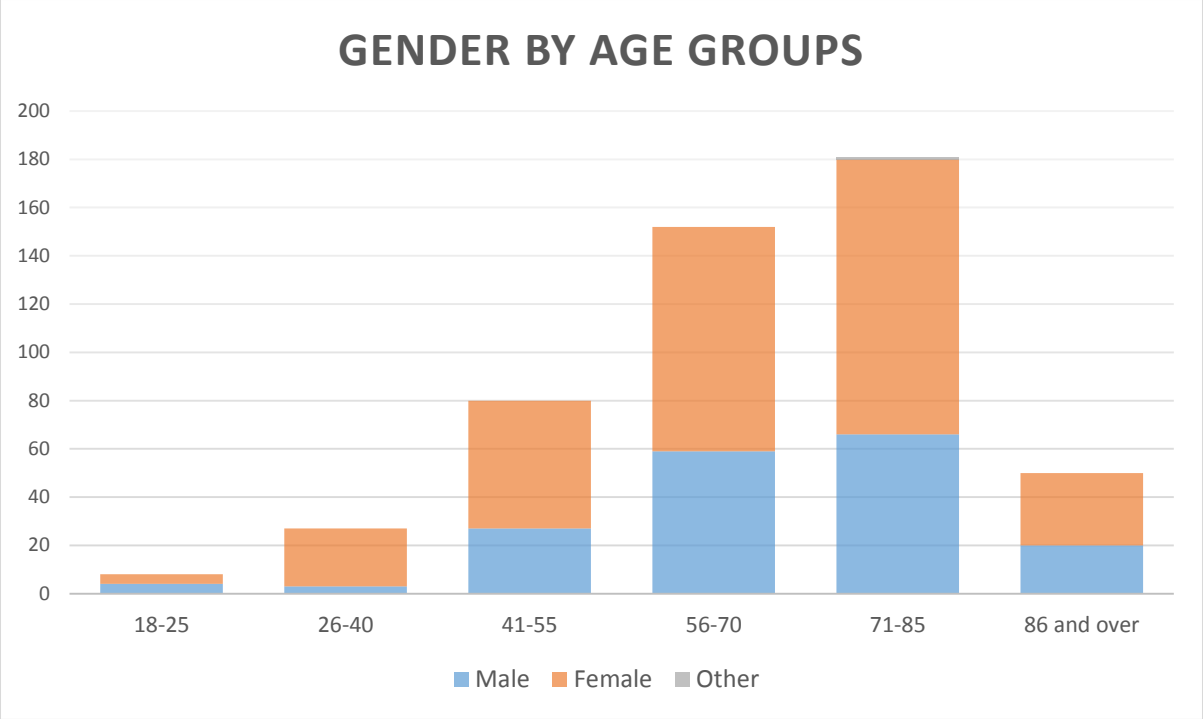
Results

Of a total 2556 surveys sent out (2351 in Australia and 205 in Scotland) 610 were returned, a return rate of 24%; around average for a postal survey (Sahlqvist et al., 2011). In Australia 497 surveys were returned. After review of the completed surveys, 9 surveys were removed

from analyses due to participants reporting that they did not receive a pastoral care visit. Due to concerns about the accuracy of family members acting as the patient's proxy, a further 92 surveys that were found to be completed by family members were removed. Thus, a total of 396 surveys were included for analysis. In Scotland, 113 surveys were returned. Those with any PROM data missing were also excluded (ie, those who did not complete gender or age group for example, but completed all PROM items were included). In summary, 499 respondents completed the survey themselves and provided complete data.

Figure 3 shows most (40%) respondents described themselves as neither religious or spiritual, followed by 36%: spiritual and religious. 'Religious only' were 13% and 11% just spiritual. Figure 4 shows that the largest age group was the older group: 71-85. Females made up 57%, males 33% with 1 person self-describing as 'other'. Figure 5 shows the number of visits people had, with around two thirds people (65%) having 1 or two visits. Mean PROM score was 11.8(4.6) with a range of zero to 20.

Figure 3. Religious, spiritual, both and neither.



