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

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ABSTRACT

Around the world, chaplains provide specialist spiritual care for people with complex healthcare needs. If the nature of chaplain interventions was better understood then multidisciplinary colleagues could both improve their own skills in spiritual care and better understand when to refer people to chaplains. A survey was constructed to establish what aspects of the chaplain/patient relationship were most important for patients in Scotland and Australia. Outcomes were measured with the Scottish Patient Reported Outcome Measure (Scottish PROM©). Results from 610 respondents showed the strongest correlation was between '*being able to talk about what is on my mind*' and the Scottish PROM ($r_s(452) = .451$, $p < .0005$). '*Being able to talk about what is on my mind*' proved more important than being listened to, having faith/beliefs valued, or being understood. Given the importance placed on listening and understanding by clinicians, this original and counterintuitive finding goes some way to explaining the unique role and function of healthcare chaplaincy.

KEYWORDS

Chaplain; pastoral care; outcome measures; psychometrics; therapeutic relationship; spirituality; spiritual care; health care

Introduction

Most international models of health and social care include spirituality as a key component. See for example all recent nurse theorists in Snowden, Donnell, and Duffy (2010). As a clinical example, cancer care in the UK and Canada is focused on helping the 'whole person', which consists of physical, emotional, mental, social, environmental and spiritual elements according to National Cancer Survivorship Initiative (2013). There is enduring debate about the concept of spirituality (Weathers, Mccarthy, and Coffey 2016), but most conceptualisations include elements of meaning, purpose and connectedness, for example:

> 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 et al. 2014, 463)

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Chaplains help patients with their spiritual needs[1] by connecting deeply with them (Cramer, Tenzek, and Allen 2015; Mowat and Swinton 2007). Although some nurses feel comfortable offering spiritual support, they also recognize the need for specialist spiritual care as delivered by chaplains (Kim et al. 2017). Sinclair and Chochinov (2012) have shown that patients experience better quality of life where interdisciplinary teams include chaplains. Raffay, Wood, and Todd (2016) go further by suggesting holistic care is not possible without chaplains on the multidisciplinary team.

The purpose of this paper is to gain a better understanding of how chaplains improve outcomes for patients, and the reason is twofold. First, this knowledge may enable non-chaplain health colleagues to use transferable techniques where appropriate. Second, understanding the unique skills of the chaplain will help colleagues to recognize when a referral should be made to them.

Background

Healthcare chaplains around the world are becoming more research literate (Snowden et al. 2017). Most chaplaincy research is qualitative (see Fitchett 2011; King 2012) because chaplaincy is about stories (Nolan 2016). However, quantitative research has also proved useful. Flannelly et al. (2012) used 'big data' to show that there were lower death rates in hospitals that employed chaplains than in those that did not. Kevern and Hill (2015) used survey methods to show that chaplains improved the wellbeing of people in primary care. In a retrospective review, Macdonald (2017) found primary care chaplains to be as effective as antidepressants. All these authors concluded that the next step for chaplaincy research is to measure outcomes of chaplaincy interventions. This study takes that step, using the first validated outcome measure designed for chaplains: the Scottish Patient Reported Outcome Measure (PROM) (Snowden and Telfer 2017).

The Scottish PROM entails five questions and is usually embedded within a short survey (Figure 1). The survey is designed to gather basic demographic and service data such as number of times the patient had seen the chaplain, age and gender; and it includes a question about whether people self-describe as religious, spiritual, both or neither. The reason for these questions is to establish whether one group benefits more than another. For example, early data obtained when piloting the PROM showed that everybody benefitted equally from seeing a chaplain, regardless of age, gender or whether they self-described as religious, spiritual, both or neither (Snowden et al. 2012). These are important issues to understand from a referral point of view. Sometimes in primary care people can be put off the idea of seeing a chaplain because of its religious connotations. It has been helpful for General Practitioners (GPs) making referrals to assure patients that chaplains are for everyone.

