

# Active Listening by Hospital Chaplaincy Volunteers: Benefits, Challenges and Good Practice

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**Abstract:** Active listening (AL) is a communication technique frequently used in counselling. This study explored the feasibility of implementing a ward-based AL intervention for patients by chaplaincy volunteers in the UK National Health Service. Seven focus groups (n=47) included healthcare researchers, lecturers, nurses, patients, AL tutors, active listeners volunteers and chaplaincy volunteers. Acceptability and perceived effectiveness of a patient/volunteer listener intervention were explored. Analysis followed the framework approach. Four themes emerged: (a) Listening as a wellbeing generator; (b) Benefits of AL delivered by volunteers; (c) Spirituality and public perceptions of hospital chaplaincy; (d) Challenges of structured communication techniques in acute care. Participants reported positive attitudes towards the introduction of AL provided by volunteers in acute wards. They shared a common belief that when people are listened to, wellbeing improves through control, choice and empowerment. Patients' acceptability of the intervention increased if it was delivered by volunteers.

**Keywords:** Active listening; health communication; hospital chaplaincy; volunteers.

## Introduction

Active listening (AL) also called supportive, empathic or reflective listening, is a communication skill that involves hearing, evaluating and responding to what is

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heard (Hargie, et al., 1994). It requires the active and emotional involvement of a listener in at least three key stages: (a) active sensitivity to the emotional needs of the speaker; (b) processing by remembering, understanding, and comprehending conversational content; (c) responding back with verbal and nonverbal communication to indicate active attention (Bodie, et al., 2013). How active listening aids relationships other than the patient- clinician relationship is still not widely empirically documented (Weger et al., 2010).

What has been highlighted is the failure to listen to patients in the British National Health Service (NHS). A recent public inquiry noted that in some hospitals 'management had no culture of listening to patients' (Francis, 2012, p.44). If listening to patients' concerns and treating them with respect and empathy becomes a priority at the centre of healthcare delivery, strong, interpersonal communication skills are essential for patient outcomes (Thompson, 1998; Babrow and Mattson, 2003; Silverman et al., 2013).

Although communication occurs in formal and informal interactions in healthcare institution (Cline, 2003), research has largely focused on formal interpersonal encounters, primarily between physicians and patients (Ong et al., 1995; Thompson, 2003; Connolly et al, 2010; 2014). Some of the patient centred communicative behaviours commonly identified in the literature are empathy, immediacy, humour and listening (Steward, 2001; Epstein et al., 2005). Despite scholar disagreement on listening definitions ( Witkin and Trochim, 1997; Janusik, 2002; Bodie, et al., 2008), two main models (Witkin, 1990) have been used to explain listening: cognitive (based on the listener) and behavioural (based on the listener-speaker interaction and the environment).

There is an ongoing debate about the value of chaplaincy in hospitals (Orchard, 2001) but listening to patients remains one of their key contributions to healthcare institutions (Piderman et al., 2008). Since the inception of the NHS in 1948, there has been a long tradition of employing hospital chaplains from different denominations to provide spiritual care. Currently chaplaincy volunteers and trained lay visitors assist chaplains with spiritual, pastoral and social support. Chaplaincy volunteers have increased their presence in hospital settings for two reasons. Firstly, funded chaplaincy appointments have not increased in line with the number of patients accessing NHS services and volunteers have become a significant resource to provide direct contact with as many patients as possible. Secondly, smaller faith groups have enjoyed limited opportunities to apply for paid positions and many have begun their involvement in chaplaincy as volunteers, although this has often been a slow process (Gilliat-Ray et al., 2013).

In the UK, volunteers have engaged in a wide range of roles (instrumental, emotional and strategic), contributing at different levels to the delivery of health and social care in the public sector, including a growing community of lay involvement in public health programme delivery (South et al., 2011). How volunteers have contributed to the emotional needs of patients has not been investigated, with institutional studies mainly focusing on the communication skills of paid staff (Naylor et al., 2013). The importance of exploring the impact and scale of volunteering in healthcare institutions relates to the need to re- think the role of volunteers and also to add evidence to the literature associating support from volunteers with important patient outcomes such as improved wellbeing and health behaviours (Casiday et al.,

2008; Department of Health, 2011). Against this background, this study explores the benefits and challenges faced by chaplaincy volunteers seeking to implement a hospital-based AL intervention for patients in the UK NHS. In the process of doing this, some good practices in AL are also identified.