	18-25	26-40	41-55	56-70	71-85	86 +
Male	4	3	27	59	66	20
Female	4	24	53	93	114	30
Other	0	0	0	0	1	0

Figure 4. Age group cross tabulation by gender

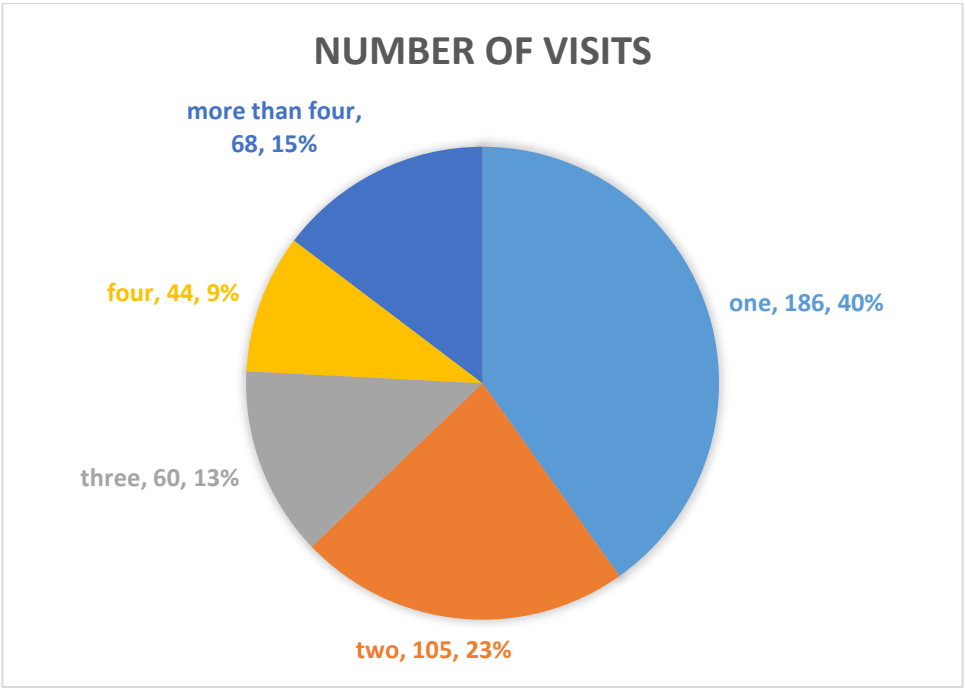


Figure 5. Number of visits by chaplain

Analysis

The primary hypothesis stated that "'*I was able to talk about what was on my mind'* will demonstrate the strongest correlation between any statement and total PROM scores."

Scottish PROM response data were not normally distributed. This was in part due to a preponderance of zero scores and twenty scores (figure 6, left).

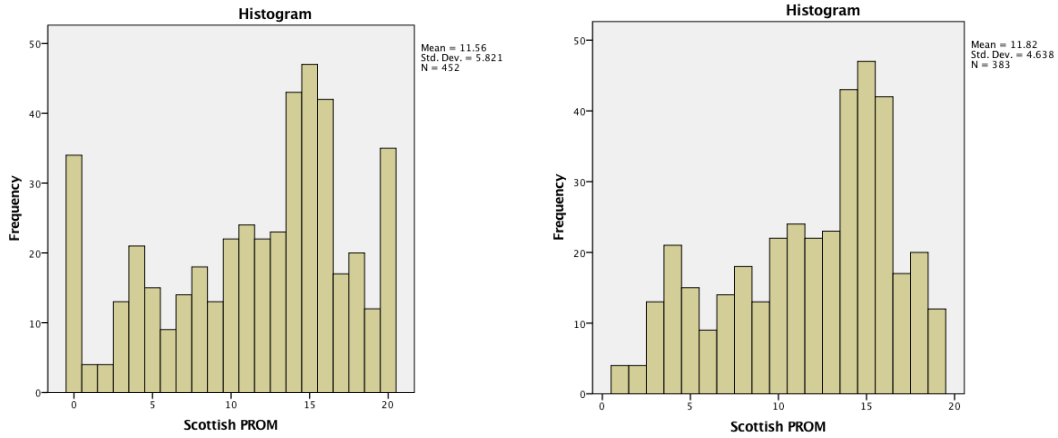


Figure 6. The zero and twenty outliers at the extreme values on the histogram on the left clearly don't fit with the trend and so were removed (right)

In order to score either zero or twenty people had to tick the same extreme response in every question. These scores had never been obtained in previous iterations, when a reverse item had been used in part to militate against this. Whether zero or twenty was an accurate representation of how they felt or not is difficult to ascertain, but the proportion of zeros and twenties look out of place in relation to the rest of the distribution (figure 6), and could be an example of 'yeah saying' (Lietz, 2010), where participants just tick the same response without a great deal of thought. These extreme responses were therefore excluded from further analysis on the assumption that they were logically anomalous (Lund and Lund 2017).[2]

[2] The Scottish PROM now contains a reversed item to mitigate this happening in future. In the latest version, just ticking all the top or all the bottom categories will be logically inconsistent and we will therefore be more certain that these responses are irrational in future.

