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

Abstract

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

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

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

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

Introduction

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

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

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

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

Background

Chaplaincy in the UK context

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

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

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

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

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

Aims

The aims of this study were to:

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

Methods

Ethics, sampling and recruitment

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

Data collection

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

Interpretative phenomenological analysis (IPA)

IPA, developed by Smith (1995, 1996) is a seven-phase (Table 1) analytical method that examines human lived experience, expressed in its own terms rather than from the perspective of pre-defined categories (Smith, Flowers, & Larkin, 2009); essentially committed to understanding the first-person perspective (Larkin, 2012).

Insert Table 1

IPA was utilised as a qualitative method to facilitate interpretation and analysis of patients' lived experience of the CfWB service. However, it was recognised CfWB themselves would regularly utilise phenomenological ways of working with patients to enable patients to find meaning and purpose in their struggles, although not necessarily term their work 'IPA'. Essentially, the spiritual care offered to patients by CfWB comprised a "psychotherapy based on philosophical-phenomenology of using the human self as a therapeutic tool" (Ramakrishnan, 2015, p. 7). Parameshwaran (2015) suggests chaplains

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

Development of superordinate themes

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

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

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

Results

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

Insert Table 2

Patient characteristics

Demographics

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

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

Insert Table 3

Superordinate Theme 1: Loss

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

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

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

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

Superordinate Theme 2: GP care

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

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

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

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

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

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

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

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

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

Superordinate Theme 3: CfWB care

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

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

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

Environment

An environment that patients considered "comfortable", "relaxed, "safe" and "calm" appeared important:

> "[First chaplaincy experience] was really relaxing, […] comfortable, […] safe environment […] absolutely felt freed up to really express and tell [the chaplain] exactly how I was feeling." ('Michelle', L. 10).

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

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

Perhaps the most fundamental aspect of the consultation environment links to how the chaplain facilitated the consultation, instilling a sense of "calm":

> "[The environment] was a very calm place […] [the chaplain] was always on time, and always had enough time, without cramming in people, […] not like a doctor's consultation..." ('Victor', L. 74).

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

CfWB demeanour

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

> "[The chaplain] was happy to me […] I respect [they were] kind to me, [they] respected me, listened to me, when I was talking [they] respected me." ('Hakim', L. 106).

> "[The feeling of comfort and friendliness manifested in] the way [the chaplain] came across, a very open, trustworthy, kind, considerate person, and how [they] spoke." ('Joan', L. 54).

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

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

Articulating the notion of wisdom was complex, but it appears linked to the chaplain actively 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':

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

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

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

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

Dignified care

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

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

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

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

Offloading

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

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

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

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

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

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

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

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

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

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

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

Active listening

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

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

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

> "[…] That skill of not just listening to what [the patient] is saying, but actually what they are not saying, and using an approach which you feel is best going to meet the not said, rather than the said." ('Janet', L. 101).

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

> "[…] [The chaplain] helped me get [my issues] out of myself […] I was able to talk to somebody about it, was there to listen, at a time when I hadn't got anyone else to talk to." ('Peter', L. 116).

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

Insight into issues

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

> "[…] I went to [the chaplain] with a list of losses, I hadn't realised until […] doing this piece of homework […] knowing some of the theory […] no wonder I am where I am." ('Beatrice', L. 28).

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

> "I was just numb, I couldn't do anything, my life was suspended whilst [the problems were active], I couldn't do anything." ('Victor', L. 50).

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

> "[The chaplain] helped with the ideas of writing things down […] try and stop this going round at night where one problem was following another, was following another [et cetera]." ('Lionel', L. 56).

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

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

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

> "[The chaplain] was instrumental in getting me off sleeping tablets. […] I just lay in bed and with everything going on […] could not get to a point where you could nod off and sleep." ('Victor', L. 88).

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

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

Prayer

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

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

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

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

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

> "The second time I went back [to the chaplain] […] I decided I would have to mention [the issue of prayer] […] [I] had a bit of a sort of giggle with [them] over it." ('Beatrice', L. 30).

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

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

The conception of prayer as being "powerful" illustrates the degree of suffering patients were experiencing and the divine support patients will often turn to in times of extreme turmoil. For 'Victor', the notion of prayer being powerful was expressed eloquently through the notion of forgiveness:

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

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

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

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

> "[Prayer was not a separate independent part of the consultation] no, it was something that came […] quite naturally." ('Janet', L. 47).

> "[Prayer] came about [as a] result of all the talking." ('Bimal', L. 88).

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

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

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

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

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

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

Discussion

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

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

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

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

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

The single most important contribution offered by the chaplain was the gift of time: long appointments repeated over months or years if necessary. This implies that any attempt to make the service more efficient by employing more highly-trained (and so highly-paid) staff for fewer hours would be counter-productive.

The other very important contribution by the chaplains was active listening, in which the act of attending to the patient is itself a validation of their experience and identity; supporting findings from the *Community Chaplaincy Listening* service in Scotland (Mowat & Bunniss, 2013). In addition to active listening, CfWB also utilised relaxation and visualisation techniques, where appropriate. Patients reported the importance of simple reassurance, but also of 'offloading', and integration of a new life-narrative.

Conclusions

IPA led to the development of pertinent themes in relation to the patients' experience of primary care chaplaincy. All patients reported significant benefit from accessing the CfWB service for many reasons.

The key-presenting theme seemed to be one of 'loss' derived from bereavement, unemployment, or family breakdown. This was expressed through loss of hope, self-confidence, self-efficacy, and sense of purpose and meaning. In essence, it represents the antithesis of well-being, and so helps to define the role and contribution of the CfWB service.

Patients appreciated the role of GPs and other health professionals in maintaining their well-being, but also understood the limitations of time and abilities with which they were confronted. Patients understood that a busy GP cannot always spend time on an individual's complex psychological needs, or have the appropriate range of competencies to 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

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