## **Methods**

A two-phase study was undertaken to develop an AL intervention in acute care. The first phase, completed in September 2012, was a focus group study, assessing the acceptability of the AL training package for chaplaincy volunteers to use in hospital. The second phase aimed to explore the feasibility study to support the development of a randomised control trial to measure the therapeutic value of AL. The study was granted ethical approval by the School of Healthcare Research Committee at the University of Leeds (SHREC RP 226).

The data reported in this article is for phase one of the study and originated from a series of seven focus groups conducted between February and April 2012. Purposeful sampling was used to recruit participants and to maximise sample diversity. Participants were eligible to participate in the study if they were at least 18 years of age and if they had been identified as belonging to the stakeholder category in each group. These included healthcare academics (researchers and lecturers), postgraduate nursing staff, hospital chaplaincy volunteers, trained active listeners volunteers, active listening tutors and patients.

Stakeholder categories were purposively selected because of their theoretical and/or practical knowledge of listening processes in acute care. Focus group composition was homogenous (participants from each specific stakeholder category were placed in the same group) in order to maximise participant's shared experiences (Kitzinger, 1995). Group sizes varied (3-12 people) achieving a total sample of 43 participants (See Table 1).

**Table 1:** Focus groups participants

Group Code	Type of Group	Participants
G1	Health Lecturers	4
G2	Health Researchers	3
G3	Postgraduate Nurses	6
G4	Active Listening Tutors	12
G5	Trained Active Listeners	8
G6	Hospital Chaplaincy Volunteers	6
G7	Patients	4
Total		N = 43

Participants were recruited via email from different locations: a university campus for health lecturers, researchers, patients and students; a local hospital chaplaincy team for chaplaincy volunteers; an organisation that provided active listening training for tutors and trained listeners (Acorn Christian Healing Foundation). Six focus groups were held in a meeting room on campus and the discussion with chaplaincy volunteers took place in the local hospital chaplaincy department.

Two researchers were present in each session: one as a facilitator and the other as an observer. Following a 15 minute DVD demonstration (filmed by Acorn) of an AL patient with a chronic condition/listener intervention, impressions were solicited to explore the acceptability and perceived effectiveness. Focus groups lasted from 60 to 90 minutes and were audio-recorded and transcribed verbatim.

**Table 2.** Focus groups topic guide

<b>The focus group discussion will focus on the following areas:</b>	
Any benefits envisaged and/or experienced by using the training package	Any barriers to offering chaplaincy volunteers as active listeners
Any benefits to offering chaplaincy volunteers as active listeners	How the training may benefit or proved to be a barrier to improved patient care compared to existing service provision
Any difficulties envisaged and/or experienced using the training package	The impact of using the training material for volunteers in a medical ward setting
Could this be developed into an intervention in an acute medical ward?	
<b>Questions</b>	<b>Prompts</b>
Q1. Let's start the discussion by talking about what you think about this model of active listening? What did you think about the DVD?	<p>What is good about the training?            What do you think are the benefits of this training?            What is not so good?            What difficulties do you envisage/have you experienced in this training?            What would be the benefits of using volunteers trained in this way?            What would be the difficulties?            Would it work in practice on a hospital ward?            Perhaps you could describe how you could see this model working in a hospital ward?            What about when people go home?</p>
Q2. What do you think would be the impact of offering chaplaincy volunteers trained to be active listeners?	<p>Do you think people would be able to be discharged from hospital earlier?            Do you think it would affect any patients' outcomes e.g. anxiety, pain or any other? If so how do you think it would affect these outcomes?            How do you think the offer would be received? By patients? By staff?            Do you think it makes a difference that is a chaplaincy intervention?            What would be the best way to offer the intervention? For example, referral from ward staff, or leaflets given to patients, or something</p>

	else?
Q.3. Can I now ask your opinions on developing a chaplaincy intervention using volunteer active listeners in this setting?	<p>Can you describe what you think an intervention designed to use active listeners on a ward may look like?</p> <p>Should active listeners visit on demand? From patients? From ward staff?</p> <p>How long should listeners stay with patients for each visit?</p> <p>How many visits would be appropriate/necessary?</p> <p>How can confidentiality be assured in this setting?</p>
Q.4 Is there anything else that you would like to say that hasn't been covered yet in the discussion?	