Despite this adjustment, the PROM data were still not normally distributed (Shapiro-Wilk test < 0.001). Response data to the four statements: *During my meeting with the chaplain*: '*I was listened to'*, '*I was able to talk about what was on my mind*', '*My situation was understood*', and '*My faith/beliefs were valued*' were also not normally distributed (Shapiro-Wilk test < 0.001), so Spearman's rank-order correlation was run to assess the relationship between Scottish PROM scores and the four statements. Preliminary analysis showed all four relationships to be monotonic, as assessed by visual inspection of a scatterplot (Lund & Lund, 2017). There was:

1. a weak positive correlation between Scottish PROM score and 'I was listened to' $r_s(452) = .254$, $p < .0005$.
2. a moderate positive correlation between Scottish PROM score and 'I was able to talk about what was on my mind' $r_s(452) = .451$, $p < .0005$.
3. a moderate positive correlation between Scottish PROM score and 'My situation was understood' $r_s(452) = .426$, $p < .0005$.
4. a weak positive correlation between Scottish PROM score and 'My faith/beliefs were valued' $r_s(452) = .323$, $p < .0005$.

There was therefore a highly significant correlation between all four individual items and the total PROM scores, even allowing for Bonferroni correction. The correlation was strongest in the item '*I was able to talk about what was on my mind'*. The primary hypothesis was therefore accepted.

Secondary hypotheses:

1. There will be no difference in mean Scottish PROM scores between men and women.

Despite the non-normal distribution of the PROM scores, both groups demonstrated homogeneity of variance, as assessed by Levene's test for equality of variance (p = 0.095). Because the t-test is usually robust enough to cope with lack of normality, particular where sample sizes are as large as this (Lund and Lund, 2017), a student's t-test was run to ascertain any significant difference between the groups. The males scored lower mean (sd) PROM scores 11.21 (4.86) than females 12.13 (4.45), but this difference was not statistically significant (t(380) = 1.784, p = 0.062).

2. There will be no difference in mean Scottish PROM scores between people of faith and people of none

Like the t-test, one way ANOVA is still considered robust even with violations of normality (Lund & Lund, 2017). However, assumptions of homogeneity of variance were not met either (Levene's test for equivalence of variance < 0.001), and so Welch's ANOVA was run. Scottish PROM scores were significantly different for different faith groups (F(3, 139.78) = 4.07, p = 0.008). See figure 7 and table 1.

Multiple comparisons. Scottish PROM dependent variable
Games-Howell

(I) Religion	(J) Religion	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Neither	Religious	-1.628*	0.589	0.033	-3.16	-0.1
	Spiritual	-1.983*	0.656	0.017	-3.7	-0.26
	Both	-1.128	0.588	0.223	-2.65	0.39
Religious	Neither	1.628*	0.589	0.033	0.1	3.16
	Spiritual	-0.355	0.698	0.957	-2.18	1.47
	Both	0.5	0.635	0.859	-1.15	2.15
Spiritual	Neither	1.983*	0.656	0.017	0.26	3.7
	Religious	0.355	0.698	0.957	-1.47	2.18
	Both	0.855	0.697	0.611	-0.97	2.68

Both	Neither	1.128	0.588	0.223	-0.39	2.65
	Religious	-0.5	0.635	0.859	-2.15	1.15
	Spiritual	-0.855	0.697	0.611	-2.68	0.97

