The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK.

THE IMPACT OF COVID-19 ON THE PRACTICE OF PASTORAL CARE PRACTITIONERS IN A RELIGIOUS SETTING IN THE UK

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A thesis submitted in partial fulfilment of the requirements of the University of West London for the degree of Doctor of Health Studies

September 2024

Acknowledgements

Firstly, I would like to extend my deepest gratitude to my supervisors, Professor Anne Manyande and Professor Raffaella Milani, for their constant help and unwavering support throughout this research. I would particularly like to thank them for always asking insightful questions and offering invaluable advice. Their professional guidance, wisdom, and patience helped me gain confidence and self-efficacy as a research practitioner. I am additionally grateful to the doctoral course leaders, Professor Rowan Myron, Professor Mike Mimirinis, Professor Alison Wakefield, and Professor Simon Harding, who provided an introduction to professional doctorate studies and set the foundations of academic research. I would also like to convey my utmost appreciation to my examiners, Professor Robert Vaughan and Professor Wayne Morris, for their valuable time and expertise in evaluating my research, which significantly enhanced the quality of this thesis. I am particularly thankful to the pastoral care practitioners who participated in this study. Their openness and courage to share their personal experiences provided invaluable insights, and this research could not have been completed without their contribution.

I wish to give special thanks to my wife, Eunjeong Esther Yu, who was the first to believe in the value of this research and has stood by me through the ups and downs, and twists and turns throughout this endeavour. Words cannot do justice to how instrumental she has been in supporting me over the years of this doctorate. To my son, Iwan Timothy Bali, born in 2022, literally halfway through the doctorate. Whose bright smile in the morning was a true source of motivation and whose crying at night kept me alert. It was often during these nights when ideas flowed, and new connections were made. I would also like to thank my elder sister, Faith Ruto, for

always believing in and supporting me and whose timely words of encouragement kept me going.

Ultimately, I would like to acknowledge God, who has been my True North throughout this research. Who has guided me when the direction was not clear and sustained me when the going was tough.

Abstract

Background: Pastoral care's primary objective is to provide emotional and spiritual support to vulnerable and critically ill individuals. While pastoral care is often linked to religious practices, practitioners have played a critical role in aiding those in need throughout society during the pandemic and in normal times. The global pandemic caused widespread challenges and hardships, leading governments to implement critical measures to contain its transmission. These measures encompassed travel limitations, compulsory mask-wearing, lockdowns, prohibitions on in-person gatherings, and curfews. The pandemic also impacted social interactions, significantly straining families and communities, necessitating increased pastoral support. Despite the need for heightened pastoral care, practitioners encountered significant hurdles in carrying out their duties due to the pandemic. Therefore, the study's objective was to explore the impact of COVID-19 on pastoral care and make recommendations to improve pastoral care during normal and challenging times.

Methods: Semi-structured interviews were used to explore the impact of COVID-19 on 25 pastoral care practitioners. The participants were selected based on their experience in delivering pastoral care within a Christian context in the United Kingdom before and during the pandemic. Data were analysed using thematic analysis. A pilot study was first conducted to examine the feasibility of the research and to identify potential problems with the research design. The main study expanded the scope of the pilot study by increasing the target population and advancing the investigation to meet the research objectives.

Findings: Eight themes were identified in this study, which included the following: the importance of pastoral care, the roles and responsibilities of the pastoral community, the impact of the pandemic on pastoral activities, the impact of the pandemic on communities, how the pastoral communities adapted to the pandemic, the internal and external barriers to adaptation to the COVID-19 pandemic, the lessons from the COVID-19 pandemic for the pastoral community, and the future of pastoral care. The findings suggest that the COVID-19 pandemic presented challenges to the traditional methods of pastoral care. To adapt, practitioners turned to virtual platforms to maintain social distancing guidelines. Despite the benefits of this approach, limited resources hindered its widespread adoption, and practitioners reported experiencing burnout due to the increased workload and the challenges of adapting to these novel strategies.

Conclusion: COVID-19 affected pastoral care considerably. Adopting novel strategies and technology could improve care access during pandemics. Moreover, the need to enhance the personal well-being of pastoral practitioners is a critical lesson observed in the research.

Keywords: Pastoral care, COVID-19, spiritual, well-being, psychological, impact, access.

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Glossary

Some of the main terms that have been employed in this study are defined below:

- Pastoral Care denotes attending to individuals' religious or spiritual needs to enable them to deal with health challenges, including their family members (Batstone et al., 2020). The challenges may include questions and concerns about purpose, personal meaning, faith, and hope. Confidentiality is both an integral and expected aspect of the role.
- Pastoral Care Practitioners refer to individuals who provide pastoral care and support to congregants and patients (Johnston et al., 2022). The individuals are trained to provide pastoral care, alleviate suffering during periods of turmoil such as sicknesses and provide spiritual nourishment to congregants.
- Chaplaincy refers to the act of clergy members attached to institutions providing pastoral care and improving the emotional well-being of individuals (Snowden, 2021). Chaplaincy relates to the ability of individuals to cope with various healthcare challenges; hence, it is an integral part of healthcare and mental health well-being.
- Healthcare Settings refer to locations such as nursing homes, hospitals, and other care facilities where the provision of pastoral care may be relevant for patients and their families (Asgari et al., 2022).

Chapter One: Introduction

This chapter introduces the fundamental components of the thesis to provide a comprehensive understanding of the background and intentions of the research. It includes the statement of the problem, the research aim, questions, objectives, and theoretical framework. Additionally, the chapter highlights the delimitations of the investigation, which provides a clear scope for the study.

1.1 Overview

The COVID-19 pandemic disrupted pastoral care, causing practitioners to adapt to the new challenges and opportunities they faced. Improving pastoral care provision during pandemics requires identifying practical courses of action and addressing the problem. In expanding knowledge on this topic, the current study utilised the crisis management model, which is based on offering immediate support and intervention to communities and individuals during crises (Levers et al., 2022). The qualitative methodology was utilised in this study to achieve the set goals, justified by its ability to collect data in social studies (Doyle and Thomas, 2022). The social implications include enhancing understanding of the pandemic's effect on spiritual well-being and informing the strategies and resources for pastoral care practitioners to serve their communities better in times of crisis. The research is anchored on sociological perspectives because they define human interactions, assistance, communication, solutions to challenges and societal change.

1.2 Structure of Thesis

The current research was completed in six chapters. The first chapter covered an introduction where the research question and objectives were highlighted. Moreover, the introduction chapter indicates the background and problem statement to reveal the context of the topic, thereby justifying the need for this research. Meanwhile, the second chapter involved a literature review where previous research was analysed to show the major trends in pastoral care and the significant gaps that remain. The methodology chapter indicated the procedures employed to implement this research and ensure the set goals are achieved. In particular, the third chapter provided specific data collection and analysis details to enable replication of this study by other researchers. The fourth chapter involves interviews, where a summary of the interviews conducted in this research is presented. In the chapter, results from thematic analysis and significant responses from interviews were shown, and the main themes from interviews were indicated. The responses from different participants were compared and contrasted with increasing insight into the research topic. The fifth chapter entailed a discussion where the significant findings of this research were explained to understand their implication while comparing interview results with existing literature. Lastly, a conclusion chapter was presented, showing how the set research question and objectives were addressed and highlighting the research limitations and recommendations.

1.3 Background

1.3.1 The sociological nature of the thesis

The present research is grounded on sociological theories and concepts underpinning pastoral care during pandemics. Ballano (2020) noted that vicar-generals, pastoral theologians, and pastoral sociologists were significant proponents of adopting and using sociology in understanding religion. Klaasen (2020) reported that sociology in the context of religion tries to achieve a better grasp/understanding of the complexity and contours of the social environments in which pastoral care practice operates. While sociological knowledge regarding epistemological status within pastoral thinking remains undisputed, there is fear that it could contribute to an undue preponderance of causal and sociological explanations (Klaasen, 2020). The present investigation seeks to firmly grasp societal constraints by developing an empirical gaze at society. In this context, examining pandemics, such as COVID-19, offers the opportunity to appreciate social organisation during difficult times. Therefore, adopting the practical use of sociological methods and concepts constitutes social scientising, that is, the continuing arguments of social science experts and research outcomes (Hoover, 2021). Although there was potential to tackle the research topic using traditionally theological methods, such as contextual, pastoral and practical theology, this was not explored because the approach of this research and the questions it seeks to address are not theological but sociological. Understanding the sociological implications of religious activities contributes significantly to better pastoral care. Social interactions, social fabric, and social networks are critical to solving problems and challenges. In this context, sociological concepts and theories can be applied to religion in order to understand various dynamics like attitude, feelings, and reorganisation.

Kurtz (2022) and Ballano (2020) argue that the sociological perspective allows researchers to view religious sociology as accumulating complexity and diversity, bringing variations between well-being and suffering. Based on the above explanations, COVID-19 considerably disrupted many people's lives and caused deaths. Consequently, pastoral care was needed despite the challenges practitioners faced in reaching their clients.

1.3.2 Pandemic Context and Societal Impact

Guryanova, Petinova and Guryanov (2021) reported that the COVID-19 Pandemic broke out in 2019 and marked the fifth recorded pandemic since the flu pandemic that was documented in 1918. The onset of the coronavirus pandemic was attributed to the emergence of Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), identified on December 8, 2019 (Malik et al., 2020). The first case of COVID-19 was reported in China's Wuhan city. The pandemic subsequently spread globally. COVID-19 was declared a global pandemic with far-reaching social, cultural, technological, political, infrastructural, and economic consequences (Bradley and Meme, 2022). Moreover, Guryanova, Petinova and Guryanov (2021) reported that COVID-19 emanated from animal coronavirus, which adapted to infect humans. COVID-19 was highly contagious; hence, it spread rapidly and continued to evolve in the human population. As explained by Cobb, Savage, McDevitt, Attema and Radin (2022), COVID-19 caused immeasurable damage to world economies and many people's lives. Due to the pandemic, societies experienced extreme changes, which affected daily operations and livelihoods. COVID-19 also led to lockdowns and travel restrictions across the world (Cobb et al., 2022).

Similarly, unemployment rates increased because companies could not operate normally (Raxima, Ikromiddin, and Musaxon, 2021). Moreover, the pandemic led to the deaths of 233,791 people in the United Kingdom and the total cumulative deaths of 7,037,007 people worldwide (UK Health Security Agency, 2023; World Health Organisation, 2024). Meanwhile, others were left impoverished because of destroyed livelihoods, and some of the effects of COVID-19 remain ongoing (Cobb et al., 2022). Therefore, many traumatised individuals sought pastoral care to cope with these challenges. Thus, this research aimed at defining and re-defining pastoral care in the context of the constraints posed by the social, spiritual and financial crisis caused by COVID-19.

1.3.3 Influence of COVID-19 on pastoral care

COVID-19 significantly affected various areas of life, including pastoral practice and care. With a rising number of infections and mortality rates, restrictions in social and physical contacts and enhanced economic uncertainties, the level of distress in the population increased (Domaradzki, 2022). Despite the increased need due to psychological uncertainty, pastoral care was significantly affected by social and physical restrictions, thereby limiting the roles of pastoral care practitioners. The pandemic also placed pastoral care practitioners at increased risk as they often aided those in distress without personal protective equipment (PPE) while providing spiritual assistance, comfort, and prayers (Haußmann and Fritz, 2022). Pastoral care practitioners faced risks during the pandemic while visiting patients in hospitals due to the short supply of personal protective equipment and work overload that elevated the risk of contracting COVID-19 (Bard, 2020). Hence,

like other healthcare professionals, pastoral care practitioners faced significant health risks following their decision to offer pastoral care during the pandemic. For instance, the Council of the Bishops' Conferences of Europe indicated that the pandemic led to the death of 400 priests, elderly religious leaders, and nuns (Haußmann and Fritz, 2022).

Moreover, the pandemic revealed the importance of incorporating pastoral care during healthcare provision because pastoral care alleviated anxiety and depression during the crisis, thereby improving the well-being of patients (de Diego-Cordero et al., 2022). Hence, pastoral care practitioners were crucial in offering patient care during this period. According to Busfield (2020), there was an increased demand for pastoral care during the pandemic, while many care facilities were limited.

Despite the negative impacts of the pandemic, valuable opportunities were also experienced. One of the valuable experiences obtained by pastoral care practitioners was an understanding of the importance of pastoral care in times of crisis, which enhanced the ability of practitioners to provide more focused and attentive care to individuals during the period to alleviate depression and mental health challenges (Drummond and Carey, 2020). As a result, there was an increased awareness of the importance of pastoral care during the period.

1.3.4 The use of technology to offer pastoral care during the pandemic

The disruptive nature of the pandemic created many challenges for religious leaders, leading to the adoption of technologies in pastoral care as a strategy for clergy self-care

during the pandemic. Religious leaders adopted technologies such as video calls and social media engagements to assess and offer spiritual guidance to individuals during the pandemic (Timmins et al., 2022). Moreover, technology use in pastoral ministry during the pandemic facilitated end-of-life care, improving the role played by pastoral care amid trauma, loss, and suffering (Connolly and Timmins, 2022). To improve personal connection, which contributes to health outcomes, pastoral care practitioners also adopted technologies such as offering virtual spiritual guidance to draw the personal well-being of those distressed by the Gospel. In addition, technologies, such as acquiring electronic tablet devices, opened up possibilities for pastoral care practitioners to offer pastoral care in a new, dynamic, and safe manner (Byrne and Nuzum, 2020).

The main benefit of the virtual video chaplaincy service was reduced depersonalisation and "othering" of the chaplain and patient, improving health outcomes (Byrne and Nuzum, 2020). Technology played a central role in improving patients' outcomes by offering personalised and closed pastoral care, even in physical distancing. The strategies adopted during COVID-19 to provide pastoral care ensured that close contact with persons needing spiritual encouragement enhanced the safety of practitioners (Bard, 2020). Technology was a crucial motivator of close pastoral care provision that enhanced health outcomes.

1.4 Problem Statement

Pastoral care improves care outcomes during times of distress and turmoil, such as the COVID-19 pandemic (Roman, Mthembu and Hoosen, 2020). Pastoral care offers spiritual

support, develops personal relationships, and reduces emotional distress, which is vital during end-of-life care for patients. Pastoral care aids in managing anxiety among family members of patients who are severely ill. Pastoral care could facilitate recovery by improving emotional stability among patients during care (Ghorbani et al., 2021). Despite the importance of pastoral care during times of distress, there is a literature gap on strategies for improving the ability of religious leaders to offer continual care during significant crises, such as the COVID-19 pandemic. Although some studies have examined the impact of COVID-19 on pastoral care provision, there have been conflicting and inconclusive views. For instance, the study by Heidari, Heidari and Yoosefee (2020) indicated that disruptions caused by the pandemic reduced personal contact and connection between patients and religious leaders, increasing anxiety and distress. However, according to Byrne and Nuzum (2020), technologies adopted during this period, such as video meetings, improved personal connection and closeness between patients and religious leaders.

Although the need for pastoral care during this period increased due to the physical, economic, psychological, and social uncertainty caused by the pandemic (Timmins et al., 2022), at the height of the pandemic, government directives prohibited churches from remaining open for communal services, with many churches, synagogues and mosques in England opting to remain closed during this period (Village and Francis, 2021). Nonetheless, evidence of strategies that could have been used to balance the increasing need for pastoral care while maintaining physical distancing is limited.

1.5 Research Aim and Research Questions

This study aimed to investigate how the pandemic has impacted the work of pastoral care practitioners in a religious context. The research questions were:

1. What was the impact of the pandemic on pastoral care and pastoral care practitioners?
2. What were the pastoral care benefits during COVID-19?
3. What is the future of pastoral care following the lessons from COVID-19?

1.6 Research Objectives

The objectives of the present study were:

1. To investigate the perspectives of 25 ministers of religion on their practice adaptations during the COVID-19 pandemic.
2. To investigate challenges encountered in pastoral care during COVID-19.
3. To explore strategies for improving pastoral care efficacy during times of crisis and in normal times.

1.7 Theoretical Framework

In underpinning the current research topic, the *crisis management model* has been utilised (Le and Phi, 2021). The model is crucial in offering a framework for recovery from a crisis as well as preparation, prevention, and coping strategies. Through the model, it is possible to gain a context of the crisis and apply best practices for crisis management. The model adopts researchers' definitions, such as Christine Pearson and Judith Clair (Pearson and Clair, 1998). Through these views, the model posits that it is vital for

stakeholders to understand unpredicted events as a threat. The crisis management model enhances individuals' ability to anticipate crises, imparting lifelong lessons in crisis management. As Le and Phi (2021) expressed, crisis management adopts three stages: crisis diagnosis, planning and change adjustment. In the first stage, the early indicators of crisis should be identified to prepare individuals to face the crisis with courage and determination. The present study uses theoretical postulations to show how COVID-19 threatened the social fabric and limited the capacity of practitioners. In the second stage, individuals should be assisted not to panic through the crisis by devising relevant strategies to avoid an emergency (Jaya et al., 2020). In the third stage, individuals should be assisted to adjust well to new situations and changes. The theoretical framework is crucial in understanding how pandemics on the scale of COVID-19 affect pastoral care practice.

Three social theories underpin this research: role theory, relational frame theory, and terror management theory. The above constructs were used to understand the conduct of pastoral care practitioners concerning their role in the community during challenging times, like the COVID-19 era.

1.7.1 Role theory

The role theory posits that individuals' societal actions are dictated by their position or relationships (Li et al., 2021). For instance, parents, children, bosses, and employees demonstrate different but predictable behaviours determined by their assigned position. Kelle (2019) explained that the knowledge of social context is a crucial requirement to

define specific human behavioural patterns called roles. The implication is that people have expectations or ideas about the expected behaviours of specific people or the work they are supposed to perform in the community. In agreement, Wampold (2019) noted that roles could be categorised as duties, rights, behaviours, expectations, and norms. The underlying concept is that the role undertaken by an individual can be an obligation based on a position or simply an action that has been adopted temporarily. According to Kearney et al. (2021), carrying out the expected social roles is essential in ensuring harmonious living in society as well as ensuring interdependency and collaboration. However, Kearney et al. (2021) indicated that circumstances that interrupt social systems might hinder the fulfilment of roles as expected. In the current research context, pastoral practitioners occupy the position of ministering to the spiritual and emotional needs of individuals who are depressed, anxious, or sick. Society expects them to deliver their responsibilities to maintain a harmonious community. Kearney et al. (2021) noted that the COVID-19 outbreak interrupted social norms; hence, it is probable that pastoral practitioners were adversely affected. Specifically, this view suggests that the pandemic disrupted the ability of pastoral carers to complete their social roles, consequently upsetting the social network of collaboration in local religious communities.