The survey then has a set of four Likert questions designed to ascertain the patient's experience of the chaplain encounter(s). These questions are asked in order to help chaplains reflect on the link between the patient's perspective of the encounter and the outcome of it. The PROM is included next. It asks people to rate how they felt in the last two weeks in relation to the following five statements: 1. I could feel honest with

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

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 time	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:

[NB: This empty box is much larger in the paper version. It is condensed here to save space.]

Figure 1. The survey containing the Scottish PROM.

myself about how I was really feeling; 2. Anxious; 3. I had a positive outlook on my life; 4. In control of my life; 5. A sense of peace. Finally, there is a free text box for participants to write anything they wish. The survey is illustrated in Figure 1.

During a pilot study, correlations were examined between responses to the experience of the chaplain encounter and the outcome items. There was a striking positive relationship between the item '*I was able to talk about what was on my mind*' and all the outcome items (Snowden et al. 2013). 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, being in control and feeling a sense of peace. None of the other items showed

this strength of relationship. If generalizable, this finding would be important to explore in some depth. However, the pilot was based on a total of only 37 responses so the generalizability was unknown. The primary aim of this study was therefore to retest for this relationship in a larger cohort of respondents.

The secondary aim of this study was to examine the relationship between the number of times people saw a chaplain and PROM scores. Is there an optimal number of sessions people should have with chaplains? Is there any point in having more? Whilst a single cohort study cannot answer these questions, it can still look for trends to support future hypothesis generation. For example, the survey lends itself to further subgroup analysis by age, gender and religion. This study explored whether any of these groups scored differently.

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 survey statement and total PROM scores.

The secondary hypotheses are:

(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.

Method

Design

This was a cross-sectional survey, correlational study.

Participants

These were selected from among people in UK and Australia who had been seen by a chaplain in the community (see below).

Process

In the UK, patients were referred to the chaplain by their GPs, primarily for bereavement issues, low mood, anxiety problems or loneliness and other non-medical issues (Macdonald 2017). Patients would then see the chaplain for as many sessions as they needed in order to resolve their personal issues. Following discharge, those who had agreed to take part in this study were posted the questionnaire shown in Figure 1. A stamped addressed envelope was included to return completed questionnaire to the study team. In total, questionnaires were sent to 205 patients between June 2015 and June 2016.

In Australia, participants came from a network of Catholic hospital sites along the East coast. Participants consisted of patients who had seen a chaplain in hospital, for the same reasons as in the UK study, and had subsequently been discharged. Those who agreed to

take part in the study were sent the survey. In total, 2351 surveys were mailed to patients and family members at 7 clinical sites (acute, rehabilitation and palliative care) between December 2015 and June 2016.

Analytic plan

To combine datasets, some of the demographic data were transformed to construct comparable groups. For example, Australia recorded age data in groups, UK recorded actual age, so the UK data were transformed into the same age groupings as the Australian dataset. All data were then 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. Depending on the outcome of normality tests and treatment of outliers, either parametric or non-parametric tests were 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 and Lund 2017).

For the secondary hypotheses, 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 used to compare mean PROM scores.