*Significant at $p < 0.05$

Table 1. Games Howell post hoc comparisons

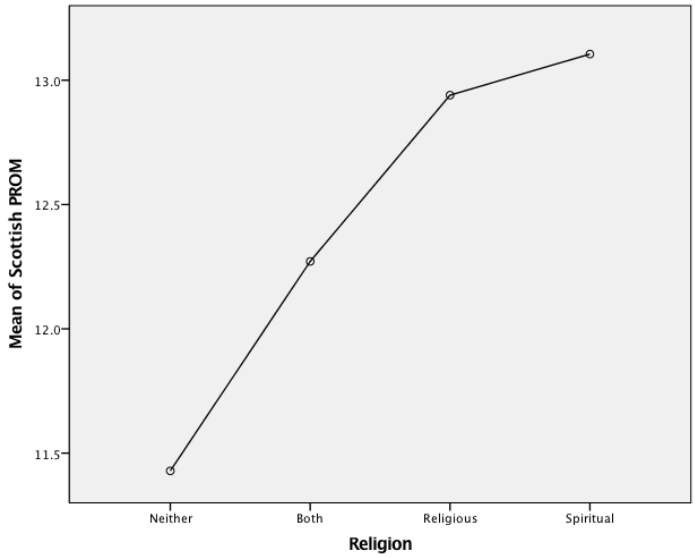


Figure 7. Means plot for Scottish PROM by religion or faith

A Games-Howell post hoc test was run (table 1). Data are mean ± (SD) unless stated. There was a non-significant increase in PROM scores from 'neither' to 'both'. However, there was a significant increase from 'neither spiritual or religious' 11.26 ± 4.56 to 'religious only', 12.89 ± 3.3, a significant difference of 1.67 ($p = 0.033$), and between 'neither spiritual or religious' and 'spiritual only' 13.24 ± 3.3, a significant difference of 1.98 ($p = 0.017$). Those people declaring themselves solely religious or solely spiritual got a significantly greater benefit from visiting the chaplain than those describing themselves as believing in both religion and spirituality or neither.

3. There will be no difference in mean Scottish PROM scores between age groups

Assumptions of homogeneity of variance between groups were not met (Levene's test for

equivalence of variance < 0.018), and so Welch's ANOVA was run. There were no significant differences between the age groups. People of all ages benefitted equivalently from the consultations with chaplains.

4. There will be no difference in mean Scottish PROM scores according to number of consultations

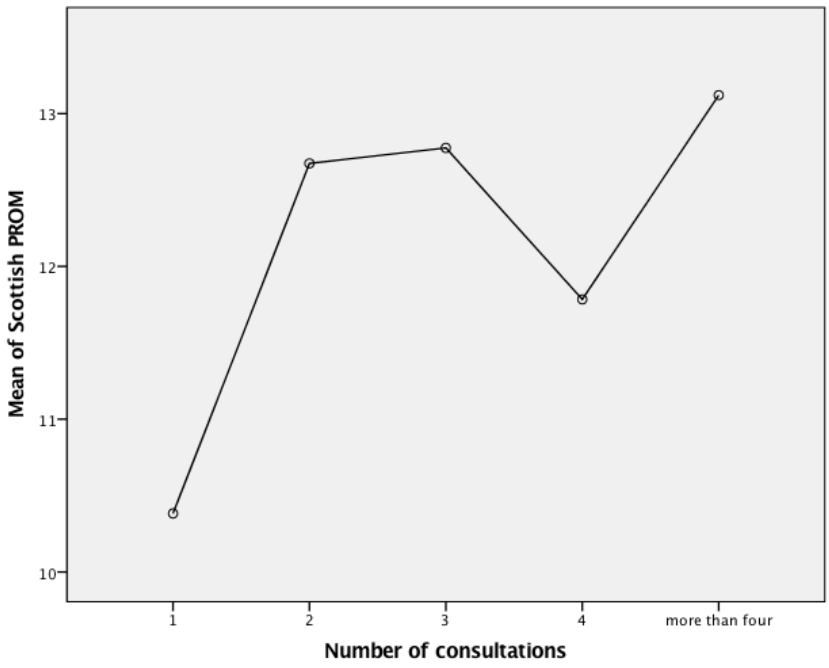


Figure 8. Means plot: scores by number of consultations

Figure 8 shows mean PROM scores by number of consultations held. There is a clear trend of rising scores to three, beyond which the relationship between number and benefit seems to go awry. Levene's test showed homogeneity of variance (p = 0.54) between the groups and so a one-way ANOVA was run to see if there was a significant difference between the number of consultations attended and PROM scores. Scottish PROM scores rose from one consultation (10.38 (4.8)) to two consultations (12.67 (4.4)) to three consultations (12.78 (4.1)) to more than four consultations (13.12(4.25)), featuring a drop at four consultations (11.78 (4.6)). The differences were statistically significant (F (4, 356) = 5.76, p > 0.001). The immediate

interpretation of this is that more consultations are better up to a point. Three consultations may be optimal. The benefit of having more consultations is not clear. The biggest jump is between one and two, suggesting that two consultations are definitely better than one.