1.7.2 Relational frame theory

While the role theory focuses on human actions predicated by social positions, the relational frame theory (RFT) addresses individuals' ability to connect words and concepts to inform action. Abbott (2020) pointed out that RFT is concerned with behaviour analytics, whereby language or words are processed by humans to generate and

understand complicated ideas, which, in turn, influence the individuals' actions. The arguments of Abbott (2020) are corroborated by Ahlqvist and Uotila (2020), who noted that RFT informs that the cognitive capacity of individuals depends on the ability to develop relational links between stimuli. The result means that according to RFT, people tend to change their behaviour based on perceived stimuli, mainly from words and concepts. Barnes-Holmes et al. (2020) noted that despite the importance of pastoral care, its effectiveness might be altered depending on the prevailing situations. However, Kearney et al. (2021) and Kelle (2019) asserted that for pastoral practitioners, the pandemic presented a dilemma of serving people or prioritising safety. The RFT theory applies in this study to understand pastoral practitioners' actions and communities' responses at the onset of the pandemic. The pandemic outbreak acted as the stimuli that informed society's perception of the significance of pastoral care roles.

1.7.3 Terror management theory

Terror management theory (TMT) postulates that death triggers terror in people and compels them to adopt particular worldviews about life as a means of insulation from the negative thoughts of the afterlife (Vail III et al., 2019). The social psychologists who developed TMT included Sheldon Solomon, Jeff Greenberg, and Tom Pyszczynski in 1986 (Pyszczynski et al., 2021; Vail III et al., 2019). TMT explains that awareness of death prompts the belief that one is performing an essential role in the world and is worthy of living on or departing peacefully. People tend to distance themselves from the idea of living a meaningless life that death should eradicate (Fitri et al., 2020). Further, Wolfe and Tubi (2019) indicated that TMT proposes close relationships between individuals and

cultures for self-motivation in continuous life, irrespective of the impending deadly circumstances. Pastoral care has inspired people to value life and hold positive thoughts amidst crises. TMT application in this research enabled an understanding of the genesis of pastoral care services during the pandemic and the societal responses that affected pastoral care provision. The arguments are supported by Pyszczynski et al. (2021) and Fitri et al. (2020), who observed that people were threatened by the COVID-19 virus and needed encouragement to overcome the social and economic challenges. Pastoral practitioners fulfilled the principles of TMT of developing and communicating the meaning of life and value to society despite COVID-19's challenges. Pastoral care programs sought to alleviate anxiety and encourage people to remain optimistic despite the overwhelming personal and social challenges.

1.8 Delimitations

This study is guided by certain delimitations beyond which it did not cover. Delimitations are crucial in ensuring that the results can be reliably interpreted within the scope of the study (Pandey and Pandey, 2021). Firstly, this study only investigated COVID-19's impact on pastoral care practitioners. The influence of the pandemic on the general population was not considered due to resources and time limitations. Although the collaboration between pastoral care practitioners and healthcare professionals is a noteworthy aspect of this study, it was not investigated since it falls outside the scope of the research. The present study also did not consider the impact of other factors unrelated to COVID-19 on the provision of pastoral care. Aspects of pastoral care in other settings not related to healthcare were not considered due to the limitations of the scope of the study. The

delimitations of the study considered are crucial in ensuring that the study boundaries are specified to improve the study's relevance and the accuracy of the findings obtained.

1.9 Summary

In conclusion, in this chapter, the background main theoretical frameworks have been discussed, providing detailed insight into the significance of this study and its aim. The COVID-19 outbreak presented several difficulties, which adversely affected several areas of life, including pastoral care provision limitations due to restricted physical contact as part of the virus containment measures. Pastoral care practitioners faced high risks during the pandemic due to the short supply of personal protective equipment; technology, such as virtual pastoral care meetings, was used to maintain close pastoral care even in the face of physical distancing. The major research question this research seeks to address is the impact of the COVID-19 pandemic on the practice of pastoral care practitioners. The current investigation is crucial in identifying the pandemic’s effect on the provision of pastoral care, enabling the identification of effective measures for the provision of pastoral care for future circumstances of crisis. The current work employed a crisis management model for crisis preparation, prevention, and coping. The study adopted a qualitative methodology in data collection and analysis using semi-structured interviews for data collection and thematic analysis in analysing the collected data. To facilitate the investigation, some of the assumptions made include the willingness of the research population to take part in the study and the methodology's effectiveness in capturing the experiences of the research participants. The research delimitations included

consideration of only the influence of COVID-19 on pastoral care, with the other healthcare factors not covered.

The following chapter critically analyses the literature on COVID-19's effects on pastoral care. The chapter enabled in-depth insight into the existing literature on the study topic and the research gaps the investigation attempts to fill.

Chapter Two: Literature Review

This chapter describes the literature search and selection process. It is followed by a critical review of relevant literature pertaining to the research topic, which provides insight into the state of knowledge in the field and identifies gaps, inconsistencies, and areas that require further research.

2.1 Overview

The aim of the literature review was to explore current research on the role of pastoral care during the COVID-19 pandemic. Since the outbreak of the pandemic, several studies have been conducted on the subject of pastoral care in hospitals and homes. These studies are considered in this research to guide the investigation of pastoral care provision during the pandemic and identify the research gaps, which are crucial components justifying the rationale of the current investigation.

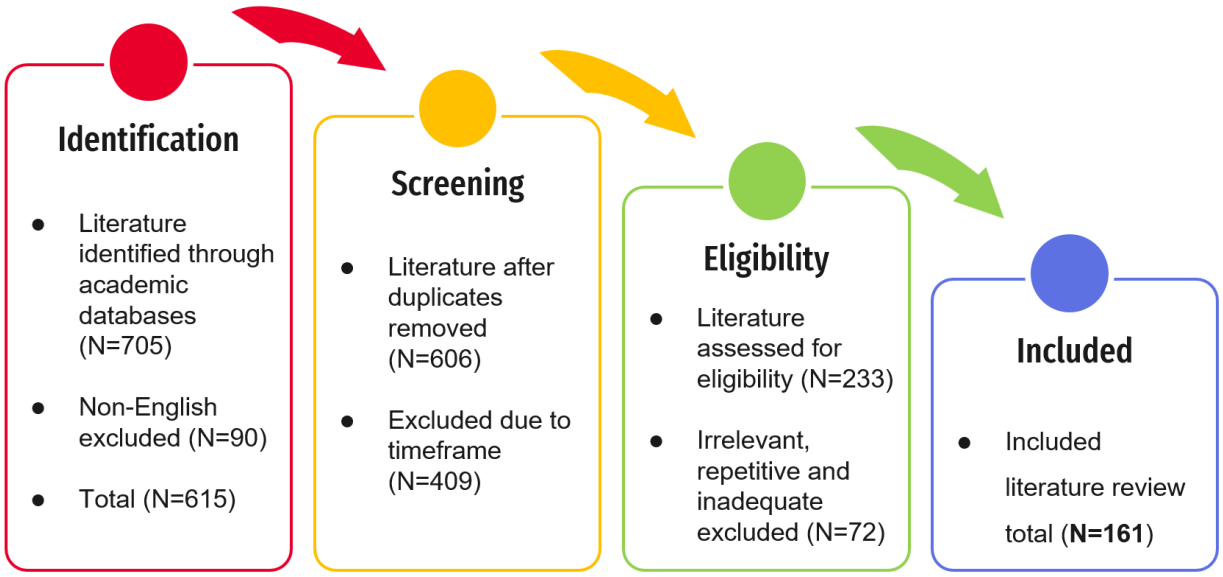
2.2 Method: Literature Search and Selection Strategy

A detailed search strategy is imperative for locating and selecting the best articles and studies for the literature review. According to Chaabna et al. (2020), the strategy ensures that the review section serves the purpose of the study by giving relevant and accurate information on the researched subject. In this context, the focus was on pastoral care in relation to COVID-19. The first step of the literature search was the formulation of search terms. Search terms are phrases that guide the search by narrowing down the search grid. The search terms were derived from the research objectives and questions. The keywords were identified, including *pastoral care, spiritual care, practitioners, COVID-19,*

pandemic, caregivers, crisis, quality, efficiency, and role. The identified terms were combined to develop suitable phrases that refine the search by using Boolean operators, including AND, OR and NOT. Examples of search phrases generated included *pastoral care AND pandemic, the role of pastoral caregivers or practitioners, pastoral care efficiency AND COVID-19, COVID-19 pandemic AND pastoral care quality AND role of pastoral care practitioners during the pandemic*. The search phrases were used to locate relevant articles from published research databases online. The article search was done in several databases, including the databases of the *University of West London* (*UWL*), *Directory of Open Access Journals* (*DOAJ*), *Science Direct, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane, PubMed, Web of Science,* and *Journal Storage* (*JSTOR)*. The databases were selected because they allow full-text access to many articles and have an excellent reputation for including high-quality articles in their databases. The search yielded over seven hundred articles, which were filtered using language and timeline inclusion criteria. In particular, the literature review utilised studies that were published in English and prioritised sources that were dated from 2019 onwards. However, earlier studies were considered and incorporated into the literature review if they demonstrated a significant relevance to the research topic. Thus, the inclusion and exclusion criteria of the study consisted of language, duplicates, timeframe, and relevance to the research topic.

Figure 1 - Literature retrieval and selection

The following data flow chart displays the process by which the studies were retrieved and selected for the literature review.



2.3 Pastoral Care and Professional Practice

2.3.1 Pastoral Care Defined

In seeking to define pastoral care, it is important to note that there is no consensus on a single definition among scholars (Campbell, 1986). The terms ‘pastoral care’ and ‘spiritual care’ are often used interchangeably throughout the literature. Furthermore, according to Seary and Willans (2020), having a single definition of pastoral care would underestimate its importance. The term ‘care’ is multidimensional, and this means that having a universal definition of pastoral care might be difficult to achieve.

Originally entrenched in ecclesiastical ministry, pastoral care historically emanated from pastors extending aid to their congregants during challenging circumstances (McClure,

2012). McClure (2012) contends that pastoral care functions as a fundamental pillar of support for individuals during moments of adversity, triumph, and elation. McClure (2012) expounds on the premise that pastoral care is deeply rooted in an ancient framework of emotional and spiritual sustenance observed across various global cultures. This form of aid is administered by adept practitioners equipped to discern and cater to the emotional exigencies of those they serve.

In this vein, the theologian Alistair Campbell (1986) disagrees with what he perceives as the secularisation of pastoral care. While acknowledging the evolving nature of language and the changing connotations of religious terminology, Campbell (1986) advocates for the revitalisation of religious language in the context of pastoral care. Campbell (1986) critiques the use of terminology that connects pastoral care and counselling expertise and presents a critical assessment of psychotherapy, contending that it can identify guilt but cannot provide hope. In this regard, Campbell (1986) defines pastoral care as integrity, encompassing the ideals of honesty, steadfastness, wholeness, and oneness (Campbell, 1986). In concurrence, Lyall (2001) underscored the significance of harmonising theological and practical elements within the realm of pastoral care. Drawing from a diverse array of case materials, Lyall defined pastoral care as a pivotal component of the church and an indispensable facet of Christian ministry (Lyall, 2001).

In agreement, Schuhmann and Damen (2018) conducted a study focusing on in-patients within an Arizona hospital, asserting that pastoral care primarily encompasses the religious responsibilities of local pastors in shepherding or tending to individuals who are

under their spiritual guidance. These responsibilities include hospital visitations, attending to elderly family members, providing pastoral counselling, engaging in prayer with congregants, offering premarital counselling, presiding over matrimonial ceremonies and funerals, overseeing infant dedications, and conducting related pastoral rites (Schuhmann and Damen, 2018).

Similarly, Baab (2018) stresses that the underpinning of pastoral care lies in the Scriptures, highlighting the importance of neighbourliness and universal love. These contentions align with the biblical narrative in the gospel of John, which depicts the ministry of Jesus Christ as the fundamental basis of pastoral care. For instance, Jesus assumed the role of a pastor, stating, "*I am the good shepherd. The good shepherd lays down his life for the sheep*" (NRSV, John. 10:11). Rather than solely encompassing preaching and education, pastoral care is comprehended as embracing all dimensions of pastoral ministry. As a result, it can be regarded as a broader human demonstration of love, as love forms the biblical cornerstone of pastoral care (John 21:15-19). Likewise, according to Roberts and Kovacich (2020) and Clinebell and McKeever (2011), pastoral care can be defined as the act of one individual demonstrating love and concern for another while fully recognising and respecting the recipient's autonomy to decline or not engage with the care being offered.

In congruence, Clinebell and McKeever (2011) and Bone et al. (2018) argue that pastoral care must be approached through a biblical lens within the context of the prevailing sociocultural milieu. Culture serves to shape and delineate human experience, prompting

efforts to advance and embody the mutual objective of academic excellence and pastoral care. Trained professionals are entrusted with the provision of pastoral care, equipped with the skills necessary to comprehend and impart religious beliefs that resonate with the spiritual and emotional needs of individuals. In line with this, Schuhmann and Damen (2018) assert that when extending aid, pastoral care practitioners should incorporate empathy, adept listening skills, and deep engagement with recipients to ascertain their aspirations and requirements.

However, while agreeing that pastoral care is an ancient model of social, spiritual, and emotional support found in nearly every tradition and culture, Schuhmann and Damen's (2018) findings suggested that pastoral care encompasses non-religious support as well as support for individuals from diverse religious communities. These findings are consistent with those of Doehring (2014), although the latter focused on the modern definition of the term. Doehring (2014) argued that contemporary pastoral care is distinct from conventional pastoral ministry, which is primarily rooted in Christianity and historically associated with various Christian beliefs. As a result, they suggested that pastoral care in the modern context is not faith-based but involves humanist approaches to providing comfort and support (Doehring 2014). Another study by Raffay et al. (2016) highlighted the role of pastoral care in comforting individuals, particularly during times of distress, such as pandemics. These findings collectively indicate that pastoral care significantly contributes to supporting all individuals, regardless of their religious affiliation, in meeting their needs and addressing their requirements to enhance their well-being within society.

Moreover, Doehring (2014) and Giorgini et al. (2015) argue that the limited research data on the immediate impact of pastoral care precludes its generalisation to all settings. They contend that current accounts of pastoral care fail to consider the link between curriculum changes and the broader context. The authors also highlight the transformation of pastoral power from religious authorities to individualised power within the state's secular paternalistic framework, underscoring the education and health systems as pivotal sites for interfacing with individuals and the state (Doehring, 2014 and Giorgini et al., 2015).

In this regards, Seary and Willans (2020) suggest that pastoral care is not confined to the church because it remains an integral aspect of pedagogy. Teachers can provide pastoral care to students by identifying and addressing their needs with the aim of improving their well-being and educational outcomes. Pastoral care is anchored on recognising the competencies, experiences, and insights that individuals possess and the values that they place on them. Recognising these issues enables practitioners to help address the challenges that individuals face and improve their well-being.

Best et al. (2020) agree with Seary and Willans (2020) that pastoral care can improve the well-being of individuals but disagree on what pastoral care means. According to Best et al. (2020), pastoral care improves the well-being of individuals from a spiritual perspective. Such care enhances the well-being of an individual by addressing their quest for connection, meaning, purpose, and hope. Best et al. (2020) posit that the provision of pastoral care to patients serves to enhance their inner well-being and address prevailing

challenges. It is emphasised that pastoral care transcends formal religious practices by adopting a holistic approach that accommodates diverse religious beliefs.

In this regard, Lartey (2003) espouses an intercultural approach to examining pastoral care within a multicultural context. Lartey argues that effective pastoral care must acknowledge diverse cultural influences and their impact. Additionally, he emphasises the importance of recognising the interconnectedness between pastoral care, various counselling models, and spiritual care, thereby shedding light on its holistic nature (Lartey, 2003).

In light of the divergent viewpoints regarding the definition of pastoral care and the subjective nature of spiritual care interpretations, this study will adopt a holistic approach. That is to say, it will regard pastoral care and spiritual care as interconnected disciplines. Consequently, this literature review aims to encompass a broad spectrum of religious and non-religious sources that can provide valuable insights into the research topic and facilitate the identification of research gaps.

2.3.2 Pastoral Care and Academia

As stated by van DeusenHunsinger (2015), pastoral care is a common provision in both education and healthcare facilities, focusing on enhancing the emotional and social well-being of students and patients rather than solely on their cognitive needs. Additionally, Magezi (2016) highlights the importance of schools balancing academic performance and pastoral knowledge for overall development. The distinction between academic and

professional knowledge in pastoral care has only recently become more apparent (Ashton et al., 2016; Kyriacou, 2015). Achieving the right balance between professional and academic knowledge becomes more critical at the advanced stages of practice. Furthermore, van DeusenHunsinger (2015) notes that while the education system prioritises academic knowledge, it is equally essential to ensure that students are well-rounded, as various factors contribute to the increasing demand for professional knowledge in pastoral care.

However, Chisale (2018) argues that the increased secularisation of the curriculum influenced the distinction between academic and professional knowledge in pastoral care. As religious and moral objectives became less dominant in the curriculum, they were, to some extent, marginalised or ignored as discrete concerns. Nonetheless, Van DeusenHunsinger (2015) contends that the advancement of professional knowledge in pastoral care does not necessarily imply the absence of moral content in the curriculum. Even though didactic moralising of subjects was minimal in educational institutions, certain subjects inherently encompass ennobling objectives.

In contrast, Giorgini et al. (2015) and Doehring (2014) argue that while academic knowledge meets students' cognitive needs, professional knowledge in pastoral care is associated with attitudes of deference and submission. For instance, pastoral care training in educational institutions equips learners with the necessary life skills to function in society. In this regard, Doehring's (2014) study sought to ascertain the contemporary relevance of pastoral care within the healthcare context, highlighting the imperative for

pastoral care practitioners to draw upon both academic and professional acumen in addressing the multifaceted challenges impacting patients.

In support of these assertions, Bone et al. (2018) argue that pastoral care practitioners should adhere to professional flexibility, understanding, and the implementation of sustainable methods in assisting patients. Likewise, LaMothe (2017) emphasised the significance of academic knowledge in pastoral care, stating that it provides a strong expertise background to understand various phenomena and activities. Academic knowledge is also crucial for establishing the most effective ways of comprehending the practice and building rapport with patients. With modern technological advancements and increased accessibility to the internet, pastoral care practitioners are able to promptly access the information they need (LaMothe, 2017).