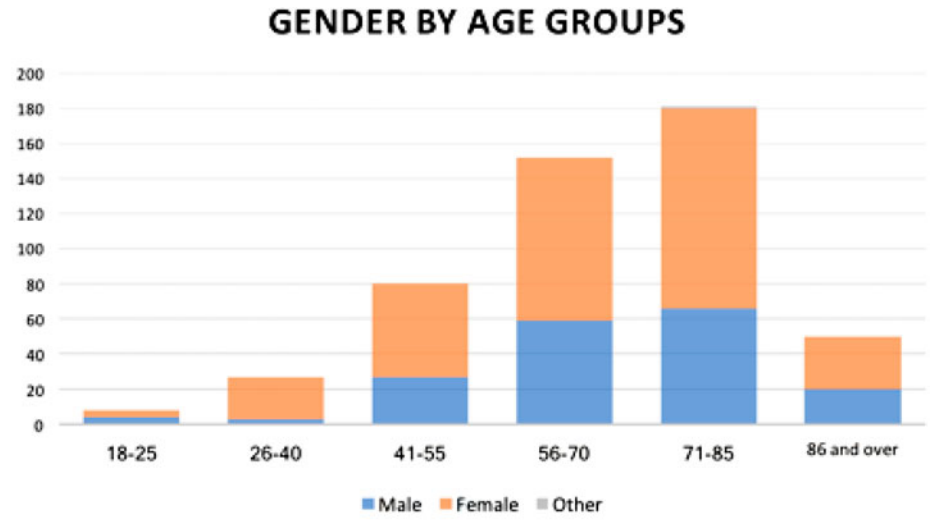
Ethics

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

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 where participants did not recall seeing a chaplain. A further 92 surveys were removed because they had been completed by a family member, not the patient. In Scotland, 113 surveys were returned and then subjected to the same exclusion criteria. In summary, 499 respondents completed the survey themselves and provided complete data.

Most (40%) respondents described themselves as neither religious nor spiritual, followed by 36% who said they were spiritual and religious. 13% identified as 'religious only'; 11% as just' spiritual'. Figure 2 shows that the largest age group was the older group: 71–85. Females made up 57% of the sample; males 33%, with 1 person self-describing as 'other'. Around two-thirds of respondents (65%) had one or two visits; with a range of 1 to 16. Mean PROM score was 11.8(4.6) with a range of zero to 20.



	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 2. Age group cross tabulation by gender.

Analysis

Primary hypothesis

This 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 data were 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 and 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 and 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 Table 1).

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

Table 1. Games Howell post hoc comparisons.

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 $p < 0.05$.

people declaring themselves solely religious or solely spiritual scored higher on the PROM than those claiming to be neither spiritual nor religious (Figure 3).

(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 equally from the consultations with chaplains.

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

Figure 4 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 ($F(4, 356) = 5.76$, $p > 0.001$).

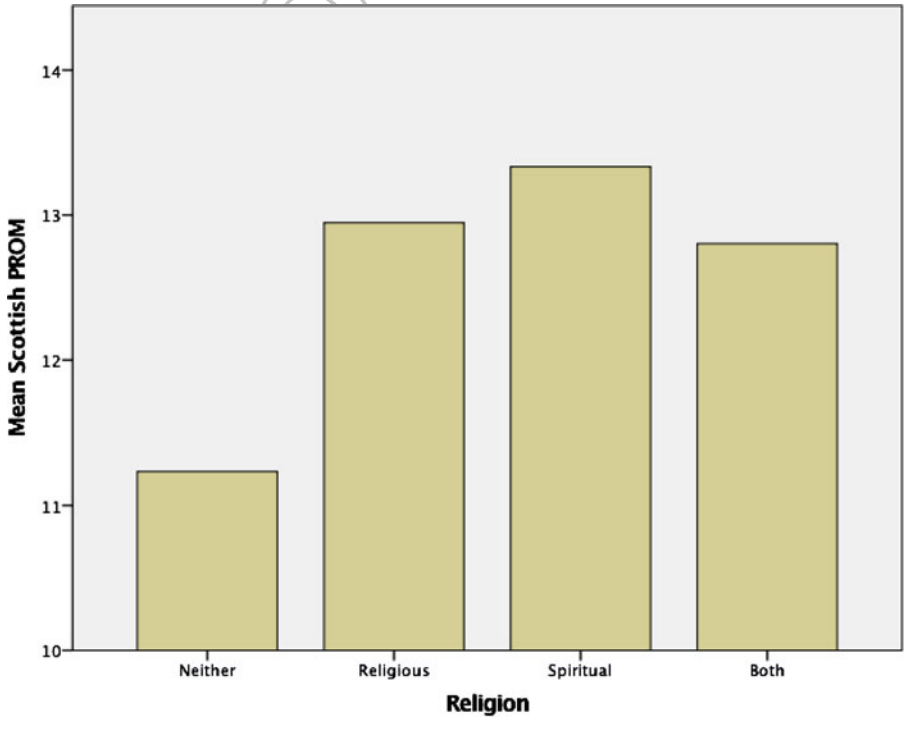


Figure 3. Means plot for Scottish PROM by religion or faith.