Discussion

As predicted, 'being able to talk about what was on my mind' was the strongest correlate with total PROM scores. This means that being able to talk about what is on your mind is more important than being listened to, having your faith/beliefs valued or even being understood. All are important, but 'being able to talk about what was on my mind' was the most important element of a chaplain's consultation in these results. This section will interpret this along with the secondary outcomes: that more sessions with the chaplain led to better outcomes, but only up to a point; and that people who self-describe as either religious or spiritual, but not both or neither, scored higher on the PROM.

To explain the relative importance of being able to talk, it was first considered in relation to the other items. 'I was listened to', for example, is a necessary but insufficient aspect of two-way communication. Listening by itself may not be enough to generate any sense of resolution. For that to happen both parties need to play an active part in the consultation (Richard, Glaser, & Lussier, 2016). In a fascinating paper, Agledahl, Gulbrandsen, Førde, & Wifstad (2011) showed that some doctors in their study were highly skilled at being courteous to patients, but actually used this courtesy as a mechanism to distance patients from them; to ignore them. Naturally this was picked up by patients, who in turn also disengaged. This is hopefully an extreme example, but it demonstrates that paying attention is very important to people. Whilst listening is clearly an important element of this 'presence' it is not enough by itself.

Likewise, having 'my faith/beliefs were valued' is also a necessary but insufficient element of spiritual care. Like listening, 'having my faith/beliefs valued' is a prerequisite to a successful chaplaincy encounter but not enough in itself. Being understood, on the other

hand, is rated almost as highly as being able to talk. This makes sense. Being understood is a function of 'having my faith/beliefs valued' and 'being listened to'. It is the hopeful outcome of those attributes. However, being understood is also a function of 'being able to talk'. That is, it is hard to imagine being understood without being able to talk about what is on your mind. Being understood is the *endpoint*. So why is the means more important than the end? Logically it should be the other way around.

We would argue it is about ownership and control. Being able to talk about what is important to someone implies a sense of ownership over the direction of the conversation and suggests that, at the very least, the person has a degree of perceived control over the topics being discussed. This is very important. The act of putting into words what may be their deepest fears is hugely challenging, especially if it is in relation to illness and a poor prognosis (Courtois, 2015). Relentlessly thinking about a problem, and not being able to talk can be akin to a kind of torture, it can feel suffocating, stressful, physically painful, isolating and all-consuming (Johnson & Lubin, 2015). Being able to talk, even if there is no solution, releases the pressure of 'keeping it all in', or 'bottling it all up' (Martin, 2015).

Being understood isn't as important as being truly heard on this view. This may be because understanding is not necessarily be possible. In other words, understanding is not necessarily in anyone's gift (Häfner, 2015). Hearing the story is though. Creating the conditions for people to be able to talk is therefore the *endpoint* for chaplains (Mowat et al, 2013). Because being present is their primary function, the space opens up for people to help themselves:

> *"Being able to talk to me in confidence allows her to analyse and reflect on her situation and come to her own conclusions."*
>
> Chaplain free text in Snowden, et al., (2012, p38)

More commonplace, chaplains have no other agenda than to deliver spiritual care. They are able to be present in a way other professions struggle to be. Chaplains don't deliver clinical care - so patients are free to complain about their care, or anything else, without the perception that complaining will influence their care (Friele, Reitsma, & de Jong, 2015). Chaplains are also perceived as confidential and trustworthy (Nolan, 2016), so deeper existential issues or indeed anything at all can be discussed in a safe place. This is particularly true where fellow health and social care professionals are often too busy to do anything outside routine care (Paton, 2015). There is more and more pressure on every health professional to deliver more with less (Aiken et al., 2016) as people live longer with increasingly complex healthcare needs (NHS England, 2014). This domain, where the person is 'able to talk about what is on their mind' is increasingly inhabited *only* by the chaplain and in other settings by a pastoral care worker. The chaplain is the only person left that it is possible to talk with freely.