2.3.3 Pastoral Care and Healthcare

Best et al. (2020) have highlighted the historical presence of pastoral and religious caregivers from diverse faith traditions offering support to patients within healthcare institutions. Particularly, in the United Kingdom, chaplaincy services became an integral component of modern healthcare practices commencing in the 1920s. Best et al. (2020) also posit that the integration of chaplaincy into contemporary healthcare systems was facilitated by the participation of theology students in healthcare settings. Likewise, the establishment of this practice in the United States can be attributed to the pioneering efforts at the Worcester State Hospital under the leadership of Anton Boisen (Best et al., 2020). Additionally, both Roberts and Kovacich (2020), alongside Vilmos (2018),

underscore the imperative of upholding professionalism in the provision of pastoral care to vulnerable populations and social cohorts.

Extensive discussions have revolved around the correlation between pastoral care and healthcare. As asserted by Schuhmann and Damen (2018), regulatory and accrediting bodies within the health sector have identified spiritual needs as a fundamental right of patients. The Joint Commission on the Accreditation of Healthcare Organizations (2021) highlights the entitlement of patients to compassionate care, safeguarding their dignity and preserving their cultural, spiritual, and psychological values. The quest for enhanced healthcare provision and patient safety has propelled a heightened emphasis on professionalism and accountability. Furthermore, the Canadian Council on Health Services Accreditation (2019) emphasises the necessity of considering the spiritual needs of patients in the development of service plans, underlining the imperative to honour the cultural and religious beliefs of patients.

In this regard, Baab (2018) argued that pastoral care holds a central position in the health sector, emphasising its relevance in addressing the holistic needs of patients in expediting their recovery. They point out the pivotal role of pastoral care in an individual's recuperative journey, highlighting the significance of spiritual nourishment and prayer in the healing process. Namely, individuals grappling with severe illnesses often retreat from their social support systems, thereby impeding their recovery (Baab, 2018). Thus, Baab (2018) underscores the association between pastoral care and healthcare as a means of mitigating the loneliness and fear experienced by patients during their illness.

Consequently, pastoral practitioners provide heightened support to these communities during such circumstances. Hence, pastoral care for patients is oriented towards facilitating their reintegration with their support networks, expediting their recuperation.

Schuhmann and Damen (2018) align with this perspective and uphold the influential role of pastoral care in the lives of patients. Furthermore, Vilmos (2018) and Chisale (2018) contend that pastoral care practitioners must exhibit qualities of compassion, consideration, and empathy. This is crucial as these practitioners continuously support and guide their patients, striving to motivate them and their families while deeply understanding their unique situations (Kyriacou, 2015).

However, de Vries (2018), Bone et al. (2018), and Clinebell and McKeever (2011) contend that while pastoral care may be associated with healthcare, it lacks quantifiable quality standards. They advocate for the adoption of a multidisciplinary approach to broaden the application of pastoral care within the healthcare system. Clinebell and McKeever (2011) conducted a study with the objective of investigating the importance of pastoral care within the healthcare domain, specifically focusing on patients diagnosed with terminal illnesses. The primary aim was to devise an evidence-based program tailored to offer support to these patients. The study revealed that pastoral care practitioners play a vital role as part of the interdisciplinary team responsible for patient care. The escalating requirement for an evidence-based program to enhance the quality of care for patients has garnered global recognition.

In accordance with this perspective, Schuhmann and Damen (2018) and Bone et al. (2018) underscored the indispensability of individuals facing various life stressors, including diseases, to receive care, encouragement, medication, and spiritual nourishment. Consequently, providing pastoral care for these vulnerable groups is fundamental to fortifying overall well-being. Pastoral care has proven to expedite the convalescence of patients through the emotional sustenance it provides, as practitioners form therapeutic relationships with patients and extend support beyond religious contexts. It was concluded by Clinebell and McKeever (2011) that pastoral care represents an advanced form of therapy.

2.3.4 Pastoral Care and Codes of Practice

Within the United Kingdom, pastoral care practitioners fall within the categorisation of social workers, rendering them subject to the Codes of Practice for Social Care Workers delineated by the General Social Care Council (2010). These codes stipulate a range of standards which pastoral care practitioners are mandated to observe, predominantly centred on the imperative of demonstrating respect toward and nurturing trust and confidence among the patients under their care. According to Giorgini et al. (2015) and Nandan et al. (2015), fostering trusting relationships with patients augments professionalism and the provision of patient-centred care.

The Code of Practice delineates six guiding principles incumbent upon pastoral care practitioners. Foremost among these is the advancement of the interests and entitlements of the patient, which necessitates the prioritisation of patient interests and the recognition

of their cultural diversity (General Social Care Council, 2010). The second guiding principle pertains to the preservation of trust and confidence among patients, achievable through transparency, forthright communication, and dependability. The third principle pertains to upholding the autonomy of patients, entailing the facilitation of their awareness of their rights within the care regimen.

2.3.5 Pastoral Care and Code of Ethics

Giorgini et al. (2015) underscore the significance of integrating a code of ethics into the practice and research of pastoral care, with the primary aim of observing, safeguarding, and optimising benefits for patients. Various directives govern the behaviour of pastoral care practitioners. The Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students (CCECPCPES) stands as the principal standard regulating pastoral care (Spiritual Care Professionals, 2004). Establishing a unified benchmark for pastoral care activities serves to direct and oversee progress. The Code stipulates that recipients of pastoral care encompass patients, family members, and healthcare establishments.

Article 1 of the guideline delineates the relationship between clients and care professionals. Additionally, the Code necessitates care practitioners to engage with patients in a manner that upholds the clients' dignity (Spiritual Care Professionals, 2004). Furthermore, Article 1 of the Code accentuates that care practitioners must acknowledge their limitations and make referrals should the matter at hand surpass their expertise. Schuhmann and Damen (2018) contend that formulating a standard practice is imperative

in steering and guiding professionalism in pastoral care. Similarly, Bone et al. (2018) posit that honouring patients and vulnerable individuals under care expedites recovery and fosters resilience. The pastoral care provider should additionally act in the best interest of patients while respecting the patient's cultural beliefs. In concurrence, Giorgini et al. (2015) emphasise that the association between patients and pastoral care providers should be exclusively professional. Bone et al. (2018) argue that prioritising patients' needs and acting in their best interest is an inherent expectation in pastoral care. Effective coordination and communication ought to epitomise pastoral care.

In contrast, Baab (2018) and Giorgini et al. (2015) contend that the emphasis on codes of ethics alone cannot serve as the sole foundation for impartial pastoral care. They stress the importance of adequate training and altruism for achieving better outcomes, as it is essential for pastoral care professionals to demonstrate a thorough understanding of their responsibilities to patients and all aspects of society.

Article 2 of the Code delineates the optimal relationship between supervisors and students in the pastoral care profession. It acknowledges that students may be involved in delivering services to patients under supervision. Giorgini et al. (2015) stress the importance of pastoral care professionals maintaining a relationship devoid of coercion or intimidation, as this can impact the quality of care. Supervisors are tasked with upholding a professional relationship with students while providing timely feedback. Chisale (2018) also highlights the need for maintaining a professional patient relationship,

focusing solely on matters relevant to treatment and context. Additional information may be shared with the patient's consent if it supports the healing process.

In acute care settings, pastoral care is overseen by the Standards of Practice for Professional Chaplains (SPPC), which defines the range of services provided by pastoral care practitioners (Association of Professional Chaplains, 2015). This includes assessing and establishing a treatment plan that contributes to the patient's overall care.

In a similar vein, Baab (2018) argues that pastoral practitioners should record and quantify the care they provide. Additionally, it is expected that practitioners engage in interdisciplinary teamwork to elevate the standard of care offered to patients, as the SPPC advocates for accountability among pastoral care practitioners. Supporting this view, de Vries (2018) emphasises that these regulations help to ensure the delivery of high-quality services and enhance relationships with patients.

In contrast, Chisale (2018) asserts that the public has expressed a desire for pastoral care practitioners to place greater emphasis on moral considerations, as opposed to merely adhering to basic ethical guidelines, a view divergent from de Vries (2018) who underscores the primary importance of ethical guidelines. Chisale (2018) acknowledges that notwithstanding the availability of diverse guidelines, ethical conduct remains integral. However, the virtue of character is deemed more suitable given the need for pastoral care practitioners to cultivate trusting relationships with patients (Chisale, 2018).

2.3.6 Pastoral Care and Professional Guidelines

Numerous guidelines have been established to govern the standard of care provided by pastoral care practitioners. One such guideline is the Standards of Practice for Professional Chaplains in Acute Care Settings (SPPC), pertinent to the health sector. The SPPC delineates the various standards that pastoral care practitioners are mandated to uphold when attending to patients (Association of Professional Chaplains, 2015). These practitioners are obligated, under section 1, to perform assessments to comprehensively discern the patient's situation by assimilating all relevant data. Subsequently, the second standard of care delivery encompasses the pastoral care practitioner's formulation and execution of a care plan to enhance the patient's well-being (Association of Professional Chaplains, 2015). Following this, the third standard encompasses the documentation of care, entailing the meticulous recording of patient data in pertinent medical records that reflect the medical, spiritual, and psychological goals of the patient's care. The fourth standard under the Code is teamwork and collaboration (Association of Professional Chaplains, 2015). To ensure the efficient delivery of care, pastoral practitioners must seek collaboration with other personnel in health facilities to ensure patients receive holistic care. Collaboration to improve patient health outcomes is central to pastoral care in healthcare settings (Giorgini et al., 2015). The fifth standard pertains to ethical practice, where common codes of ethics guide pastoral care practitioners in their decision-making and behaviour. Upholding confidentiality is the sixth standard, with pastoral care practitioners entrusted with patient information, including confidential details, and are obligated to safeguard this information from disclosure to third parties. Lastly, the seventh standard pertains to upholding diversity by acknowledging cultural differences. In light of

current global trends leading to a society of diverse cultures (Brayne et al., 2015), pastoral care practitioners must affirm and respect the varied beliefs of their patients without discrimination.

In Section 3 of the SPPC, there is a provision for reflective practice. The Code emphasises the importance of maintaining competent pastoral care (Association of Professional Chaplains, 2015). Standard 11 states that practitioners must ensure continuous quality improvement. This involves creating opportunities to advance the quality of practice. Standard 12 emphasises the need for competency improvement through research to enhance the quality of care. Pastoral care practitioners are required to establish evidence-based care and regularly evaluate emerging practices to establish a more appropriate framework. Conducting research helps improve the available information on specific topics. Lastly, under Standard 13, there is a provision for furthering education for professional development to enhance the practitioner's professional qualifications.

2.3.7 Pastoral Care and Reflective Practice

LaMothe (2017) and Roberts and Kovacich (2020) argue that pastoral care practitioners must reflect on their roles and the welfare of patients to avoid conflicts of interest when carrying out pastoral care activities. In this regard, Peeters (2020) examined the factors contributing to job satisfaction among pastoral care practitioners. The author posits that individuals in this profession often derive fulfilment from effecting positive change in the lives of others. Irrespective of one's tenure in pastoral care, it is imperative for caregivers

to allocate time for introspection. Such contemplation may be undertaken in collaboration with supervisors or independently, involving a review of the day's tasks. Murphy and Holste (2016) substantiate Peeters' assertions, emphasising that reflective practice entails an appraisal of one's thorough understanding of the primary duties and responsibilities as well as personal assessments of knowledge application. Similarly, Kyriacou (2015) suggests that pastoral care practitioners should actively cultivate peer-based relationships, with reflective practices playing a key role. While varying approaches cater to individual preferences, the cultivation of self-worth stands as an indispensable element.

In contrast, van DeusenHunsinger (2015) and Schuhmann and Damen (2018) assert the necessity of cultivating resilient, high-quality relationships capable of accommodating constructive criticism and challenges while remaining grounded in authentic concern for the well-being of others. Giorgini et al. (2015) expound on reflective practice, which involves guiding an individual's career to facilitate professional growth, a process that necessitates the support of managers and supervisors for pinpointing areas requiring improvement.

Conversely, Bone et al. (2018), Clinebell and McKeever (2011), and Baab (2018) assert that the capacity to reflect on pastoral care practice is initiated by the individual. They emphasise the importance of self-motivation as a fundamental aspect of professionalism and further argue that continuous reflection in pastoral care contributes to the achievement of best practices and improved health outcomes.

Furthermore, Giorgini et al. (2015) assert that reflective practice encompasses the capacity to contemplate one's professional conduct, thereby fostering continuous learning within the profession. This process is notably observable when pastoral care practitioners encounter novel situations, presenting invaluable learning opportunities. These encounters facilitate the acquisition of new skills, ultimately augmenting future pastoral care provision. Thus, within the field of pastoral care, reflective practice is pivotal for cultivating professional competence, which involves a conscientious understanding of professional responsibilities and adherence to established standards.

2.4 COVID-19 Pandemic and Pastoral Care

2.4.1 Church response to COVID-19 in the UK context

On 23rd March 2020, the Foreign Secretary of the UK, Dominic Raab, announced a stringent full lockdown two months after the first cases of coronavirus were recorded (Freedman, 2020). The initial regulation implemented in the UK was the Health Protection (Coronavirus) Regulations 2020, which underscored screening for the virus among UK citizens and imposed restrictions aimed at curtailing the spread of the virus (Freedman, 2020). This regulation significantly impacted the UK church community, particularly in the execution of religious activities. In a similar vein, the Bishop of Peterborough, a prominent figure in the Church of England, issued a decree on 20th February 2020, which, while not implying the cessation of Holy Communion, stressed the importance of hygiene during its administration, disapproving of congregants receiving Holy Communion directly on their tongue (Cranmer and Pocklington, 2020). Other church-related activities disapproved by

the Bishop of Peterborough included the dipping of consecrated bread in chalice wine, the pouring of water during baptism, and the laying on of hands by priests during ordinations and confirmations (Cranmer and Pocklington, 2020). The findings suggest that COVID-19 detrimentally impacted the religious experience of UK Christians. The restrictions affected fundamental aspects of the Christian religion, such as baptism, resulting in congregants being unable to interact freely with pastoral care providers in the accustomed manner. Moreover, Cranmer and Pocklington (2020) explicate that the Church of England holds a distinctive position in English law as it was established by legislation of the country. Consequently, any internal regulatory changes concerning religious services made by the Church of England must receive approval from the UK Parliament before being enforced.

Similarly, in the document "Church in Wales Guidance Note," the Bench of Bishops (2020) of the Anglican Church in Wales outlines changes in church activities. A key point emphasised by the Anglican Church leaders in the note is that priests should refrain from physically visiting individuals who are ill, the discontinuation of the physical sharing of peace involving handshakes, and the cessation of chalice administration in the Church (Bench of Bishops, 2020). These measures align with similar restrictions implemented by the Church of England, potentially impacting the worship experiences of UK citizens during religious services.

However, many Anglican leaders in the UK agreed with the decision to close church buildings during the pandemic but disagreed with preventing clergy from accessing the

premises. Bishop Peter Selby (2020a) expressed his concerns in an article titled "Is Anglicanism Going Private?" published in The Tablet. He argued that closing Anglican church buildings not only for services but also for private prayer or livestreaming worship could signify a significant shift from the public sphere to the private realm. In solidarity with Selby's position, 807 lay and ordained church leaders signed a letter sharing this concern, fearing that it could fundamentally alter the church's role in society (Selby 2020b). This example shows that the pandemic prompted reflection on the church's place and purpose and highlighted the politically contentious debate within Anglicanism.

In contrast, the Church of Scotland, a Presbyterian denomination, initially only imposed limitations on religious activities but subsequently ceased church services on 17th March 2020 in compliance with directives from the Scottish government (Church of Scotland, 2020). Consequently, adherents of the Church of Scotland embraced the usage of online technology, such as Zoom, Skype, and Facebook Live, to participate in pastoral activities (Church of Scotland, 2020).

Moreover, Huang et al. (2021) conducted a study on the impact of the COVID-19 pandemic on the British Chinese Christian Community (BCCC) with an emphasis on pastoral care. The research revealed that attendance at church services was restricted, and hand sanitisers were provided on church premises as preventative measures. Additionally, church leaders adapted their sermons to emphasise biblical disasters, such as the Egyptian plagues, in order to address the spiritual implications of the COVID-19 crisis and underscore the importance of fortifying faith during times of adversity. However,

the BCCC encountered challenges in securing interpreters proficient in English, Cantonese, and Mandarin for their online platforms on WeChat, Zoom, and YouTube (Huang et al., 2021). The study concluded that the pandemic-induced disruption significantly impacted congregational life.

While the primary focus of this investigation is specific to the UK, it is essential to acknowledge the significant contribution of global research. As a result, this literature review will encompass literature from both the UK and abroad to extract valuable insights and pinpoint research gaps.

2.4.2 Positionality of pastoral care practitioners

The study by Best et al. (2020) examined the perspectives of pastoral care staff at a hospital to gain insights into the importance of the pastoral care practitioner. The research findings indicate that pastoral care is essential because it provides whole-person care, meaning that it enables individuals to view themselves as unique and valued members of society. Pastoral care practitioners also educate and provide psychosocial support to those in need. In all these, spirituality forms a core part of how pastoral care practitioners perform their work. Indeed, Gardner, Tan, and Rumbold (2020) agree that pastoral care practitioners should rely on spirituality to treat each patient as a person and remind them of their capabilities and the things that matter. The claim shows that pastoral care practitioners can improve the well-being of individuals in hospital settings by using spirituality to motivate them and give them hope in regard to what could be.

A limitation of the studies conducted by Gardner, Tan, and Rumbold (2020) and Best et al. (2020) is that they focused on a hospital setting where perhaps spirituality is crucial for improving the hope and mental well-being of patients. The findings of the studies thus fail to provide insights into how pastoral care would be necessary in normal settings where hope is not an essential requirement and the extent to which spirituality might hinder the provision of effective care. Dozier et al. (2020) advanced a similar narrative as Best et al. (2020) on the importance of spirituality in pastoral care but also explored whether religiosity can limit the quality of care provided. Dozier et al. (2020) examined how pastoral care can be used by religious leaders to provide care to those who have procured an abortion and shape attitudes toward abortion. They found that religious leaders who provide pastoral care use spirituality to provide emotional support to those who have procured an abortion or are conflicted about the issue of abortion due to moral and religious beliefs. However, the authors noted that while religious leaders may have stances such as pro-life or pro-choice when providing pastoral care, they tend to shelve such beliefs to attend to the needs of those who require their services and work together with them to improve their mental wellbeing. The argument shows that pastoral care practitioners should decentre themselves from the challenges that individuals face and work on providing the best care. The argument implies that persons whose judgements are clouded by their spiritual beliefs would not make ideal pastoral care practitioners. Thus, spirituality should not be used to force religious beliefs upon individuals but to help them find meaning and hope. Gardner (2020) supports the claims made by Dozier et al. (2020) that practitioners should avoid using their religious beliefs and spirituality to impose solutions on individuals in need of care. According to Gardner (2020), pastoral care

practitioners should be able to listen deeply and well to the needs of those who require their care.