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After explanation of the study and signed consent, each focus group session was structured around a series of open-ended questions (see Table 2). All the research questions and prompts were included in the topic guide used to facilitate the group discussions. These included: group perception of barriers and facilitators of AL intervention as showed in the DVD; training hospital chaplaincy volunteers as active listeners; implementing the AL intervention in the acute care environment.

Data analysis followed the framework approach (Ritchie and Lewis, 2003) and it entailed three main steps. Initially, an experienced qualitative researcher (AM) read through each transcript and identified themes. NVivo 8 qualitative analysis software was then used to create categories to represent these themes. As coding progressed and the number of categories developed, they were grouped into broader categories. These were reviewed by a second investigator (MB), producing agreement on the coding and emergent themes. Finally, having compiled texts by codes, framework tables were created with summaries of each theme to establish cross-references and by exploring relations among themes and established literature. Further theme development and consensus was sought through discussion with the wider research team (SJC, CS).

## Results

Examination of the focus group data revealed four recurrent themes (listed below). In the following section, we describe each theme and provide illustrative quotations with pseudonyms.

- (i) Listening as a wellbeing generator
- (ii) Spirituality and public perceptions of hospital chaplaincy
- (iii) An intervention delivered by volunteers and
- (iv) Active listening as a structured technique.

### Listening as a Wellbeing Generator

All groups reported advantages of an AL intervention for hospital patients. In particular, they shared a common belief that when people are listened to, this directly reduces their anxiety levels. Hospitalisation for any illness exacerbates a patient's sense of powerless and lack of control (Beder, 2006) affecting their wellbeing.

Participants highlighted the element of choice and consequent empowerment this offered to patients as one of the most significant benefits of AL. This relates not only to the listening technique, which is patient-driven (by using a non-directive approach) but also by the service itself, which is an option offered to patients to accept or refuse. A listener with no agenda, no judgment or disapproval, was seen by nursing staff in our focus group as an important attribute of the service provided by chaplaincy volunteers. Health lecturers also viewed this characteristic as a powerful element of the intervention:



*Our biggest limitation as health professionals is that we don't spend enough time talking to patients and it's good if someone else can help them to do that and help them, just by them talking through and being able to express themselves.[...]I think it's in stark contrast to the rest of hospitalisation in that you're having someone coming to you who doesn't have an agenda at all. Whereas everyone else that has an interaction wants a certain piece of information from you when you're in hospital. [G1]*

Experienced AL tutors in our focus group pointed out this empowerment as a key feature of the intervention when applied in acute care. Hospitalisation increases vulnerability to anxiety and by giving patients control over what they want to talk about, there is the potential that patients will feel less anxious. Patients in our user group linked being listened to with being acknowledged as an individual. One of our focus group participants with chronic cancer explained the benefits of the intervention in the following terms:

*Someone makes you feel important, not just a number, not just a bed. 'We need some Paracetamol at 34' [they say in hospital]. So, you've now become 34. But unfortunately they are so incredibly busy[...]. So I can see why that happens. So someone who just has time, someone that has time. Because they are volunteers, therefore hopefully, they're not pushed for time. They might say initially, 'okay, well we'll have a chat, maybe 20 minutes,' but then if you feel that you need 40 minutes then they have no problems, they can afford 40 minutes, I think that's very rewarding. [G7]*

As this participant explained, patients understand that the contemporary model of acute care does not account for listening time as an interaction expected of healthcare staff. In their encounters with staff, patients' individual characters and how these are affected by illness or acute admission are not taken into account. The task-oriented approach challenges opportunities for healthcare staff to incorporate in

their daily routine the option to spend extended periods of time with patients or to provide a more individualised form of care.

Experienced listeners explained that offering an individual experience even if it is of short duration can have an immediate tangible effect in acute patients.