This depressing conclusion is hopefully not true. More research is needed to establish what, if any of the chaplains armoury could be adopted by other health professionals. That chaplains are unique has been understood for a long time. The seminal work of Mowat and Swinton (2005) showed that their neutrality sets the interventions offered by chaplains apart from those offered by any other healthcare professionals. In this space, chaplains are free to be *present*. Minton, Isaacson, Varilek, Stadick, & O'Connell-Persaud, (2017) describe presence as a function of 'sentience' and 'sagacious insight'. Sentience is beyond cognition and everyday perception according to Minton et al (2017). It is an innate ability to be present alongside the willingness to engage in meaningful discussions where the direction was unknown. The concept of sagacious insight describes the discernment one must rely on to engage wholly, with awareness, willingness and delicacy on a journey where the path is

uncertain (Minton, Issacson, Varilek, Stadick and O'Connell-Persaud, 2017).

This all sounds a bit mysterious. Interesting to note then, that Minton et al (2017) are not talking about chaplains. They are talking about nurses delivering spiritual care. This infers two things. First, and most importantly, the fact that they are trying to understand the art of being present so they can also be present with patients infers that there *is* at least some time for other professionals to engage meaningfully with patients. Secondly, nurses are still struggling to understand how spirituality can be expressed within their role (Ross et al., 2016). Chaplains by contrast already know what to do because this is their job. They help people to talk about what is on their mind by being present to the response. Whilst this very simple conclusion explains how chaplains help people, the degree of transferability to other professionals has not been studied. In other words, anyone can ask the question: 'what's on your mind?', but as yet there is no evidence that any other profession has the skills, time or neutrality to be able to hear the response.

Results also showed that people describing themselves as solely spiritual or solely religious scored higher on the PROM than those describing themselves as not religious or spiritual but those also describing themselves as both spiritual and religious. Whilst not significant, the group scoring the lowest was the 'neither' group. One explanation could be that those people clearest in their beliefs are better prepared to receive care they feel is consistent with their beliefs. Previous studies have shown the positive relationship between being religious and wanting a chaplain visit in hospital (Piderman et al., 2008). This will be explored again in future studies because previous unpublished data gathered during the validation of the PROM had shown no differences between the groups.

The study also showed that people who had two or three sessions with the chaplain reported significantly higher PROM scores than people who only saw the chaplain once. People who saw the chaplain more than four times got slightly more benefit still. The fact that there was a sharp drop at four sessions is difficult to explain, especially since the only comparable data suggested that there was no difference in benefit by having more than one session (Kevern & Hill, 2015b). The best interpretation of the overall pattern is an exponential relationship. There is a sharp increase in scores from one to two, followed by a further smaller increase at three, followed by an exponentially smaller increase as sessions increase. In other words, more and more sessions do not seem to add much benefit once a ceiling has been reached. Of course, this is describing a population, and different people clearly benefit from different interventions. However, the overall interpretation is that two or three sessions offer greater benefit than one, and following Kevern & Hill (2015), the value of more than three sessions is difficult to see.

Conclusion

This study has shown that being 'able to talk about what was on my mind' was most strongly associated with the outcome of chaplaincy interventions. This finding moves us a step closer to valuing the skills of chaplains and pastoral care workers in facilitating the conditions for encouraging people in distress to talk *as an end in itself*. For other health professions, talking is generally seen as a means to an end, a method of ascertaining the outcome. This is not the case for chaplains, an argument well developed by Mowat et al, (2013), where authentic listening was viewed as the endpoint.

Elements of this finding may be transferable to other professions. Certainly, anyone could ask: 'what's on your mind?'. It would be a very interesting research study to compare

outcomes of different professionals asking this question. Chaplains and pastoral care workers are trained to be present. They have the skills, the time and the absence of agenda necessary to authentically hear the response. There may be occasions when other professions could approach these conditions, but this needs further research.

Creating the conditions for people to be able to talk completely freely is crucial because in everyday life people largely don't talk about what is on their mind when the subject is distressing or deemed socially unacceptable or awkward in any way. In these cases, the chaplain encounter may be the only place people feel able to talk about what is on their mind. The importance of this is difficult to overstate.

Aiken, L. H., Sloane, D., Griffiths, P., Rafferty, A. M., Bruyneel, L., McHugh, M., … Sermeus, W. (2016). Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. *BMJ Quality & Safety*, (November), bmjqs-2016-005567. http://doi.org/10.1136/bmjqs-2016-005567

Bunniss, S., Mowat, H., & Snowden, A. . (2013). Community Chaplaincy Listening: Practical Theology in Action. *The Scottish Journal of Healthcare Chaplaincy*, *16*, 47–56.