2.4.3 Companionship and social support

The function of pastoral care practitioners is evident in the provision of companionship and social support to residents. Wells et al. (2021) revealed that aged clients and residents valued pastoral care as enabling them to realise companionship during the pandemic when social distancing measures disrupted social gatherings and travelling to visit friends and relatives. The view implies that pastoral care offered union and togetherness, which created a sense of belonging in society. In agreement, Best et al. (2022) noted that pastoral practitioners developed a special bond with their clients that resulted in open and comfortable conversations. Pastoral practitioners could address sensitive topics such as death and other personal issues, thus becoming a source of encouragement in times of distress and hopelessness. The variation between Wells et al. (2021) and Best et al. (2022) is that the former focused on elderly care while the latter handled pastoral care in hospitals. A closer look at the two studies shows that pastoral care is important across all age groups and only relies on the nature of the situation needing support.

Meanwhile, Domaradzki (2022) revealed that the companionship role extended to family members of the clients, especially when one was deceased or critically ill. Pastoral care professionals offered emotional support to sick patients and close family members and friends, thereby positively affecting the whole society. Cadge (2019) states that pastoral

practitioners are companion professionals in the healthcare environment. Chaplains were noted to assert their value by integrating the spiritual language with the healthcare frameworks to win the patients' confidence. Whereas Cadge (2019) detached the chaplains from the medical profession, Batstone et al. (2020) showed that some pastoral caregivers were qualified nurses who embraced a religious and holistic caregiving perspective to extend acceptance, warmth, and love to the patients. Therefore, pastoral care is a crucial part of caregiving.

2.4.4 Spiritual support

Pastoral care is widely perceived to involve spiritual support to the community. Therefore, the studies identifying the roles of pastoral care practitioners were anchored upon the principles of spiritual intervention. Lobb et al. (2019) showed that patients praised regular pastoral care visits to the hospitals because the sessions appealed to their faith with a sense of peace, giving them hope and control. Through pastoral care imparted through spiritual conversations, the patients were able to think of something better and greater than their illness. Tan et al. (2020) shared the views of Lobb et al. (2019) by observing that pastoral care provided the opportunity to understand existential issues, explore meanings, and tackle fears in challenging times. Although both Lobb et al. (2019) and Tan et al. (2020) assessed the hospital setting, the former received patients' opinions of pastoral care while the latter took the staff's perspective. The implication is that the spiritual support role has affected both patients and staff. Providing adequate pastoral care enables individuals to overcome life challenges. Connolly and Moss (2021) defined spirituality as the connection to one's being or wholeness while noting that pastoral care

inspires spiritual beliefs towards self-reconciliation. The distinction between Lobb et al. (2019) and Tan et al. (2020) is that Connolly and Moss (2021) focused on dementia along with the integration of music therapy, suggesting that pastoral care can be applied in conjunction with other therapies to achieve spiritual uplifting. According to O'Callaghan et al. (2020), pastoral care visits produced comfort in 84.4% of palliative caregivers, with 32.8% reporting greater and significant spiritual well-being. The outcome was profound among caregivers who either prayed or meditated at work, implying that pastoral care for spiritual well-being corresponds to the faith of individuals. However, Jones et al. (2021) and Tan et al. (2021) observed that the significance of pastoral care has prompted pastoral care training in places such as the Australian healthcare sector.

2.4.5 Education and leadership

Pastoral care practitioners performed educational and leadership roles for clients. Koper et al. (2019) noted that apart from discussing spiritual issues, pastoral practitioners also addressed medical care matters, including treatment for different illnesses and patients' wishes. Because of the spiritual ambience created, the patients gained more insight into their conditions and clinical interventions. In agreement, Papadopoulos et al. (2021) pointed out that patients viewed nurses who participate in pastoral care activities as leaders. Many of the patients and individuals who sought assistance often believed in spiritual healing.

Moreover, Papadopoulos et al. (2021) asserted that the concept was only applicable where there was sufficient expertise and similarity in faith. The view indicates that in some

circumstances, pastoral care can be perceived as distractive. For example, in the care for cancer patients, Farahani et al. (2019) revealed that pastoral care helped patients understand various disease stages and therapies. Pastoral care improved personal awareness and acceptance of the health conditions and the accompanying treatment. A synthesis of three studies (Koper et al., 2019; Papadopoulos et al., 2021; Farahani et al., 2019) shows that pastoral care practitioners supplemented the efforts of medical caregivers in informing the patients.

On the other hand, Ferrell et al. (2020) noted that pastoral care practitioners were the guide to whole-person palliation. The pastoral caregivers led patients in spiritual definition and fulfilment, promoting positive living and complementing medical care. Similar observations were made by Sukcharoen et al. (2020), who, in a study of palliative care from the spiritual dimension, revealed that pastoral care encouraged self-awareness and faith since the practitioners conversed and acted as counsellors. Therefore, they offered leadership roles to the patients to enhance palliative care.

2.4.6 Pastoral care and families

One of the main areas where pastoral care operated during the COVID-19 pandemic was supporting families. The scoping review by Connolly and Timmins (2022) revealed that family members on hospital premises expressed a great need for spiritual support as they waited for loved ones on life-support machines. Indicating that spiritual well-being was fundamental for the psychological health of families, as the pandemic was associated with high levels of depression and stress. The arguments are corroborated by Roman et

al. (2020), who noted that individuals, communities, and families found solace in religious beliefs in times of adversity and anxiety. Similarly, de Diego-Cordero et al. (2022) reported that pastoral care imparted beliefs, which aided reasonable decision-making among family members of patients. The three studies (Connolly and Timmins, 2022; Roman et al., 2020; de Diego-Cordero et al., 2022) point to the pastoral care role as crucial in supporting the health outcomes of people whose relatives were infected by COVID-19, thereby reducing anxiety and disillusion among the general population.

Timmins et al. (2022) highlighted the vital contribution of pastoral care in the event of death. During COVID-19, the researchers noted the rising trend in receiving news about the death of family members, congregants, or friends. Pastoral care provision was central for families when they reported to hospitals. The strategy was intended to address potential fears and promote life satisfaction. In this regard, Byrne and Nuzum (2020) highlighted the impact of lockdowns during the pandemic, which created a sense of loneliness for those at home and isolation for the hospitalised. With face-to-face interaction limited, pastoral care was deemed as one of the ways to spur hope for the people.

Similarly, Giffen and Macdonald (2020) asserted that spiritual reassurance enabled families and individuals to generate optimism and hope for a better life during the pandemic. The three studies (Byrne and Nuzum, 2020; Giffen and Macdonald, 2020; Timmins et al., 2022) were all European-based and depicted new ways of delivering pastoral care to families both at home and in hospitals because of the COVID-19

containment measures. From these studies, pastoral care was evidenced to foster hope in the face of fear and comfort for those bereaved.

2.4.7 Pastoral care and clinical environment

According to Tata et al. (2021), healthcare staff experienced a high emotional burden due to the considerable workload in medical facilities during COVID-19. As a result, 84% of the surveyed chaplains were contacted to provide pastoral care to staff from 82% of the hospitals. Kwak et al. (2022) explored the perspectives of certified chaplains on pastoral care provision during COVID-19. The authors noted an increased need for spiritual support for the healthcare staff due to the rise in psychological needs during the pandemic. It is important to note that Kwak et al. (2022) focused on the context of the United States of America (U.S.), whereas Tata et al. (2021) drew participants from all six continents. Nevertheless, the observations of the two studies reveal that similar scenarios of pastoral care demands were experienced globally.

Similar views were presented by Amiel and Ulitzur (2020), who explored the burden experienced by pastoral practitioners during the COVID-19 pandemic. The authors observed that the healthcare burden came from other patients with chronic illnesses. The increased care burden contributed to burnout, leading to frustrations, exhaustion, depression, and anger. Thus, to overcome the associated aftermath of secondary traumatic stress and compassion fatigue, pastoral care was recommended for the caregivers. Vesel et al. (2022) noted that pastoral care was a form of palliative care that alleviated the emotional pain of COVID-19 patients and was aligned with the principles of

high-quality healthcare. The study revealed that pastoral care was crucial in reinforcing positive perceptions in the patients and providers, thus mediating the two sides in hope. Vesel et al. (2022) took a more holistic approach compared to Amiel and Ulitzur (2020) and Tata et al. (2021), as they utilised evidence from clinicians and hospital leaders in addition to pastoral caregivers. Nonetheless, the evidence suggests that there was tangible reason to incorporate and expand pastoral or pastoral care services during the COVID-19 pandemic since it provided hope and promoted the emotional well-being of many people.

2.4.8 Sustaining spiritual and emotional well-being of individuals

The literature suggests that pastoral care sustained the emotional and spiritual well-being of individuals during the pandemic. An exploratory study by Jones et al. (2022b) using semi-structured interviews with Chaplains in Australia revealed that COVID-19 increased anxiety and fear among the population. Chaplains helped patients to foster hope and promote calmness through pastoral care. Similarly, Alquwez et al. (2022) investigated the spiritual well-being of nurses during the COVID-19 pandemic using unstructured interviews. They noted that pastoral care served the purpose of spiritual encouragement for the nurses to continue attending to the patients based on the element of trusting God. Essentially, the studies (Jones et al., 2022b; Alquwez et al., 2022) coincide on the ground that pastoral care serves to inform and remind of the role of God in sustaining humanity in times of crisis. However, Alquwez et al. (2022) limited their focus to nurses only, whereas Jones et al. (2022b) acknowledged the function of pastoral care to the patients, community, families, and staff.

Meanwhile, Alquwez et al. (2022) added to the work by Hawthorne and Barry (2021) and revealed that nurses used pastoral care for self-care during the depressing moments of COVID-19. For the nurses, pastoral care worked as a self-renewing dose after the suffering and stress of attending to patients. Contrary to Alquwez et al. (2022), who only considered the religious aspect of pastoral care, Hawthorne and Barry (2021) affirmed that even non-religious pastoral care rehabilitated and sustained nurses on duty despite overwhelming tasks.

In addition, the research by Zollfrank (2021) revealed that COVID-19 led to disconnections in society since families lived separately from loved ones, leading to profound loneliness, especially for those in psychiatric hospitals. Therefore, pastoral care through digital platforms enabled chaplains to appear with crucial counselling that supported the communities in positive faith. From the congregation perspective, Rosales (2020) and Rosales (2021) noted that pastoral care through online ministrations sustained the mental well-being of the faithful during the COVID-19 pandemic. Both studies explored the impact of online Catholic preaching and celebrations and realised that they provided a new sense of life for people to face their circumstances. Religious sectors were sustained by having pastoral care services during the pandemic. Evidence shows that the absence of pastoral care during the pandemic led to widespread hopelessness as well as depression and severe mental health concerns. Thus, pastoral care helped encourage those suffering directly from COVID-19 and those impacted by the isolation and restrictions.

2.4.9 Reconciling relationships

Addressing conflict and reconciliation, Papadopoulos et al. (2020) investigated the pastoral care provision among those hospitalised and highlighted the need for reconciliation as a significant process objective. In this case, spiritual support was offered to individuals who were hopeless and felt abandoned by the world and God. Therefore, the role of pastoral care was to alleviate the state of spiritual distress and restore the perception of reality, thus reconciling the patients with themselves, God, and their loved ones. Similarly, Trothen (2022) noted that the pandemic period was characterised by strained and broken relationships, primarily due to the inherent stress of living. Pastoral care took the spiritual perspective to re-introduce the concept of love, thus encouraging reconciliation among people in communities, suggesting that pastoral care fostered increased cohesion and togetherness during the difficult moments of the pandemic.

Furthermore, Modise (2023) highlighted the reconciling effect of spiritual songs during the COVID-19 period. The author noted that while the society remained fragmented through lockdowns, the religious-influenced song *Jerusalema* became an icon of unity among healthcare workers and people from across cultures and nations worldwide. The song promoted self-reconciliation and hope amidst the high mortality rate caused by the pandemic. The implication is that pastoral care was also provided through music and helped bring together diverse people for a common goal. While Modise (2023) focused on musical contributions, the earlier observations by Trothen (2022) were based on robotic pastoral care. Thus, the two types of research showed that pastoral care functions

could be effective among communities despite the physical absence of a designated practitioner. Notably, Papadopoulos et al. (2020) conducted the study between March and May 2020, the prime season of the first wave of COVID-19, thereby receiving first-hand experience information compared to the later examinations of Trothen (2022). Nonetheless, the literature shows that pastoral care was essential in restoring connections during COVID-19.

In a separate study, Gampetro et al. (2023) explored the lived experiences of individuals during the COVID-19 pandemic and reported the significance of spiritual fortitude in promoting resilience. The authors observed that spiritual fortitude was instrumental in reconciling the people with the circumstances opposed to their livelihoods, such as bereavement, psychological challenges, and unsafe work environments. The strategy was accomplished by sharing experiences in pastoral care sessions and attaining relevant education. The view was also reflected in Elliott et al. (2021), who analysed discussions from live webinars. The report revealed that in times of bereavement during the pandemic, individuals required spiritual consolation to reconcile with the truth and learn to cope with separation from their loved ones. Therefore, pastoral care enabled individual and community reconciliation during the pandemic.

2.4.10 Spiritual healing

Situmorang (2021) acknowledged the contribution of spiritual music in aiding the healing of individuals from depression and anxiety caused by COVID-19 terror. The researcher analysed the contents of an Indonesian song, *A Prayer for Nation*, whose lyrics and

rhythm contained a pastoral message that encouraged recovery and healing for the nation. In agreement, Dalle Ave and Sulmasy (2021) evaluated the spirituality of healthcare professionals during the pandemic and reported positive healing outcomes. The authors reported that healing came in the form of the restoration of all of the disrupted relationships between God, community, families, natural order, and oneself. These were all realised through pastoral care, thus exemplifying the contribution of spiritual intervention in healing. The difference from Situmorang (2021) is in the scope, whereby Dalle Ave and Sulmasy (2021) only concentrated on self-care for healthcare professionals. Consequently, the conclusion is that both COVID-19 patients and healthcare providers require internal healing from trauma associated with the pandemic.

On the other hand, Carey et al. (2022) covered pastoral care for nurses and patients during the pandemic. The distinction of Carey et al. (2022) from the other two studies (Situmorang, 2021; Dalle Ave and Sulmasy, 2021) was that nurses assumed the role of pastoral care practitioners. The arguments of Carey et al. (2022) were more explicit for the patient healing process. Specifically, the study indicated that spirituality, such as yoga, was good for relieving pain and speeding up recovery. Pastoral care has pain-related beliefs, which are essential for setting the minds of the patients on the path of positive healing.

Further, Corpuz (2021) indicated that pastoral care was essential for the healing process of those anxious about social distancing measures and those bereaved. During COVID-19, pastoral care offered emotional support and ensured resilience for those infected by

the virus. On the other hand, pastoral care was helpful for comforting the bereaved and mending the broken spirits. However, a more recent study by Lazzarino and Papadopoulos (2023) found that there were limitations in terms of the impact of pastoral care under pandemic restrictions, which were partially due to the absence of the physical presence of the practitioner. The analysed data sources demonstrated below expected scores where technology, media and social media platforms were used for pastoral care. The healing effect of pastoral care during the pandemic was slower due to the lack of face-to-face interactions. Sarmiento (2021) noted that the trend was significant among healthcare professionals who did not have time for online sessions due to the excessive workload during the pandemic. Therefore, the recipients only partially felt the healing aspect of pastoral care during COVID-19.

2.4.11 Guidance on public health and safety

The research evidence on the Philippine church sector by Del Castillo et al. (2020) revealed that pastoral care to the congregation, homes and healthcare facilities helped people understand the COVID-19 disease and public safety measures. Spiritual intervention at a professional level helped debunk myths surrounding coronavirus, thus encouraging individuals to embrace proposed medical solutions. In support of these arguments, Rentala and Ng (2021) indicated positive results of reduced somatic symptoms when mobile call-based integrated Body-Mind-Spirit (IBMS) was used for pastoral care in a COVID Care Centre. The IBMS intervention was used to engage the patient through eight sessions in which several issues related to the COVID-19 disease were discussed. From the guidance received, the patient was able to register significant

improvements. However, the weakness of Rentala and Ng (2021) was that the case study involved a single patient, which limits the clinical replication and validation of the IBMS system.

On the other hand, Egargo and Kahambing (2021) noted that spiritual or pastoral intervention conducted by the general church during the pandemic guided people from destructive actions of suicidal ideation. Religious-based pastoral care served to redefine the meaning of life to the desperate people who lost work, possessions, income, or loved ones in the pandemic. A synthesis of the three articles (Del Castillo et al., 2020; Rentala and Ng, 2021; Egargo and Kahambing, 2021) revealed that pastoral care guided individuals using a message of hope to give a positive attitude about COVID-19 and overcome the health and social challenges they faced.

According to Jaysawal and Saha (2022), religion shaped individuals' beliefs concerning COVID-19 because it is a component of spirituality and encompasses personal attitude and personality factors. The ability of pastoral care to appeal to the attitudes of individuals transformed their perception of suffering, helping them come to terms with the status quo. The strategy was helpful for initiating COVID-19 containment measures, hence faster restoration of a healthy population. Fardin (2020) asserted that spirituality was proportional to cleanliness. Through pastoral care, it was possible to offer practical guidance on basic COVID-19 prevention measures such as regular handwashing, sanitising items, and disinfecting surfaces.

Further, the review by Fardin (2020) pointed to the obedience aspect of religious spirituality ensuring improved adherence to COVID-19 containment measures, including lockdowns. The arguments regarding spirituality and personality factors are supported by Jaysawal and Saha (2022). On the same note, Kadafi et al. (2021) noted that Islamic counselling during COVID-19 increased awareness in a quasi-experimental design with a non-equivalent control group study. Therefore, pastoral care was helpful in offering positive guidance during the pandemic. Although non-religious spirituality approaches to care are effective, the literature lays more emphasis on the religious component regarding the subject of guidance.