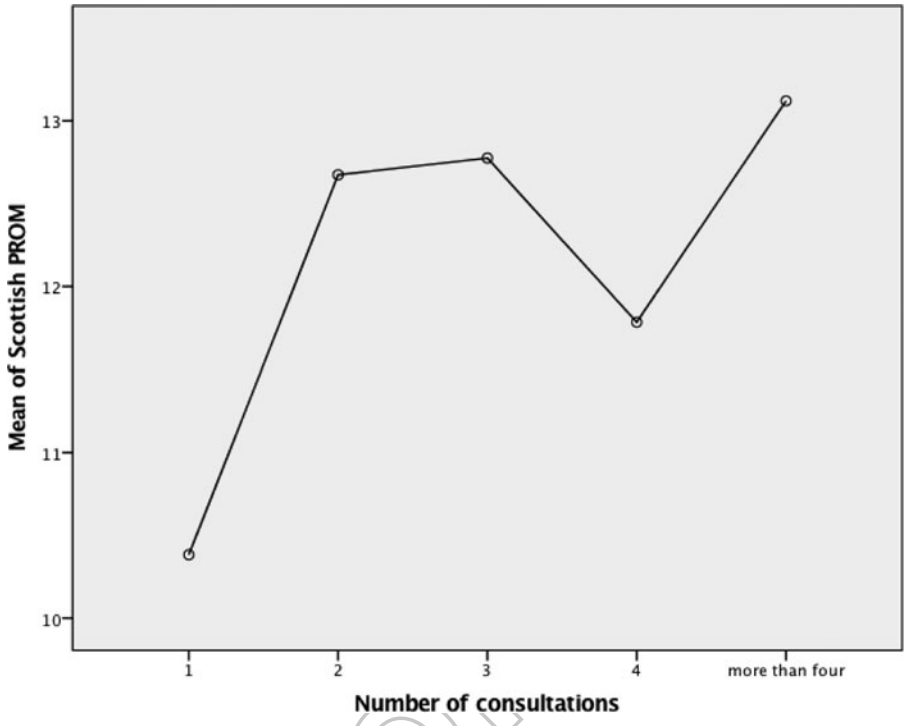


Figure 4. Means plot: scores by number of consultations.

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 findings: that more sessions with the chaplain are associated with higher PROM scores 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, and Lussier 2016). In a fascinating paper, Agledahl et al. (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. Naturally this was picked up by patients who, in turn, also disengaged. This is perhaps 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, feeling '*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 suggest 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 talking has a degree of perceived control over the topics being discussed. This is very important. The act of putting into words what may be people's deepest fears is hugely challenging (Håkansson 2015), 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 and 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 is not as important as being truly heard on this view. Understanding may not necessarily be possible, nor in everyone'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). What happens next is unknowable but, because being present is chaplains' primary function, the space often 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's reflection (in Snowden et al. 2012, 38).

More fundamental still, chaplains have no other agenda than to deliver spiritual care. They are able to be present in a way that no other professions can be. Chaplains do not deliver clinical care – so patients are free to complain about their care, the food, or anything else, without the perception that complaining will influence their care (Friele, Reitsma, and de Jong 2015). Further, 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. Fellow health and social care professionals often complain of being too busy to do anything outside routine care (Paton 2015). There is consistent 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 or pastoral care worker. The chaplain is often the only person left with whom it is possible to talk freely.

It is to be hoped that this depressing conclusion is not entirely true. More research is needed to establish what, if any of the chaplain's 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 (2007) showed that their neutrality sets the interventions offered by chaplains apart from those offered by any other healthcare professionals. As alluded to above, in this space, chaplains are free to be *present*. Minton et al. (2017) describe presence as a function of 'sentience' and 'sagacious insight'. According to Minton *et al.*, sentience is beyond cognition and everyday perception. It is an innate ability

to be present alongside the willingness to engage in meaningful discussions where the direction is 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 et al. 2017).