Carey, L. B., Hodgson, T. J., Krikheli, L., Soh, R. Y., Armour, A. R., Singh, T. K., & Impiombato, C. G. (2016). Moral Injury, Spiritual Care and the Role of Chaplains: An Exploratory Scoping Review of Literature and Resources. *Journal of Religion and Health*, *55*(4), 1218–1245. http://doi.org/10.1007/s10943-016-0231-x

Courtois, C. A. (2015). First do no harm: Ethics of attending to spiritual issues in trauma treatment. In *Spiritually Oriented Psychotherapy for Trauma* (pp. 55–75). http://doi.org/10.1037/14500-004

Cramer, E. M., Tenzek, K. E., & Allen, M. (2015). Recognizing Success in the Chaplain Profession: Connecting Perceptions With Practice. *Journal of Health Care Chaplaincy*, *21*(4), 131–50. http://doi.org/10.1080/08854726.2015.1071543

Fitchett, G. (2011). Making our case(s). *The Journal of Healthcare Chaplaincy*. http://doi.org/10.1080/08854726.2011.559829

Flannelly, K. J., Emanuel, L., Handzo, G. F., Galek, K., Silton, N. R., & Carlson, M. (2012). A national study of chaplaincy services and end-of-life outcomes. *BMC Palliative Care*, *11*(10), 1–6. http://doi.org/10.1017/CBO9781107415324.004

Friele, R. D., Reitsma, P. M., & de Jong, J. D. (2015). Complaint handling in healthcare: expectation gaps between physicians and the public; results of a survey study. *BMC Research Notes*, *8*(1), 529. http://doi.org/10.1186/s13104-015-1479-z

Häfner, H. (2015). Descriptive psychopathology, phenomenology, and the legacy of Karl Jaspers. *Dialogues in Clinical Neuroscience*. http://doi.org/10.3897/zookeys.500.9360

Johnson, D. R., & Lubin, H. (2015). Principles and techniques of trauma-centered psychotherapy. *Principles and Techniques of Trauma-Centered Psychotherapy.*

Kevern, P., & Hill, L. (2015a). "Chaplains for well-being" in primary care: analysis of the results of a retrospective study. http://doi.org/10.1017/S1463423613000492

Kevern, P., & Hill, L. (2015b). "Chaplains for well-being" in primary care: analysis of the results of a retrospective study. *Primary Health Care Research & Development (Cambridge University Press / UK)*, *16*(1), 87–99 13p. http://doi.org/10.1017/S1463423613000492

Kim, K., Bauck, A., Monroe, A., Mallory, M., & Aslakson, R. (2017). Critical Care Nurses' Perceptions of and Experiences With Chaplains. *Journal of Hospice & Palliative Nursing*, *19*(1), 41–48. http://doi.org/10.1097/NJH.0000000000000303

King, S. D. W. (2012). Facing fears and counting blessings: a case study of a chaplain's faithful companioning a cancer patient. *Journal of Health Care Chaplaincy*. http://doi.org/10.1080/08854726.2012.667315

Lietz, P. (2010). Research into questionnaire design: a summary of the literature. *International Journal of Market Research*, *52*(2), 249. http://doi.org/10.2501/S147078530920120X

Lund, M., & Lund, A. (2017). Dealing with violations of normality. Retrieved from https://statistics.laerd.com/premium/spss/istt/independent-t-test-in-spss-12.php

Macdonald, G. (2017). The efficacy of primary care chaplaincy compared with antidepressants: a retrospective study comparing chaplaincy with antidepressants. *Primary Health Care Research & Development*, 1–12. http://doi.org/10.1017/S1463423617000159

Martin, S. (2015). “How can you be strong all the time?”: discourses of stoicism in the first counselling session of young male clients. *Counselling and Psychotherapy Research*, *16*(June), 100–108. http://doi.org/10.1002/capr.12062

Minton, M. E., Isaacson, M. J., Varilek, B. M., Stadick, J. L., & O’Connell-Persaud, S. (2017). A willingness to go there: Nurses and spiritual care. *Journal of Clinical Nursing*, pp. 1–9. http://doi.org/10.1111/jocn.13867

Mowat, H., Bunniss, S., Snowden, A., & Wright, L. (2013). Listening as health care. *The Scottish Journal of Healthcare Chaplaincy*, *16*, 39–46.

Mowat, H., & Swinton, J. (2007). *What do Chaplains do?* Aberdeen.