2.4.12 Supporting self-efficacy of communities

Pastoral care was instrumental in restoring and supporting self-efficacy for patients and healthcare professionals during the COVID-19 pandemic. Sahay and Wei (2022) explained that through interpersonal pastoral care and encouragement, nurses were able to regulate other concerns during the pandemic and attend to patients with undivided attention. Spiritual intervention at the peer-to-peer level promoted self-esteem through the bond of co-workers, hence, more energy for service. Similar observations were made by Ariffin et al. (2022), who investigated the impact of psycho socio-spiritual support on the self-confidence of students during COVID-19. Notably, the study focused on the education sector, where 22 participants were surveyed and seven more were interviewed, as opposed to Sahay and Wei (2022), who used a healthcare setting. In their findings, Ariffin et al. (2022) observed that psycho socio-spiritual support positively affected the students' self-confidence despite the pandemic's negative psychological impacts. The

two studies complement each other since both focused on peer support, thereby providing a holistic view of pastoral care practitioners' role in enhancing self-efficacy during the pandemic.

Meanwhile, Sánchez-Garcés et al. (2021) examined self-efficacy outcomes of COVID-19 patients who received spiritual support at some point of care and highlighted positive attitude as a crucial outcome of spiritual support. Religious faith from the spiritual interventions produced spiritual resilience expressed as confidence, trust, security, and healing. Contrary to the other studies (Sahay and Wei, 2022; Ariffin et al., 2022), peer-to-peer support was not considered in the case of patients. However, the strength of Sánchez-Garcés et al. (2021) was that it involved a two-step analysis criterion to process the interview data, thereby refining the findings.

Maspul (2022) examined spiritual therapy's impact on families during the COVID-19 pandemic and acknowledged the contribution of building confidence. Pastoral care enabled the development of resilience in times of distress through religious advice, positive emotion, and the right attitudes, which generated self-confidence. The arguments of Maspul (2022) are echoed by Sánchez-Garcés et al. (2021), who pointed out that there was no peer-to-peer concept. Therefore, a third-party pastoral care practitioner best addresses the issues of patients and couples. However, Rosa et al. (2022) discovered low self-efficacy in 64% of palliative specialists in the U.S., thus lowering the quality of pastoral care delivered via telehealth. The observation was attributed to the sudden shift to telehealth and inadequate training on using the new method to deliver palliative care.

Compared to Maspul (2022), Rosa et al. (2022) concluded that the quality of pastoral care outcomes depends on the type of practitioner and the mode of delivery.

2.4.13 Providing counselling programs

Regarding the role of counselling in pastoral care, Bard (2020) noted that pastoral care providers are trained counsellors with the expertise to enable individuals to overcome guilt and restore their purpose of existence. These qualities were beneficial in counselling people undergoing post-traumatic stress disorder (PTSD) and moral distress during COVID-19 (Bard, 2020). Therefore, pastoral care went beyond the normal scope of a general counsellor to aid in holistic recovery from trauma. Apart from the work and social based stress of the pandemic, Madigele and Baloyi (2022) highlighted the importance of counselling in pastoral intervention for troubled families. The authors focused on the violence in homes during the lockdown distress, indicating that the majority of peace talks and marital advice came from respective religious leaders.

Similarly, Peteet (2020) asserted that the COVID-19 pandemic was associated with rising anxiety, which required expert attention. Although Peteet's (2020) focus was the impact on health condition self-care, the presence of anxiety explains the increased family conflicts later addressed by Madigele and Baloyi (2022). In this regard, individuals relied on pastoral care and spiritual advice to address some of the negative psychological issues causing irritation and anger. Therefore, pastoral care counselling was an important resource during the pandemic.

In a separate research study, Ribeiro et al. (2020) reported on the effectiveness of a Pastoral Hotline Project for Brazil designed in response to the rising need for pastoral care during COVID-19. According to the authors, one observation was that through pastoral care initiatives, residents could ask personal questions and get professional counselling based on their religious and spiritual beliefs. The strategy was essential for positive living during isolation and rising cases of COVID-19 mortality. Pastoral care practitioners helped individuals overcome their sense of loss through bereavement counselling. In agreement with these arguments, Wu et al. (2020) highlighted that pastoral care was an effective alternative technique for providing counselling therapy to healthcare staff during COVID-19. Healthcare staff rarely admitted the regular counselling approaches; hence, pastoral care became the central tool for offering these workers useful advice towards mental health support. The reviewed literature shows that pastoral care effectively provided counselling to individuals from different cultures, communities, and industries.

2.5 The Impact of COVID-19 on Pastoral Care Provision

2.5.1 Impact on demand for pastoral care

Xiong et al. (2020) presented a worldwide reflection on religious sectors during the outbreak of the pandemic. From the separate narratives by Christian, Buddhist, and Muslim Practitioners, it was identified that healthcare workers and families overwhelmed by emotional and mental health challenges sought pastoral care for spiritual nourishment. The result implied that COVID-19 increased the demand for pastoral care globally. The trend was supported by Jin (2023), who assessed the factors affecting nursing students'

spiritual well-being. The researcher acknowledged that the COVID-19 pandemic presented a spiritual health crisis among nursing students due to the high demand for pastoral care for the individual's mental health. Although the findings coincide, Xiong et al. (2020) included pastoral care practitioners as participants, whereas Jin (2023) gathered data from healthcare students. The results implied that the perceived rise in pastoral care demand during the pandemic was felt by nearly all healthcare stakeholders, increasing the prevalence of depression among caregivers.

Similarly, Mizutani (2022) indicated that COVID-19 contributed to the increased demand for pastoral services due to high rates of loneliness, material losses, deaths and suffering from disease, which prompted a hike in mental well-being concerns. The trend translated to a need for enhanced spirituality, hence a growth in pastoral care demand for patients, providers, and families. A synthesis of the three studies (Xiong et al., 2020; Jin, 2023; Mizutani, 2022) reveals that COVID-19 severely affected the social, economic, and psychological life dimensions, making religious and pastoral services vital for survival.

Johnston et al. (2022) noted that ministers reported a rise in pastoral care demand among their congregations despite the lockdowns and other COVID-19 restrictions. Specifically, 54% indicated an increase in comforting grieving families, ministering to the sick under isolation and presiding over funerals. Further, an increase in loneliness, depression and anxiety during the pandemic was reported. However, with the expansion of pastoral care provision, Osei-Tutu et al. (2021) recorded reduced stress and increased faith that helped families and societies cope with the pandemic. The results implied that there was a

substantial response to increased demand for pastoral care during the pandemic. Evidently, COVID-19 escalated the demand for pastoral care provision.

According to Byrne and Nuzum (2020), COVID-19 led to isolation for persons suffering from the coronavirus disease, a factor that impacted their physical and emotional well-being negatively. Furthermore, the isolation created challenges for those who provided pastoral care because they could not be physically close to those who required their care. Byrne and Nuzum (2020) claimed that practitioners had to develop innovative strategies to connect with individuals who required their services. One of the strategies that they developed was the use of information technology to reach those who needed their services. Some practitioners used virtual video call technology to connect with individuals who required their services. However, Hall (2020) emphasised face-to-face communication when providing pastoral care, especially to those in hospitals. According to Hall (2020), the administrators of healthcare organisations should develop policies to enable practitioners to visit patients in hospitals without increasing the risk of transmission. At the same time, Hall (2020) claimed that it is acceptable for practitioners to use information technology to connect with patients when physical visits are untenable. A significant limitation of the study conducted by Hall (2020) is that it failed to obtain the perspectives of hospital administrators and pastoral care practitioners. Most of the claims made in the study were thus based on assumptions on what constitutes the best approach towards providing pastoral care to those in hospitals. Nevertheless, the arguments have implications for the proposed research because they provide insights into the challenges posed by making physical visits to patients in hospitals during the pandemic to provide

pastoral care. Additionally, they highlight the challenges that arise when using information technology to connect with those who require care because the lack of physical presence can reduce the quality of care outcomes.

As argued by Brady and Dolan (2020), in support of the claims made by Hall (2020), physical presence can improve the quality of the relationship between pastoral care practitioners and those receiving care and, thus, care outcomes. However, Brady and Dolan (2020) argued that being present is not confined to physical presence but mainly entails being available to provide care when an individual is in need. The implication is that even the use of technology can enable practitioners to be present for those who need their services. Similarly, Hart et al. (2020) claimed that COVID-19 increased the need for pastoral care due to the health challenges faced by those who had contracted the coronavirus disease. Technology-enabled pastoral care practitioners engage in structured, routine, and predictable communication that is integral to providing family-centred care. However, Hart et al. (2020) also argued that the use of information technology to provide pastoral care has various limitations, including the potential for privacy violations and an increase in geographic, racial, and socioeconomic disparities for persons who do not have access to reliable internet.

2.5.2 Impact on availability of pastoral care

Whereas an upward trend in the demand for pastoral care was witnessed, the availability of pastoral care was affected following the COVID-19 outbreak. According to Afolaranmi (2020a), the lockdowns and pandemic restrictions compromised the traditional ways of

ministering pastoral services, thus limiting access to pastoral care. The implication is that those needing such services could not get them due to the inability of the pastoral practitioners to reach them. Similarly, Del Castillo (2021) acknowledged that individuals' inability to move freely during the pandemic reduced pastoral care accessibility. The issue was exacerbated by the extremely high number of people suffering from psychological issues from the effects of COVID-19 that overwhelmed pastoral care practitioners. Intra-family pastoral care was adopted. Notably, Afolaranmi (2020a) only focused on the ministers and their ministries; hence, the observations are limited to the Christian and church ministry context, whereas Del Castillo (2021) took a broad perspective of overall faith. Flynn et al. (2021) widened their investigation to include pastoral care in the three continents of Australia, Europe, and North America. The challenge of the availability of pastoral care during COVID-19 affected different groups, including staff, patients, and families, creating the need to prioritise care provision for vulnerable demographics. Some groups were neglected due to the limited number of pastoral care practitioners. The available pastoral care resources were insufficient to meet the high demand encountered during the pandemic. The interplay of movement restrictions and an exponential increase in pastoral care needs overpowered the available pastoral care resources during COVID-19. Thus, there was a shortage of pastoral care provision (Afolaranmi, 2020a; Del Castillo, 2021; Flynn et al., 2021).

Furthermore, Heidari et al. (2020) indicated that although pastoral practitioners offered pastoral services during the pandemic, the infectious nature of the disease reduced their readiness to support affected patients. The result implied that only a few pastoral care

practitioners were willing to visit affected patients and encourage them spiritually. Heidari et al. (2020) views resonate with Kim et al., (2021), displaying that pastoral practitioners and healthcare workers were not trained for such stressful situations as observed in the wake of COVID-19. Therefore, the problem of coping with personal burnout limited the availability of pastoral care provision. The two studies (Heidari et al., 2020; Kim et al., 2021) agree that during the pandemic, even pastoral care practitioners needed pastoral care to cope. Based on the available evidence, limited pastoral care for patients adversely affected access to pastoral services for COVID-19 patients.

2.5.3 Impact on pastoral care provision mode

A study on pastoral care services during COVID-19 by Finiki and Maclean (2020) revealed that lockdowns transferred pastoral care meetings in New Zealand to virtual platforms like Zoom. The strategy was required to reduce the chances of physical contact with patients and adhere to COVID-19 containment measures. Furthermore, weekly medications and communication were done through digital newsletters. Similarly, Drummond and Carey (2020) noted that pastoral support and counselling sessions in Australia were conducted through Zoom, Facetime, Webex, and Skype. From the experiences of the clients and support providers, the exclusive usage of technology for pastoral care was initially challenging to implement, but gradually, there was more acceptance and use. Both studies (Finiki and Maclean, 2020; Drummond and Carey, 2020) were case studies, thus bringing out the detailed digitisation of pastoral care activities during COVID-19. The implication is that hospitals and care centres took personal initiatives to compensate for the lack of physical pastoral care provision. In the

same vein, Carey et al. (2020) noted that in England, chaplaincy ward times were limited with the pandemic, leading to the implementation of virtual communication technology for regular patient pastoral care. The trend was similar in Australia, Ireland, Italy, Netherlands, New Zealand, and Scotland. Carey et al. (2020) took a multinational perspective contrary to Finiki and Maclean (2020) and Drummond and Carey (2020), affirming the generalised form of virtual communication for pastoral care provision during the COVID-19 pandemic. In agreement, Winiger (2023) reported changes in pastoral care practice following the COVID-19 pandemic in the U.S. healthcare system. Similar to Carey et al. (2020), Winiger (2023) highlighted that information and communications technology (ICT) introduction in pastoral care through tele-chaplaincy enabled chaplains to extend pastoral care services to patients at any time without physical presence. Apart from disease protection benefits, tele-chaplaincy improved the convenience of pastoral care services. An earlier study by Situmorang (2020) revealed that the initiative of online pastoral care was not new since cyber counselling sessions existed before COVID-19. However, the pandemic pushed the pastoral care department to maximise the use of technology in fulfilling the spiritual needs of individuals. Therefore, a shift in the approach of pastoral care provision to digital means has been widely favoured.

The perceived effectiveness of pastoral care services upon recipients, patients, and clients during COVID-19 has been globally researched. From an African perspective, Nigerian church ministers acknowledged that using the Internet for pastoral care during the pandemic was generally effective for the congregants (Afolaranmi, 2020b). The success was attributed to the ministers' ability to respond promptly to messages via digital

media, facilitating consolation, spiritual growth, and psychological healing amid COVID-19's challenges. The view of Afolaranmi (2020b) was supported by Vandenhoeck et al. (2021), indicating that the new way of using digital technologies in pastoral care during the pandemic afforded flexibility for service provision. More people could be reached simultaneously, and the services were extended to include the healthcare staff. Vandenhoeck et al. (2021) compared the traditional approaches of administering pastoral care to the new ways and supported the perceived effectiveness as opposed to Afolaranmi (2020b), who directly addressed the effectiveness.

Nonetheless, both authors concur on the increased constant and connection associated with digital pastoral care during the COVID-19 pandemic. The evidence of pastoral care effectiveness was presented by Nodoushan et al. (2020), who described the emergence of online pastoral care as a means of reducing stress and antenatal effects on pregnant women during the COVID-19 pandemic. Pastoral care availability prevented severe mental effects on pregnant mothers, underlining the effectiveness of pastoral care services during the pandemic. Similar observations were made by Tang et al. (2022), showing that the wide use of digital communication technology enabled seafarers to receive pastoral care from various quarters, including colleagues, family, practitioners, and government agencies. Thus, COVID-19 positively affected the effectiveness of pastoral care provision. Palma et al. (2021) performed telehealth pastoral sessions with 73.6% of patients who asked for pastoral assistance while having severe COVID-19 symptoms. The results based on a satisfaction survey reported high rates of satisfaction. Notably, Palma et al. (2021) was a pilot study and hence provided real-time experience-

based results as opposed to Afolaranmi (2020b) and Vandenhoeck et al. (2021), who relied on third-party observations. Nonetheless, the common theme from the literature is that pastoral care provision continued to be effective for the recipients.

2.5.4 Impact on the quality of pastoral care

O'Connor (2022) investigated the trend of school counselling during COVID-19 and reported an increase in personal issues related to mental health. The finding implied that the pandemic affected the prioritisation of pastoral care services, affecting the overall quality. Similarly, Vandenhoeck (2021) explored the perception of chaplains about their services in healthcare facilities and revealed that during the initial months of the pandemic, some of the chaplains were sent home or assigned other duties like policymaking, which interfered with their capacity to deliver pastoral care. The two studies (O'Connor, 2022; Vandenhoeck, 2021) acknowledge that both client and provider factors lowered the quality of pastoral care during the pandemic. Both COVID and non-COVID patients suffered pastoral guidance deficiencies.

Meanwhile, Galbadage et al. (2020) noted that the pandemic brought about the deprioritisation of pastoral care, thus explaining the early months' trend of downsizing pastoral care services identified by Vandenhoeck (2021). Consequently, most patients were reported to have died in isolation without the closeness of religious leaders and family. The scenario meant the standards of pastoral care provision had been compromised.

Szilagyi et al. (2022) explored the perception of chaplains about service delivery during COVID-19. The identified issues were related to professional confidence to establish trust with the patients and make the right decisions. Chaplains reported a lack of knowledge and expertise amidst the pandemic, which lowered their self-efficacy to serve their responsibilities. Personal factors contributed to the deterioration of pastoral care quality during the pandemic. The views were supported by Khalesi and Pourmohammad (2022), where pastoral care practitioners indicated that the main challenges of COVID-19 included inadequate knowledge about the disease, the absence of a specialised team and limited access to quality services. The underlying theme in the two studies was that the educational aspect of pastoral care could not be provided, compromising care quality. In conclusion, the literature suggests that COVID-19 negatively affected the quality of pastoral care services during the initial stages of the pandemic.

2.6 Challenges to Pastoral Care during COVID-19

2.6.1 Social distance and lockdowns

Social distancing and lockdown restrictions affected the pastoral care provision during the COVID-19 pandemic. According to Haußmann and Fritz (2022), the first lockdown in the spring of 2020 resulted in a drastic decline in opportunities for face-to-face conversation, which was the primary medium of pastoral care. The result implied that pastoral care practitioners had to devise alternative ways to reach clients within a short timeframe. A similar observation was reported by Carter (2022), who investigated pastoral care challenges in education due to COVID-19. The results noted that face-to-face interaction between the pastoral care providers and students was reduced during the first lockdown.

Further, where such meetings were possible, social distancing measures reduced the closeness necessary for therapy. The implication is that essential aspects of care, such as a reassuring hug and comforting touch, were unachievable. Notably, Haußmann and Fritz (2022) and Carter (2022) were in synchrony as per the period of study that covered the first wave of lockdowns in Europe, suggesting that several sectors of social service where pastoral care was offered suffered the drawback of inability to interact with clients during COVID-19. Village and Francis (2020) noted that besides the inability of pastoral care practitioners to reach the people, lockdowns made it difficult for the population to access pastoral care, especially in rural areas. The trend was attributed to the changing mode of pastoral care provision to technological platforms.

Village and Francis (2020) supported the finding by Naidoo et al. (2021), who investigated pastoral care modes from ministers to congregants during COVID-19 in South Africa. The study showed that social distancing created physical and emotional detachment among the believers and between them and the ministers. The trend made it challenging to gratify spiritual needs as such needs usually depended on social interactions. Whereas Village and Francis (2020) relied only on surveys, Naidoo et al. (2021) utilised mixed methods and presented a more detailed and in-depth analysis of the problem. Meanwhile, Ford (2021) discovered that social distancing progressively reduced physical and online interpersonal connections. Although some people experienced decreased psychological well-being, they lost interest in interactions, thus cutting out the efforts of pastoral care providers. The finding was based on real-time self-reported daily social distancing

behaviour; hence, Ford (2021) offered a clearer view of the restrictions' impacts on the delivery of pastoral care compared to Naidoo et al. (2021). Thus, according to these studies, social distancing and lockdowns limited the accessibility of pastoral care.