This all sounds rather mysterious. Interesting to note, then, that Minton et al. are not talking about chaplains. They are talking about nurses delivering spiritual care. This implies two things. First, and most importantly, the fact that nurses are trying to understand the art of being present so that they, too, can be present with patients implies that there *is* at least some identifiable time for them to engage meaningfully with patients or, at the very least, to utilize their diminishing time in a more fruitful way. Consider the concept of 'phatic' listening, as described in mental health nursing (Burnard 2003), where casual chat is used purposefully to check how people are. Second, nurses value spiritual aspects of care and are getting better at articulating how spirituality can be expressed within their role (Ross et al. 2016).

Nurses and other professionals still have a long way to go to match the chaplains here though. Chaplains can already articulate how to deliver spiritual care 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. Clearly, anyone can ask the question: *'what's on your mind?'* Somewhat dispiritingly, it is even the opening greeting on a billion Facebook homepages. However, as yet, there is no evidence that any other professional apart from the chaplain 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. The significance of this is difficult to explain because the method used here does not take into account baseline PROM scores, and baseline scores would be necessary to claim subsequently that one group necessarily benefits more than another. People who are religious often score higher on wellbeing scales in general (Graham and Crown 2014). They even live longer than non-religious people (Larson 2003). The finding that religious or spiritual people score higher on a spiritual health outcome measure simply corroborates what is already known. For example, there is a positive relationship between being religious and wanting a chaplain visit in hospital (Piderman et al. 2008). Whether faith or lack of it has any impact on the benefit of seeing a chaplain will be explored further in planned pre–post studies, where measures before are compared with measures after seeing a chaplain. Previous unpublished data gathered during the validation of the PROM had shown no differences between the groups: that chaplains had been equally beneficial to people of all faith and none.

This 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 scored higher still. Again, these findings are difficult to explain, especially since the only comparable data showed no relationship between wellbeing scores and number of visits (Kevern and Hill 2015). As above, these apparent trends will be examined in further detail using a pre–post method. Only then can the 'dose' relationship be examined.

A further and final limitation is the issue of effect size. The statistically significant differences discussed above may be clinically significant, but this is not known. This is because the PROM has not been calibrated yet, so it is difficult to interpret the scores. With a larger dataset, cross referencing to comparable instruments such as the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) will help (Tennant et al. 2007). Planned Rasch analysis (Saltzberger 2012) will also help to show how relevant the PROM items are to participants, and whether different groups of people respond consistently or not.

The wide distribution of scores obtained here is promising though. Often, scales designed to ascertain patient feedback on clinical interventions suffer from 'ceiling effects' (Arias González et al. 2015) where everybody scores highly because they want to please the clinician: see, for example, the Care and Relational Empathy Scale (CARE) by Mercer and Murphy (2008). Differentiation between scores is minimal in such scales, meaning they are of limited use in comparing efficacy of interventions. By contrast the mean (sd) PROM score was 11.8 (4.6), with a range of 0 to 20. This is very promising because the PROM appears to measure a wide range of spiritual wellbeing. An average PROM score in this cohort is around 12. Given that all these people had recently been discharged from chaplaincy, it is reasonable to assume this average score represents reasonable spiritual health. Further psychometric analysis is needed to establish this, and this work is also planned. When complete, the hope is that healthcare workers around the world could meaningfully use the Scottish PROM not just for outcome measurement but also, potentially, as a quick screening tool to identify patients who may be in need of chaplaincy support.

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 understanding 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 a means to an end, a method of ascertaining an outcome such as a diagnosis or assessment of mood, for example. This is not the case for chaplains, an argument well developed by Mowat et al. (2013). Authentic listening is the *goal*.

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 other agenda necessary to hear the response authentically. There may be occasions when other professionals could approach these conditions. There may be parallels with mental health nursing and its use of 'phatic' listening, but this would need further investigation.

Creating the conditions for people to be able to talk completely freely is crucial because in everyday life people largely do not 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 where people feel able to talk about what is on their mind. The importance of this is difficult to overstate.

Disclosure statement

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