Patients in our focus group noted that being given the opportunity to talk allowed them to listen to themselves and that in itself had the potential to generate change:

*Participant 3: Talking to someone gives you space to listen to yourself as well. When you're talking to someone where the conversation leads you, maybe your thoughts wouldn't have led you there. But when you're actually talking to someone and getting some response, just knowing that someone is actually listening and heard what you were saying... Because in hospital you can be in a number of days and feel that nobody's really listened to what you've said [...].*

*Participant 2: You know they're just waiting for a symptom and it's going down the diagnosis route, isn't it? You just know they're waiting for keywords. It's like, 'Yes, yes, get the emotional stuff out of the way, yes.' And I used to be like that as an advisor if I was doing legal stuff, I'd be like 'Yes, okay, and has your mother kicked your arse or not? [laughs]', because you're trying to get to the legal point. And I think doctors do it...*

*Participant 4: Sometimes just by offloading it actually speaking and, the person would acknowledge it, suddenly you get your answer yourself in your head. And you think, 'oh do you think if I went this, this and this?' And it's as if they're giving you permission to go off on another route. It's a funny thing, isn't it?*

*Participant 2: It's that light bulb moment. [G7]*

The transformational power attributed to listening encounters was unanimous within all participants and groups. This undisputed outcome seems to be based on personal experiences of being listened to or perceiving visible outcomes of those who have been listened to. The tendency for health institutions to focus on clinical outcomes can often be at odds with opportunities to listen and be listened to.

### **An Intervention Delivered by Volunteers**

Acceptance by healthcare staff of AL interventions is of great importance because staff are, in practice, gatekeepers and potential referral sources. Nurses welcomed an intervention that is delivered by volunteers and not NHS staff and also by somebody outside the clinical teams. Nurses do not always have time to spend listening to patients and patients do not always share things with relatives, perhaps not wanting to upset them with certain illness related issues. Staff accounts suggested that the opportunity to talk to a 'stranger' without links to the institution could be potentially beneficial for overall patient care.

For example, in the Liver Transplant Unit, where patients sometimes cannot talk to doctors, nurses or their relatives about behaviours that could jeopardise their transplants, they benefit from discussing potentially damaging behaviours with an impartial individual. Confidentiality is an important issue because staff perception was that volunteers would not have to report this back to staff; however, in the NHS, chaplaincy volunteers do hold contracts with the institution and are accountable to the organisation. Although they are widely perceived to be set apart from the day-to-day running of the health institution, they may, under certain circumstances, be expected to report back on something shared by a patient, despite both patient and staff being unaware of this obligation.

The link between acceptability and volunteers delivering the intervention was confirmed in the focus groups with volunteers but also patients, who explained how feelings of vulnerability decrease if interventions are delivered by non-staff. The following conversation between patients describes this view:

*Participant 3: All patients feel vulnerable, and that can make some people stroppy and difficult to deal with. And you become then a 'difficult' patient. Whereas someone like this coming in, sort of separate, especially as a volunteer somehow, not paid by the hospital...*

*Participant 4: So they're separate to the others...*

*Participant 3: Yes, sort of they are. I think you feel it as an 'in-between' sort of, they're part of the structure but they're not part of the paid structure, the employment side. And I think you can sometimes share with them... [G7]*

Several reasons were given for favouring volunteers: they could provide more time than staff; patients could feel more able to offload without the worry that 'they may not like them'; volunteers were seen as bridges to the outside community. Examples were given from their own experiences as hospital in-patients and how the lack of contact with the outside world had increased their anxiety. This closeness with the community was related to feeling like a 'whole person' and not like institutionalised patients. This was explained by one of the patients with the following personal example:

*I didn't realise there was a postal strike when I was in hospital and my mum had taken my young son to relatives in Shropshire to take pressure off my husband. I wasn't getting any letters and I was getting so stressed out. Probably if I'd have had a conversation with somebody about why aren't they writing to me and stuff, they would have said, 'well there is a postal strike on,'*

*and that would have just calmed me. But suddenly I got loads of letters telling me how my little boy had been. But I wouldn't want them to do stuff for me, because I have a fight about this myself that as much as I can do I want to do.*  
(G7)

Participants in all focus groups seemed to agree that volunteers were potentially in a uniquely privileged position to offer patient-centred communication, understanding patient's perspectives within his or her unique psycho-social context.