2.6.2 Communication failures

Pastoral care practice experienced communication issues that prevailed due to the interruption of many traditional communication channels. Istanboulian et al. (2022) demonstrated the distressing effects of the ventilators used on patients. The machines prevented the patients from communicating important information, such as sadness, confusion, and fear, making it difficult to discern the need for pastoral care. Therefore, those who were on ventilators in intensive care units (ICUs) were unable to receive pastoral care. The arguments of Istanboulian et al. (2022) are reinforced by Chan et al. (2022), who attributed communication failure to the aftermath of social distancing measures, since as people avoided physical interaction, communication gaps led to the breakdown of communication between caregivers and patients or families. The trend affected pastoral care provision for patients and their families. The significance of the studies by Istanboulian et al. (2022) and Chan et al. (2022) is that they focused on how to improve communication during the pandemic. According to Rezaee et al. (2020), COVID-19 was marked with poor pastoral care since the patients were in critical condition and could not interpret the attempt at pastoral support from the practitioners. The authors noted that the pandemic lowered participants' cognitive capacity, leading to communication barriers. The trend was also observed among nurses who suffered from

burnout and spiritual distress (Rezaee, 2020). Therefore, there was little opportunity to communicate pastoral care effectively during the pandemic.

However, McKinney (2020) presented the pastoral care communication platform issue differently. The study focused on Catholic schools and revealed that whereas pastoral care was available in other ways during the pandemic, some students were digitally excluded or alienated. The implication is that pastoral care was hindered by the lack of access to online platforms, which was the new normal. Communication was disrupted, and pastoral intervention was reduced. Similarly, Selman et al. (2020) indicated that those in critical conditions could not access or operate digital gadgets; thus, they could not access pastoral care practitioners. A similar effect was reported for frontline healthcare providers, as people died in isolation with great distress, having no emotional or spiritual support.

2.6.3 Inadequate resources

Due to the changing times of the COVID-19 pandemic, pastoral care encountered a challenge in terms of resources necessary to adapt to the new normal. Adeli et al. (2020) highlighted the shortage of human resources for administering the needed pastoral care, among other duties. The trend was attributed to the sharp rise in patients, psychological needs, and family disruption within a short span. Furthermore, the study noted that some pastoral care specialists had contracted the disease (Adeli et al., 2020). The available workforce at the time was insufficient to meet the demand for spiritual support of the moment. The observations were supported by the phenomenological exploratory study

by de Diego-Cordero et al. (2023), who showed that 56.3% of healthcare workers failed to meet the pastoral needs of their patients, citing excessive workload during COVID-19. Pastoral care providers did not have access to religious and spiritual resources needed to accomplish their tasks. The observations of de Diego-Cordero et al. (2023) are corroborated by Adeli et al. (2020), who highlighted the time factor as responsible for reducing resource organisation efficiency and assigning personnel for pastoral care during COVID-19. The results meant that the emergency state of COVID-19 disrupted smooth resource allocation for pastoral care.

However, Rao et al. (2020) contradicted the perceptions of Adeli et al. (2020) and de Diego-Cordero et al. (2023) in that the problem of healthcare resources was experienced even before COVID-19 struck. In particular, some countries were poorly resourced, such as India, where COVID-19 worsened the vulnerable healthcare system. The position of Rao et al. (2020) is that COVID-19 only exposed the weak status of world healthcare systems regarding resources for basic care, such as the provision of pastoral care. The finding is significant since it shows that the effects of inadequate pastoral care resources during the pandemic depend on the country. For instance, research in South Africa by Moodley and Hove (2023) showed that residents could not afford the digital resources used for virtual pastoral care during the COVID-19 pandemic. When joined with the submission of Rao et al. (2020), the conclusion is that resource deficiency plagued the healthcare systems and society alike, thus impacting the provision and reception of pastoral care during COVID-19.

2.6.4 Social isolation

From descriptive cross-sectional research by Durmuş and Öztürk (2022), a significant negative correlation was established between isolation and spiritual well-being during COVID-19. The result implied that regardless of the repeated pastoral care provided, the isolation led to the loneliness of individuals, thereby triggering a sense of hopelessness that neutralised the progress from the pastoral care sessions. The finding resonated with the earlier submission by Lucchetti et al. (2021), who also utilised a quantitative survey to establish the relationship between isolation and the spirituality of 485 participants during COVID-19. The results indicated that isolation's major components included worry, fear, sadness, and hopelessness, which were negatively associated with religious activities and spiritual growth. The result suggested that the psychological outcomes of social isolation during the pandemic suppressed the outcomes of pastoral care initiatives. In that respect, a closer look at the studies (Durmuş and Öztürk, 2022; Lucchetti et al., 2021) indicates that as far as isolation existed, little progress was made in imparting pastoral care. On that note, Mackey et al. (2022) recommended constant reconnection through telehealth applications with the socially isolated during the pandemic. The strategy was important for breaking the adverse psychological effects and improving their spirit to respond to pastoral care. Mackey et al. (2022) focused on pastoral support for older adults, as did Durmuş and Öztürk (2022); hence, the latter confirmed the observations of the former.

Similarly, Harden et al. (2020) acknowledged that in the earlier days of the COVID-19 pandemic, the negative contributions of social isolation to spiritual well-being were not

well understood, especially among older adults. Several pastoral care efforts for pastoral support under these circumstances were almost in vain. Harden et al. (2020) adopted a literature review design; the findings presented a widely observed phenomenon of social isolation and pastoral care during the pandemic.

However, a longitudinal study by González-Sanguino et al. (2021) showed that although the symptoms of depression and anxiety were bound to increase during confinement, the trend was diverted by constant pastoral support. The implication is that when offered correctly, pastoral care was able to defy the odds of isolation and confinement to improve spiritual well-being. The view by González-Sanguino et al. (2021) is attributed to the younger participants involved in the study compared to Harden et al. (2020), who only examined older adults. The literature suggests that the extent to which isolation impacted spiritual well-being and pastoral support was age-dependent.

2.6.5 Inadequate training

A significant challenge to pastoral care during the pandemic was the lack of training and preparedness needed to handle the crisis. Parveen et al. (2021) reported through a cross-sectional study that pastoral care competence was low among nurses in Faisalabad, Pakistan, during the third wave of the COVID-19 pandemic. The trend was despite having passed the pastoral care training courses from the nursing schools. The usual formal pastoral care training was insufficient during the COVID-19 outbreak. However, the response of undergraduate nursing students sampled from Guilan University of Medical Sciences (GUMS) indicated high pastoral care competence during COVID-19 (Asgari et

al., 2022). The success was attributed to the demographics of being native and having hospital work experience. The result contradicted the observation of Parveen et al. (2021), who incorporated a minimum of one year of experience in the ICU section. In that regard, a comparison of the two studies led to the conclusion that one year of experience might not be enough for excellent pastoral care performance or because the students were still learning, they were not engaged in intense pastoral care as was with the licensed nurses in Pakistan. Besides, Asgari et al. (2022) affirmed that lack of work experience attributed to low pastoral care competence despite completion of training. In a separate research, Doyle and Thomas (2022) also reported on how lack of training affected the delivery of pastoral care to UK students during the COVID-19 pandemic. Based on data from semi-structured interviews with 15 secondary school teachers, the study found that although teachers were aware of students' deteriorating social, emotional, and mental health (SEMH), they could not act due to a lack of training on how to navigate the new safety measures that had been implemented. The implication is that the education sector and society were unprepared for COVID-19 related challenges when addressing pastoral care needs. The position of the teachers was similar to that of healthcare workers reported by Jones et al. (2022a). Namely, the respondents agree that a lack of skills specific to COVID-19 hindered effective palliative care to the related patients through pastoral support. In that regard, the literature reveals that a lack of training directed to COVID-19 formed a barrier to adequate pastoral care during the pandemic.

2.6.6 Practitioners' personal safety

The nature of the virus and the associated health fears made offering pastoral care challenging for practitioners, as reported by Prazeres et al. (2021). Using a cross-sectional study on healthcare workers, the researchers realised high levels of COVID-19 anxiety and fear. The finding showed that the professionals were cautious about close exposure to COVID-19 patients, which limited their ability and capacity for quality pastoral care. The arguments are supported by Roshani et al. (2023), who also reported COVID-19 anxiety in healthcare workers. Higher anxiety was found in women than men, translating to lower spiritual health and job satisfaction in females (Roshani et al., 2023). The result implied that female healthcare workers were more considerate about personal safety than men while caring for COVID-19 patients. Pastoral care received a lower score for female practitioners than for male care providers during the pandemic. Although both studies were cross-sectional quantitative, Prazeres et al. (2021) based personal safety concerns on professional position, whereas Roshani et al. (2023) mainly focused on the mediating role of gender.

Meanwhile, Pai et al. (2020) took a more holistic approach to a mixed-method study that included interview data and published information about nurses caring for patients amidst COVID-19. The first challenge noted was the fear of acquiring the disease, as the professionals were worried about harming their families and friends by infecting them with the virus. The trend limited the extent to which the nurses were in contact with the patients for palliative care, such as pastoral support. Likewise, nursing students presented similar fears during the first wave of the virus in Malawi while undertaking clinical practice

(Baluwa et al., 2021). Similarly, an Iranian study by Mohammadi et al. (2022) also showed that nursing students on an internship during the pandemic displayed COVID-19 and death anxiety, which lowered their confidence and readiness to address the psychological needs of patients. The underlying theme from the investigations (Pai et al., 2020; Baluwa et al., 2021; Mohammadi et al., 2022) is that COVID-19 intimidated the mental strength of those responsible for pastoral care services increasing the carers' demand for pastoral care and restricting their ability to support patients. Consequently, a deficiency of pastoral support was witnessed during the COVID-19 pandemic.

2.7 Retrospective Memories of Experiences and Alteration of Memory over Time

Understanding retrospective memories is essential in order to interpret the experiences of pastoral care during the pandemic correctly. Cantrelle et al. (2020) define retrospective memory as a dynamic process of recollecting experiences. It contrasts prospective memory, which entails remembering to implement planned actions. Several researchers have pointed out that retrospective memory is significantly influenced by emotional experiences related to a specific event, where although an event may have ended and the intricate details faded, the intense feelings associated with the event can be remembered vividly (Strijbosch et al., 2019; Urban et al., 2019). In such cases, retrospective memory affects behaviour, which influences the individual's ability to repeat or reject the activity. The assertions by Strijbosch et al. (2019) and Urban et al. (2019) were supported by Llana et al. (2022), revealing that during COVID-19, up to 58% of individuals had their retrospective memories altered by traumatic experiences of family

and friends' deaths. Essentially, the traumatic events led to the development of strong negative feelings, hindering the recall of specific details.

Similarly, Chopik and Edelstein (2019) explained that memories of higher early childhood parental affection led to better mental health and lower depressive symptoms among young adults. The arguments by Llana et al. (2022) and Chopik and Edelstein (2019) implied that emotions attached to retrospective memories are amplified over time so that positive feelings of affection based on past activities promote positive mental health across an individual's lifespan, while the negative feelings of pain contribute to depressive symptoms and self-isolation tendencies. Therefore, the provision of pastoral care during COVID-19 was crucial in addressing the negative feelings associated with COVID-19 infections to ensure that individuals would not develop negative retrospective memories of the event that can adversely affect their mental health in the future. The view can be demonstrated in the study by Yang (2022), who conducted interviews with survivors of COVID-19 infection in China and realised that to them, the infection itself was not a bad retrospective memory but rather the adverse treatment and social exclusion practices that accompanied infection were most impactful. In particular, COVID-19 patients who recovered and were discharged from the hospital were openly discriminated against and stigmatised in the community. The experience was worse for survivors quarantined after discharge since they were forced to remain in restricted zones in the community while still being perceived as a threat to others. A common phrase that developed at the time among the COVID-19 survivors was, "People shunned me as they would shun the god of plague" (Yang, 2022, p.620). Therefore, as Del Castillo (2021) noted, providing pastoral care

during the pandemic had a significant influence on the perceptions of family and friends towards COVID-19 survivors. In this respect, the retrospective memories pertaining to pastoral care practice during the pandemic have yet to be explored.

2.8 Research Gaps and Rationale

While there is extensive documentation of the roles of pastoral care, research does not account for the ongoing impact that COVID-19 has had on pastoral care practitioners. Previous studies have mainly considered the perspectives of pastoral care recipients in their analysis to critique the quality of care they receive but have failed to analyse the topic from the perspective of pastoral care providers. Hence, this is the primary research gap.

Likewise, the previous research merely considered the pastoral care functions during the pandemic but failed to incorporate the pastoral care practitioners' experiences. In that regard, there is a knowledge gap on how pastoral care practitioners adjusted to adapt to the new normal while still fulfilling their societal duties. Moreover, while the details about the pandemic concerning pastoral care provision have been reflected from a negative perspective in the literature, there is a literature gap on useful lessons drawn from the pandemic that has shaped the lives of pastoral practitioners and the service at large. In addition, limited research studies have broached the topic of pastoral care in the UK context during the pandemic. Furthermore, no studies have been conducted on the experiences of pastoral care practitioners during COVID-19 in the UK.

Consequently, the current research seeks to gather the views of pastoral care practitioners to ascertain how their personal experiences during the pandemic have affected their future care administration. This study acknowledges that receivers and pastoral care practitioners reacted differently to the pandemic shock, influencing how pastoral care was delivered. The knowledge gap is addressed in this research by investigating the experiences of pastoral care practitioners in the UK.

2.9 Chapter Summary

In conclusion, the literature revealed that despite its critical importance for patients and their families, providing pastoral care during the pandemic posed a significant challenge when social contact was constrained. Therefore, practitioners utilised various technological interventions to communicate in a structured, routine, and predictable manner, which was essential for patients and families who required pastoral support. However, the shift from in-person to virtual settings proved challenging for individuals who lacked access to the internet or other means of communication. While acknowledging the challenges, there were a few notable examples of pastoral practitioners and healthcare professionals who succeeded in providing pastoral care effectively. The present study aimed to fill the knowledge gap regarding the pastoral care practitioners' perspectives and how the COVID-19 experience will inform future practice.

Chapter Three: Methodology

This chapter sets out the methodology used in this study. It begins by detailing the research philosophy, design, approach and method. The population and sampling strategy are also described, as well as the data analysis and trustworthiness of the research.

3.1 Overview

The methodology chapter presents the procedures that were used by the researcher to implement the research study and achieve the set objectives. The chapter helps in justifying the authenticity of the results and enables the audience to assess the basis of the information given. In the methodology, the researcher details how data was gathered and analysed in line with the research objectives, reconciling the study aims with the research outcomes. Furthermore, the chapter provides room for the researcher to justify the chosen technique and decisions made regarding the data utilised for the study. In this regard, the research goal was to explore the effect of the pandemic on pastoral practitioners. The chapter will cover the research philosophy, research design, research approach, research method, sampling, data collection procedure, data analysis and ethical principles. Moreover, the chapter discusses the aspects of reliability, validity, trustworthiness, and the research strengths and limitations. Finally, the researcher provides a reflection on their own reflexivity and their research experience.

3.2 Research Philosophy

Interpretivism was adopted for this research based on the research questions. Alharahsheh and Pius (2020) argued that interpretivism is anchored on the assumption that reality is subjective and socially constructed. The reality is based on one's personal experience of the specific incident or phenomenon; hence, someone must be present to give an elaborate account of the situation based on lived experience. Similarly, Pham (2018) noted that in the absence of an individual, a detailed narrative of the experience could be used to extract the nuggets of reality. Because of social construction, researchers agree that the perception of reality differs from one person to another due to the differences in experiences of the same phenomenon and event (Alharahsheh and Pius, 2020; Pham, 2018; Junjie and Yingxin, 2022). The strategy is essential for understanding various reality approaches; thus, interpretivism is characterised by an in-depth understanding and solution of the research problems. In the current context, the solution to the research questions relied on the ability to discern accurately the experience of pastoral practitioners during the COVID-19 pandemic. The interpretivism paradigm allowed for the reality of pastoral care during the pandemic to be deciphered from the personal experiences of pastoral practitioners. The selection of interpretivist research aligned with the nature of data required to address the research problem adequately. Therefore, the interpretivism paradigm opened a door for a richer and deeper understanding of pastoral care during the pandemic.

According to Nickerson (2022), interpretive research is accomplished by questioning or observation to uncover the reality sought. The strategy means that the paradigm allows

the researcher to take up an active role in gathering data. In this study, the researcher engaged with the participants in an interactive session to extract the necessary information regarding the experiences of pastoral care providers. Due to the interactive aspect and the nature of the data, Ryan (2018) reported that the interpretive philosophy is closely associated with qualitative research methods. Although there are other research philosophies, interpretivism was deemed appropriate for this research. For instance, positivism philosophy only acknowledges quantifiable observation as the truth (Sanchez et al., 2023). The use of numerical data did not apply to the current research because understanding the effect of COVID-19 on pastoral practitioners did not require quantifiable measures but rather an in-depth understanding of the practitioners' experiences.

On the other hand, pragmatic philosophy did not fit the scope of this research since the nature of data was well articulated by the research questions as social perspectives of the participants. Notably, pragmatism would have required a mixed-method approach to include both quantitative and qualitative methodologies (Pham, 2018). However, as mentioned above, the qualitative approach, and therefore interpretive philosophy, were deemed to be the most appropriate to answer the research question.

3.3 Research Design

The present study utilised a qualitative research design using a phenomenological approach. In the phenomenological approach, the researcher’s aim is to draw an understanding of the topic based on people's experiences (Umanailo, 2019). The purpose of phenomenology is to obtain an explanation of a phenomenon based on the participant’s

perception determined by lived experiences. In this type of research, the participants must have first-hand experience with the topic or phenomena under investigation (Van Manen, 2023). In the current context, the phenomenological research design was first selected in line with the interpretivism philosophy that emphasised experiential data for building social constructs. The aspect of experience meant that the research had the potential to attain a rich understanding of the research problem and solutions.

The phenomenon under probe in the current research was the impact of COVID-19 on pastoral care as experienced by pastoral practitioners. Various aspects of pastoral care were examined and explored as expressed by the practitioners who were the participants with lived experiences. In line with the interpretivism philosophy, Flynn and Korcuska (2018) pointed out that phenomenological research is closely associated with qualitative approaches. According to this approach, the researcher's contribution to data collection is valid as long as the influence remains within the peripheries of interpreting the participants' expressions.