National Cancer Survivorship Initiative. (2013). Assessment & Care Planning Definitions. Retrieved from http://www.ncsi.org.uk/what-we-are-doing/assessment-care-planning/assessment-care-planning-definitions/

NHS England. (2014). *Five Year Forward View*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Nolan, S. (2016). “He Needs to Talk!”: A Chaplain’s Case Study of Nonreligious Spiritual Care. *Journal of Health Care Chaplaincy*, *22*(1), 1–16. http://doi.org/10.1080/08854726.2015.1113805

Paton, N. (2015). One-third of employees “too busy” for health and wellbeing. *Occupational Health*.

Piderman, K. M., Marek, D. V, Jenkins, S. M., Johnson, M. E., Buryska, J. F., & Mueller, P. S. (2008). Patients’ expectations of hospital chaplains. *Mayo Clinic Proceedings*, *83*(1), 58–65. http://doi.org/10.4065/83.1.58

Puchalski, C., & Ferrell, B. (2010). *Making health care whole: Integrating spirituality into patient care.* (T. Press, Ed.). West Conshohocken, PA.

Richard, C., Glaser, E., & Lussier, M. T. (2016). Communication and patient participation

influencing patient recall of treatment discussions. *Health Expectations*, (October 2016), 760–770. http://doi.org/10.1111/hex.12515

Ross, L., Giske, T., van Leeuwen, R., Baldacchino, D., McSherry, W., Narayanasamy, A., … Schep-Akkerman, A. (2016). Factors contributing to student nurses'/midwives' perceived competency in spiritual care. *Nurse Education Today*. http://doi.org/10.1016/j.nedt.2015.10.005

Sahlqvist, S., Song, Y., Bull, F., Adams, E., Preston, J., & Ogilvie, D. (2011). Effect of questionnaire length, personalisation and reminder type on response rate to a complex postal survey: randomised controlled trial. *BMC Medical Research Methodology*, *11*(1), 62. http://doi.org/10.1186/1471-2288-11-62

Sinclair, S., & Chochinov, H. M. (2012). The role of chaplains within oncology interdisciplinary teams. *Current Opinion in Supportive and Palliative Care*, *6*(2), 259–68. http://doi.org/10.1097/SPC.0b013e3283521ec9

Snowden, A., Telfer, I., Kelly, E., Mowat, H., Bunniss, S., & Howard, N. (2012). *Healthcare Chaplaincy : the Lothian Chaplaincy Patient Reported Outcome Measure (PROM)*. Gourock. Retrieved from www.snowdenresearch.co.uk

Snowden, A., Telfer, I. J. ., Kelly, E. K., Bunniss, S., & Mowat, H. (2013). "I was able to talk about what was on my mind". The operationalisation of person centred care. *The Scottish Journal of Healthcare Chaplaincy*, *16*, 14–24.

Snowden, A., & Telfer, I. J. M. (2017). A Patient Reported Outcome Measure of Spiritual care as delivered by Chaplains. *Journal of Health Care Chaplaincy*, 1–25. http://doi.org/10.1080/08854726.2017.1279935

Wolpert, M. (2014). Uses and abuses of patient reported outcome measures (PROMs): potential iatrogenic impact of PROMs implementation and how it can be mitigated. *Administration and Policy in Mental Health*, *41*(2), 141–5.

http://doi.org/10.1007/s10488-013-0509-1

There are parallels here with early twentieth century psychiatry. Karl Jaspers was a Swiss psychiatrist working with people suffering hallucinations and delusions in the 1920's. Diagnostic criteria for schizophrenia were not clear. There was no consensus on the signs and symptoms that would distinguish someone with a truly psychotic presentation from someone with less harmful symptoms. Jaspers came up with the term 'ununderstandable'. If he could not understand the thought processes of his patients then they were 'ununderstandable' and therefore psychotic. This distinction has broadly persisted. The problem with it should be obvious in the context of this paper. Understandability is a function of the clinician. A poor clinician would likely reach a conclusion of ununderstandability a lot quicker than a good one, such as Karl Jaspers. A good one would more likely want to hear more before judging.

Being able to talk about what's on their mind depends on the optimum components of a situation – time, privacy, calmness - coming together at the same time. In child health nursing, it is very often the student nurses who patients and parents will talk to, because they are more available than other members of the team. If there is not an available 'conduit' and the staff are rushed and busy with other things, it will not happen.