### **Perceptions and Myths about Hospital Chaplaincy and Spiritual Care Providers**

Hospital chaplaincy teams are a well-established service in acute care. Healthcare staff are used to the presence of the chaplaincy team, including volunteers, in the wards. Nurse participants explained how patients frequently require a conversation with the hospital chaplains or they may ask for their community religious leader to be contacted while on the ward. Chaplaincy services are available and often publicised in posters on the wards. There is evidence that staff are aware of patient's spiritual needs and religious affiliations and referrals to this service are part of their routine clinical practices. However, a physician lecturer explained that from her work in a hospice she had observed how many patients did not want to speak to the chaplain "just because she's the chaplain. So it's a barrier in terms of you will lose some of your audience"[G1]. Therefore benefit was recognised in the distinction between qualified clergy and volunteers. Nurses in the focus group referred to the fact that the listener in the DVD "did not look religious", did not have the collar; they thought that 'looking religious' might put some patients off.

Health researchers in our focus group had experienced the need of patients with critical illnesses to talk about spirituality and thought a listening service provided by chaplaincy volunteers could meet that need. The following quote from an experienced health researcher illustrates how this relationship is also present in conversations with patients for research purposes:

*I have quite a lot of experience researching people in complementary therapies, and even though a lot of people think it is strange crystals or something, actually they believe that spirituality is perhaps the most important part of the healing process. Because many of them aren't religious, they're very much against organised religions. [G2]*

Factors that could hinder patient engagement with AL were associated with patient's perceptions of chaplaincy services and patient's individual characteristics. Hospitalisation is a time of fear and vulnerability for the individual who may well have to face their own mortality for the first time. This increased spiritual awareness was identified as an unmet need that chaplaincy volunteers could help with. However, patients without a faith acknowledged that, although their previous perceptions of chaplaincy would influence their initial views, their listening needs would overcome those perceptions and they would be open to a listening service provided by chaplaincy. In the following quote, a patient with a chronic illness described how despite not having a belief system, she had found spiritual encounters helpful:

*I'm gay and at the moment, with everything that's going on about gay marriage, I've got an absolute ... about any religion really. So it would take a lot to get over to me. And yet I know I used to be a homelessness advisor, and that used to get really quite stressful. I'd have a whole day of hideous situations with people, poverty and everything. And I just used to go and walk*

*into the Cathedral at lunchtime, just because I wanted peace and quiet. And once the vicar did pop over and said, 'Oh I've seen you come in', and I just explained why I came. And he said, 'Well that's absolutely fine, that's what this building is here for that as well, you don't have to pray or whatever'. But it was just somewhere I could just completely calm down. So I think, I would possibly use the chaplaincy, if I knew I wasn't being judged; if I knew my gay lifestyle was not going to be judged. So I think you've got a lot to get over with people who aren't actively religious or actively Christian I think, before someone would use this service. And yet it could be a very, very good thing for people.[G7]*

The recurring theme of recognising the value of visits from active listeners was evident from non-religious participants, with the provision that the approach and introduction is of great importance to remove potential subconscious barriers.

A fundamental lack of understanding of what modern chaplaincy means and offers within the NHS was identified as a barrier. This was expressed by patients and was also part of the daily visiting experience of chaplaincy volunteers. Hospital volunteers' accounts confirmed patients' lack of knowledge about chaplaincy and how they often had to explain what chaplaincy is and means. This process of continuous self-explanation made hospital visiting more challenging for volunteers. Participants expressed how this barrier became stronger depending on patients' previous views and experiences with religion. However, they also thought that it could be overcome through information about what the service offers and why it is offered. In summary, ensuring that potential users of AL understood that there was no spiritual agenda was an essential requirement identified by patients, healthcare staff and academics.

Within this theme of the apprehension associated with the patients' perception of hospital chaplaincy, we identified subthemes, which characterised how the presence of chaplaincy teams in the ward seemed to create emotional reactions in patients ("I have been on a ward where the chaplaincy comes round, and you can physically see patients going down [on their chairs]" [G7]). These seem to be related to the following pre-established perceptions about chaplaincy:

- a) Chaplaincy as proselytisers: the perception that chaplaincy may persuade them to join a religious group was experienced by chaplaincy volunteers who perceive this apprehension in their daily dealing with patients: *I usually say, 'I'm H and I'm from the chaplaincy' and sometimes they look absolutely horrified. And when they do I will probably say something like, 'Don't worry, I'm not here to try to convert you to some strange religion' or something like that...*
- b) Chaplaincy as a representation of the power of religious institutions: their experiences of such organisations translate into a fear of being judged:

*In different religions the minister -or whatever they're called- they've got a lot of power over their people. We had some friends that were Catholic and they were frightened to death if the priest knocked on the door. And they were really frightened and, their demeanour changed. Well, in a hospital setting if the minister, vicar, imam or whatever they call it, was wheeled in, that blood pressure would go up. [G7]*

- c) Chaplaincy as last rites administrator: the presence of chaplains in the wards where patients are acutely ill can be associated with one of the roles of chaplaincy as giving last rites and therefore representative of impending death. This association was expressed by patients in our focus group and confirmed by



hospital chaplaincy volunteers who, confronted with this association, developed mechanisms to overcome this barrier. An experienced volunteer in an acute cancer ward explained how changing the way he introduced himself to patients helped with distancing himself from last rites administration:

*My experience on the cancer ward is that when I first started, of course I was very nervous so I used to introduce myself as a chaplaincy visitor, and it was sending alarms. I had one man say, 'Oh, my goodness they didn't tell me I was that ill I need a chaplain'. So over the years with experience I don't introduce myself as a chaplaincy visitor, I call myself the ward visitor from the chaplaincy centre. Straight away, once you say that, barriers are broken down. [G6]*

Some volunteers have naturally developed effective ways of introducing themselves dependent on the sensitivity and context of the ward to avoid chaplaincy-related myths affecting their relationship with patients. The perceptions described above must be balanced against patients' desire to have their spiritual and existential needs addressed by their healthcare institutions (Sinclair and Chochinov, 2012).

### **Active Listening as a Structured Communication Technique**

The fact that volunteers were the key intervention deliverers was also seen as a limitation. Health researchers questioned to what degree volunteers would be able to embrace the AL approach and deliver it in a standardised way. This reticence has previously been encountered by volunteers running AL services in healthcare settings. A volunteer [G4] in charge of a listening service in a GP surgery explained how this barrier was overcome when the service was established and patients who had used the service had given positive feedback to their GPs.

Challenges from the perspective of the listening skill in itself and how it would perform within the complexity of acute care were a recurrent theme across all groups. The quote below from a focus group participant, a nursing academic with expertise in acute care research, summarises the need for designing an intervention that is feasible within a challenging context:

*[Implementing AL in hospitals] is a unique opportunity; it's a very comforting and potentially beneficial thing if it happens in a skilled way. But acute care is an extraordinary difficult place to do just that. And it's not that it can't happen, it's whether people can create those conditions through this sort of training. And that is much more than principles, it's a lot more about practice and engagement with a range of individuals [...]. So I think the potential is there but the benefits are not immediately apparent to me without considering those things. [G1]*

Those difficult conditions identified by this participant create a challenging context to implement structured communication techniques. In AL, once the first open question has been put to the individual, the listening intervention is performed in an ordered approach (beginning, middle and end) based on two general principles that offer a clear structure for the listener: mirroring and goal setting.

- a) The mirroring technique (also referred to as “reflecting back”) consists of repeating the individual’s words (feeling words) as a prompt to encourage expression of feelings without commenting on the content. The listener’s self-knowledge of their own preconceived ideas and judgments (‘filters’) must be recognised and this acknowledgment acts as way of refraining from giving an opinion or offering their own story. Reflecting back is also used as a form of

clarifying and summarising content; this demonstrates to the person that they have been heard. Trained active listeners consulted in our study explained how in practice this technique cannot always be applied to all listening encounters, as this quote illustrates:

*That [the DVD] is the perfect model that we're taught to do, but particularly, we use it in a widows group and we use it visiting people at home who have got terminal cancer. And sometimes you have to adjust it. Whereas in our sit and listen service, we give an hour and we do it more or less to that model, but you have to be a little bit flexible. [...]When we're visiting cancer patients we listen, listen, listen. We listen so much because you can't reflect back negative things. If they're saying to us, 'I'm really worried about dying,' you wouldn't say, 'so you're worried about dying'. You wouldn't totally reflect that.*  
[G4]