Specifically, compared to other research approaches, the phenomenological approach was relevant to the current research in a number of ways. For instance, phenomenology focuses on thoughts and perceptions, which translate to an in-depth understanding of the researched subject (Abutabenjeh and Jaradat, 2018). The trend is opposed to quantitative designs, such as descriptive research, which relies mainly on quantitative research methods to understand trends (Siedlecki, 2020). Since the current research

aimed to explore the experiences and feelings of pastoral practitioners, the phenomenological approach was deemed to be the most appropriate.

Similarly, other research designs, such as exploratory and experimental, were not applicable to this research since the notion of changes in pastoral care due to COVID-19 was not new. In addition, the research was not meant to test any causal relationships (Leavy, 2022).

3.4 Research Approach

The research utilised the inductive approach to plan and execute the research. In the inductive approach, the study is organised in such a way that the results contribute to the development of new theories and generalisations (Azungah, 2018). Inductive research starts by stating aims, objectives, and questions to be achieved upon research completion. Young et al. (2020) asserted that the inductive approach does not engage in hypothesis formulation at the beginning of the research. In this regard, the strength of the inductive approach is that early assumptions of expected results are avoided, enabling flexible data identification and collection. On that note, Pellegrino and Glaser (2021) explained that inductive research utilises the data gathered to establish a pattern, which gives rise to the theory at the conclusion. In the current context, the research based on an inductive approach was such that no hypotheses were formulated regarding the effects of COVID-19 on pastoral care.

Consequently, a sense of flexibility was enacted regarding the scope of data since there was no fixed conclusion to validate. The foundational principle of inductive reasoning is that the conclusion is drawn from specific observations to a more general perspective of the phenomenon (Woiceshyn and Daellenbach, 2018). In this research, the evidence was obtained from the pastoral practitioners.

According to Mitchell and Education (2018), the inductive research approach is closely linked with the exploration of phenomena. Therefore, other approaches, including deductive and abductive approaches, were deemed unsuitable for the research since they did not align with the research paradigm and design (Kennedy and Thornberg, 2018). In the inductive approach, themes were generated from the data collected via the interviews with the practitioners, which accomplished the concept of social constructs concerning pastoral care practitioners.

3.5 Research Method

This research utilised the qualitative method as the blueprint for data collection and analysis. The strength of qualitative research is in the data type, which provides in-depth illustrations and explanations of opinions, hence making it possible for the audience to develop in-depth knowledge of the subject being studied (Hennink et al., 2020). The use of the qualitative method in this research aided the effective accomplishment of the phenomenology aspect of the investigation that supported the process of addressing the research problem. The relevance of the qualitative method in this research was justified

by both its flexibility and ability to allow new themes to emerge from data analysis (Busetto, Wick and Gumbinger, 2020; Hennink et al., 2020).

The property aligned well with the research objective since there were no restrictions on hypotheses because of the inductive approach. The researcher was better placed to adopt ideas generated from the participants' perceptions and adequately inform the impacts on the practitioners. Additionally, the qualitative method allowed data to be collected in a naturalist way (Cypress, 2018). The strategy was vital for the current research in fulfilling the intention to gather information from pastoral care practitioners in their areas of practice and make recommendations. Therefore, the advantage derived from the qualitative method was that the data provided meaningful insight into the research problem and solution (Ngozwana, 2018).

3.6 Setting, Population and Sampling Strategy

The setting for the present study was the UK. The organisation selected for the study was a denomination of the Christian faith. The reason for choosing this organisation was that it had extensive experience providing pastoral care for a significant duration spanning the period before, during, and after COVID-19. The reason for this requirement was that pre-pandemic experience was integral for obtaining a complete picture of pastoral care provision in normal times, enabling the establishment of informed comparisons of the characteristics of pastoral care activities during and after the pandemic. The organisation follows a conciliar model of polity, whereby decisions are made by councils and meetings rather than by any one individual. Pastoral care is shared by the ministers and elders who

serve the congregation and community. Ministers hold pastoral charge, while the elders take care of the day-to-day running of the church. In this regard, ministers are the primary pastoral care practitioners in their respective contexts. Ministers in the organisation also serve as chaplains to hospitals, councils, military, charity, business, and education institutions. While all of the ministers belong to one organisation, some are deployed to a Local Ecumenical Partnership (LEP) and are authorised to practice in at least two of the following denominations: Baptist, Church of England, Methodist, and United Reformed Church. As an established pastoral organisation, they provided the natural environment necessary for the collection of qualitative data required for the study (Cypress, 2018).

The entire cohort of participants in this research were officially classified as Key Workers and held the formal designation of Religious Workers under the purview of Key Public Services in adherence to the regulations set forth by the UK Government (Cabinet Office, 2022). Additionally, all 25 participants were based in multi-site pastorates. Of the five participants in the pilot study, one participant operated in a rural setting, another in an urban setting, and three within pastorates that encompassed both rural and urban areas. This distribution was similarly reflected in the 20 participants of the main study. As a result, the total participant cohort consisted of five (20%) individuals exclusively operating in rural contexts, four (16%) exclusively in urban contexts, and 16 (64%) from pastorates that spanned both rural and urban settings. Thus, the participants in this study represent a diverse range of pastoral care contexts belonging to the organisation (see Table 1).

This research focused on a finite population of pastoral care practitioners since they were derived from a single organisation. The choice of a finite population was important for ensuring and promoting the quality of the qualitative data (Stratton, 2021). Additionally, the population size made it possible to determine the research saturation point in the selection of participants and collecting data (Stratton, 2021).

Sampling entails choosing individuals from a targeted group, where the researcher collects the study data (Berndt, 2020). This research used the purposive sampling technique, where the researcher invites individuals from the target population to participate in the research after establishing that they possess the characteristics relevant to the research subject (Bhardwaj, 2019). The sampling technique is suitable for selecting research participants when the participants are required to have certain characteristics or attributes that are necessary for responding to the study problem (Etikan, Musa, and Alkassim, 2016). On that note, purposive sampling targets a smaller sample mainly for qualitative research (Campbell et al., 2020). The inclusion criteria required that the participants were pastoral care practitioners who had pastoral experience that covered the period pre-, during and post-pandemic. In total, 25 participants were recruited for the interviews, and recruitment ceased once saturation was achieved. Saturation refers to the point where additional interviews would not provide new information concerning the study problem (Braun and Clarke, 2021; Saunders and Townsend, 2016).

Table 1 – Chaplains and ministers

The table provided below presents the demographic data of the participants, encompassing both the pilot and main studies. Participant names have been anonymised to uphold confidentiality. To enhance readability, the titles 'pilot study' and 'main study' have been abbreviated as 'PS' and 'MS' respectively.

Participants	Gender	Age	Ethnicity	Marital Status	Region
P1 (PS)	Male	35-44	White British	Single	Lancashire
P2 (PS)	Female	45-54	White Other	Single	Birmingham
P3 (PS)	Male	45-54	White British	Married	Manchester
P4 (PS)	Female	55-64	White British	Married	Oxford
P5 (PS)	Female	45-54	White British	Married	Essex
P6 (MS)	Female	45-54	Black British	Single	Greater-London
P7 (MS)	Female	55-64	Asian British	Married	Surrey
P8 (MS)	Male	35-44	White British	Married	Pembroke
P9 (MS)	Non-binary	45-54	White British	Married	Cambridge
P10 (MS)	Female	45-54	White British	Married	Berkshire
P11 (MS)	Male	65+	White Other	Married	South-Cambridgeshire
P12 (MS)	Male	25-34	Asian Other	Married	East-London
P13 (MS)	Female	55-64	White British	Married	Glasgow
P14 (MS)	Female	45-54	White British	Married	Sussex
P15 (MS)	Female	45-54	White Other	Married	Liverpool
P16 (MS)	Female	35-44	Black African	Married	North-London

P17 (MS)	Female	45-54	White British	Single	Cardiff
P18 (MS)	Male	45-54	White British	Married	Nottingham
P19 (MS)	Male	35-44	White British	Single	Lincolnshire
P20 (MS)	Female	45-54	Mixed White/Black	Married	London
P21 (MS)	Male	45-54	White British	Married	Leeds
P22 (MS)	Female	55-64	White British	Married	Kent
P23 (MS)	Female	35-44	Asian British	Married	Greater-London
P24 (MS)	Male	55-64	Black African	Married	Hampshire
P25 (MS)	Female	45-54	White British	Married	Leicester

3.7 Data Collection

The data collection for this research was comprised of two phases. Initially, a pilot study was conducted to ascertain both the feasibility and design of the research. Subsequently, a main study advanced the data collection and considerably broadened the target population to encompass additional participants.

3.7.1 Pilot Study

The pilot study consisted of a small-scale preliminary data collection of five participants through qualitative semi-structured interviews (see Appendix 1). According to Malmqvist et al. (2019), pilot studies serve the purpose of identifying areas of concern or issues with the research topic that would otherwise be overlooked. The data collection for the pilot study was conducted over a five-week period spanning from September to October 2021.

The primary objectives of the pilot study for this research were to assess the viability of a full-scale study and to determine the most effective research methodology. In this context, the pilot study facilitated the examination of the entire research process, the identification of any technological issues during interviews, and the identification of areas for refining the research design. The data collection process yielded valuable insights into interview techniques, pacing, and time management. Additionally, participants' feedback provided valuable input regarding the clarity of the research questions and the feasibility of utilising Microsoft Teams for interviews.

From the pilot study, two primary themes emerged: barriers to pastoral care due to COVID-19 and changes to the role of pastoral care during COVID-19. Based on the pilot study, progress was made to the main study. Initially, while the first research question remained the primary focus, two supplementary research questions were identified. Namely, what were the pastoral care benefits during COVID-19, and what is the future of pastoral care following the lessons from COVID-19? Additionally, the findings from the pilot study were consistent with those of the main study, and thus, both sets of data were included in the analysis for this research.

Upon completion of the pilot study, several objectives were attained, including the assessment of the feasibility and practicality of the study design, encompassing recruitment, data collection, and analysis methods. Furthermore, potential problems or ambiguities in the study protocol were identified, and preliminary data was gathered to refine the main study’s methodology. Specifically, the participants requested an

opportunity to clarify their interview responses; hence, the schedule for transcribing the interviews and gathering participant feedback was adjusted accordingly. In this regard, an estimation of the time and technology required for the main study was established. Thus, it was determined that both the data collection method and utilisation of Microsoft Teams were suitable for the main study, and no additional modifications were required.

3.7.2 Instruments

The instrument for the collection of data in this research was semi-structured interviews. Interviews rely on asking questions whereby the researcher moderates the process to ensure the accurate interpretation of the questions by interviewees (Roberts, 2020). Interviews effectively reveal detailed insight into the lived experiences of individuals, improving the reliability of research findings (Busetto, Wick and Gumbinger, 2020). According to Brinkmann and Kvale (2018), interviews provide room for exploring the experiences, perceptions, views, and beliefs of individual participants. The instrument allowed the gathering of detailed accounts of the practitioners' experiences to obtain and unveil the implications of COVID-19. The strategy was possible because the interviews allowed the researcher to facilitate and guide the sessions (McGrath et al., 2019).

Moreover, interviews provide the opportunity to seek clarification of responses as well as explain complicated questions to the participants (McGrath et al., 2019). Magaldi and Berler (2020) explain that semi-structured interviews consist of open-ended questions formatted aligned with study goals. The aspect of semi-structured is fulfilled by the element of having ready questions yet availing the liberty to ask additional questions as

issues emerge during the interview. Semi-structured interviews were helpful for this study since they enabled the adoption of new ideas that complement the research results as raised by the respondents in the description of their experiences. Similarly, the open-ended questions allowed the respondents to provide answers freely and in as much detail as possible without limitations. The strategy helped in collecting information clearly defined by the specific experience of the pastoral care practitioners during the pandemic.

3.7.3 Ethical principles

The study was approved by the UWL Ethics Committee prior to commencing data collection.

3.7.3.1 informed consent

The ethical principle of informed consent was observed by the research as human participants were involved. According to Manti and Licari (2018), informed consent is intended to ensure that individuals targeted as participants are informed about the study and why they are involved. In that regard, informed consent entails providing the participants with all the relevant details about a study to enable them to decide to enter the research voluntarily. Similarly, Bazzano et al. (2021) explained that the details provided to the participant for consent seeking should be informative to avoid coercion and ensure only those with the required knowledge and skills are recruited. The researcher prepared and sent the consent forms to the participants via email (see Appendices 2, 3, and 4). The participants were informed to review the form and raise any concerns. After reading, consent forms were returned via email confirming the participant's agreement with the study's terms and conditions. The forms outlined the

rights of the participants during the study, including the right to withdraw. All the participants in this research confirmed that they understood the research details and provided their consent to enter and share information with the study.

3.7.3.2 principle of beneficence

The other ethical principle upheld by the researcher was beneficence. Cheraghi et al. (2023) denote that beneficence in research involves considering participants' welfare by protecting them from psychological and physical harm. To achieve beneficence, the ethical principles considered included confidentiality, privacy, security, anonymity, and autonomy. Confidentiality ensures that the information obtained from the participants is protected from unauthorised access (Bos and Bos, 2020). All data was stored in password-secured drives.

Additionally, the interview sessions were shielded by end-to-end encryption to prevent cyber hacking into the conversations. Moreover, the researcher utilised the data obtained for research purposes only and had it destroyed at the tail end of the study. These efforts ensured that the personal information of the participants was not leaked; thus, the participants were protected. Meanwhile, ensuring participants' privacy meant that participants could share honest views because they understood that their identities would not be exposed (Nunan, 2021). Therefore, information regarded as personal by the participants was not pursued, and answers that revealed identifying details were omitted from the study.

Furthermore, the participants were interviewed in the safety of their homes or workstations. As noted by Gordon (2019), anonymity is all about keeping the identities of the participants secret from the research audience. Thus, the researcher observed anonymity by using pseudonyms to refer to the participants. Lastly, autonomy was achieved by making sure that the participants were free from any external influence of coercion while taking part in the research.

3.7.3.3 Principle of justice

The researcher also observed the justice ethical principle, involving equality in the recruitment of participants. In that regard, sampling bias was minimised by establishing an equal environment for the recruitment of the participants (Pietilä et al., 2020). A single pastoral care organisation was selected so that all the participants would have similar working conditions in terms of leadership and resources. Additionally, all the participants were subjected to the same inclusion and exclusion criteria; thus, there were no preferential treatments. As a result, there was significant diversity in the sample recruited for the research in terms of positions in the organisation and the services offered.

Similarly, the recruitment process did not favour any particular gender or ethnicity; hence, justice was upheld by giving all pastoral practitioners an equal chance to participate in the research. Furthermore, for data collection, all the participants were handled the same way through an online session and asked the same questions. Moreover, all the participants equally enjoyed the ethical privileges of confidentiality and the right to privacy. All manner

of bias was avoided in all aspects of the research. The participants were aware that they could withdraw from the study at any time without prejudice.

3.7.3.4 Procedure

The recruitment process consisted of an announcement made by the organisation to active pastoral care practitioners via email. All respondents were made aware of their right to withdraw from the study and received the corresponding documents with consent forms to be signed by those who wished to participate in the investigation. The purpose of the forms was for every individual to confirm their willingness to share information with the research without any undue influence (Roulston and Choi, 2018). Seeking consent is a standard procedure in research involving human subjects; hence, it confirms that the participants understand their rights and protects the researcher and institution from legal actions. The consent forms were sent via email with the other corresponding documents. After confirming participation by returning the consent forms, interview sessions were scheduled for actual data collection. For convenience, online interviews were employed using a teleconferencing application, Microsoft Teams (Irani, 2019). The choice of online channels helped save time and costs for the research. The participants selected suitable times for the interviews, preferably outside working hours. However, specific dates were agreed upon in consultation with the researcher to establish a seamless schedule that aligned with the research timeline.

Each participant's identity remained confidential, and they were interviewed independently to conserve the originality of their perceptions, ideas, and experiences.

Therefore, online meeting links were sent out to individual participants on the agreed date of the interview. In addition, participants were required to confirm availability so that the researcher could intervene and reschedule in case of any changes (Irani, 2019). The interview sessions were structured to last approximately 45 minutes. The duration was deemed adequate to allow elaborate answers from the participants and promote interaction on the subject of pastoral care. It is noteworthy that the actual interview duration varied, with the shortest interview lasting 36 minutes and the longest extending to 48 minutes. Consequently, the average duration of the interviews was 42 minutes.

The semi-structured interview questions consisted of two parts. The first part contained demographic questions, which sought to allow the participants to introduce the context of their pastoral practice. Demographic information is ordinarily crucial for understanding the direction or nature of responses since experiences differ based on location and level of exposure (Braun et al., 2021). The second part of the interview contained questions related to the research objectives, where participants responded to specific factors defining experiences. The strategy formed the main part of the research data.

Additionally, the entire interview sessions were recorded separately in audio formats for reference. At the same time, the researcher noted down the main ideas expressed by interviewees. The files were stored in secured locations ready for analysis. All the participants recruited showed up for the interviews; hence, there was a 100% response rate recorded. Three months following the interviews, the participants received a courtesy call to check on their well-being and to confirm their willingness to continue to participate

in the study. While the pilot study participants were content to continue in the study, three sought reassurance regarding the confidentiality of their identities. Additionally, two of the participants wanted to clarify the responses they gave during the interviews. Upon completion of the study, the interviewees were debriefed, and the confidential data was destroyed in accordance with the Data Protection Act 2018 (see Appendices 5 and 6).

3.7.3.5 Data Analysis

The data gathered from the respondents was presented for analysis in an audio format without editing. Therefore, before the analysis process commenced, the audio files were first transcribed to obtain text format data. The researcher utilised verbatim transcription whereby the audio files were transcribed word by word without any attempt to clean up the grammar (Eaton et al., 2019). For analysis, the research employed a thematic analysis technique. Braun and Clarke (2019) explain that thematic analysis of qualitative data entails reading through the data set for patterns of meaning to establish similarities and find themes. The data analysis technique enables the researcher to identify patterns of meaning within the responses provided by research participants (Clarke, Braun, and Hayfield, 2015). Thematic analysis has two approaches: inductive and deductive (Terry and Hayfield, 2021). For this study, inductive thematic analysis was used. Generally, thematic analysis involves identifying themes from the data set without preconceived topics of what to look out for (Terry and Hayfield, 2021). Inductive thematic analysis was selected because it aligned with the research objectives. The strategy allowed for the flexible adoption of the relevant observations by the participants for an all-inclusive result.