Some practitioners described that with experience they have developed tacit knowledge, which helps in deciding when and how mirroring can be used. All focus group participants who had not participated in AL training courses expressed concerns about mirroring; emotional reactions to this technique were strong, with clear rejection in some cases. Concerns that it could lead to an effective intervention for acute patients were based on two main areas: i) real listening conversations with people are complex and this technique may fail to approach that complexity; ii) patients may prefer a more directive approach but they may fail to express that because of the vulnerability of acute care. A psychologist participating in the study summarised this concern expressed by health academics in the focus group:

*Many people, if they were literally just having someone as that sounding board, and that's all they were getting, they might just be sitting there thinking, 'What's going on here? How is this helpful?' And perhaps because they're in a vulnerable position anyway, because they're unwell, because, all sorts of other reasons they might not feel able to say that. [G2, clinical psychologist]*

Although the importance of having space and time was recognised, it was felt that sometimes people wanted help in framing their own solutions or looking at alternatives. Nevertheless, the need to signpost people to other services (i.e. counselling, bereavement services, etc.) may jeopardise the self-empowering principle in AL. There is a competence to be learned by the listener that relates to the ability to interpret individual goals, and how to hand over information in a sensitive manner. Goal setting is further explained in the next section.

b) In AL sessions, after certain content has been disclosed, the listener will focus the individual into prioritisation ('Out of all you have been saying, what do you think is most important?') and goal setting. This is done by asking the person to set a goal and then to generate their own ideas about how they might achieve that goal ('is there anything you want to do about it? '). This step also encounters difficulties in some listening interventions as AL tutors explained:

*With bereavement these questions don't actually [apply]... We're always told this, that with bereavement, either cancer or bereavement you can't actually answer 'what is the most important thing you've told me today?' [G4]*

This raises the question of whether goal setting is a step that may need special attention within the context of acute care. Patients experiencing an acute

health crisis may be ready to make changes in their life, to re-evaluate goals and values but feel powerless to do so.

The finishing question is also open ('how would you like to end this conversation?' 'now we are finishing can you say how you are feeling?') by giving a clear indication that the listening intervention is about to finish. It is also acknowledged that the opportunity for prayer exists with an active listener from chaplaincy and this sets it apart from other AL interventions. The ability for nurses to provide prayer within the framework of spiritual care giving is a debated issue. However, it is acknowledged that prayer provides the potential to be supportive (Royal College of Nursing, 2011). Despite its disputed place in clinical practice, recent research has suggested that in life limiting illness most patients and practitioners view prayer as spiritually supportive (Balboni et al., 2011). If the listener and patient are both people of religious faith, the final prayer at the end of a visit may recognise and affirm that conviction by its choice of language.

This sequenced, structured form of listening offers challenges in every step for acute patients. Barriers are located in patients' characteristics (i.e. hard of hearing impairments, sleepy); content of the patient's discourse (i.e. repetitive story, bereavement, anger); specialty (i.e. cancer, mental health). However, despite their dislike of such a structured approach, healthcare staff and patients reflected on how this form of listening offered the potential to give power removed in hospital back to the patients. Patients listened to in this way control what they want to talk about as opposed to the regular ward conversations controlled by healthcare staff.

## Discussion

The purpose of this study was to examine the feasibility of implementing a hospital-based AL intervention for acute patients by chaplaincy volunteers in the UK. Overall, the participants emphasised the positive effect listening can have on patients. The themes identified were a consistent thread in the professionals' and patients' perspectives on listening. The four interconnected themes and their sub-themes formed a conceptual model to make sense of a listening intervention provided by hospital volunteers. This conceptual model may act as the backdrop to more focused investigation for implementation and evaluation purposes. This model relates to listening theories that do not focus exclusively on listening technique but that highlight the importance of the context in which communication takes place.

A coherent theoretical approach is critical for the study of listening interventions (Purdy, 2011). Bodie et al. (2008) established three main components in the process of listening: listening presage (person factors and listening context), listening process (mental processes and overt behaviours), and listening product (knowledge, relationship, affect). The themes in this study reflect how listening interventions in acute care are inevitably shaped by the listener (chaplaincy volunteers), the listened to (acute patients), the relationship they establish and the context in which this happens. The themes resonate with those components found in the communication literature.

The results of this study also serve to deepen our understanding of listening in acute care. Shifting the focus from the listening technique to who is listening, to whom and in what circumstances, provides renewed understanding of the listening process in healthcare. Traditionally, clinician–patient communication serves as a

primary mode for shaping communication in acute care and seems partially responsible for shaping patient perceptions and experiences (Nyden, 2003).

However, we argue that understanding patients' perceptions and experiences of other encounters within acute care is equally important. Most scholarship on communication in hospitals focuses primarily on how paid employees relate to patients (Connolly et al., 2010; 2014; Silverman et al., 2013) and how they manage emotions emerging from those encounters. Chaplaincy volunteers' contribution to face-to-face dialogue in hospital is significantly different from other kinds of listeners. Their interactions with patients are not driven by models of information acquisition (Bostrom, 1990) but based exclusively on affective oriented objectives demonstrated largely through nonverbal communication.

The unique role of the volunteer in health institutions has been described, especially within the hospice literature (Planalp and Trost, 2008). The development of training programmes to teach volunteers basic communication skills including listening (Coffman and Coffman, 1993) and the personality traits of volunteers have been frequently researched. Some authors have suggested that hospice volunteers are more likely to provide emotional support to patients than hospital volunteers, on the basis of their ability to communicate empathy (Egbert and Parrot, 2003). These studies have provided information on necessary communication skills to give emotional support.

The volunteering literature suggests that volunteers, regardless of their previous paid experience, required specialised skills for the tasks they performed. A relationship between volunteers' training, the quality of their interventions (Souza and Dhimi, 2008) and their commitment to service (Nassar-McMillan and Lamberd, 2003) has been extensively described. Our findings suggest that listening

encounters are attributed beneficial outcomes by healthcare staff and patients. The patient-centred care drive in health services draws on concepts of empathy, respect and unconditional acceptance that can be found in AL encounters. Task-oriented communication, however, was not perceived by patients in our focus group as a preferred form of communication. Our results emphasise the importance of communication 'without a task' for patients to feel respected. Patient empowerment through acknowledgement is the key emergent theme.

This research presents several practical implications for both research and clinical practices. AL implementation involves complexity in every aspect. Insight into the important processes can help researchers and practitioners anticipate which strategies may facilitate the development of AL as planned and which areas may need to be re-appraised. Our findings highlight a key area that could determine acceptability in those who will be delivering an AL intervention: how the service is introduced to the patients. The subtle difference of communicating ones credibility (acceptability) as a ward visitor first and foremost may be worth exploring further. Chaplaincy volunteers may feel their primary credibility and identity comes from being part of the chaplaincy team and this may consciously or subconsciously be reflected in their approach.

Structured listening approaches encounter challenges within acute care. This is not only because some patients do not have the physical or mental capacity to communicate easily but also because the physical environment (background noise, lack of privacy, interruptions, etc.) of hospitals influences communication behaviours (Pepper, 2008). Equally important, our results suggest that listeners such as chaplaincy volunteers may be reluctant to embrace the structured listening approach. This could be because their perception is that they already possess



listening skills that have worked for them and that are an essential part of their whole identity and sense of self (Kilpatrick et al., 2010).

### **Limitations**

This research contains several limitations. The results and implications of the present work should be qualified by the exploratory nature of the study since participants did not directly experience the intervention, and because their responses to AL were not observed or measured with specific variables. The focus of the investigation was hospital chaplaincy volunteer AL; healthcare professionals and patients may perceive AL interventions offered by other providers differently. Other stakeholder groups (i.e. physicians, allied health professionals, patients with specific conditions) may raise different, but equally relevant, aspects of the intervention. The study was located in the UK where most patients are treated and funded through the National Health Service, so the results may not generalise to countries with different hospital chaplaincy structures and traditions.

### **Conclusion**

Current patient care models do not allow enough time or recognition for listening encounters with patients. Despite organisational barriers embedded in acute care, healthcare professionals and patients emphasised the positive effect listening can have on patients. Feasibility studies are warranted to test the effectiveness of a structured communication approach within the challenges of an acute care. Patient interactions outside those shaped by the need to acquire targeted information are fundamental aspects of patient-centred care and chaplaincy volunteers can provide these encounters as part of their routine practice in acute hospitals.

**Acknowledgement:** The Acorn Christian Healing Foundation, a charity that provides AL courses, sponsored the development of the study. The authors thank Mrs. Helen Rayfield for editing the article.

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