It is important to acknowledge that there were alternative methods of analysis that were not selected for this study. For example, an additional approach to data analysis involves Interpretative Phenomenological Analysis (IPA), as detailed by Biggerstaff and Thompson (2008). IPA was pioneered by Professor Jonathan Smith in the 1990s in the UK and has become one of the primary analytical methods used in qualitative studies globally (Eatough and Smith, 2008). Although IPA was originally developed for psychological research, it has been adopted in diverse fields, including humanities (Hefferon and Ollis, 2006), healthcare (Cassidy et al., 2011; Peat et al., 2019), education (Thurston, 2014), and organisational studies (Tomkins and Eatough, 2014). Comparable to thematic analysis, Alase (2017) explains that IPA provides a distinct analytical framework enabling individuals to articulate their lived experiences unhindered by researcher bias. This method facilitates participants in recounting their experiences, allowing for the identification of recurring themes across multiple accounts. IPA entails a two-tiered interpretation process wherein the individual narrates their experiences organically while the researcher endeavours to identify the nuances of each individual's encounter (Alase, 2017). However, while IPA offers valuable insight into the lived experience on an individual level, thematic analysis benefits from a broader perspective beyond personal context (Braun and Clarke, 2019).

Similarly, qualitative content analysis was deemed unsuitable due to its focus on identifying redundant and similar codes within data sets (Mayring, 2014). Specifically, thematic analysis offers a more appropriate avenue for in-depth exploration of emerging themes, in contrast to content analysis, which primarily aims to delineate dominant

patterns. Furthermore, discourse analysis was excluded based on its emphasis on how participants employ language to draw conclusions about their experiences, as opposed to thematic analysis, which centres on the derivation of themes from data sets (Starks and Brown, 2007).

The thematic data analysis method employed in this research consisted of six key phases (Braun and Clarke, 2021). As exemplified by Braun and Clarke (2012), in the first phase, the researcher performed the familiarisation process, which involved reading through the transcripts to gain an overall acquaintance with the content. This phase formed the preparatory step for the development of codes in the subsequent stages. In the second phase, the coding process was commenced (Braun and Clarke, 2012). Coding is defined as assigning descriptive names to sections of the data set that transmit meaning in relation to the research questions and objectives (Williams and Moser, 2019). Similar meanings across the transcripts were assigned the same codes. Based on the inductive analysis approach, the research utilised inductive coding in which codes were derived from the data without preconceived notions (Belotto, 2018). Following transcription, open coding was performed in which the researcher passed through the data while breaking down the content into discrete excerpts defined by labels or category names depending on the meaning transmitted. In this regard, it is observed that the researcher's interpretation was employed to interpret the meaning and assign appropriate names or codes (Neuendorf, 2018). The coding process was accomplished in stages. Firstly, the codes were tentative and subject to improvement in the subsequent stages of the analysis. Secondly, the codes generated by open coding were organised into categories

based on similarities and differences in the meanings (Popat and Starkey, 2019). Codes similar to each other were brought under one category to generate thematic topics. Thirdly, verification and review of the codes were performed (Lochmiller, 2021). The activity involved doing additional rounds through the transcripts to re-examine the codes, add codes and remove duplicate ones. The third phase followed the coding process, in which themes were identified from the repeating patterns presented by the codes (Braun and Clarke, 2012). Here, themes were assigned descriptive names based on the patterns observed. The fourth phase involved a review of the developed themes to ensure that themes that were not relevant to the study problem were discarded. Likewise, the researcher returned to the collected data to identify relevant themes that might have been overlooked (Braun and Clarke, 2012). The fifth phase entailed the further defining and naming of themes as part of the thematic review and research results. Codes and themes were reviewed and discussed with the supervisors before finalising them. The sixth phase involved the production of a thesis that consisted of an in-depth thematic analysis and presentation of the research findings (Braun and Clarke, 2012).

3.7.3.6 Trustworthiness

Generally, trustworthiness defines the degree of confidence in the research method, data, and interpretation modalities of the study (Stahl and King, 2020). In qualitative research, trustworthiness is perceived as establishing the credibility, transferability, confirmability, and dependability of the findings (Rose and Johnson, 2020). As for credibility, the researcher was tasked with proving that the findings were accurate, a task that was effectively accomplished by sampling participants who had relevant experience and

knowledge of pastoral care. Specifically, the qualitative data were grouped into four data sets, and the responses were compared. The outcome was that there were high levels of consistency that confirmed the credibility of the sources, thus promoting trustworthiness. Transferability was shown using a thorough description of the findings to demonstrate the applicability of the findings in other contexts (Rose and Johnson, 2020).

On the other hand, confirmability measured the degree of neutrality of the findings with regard to potential bias in data collection and interpretation (Amin et al., 2020). Confirmability was achieved by providing all the steps used in the analysis of data to show that all the information presented was as per the data presented by the respondents. The strategy promoted trustworthiness by indicating that researcher bias did not skew the data interpretation. Finally, dependability, which measures the repeatability of the research, was assessed by allowing the supervisors to examine the research and analysis (Johnson et al., 2020). The outcome was that the findings were consistent with the research methods; thus, the research was repeatable.

3.7.4 Main Study

The main study constituted a comprehensive research project conducted after the pilot study and the data collection phase was executed over an eight-week period from March to April 2023. Its primary objective was to facilitate data collection and address the research questions with a more extensive and representative sample of 20 participants. The essential aims of the main study encompassed the collection and analysis of data, fostering generalisability to ensure the applicability of findings to the broader pastoral care

population, and analysing comprehensive and intricate data to derive meaningful interpretations. As there were no changes to the semi-structured interviews and methodology, the same data collection method was used for both studies.

In consideration of the feedback received from participants in the pilot study concerning the need for clarification of their responses, the main study interviews were transcribed within a 24-hour timeframe, and the transcriptions were subsequently sent via email to each interviewed participant within 48 hours of the interviews. Therefore, the participants were afforded the opportunity to review the interviews in order to validate whether the content accurately reflected their intended meaning. Following the participants' confirmation of their satisfaction with the transcriptions, the data analysis commenced. All participants expressed contentment with the accuracy of the transcriptions as a faithful representation of the conducted interviews.

The potential limitation of the time difference between the pilot and main studies should be acknowledged. However, it is also noteworthy that there was considerable consistency in participants' responses despite the time that had elapsed between the two studies. According to Van der Kolk (2014), experiences that are particularly stressful have the potential to remain vivid in one's memory for years following the event. Hence, the memory of the pandemic experience may have remained lucid because of the visceral impact it had on the participants. Furthermore, the consistency in findings between the pilot and main studies affirms the veracity of the responses in each study and substantiates the robustness and replicability of the data collection methodology. Thus,

due to the consistency between the two studies, the findings from the pilot study were integrated into the main study, a practice commonly referred to as an 'internal pilot' (Wittes and Brittain, 1990). In this approach, the population involved in the pilot study are incorporated into the main study.

3.8 Researcher reflexivity and research experience

As described by the interpretivist research philosophy, the involvement of the researcher is highly regarded in qualitative studies (Nickerson, 2022). In the context of this study, the researcher was an active participant in the pastoral care community, rooted in its traditions, values, and daily practices. With firsthand knowledge and experience, they possessed an understanding of the community's unique challenges and aspirations. Their academic background in pastoral theology and the sociology of religion equipped them with a nuanced comprehension of the underpinnings that influence the community's beliefs and actions. In this regard, the researcher's impetus for this investigation stemmed from their experience practising as a chaplain during the height of the COVID-19 pandemic in 2020. In light of the unprecedented situation and the challenge of formulating novel responses, the researcher was prompted to contemplate numerous questions pertaining to professional practice. The first research question provided the initial motivation for conducting the investigation, while the subsequent two research questions were developed over the course of the study.

In the capacity of a pastoral care practitioner in the UK engaged in the study of pastoral care practice, the researcher acknowledged their status as an insider owing to their close

association with the subject matter. Likewise, as a research practitioner, there was the potential for both positive and negative influences on the research. Therefore, it is plausible to surmise that this insider status may have wielded influence over the research parameters, subject matter, and investigative trajectory. For example, the researcher assumed responsibility for discerning scholarly literature, gathering data, and encoding thematic elements. In order to mitigate potential partiality, the researcher conducted an exhaustive examination of existing literature. When confronted with a paucity of literature concerning pastoral care within the UK during the specified timeframe, the researcher broadened the scope of inquiry to encompass pertinent global research. This incorporation of global literature helped to unearth implicit biases and presumptions that may have inadvertently permeated the investigative process.

Furthermore, while the researcher's personal interest and enthusiasm in the topic provided the researcher with the impetus and motivation to undertake the study, the proximity of the researcher meant that extra caution had to be exercised to limit the introduction of negative presuppositions, agendas, or biases. For example, it was imperative that the participants in this study accurately represented the breadth of diversity found in pastoral ministry throughout the UK. Hence, careful consideration was given to ensuring the equality and accessibility of the sampling and interview process. Specifically, the researcher conducted a preliminary pilot study with a small sample size to test the feasibility and methodology before launching the main study. The researcher found the initial pilot study integral in refining the research design and ensuring the

reliability of the main study. Subsequently, the main study was conducted to extend the scope of the data collection and ensure the wider applicability of the findings.

In this regard, the researcher engaged in several activities to obtain the study findings in the current context. Firstly, the researcher participated in the sampling process (Wa-Mbaleka, 2020). For successful purposive sampling, the researcher assessed the potential participants based on certain features, including practising pastoral care and experience during the COVID-19 pandemic. In that regard, the perception of the researcher about individual qualifications influenced the type and number of participants. Secondly, the researcher was involved in the data collection process to ensure there was clarity in the intended meaning of the questions (Wa-Mbaleka, 2020). Specifically, the researcher executed the role of the interviewer. Therefore, the researcher had the opportunity to seek clarification and note any non-verbal cues displayed by the respondents. Unavoidably, the implication is that the perception of the researcher partly influenced the quality and range of the research data. Thirdly, the researcher analysed the collected data to draw relevant meaning (Henderson, 2018). Thus, the number and quality of themes extracted from the data relied on and depended on the researcher's expertise in data analysis.

Through the research process, the researcher was able to gain significant experience and develop important life lessons and skills. Firstly, interaction with the participants and the research environment promoted the researcher's networking skills, as the study enabled the researcher to connect with individuals from different positions in the

professional environment. The researcher recognised the various roles in the organisation based on structure, and the tasks prepared the researcher for future engagements. Secondly, the process of data collection equipped the researcher with unique research skills such as sampling, interviewing, and analytical skills. Thirdly, implementing the methods, from seeking University ethical approval to data gathering using interviews, required effective interaction aided by good communication. The research experience significantly improved the communication skills of the researcher.

However, a few limitations were identified during the research process. For instance, owing to the researcher's insider status, it was challenging to maintain professionalism while also winning the trust of the participants, as the researcher attempted to help them feel at ease with the study. Likewise, the same challenge was encountered during the interviews, whereby the researcher had to draw the sessions back to the questions, although the participants would have liked to deviate to other topics. Additionally, the subtle and implicit nature of unconscious bias posed a significant challenge in discerning the extent of the researcher's impact on the study. Therefore, to mitigate these limitations, the researcher regularly took part in reflexive practices throughout the investigation. This involved keeping a reflective journal and seeking input from interdisciplinary supervisors experienced in academia and clinical practice, whose diverse expertise provided invaluable fresh perspectives and facilitated the identification and mitigation of potential biases. Thus, the researcher was able to consistently uphold a professional relationship with the participants while also remaining mindful of their positionality throughout the duration of the study.

3.9 Chapter Summary

The methodology chapter presented the steps taken to implement this study and provided answers to the research questions. Based on the nature of the research questions, the study adopted the interpretivism philosophy that upholds that reality is ascertained through social constructs. In that regard, the research employed a phenomenological design, inductive approach, and qualitative method, all in agreement with the principles of interpretivism and aligned with the research questions and objectives. The chapter also described the sampling, recruitment and ethical principles. Furthermore, the researcher ensured confidence in the results by evidencing that the research tested and achieved trustworthiness, credibility, confirmability, and dependability. Finally, the researcher provided a reflection on their reflexivity and research experience.

Chapter Four: Results

This chapter describes the process of identifying themes and analysing the results. Specifically, it details the process employed and explains how the data was collected and analysed. Additionally, the chapter presents the key findings of the study, highlighting the main themes that emerged from the data.

4.1 Overview

Based on the detailed thematic analysis presented below, the research identified eight main themes. The themes include i) the importance of pastoral care, ii) the roles and responsibilities of the pastoral community, ii) the impact of the pandemic on pastoral activities, iv) the impact of the pandemic on communities, v) how ministers in diverse pastoral roles adapted to the pandemic, vi) internal and external barriers to adaptation to the COVID-19 pandemic, vii) lessons from the COVID-19 pandemic for the pastoral community, and Viii) the future of pastoral care. This chapter details the findings in alignment with the eight themes in order to address the objectives outlined in the research.

4.2 Thematic analysis

The following table summarises the identification of sub-themes and themes from interview codes and the justification for the themes that were adopted. In order to analyse the interview responses, thematic analysis was employed in a stepwise manner. The first phase involved identifying codes from the responses (see Appendix 7). The researcher based the codes

on questions such as what was happening, the actors, their roles and how it was happening. The codes were justified in the study in accordance with Braun and Clarke (2022). After the possible codes were identified for the different interview questions, the subsequent phase regarded grouping the codes and identifying sub-themes and themes.

Table 2 – Development of sub-themes and themes

Interview Question	**Quotes**	**Codes**	**Similar codes**	**Sub-themes**	**Themes**	**Justification of the themes**
Can you please explain what pastoral care entails, and why do you think that pastoral care is important?	"Basically, I have pastoral oversight of 11 churches by myself, so my role is to support churches to discover what their mission is and to help guide them to carry out their mission into their local communities."	• Oversight • Support • Guide • Conduct • Mission • Local communities	• Support • Guide • Local communities • Engage • Conduct	• Offering support • Engaging local communities • Guiding missions	Benefits of pastoral care	Captures what pastoral care involves and its benefits for society.
	"I offer pastoral care to the local church congregation while also engaging with the community as I do something with refugees and for "PRIDE. The city centre church is very inclusive and has a ministry to the university, so I work in a team of ministers to support young adults and different groups.	• Offer • Support • Guide • Conduct • Engage • Inclusive • Local communities				
Who do you provide your services to?	I am on the board of governors at the local school, I am on the chaplaincy team at the hospital, and I am a chaplain at the local care home.	• Board of governors • Chaplain • Local care home	• Chaplain • Community • Board of governors	• Community services • Spiritual guidance	Roles and responsibilities of the pastoral community	Captures the roles and responsibilities of ministers within the community.

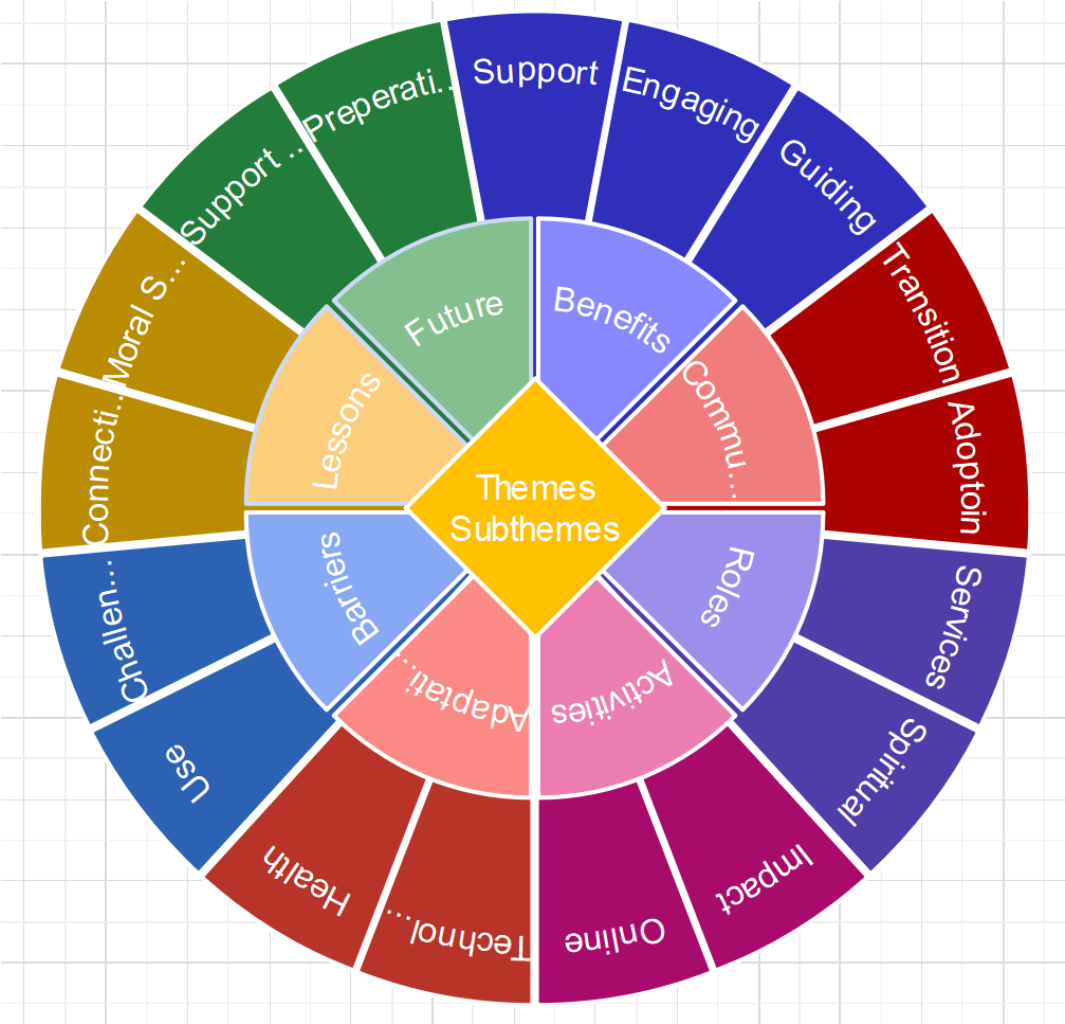
	I am a pioneer minister based on a new housing estate in Lincolnshire. Essentially, my service is to the whole community. Our Sunday church services are in the school hall.	• Minister • Chaplain • Community services				
How did the pandemic impact your work? Did you encounter new challenges?	The pandemic has been extremely challenging. Initially with the first lockdown, there were far fewer women contacting us because of social distancing, and then suddenly, it was like a flood of calls and referrals for our services.	• Social distancing • Fear • Online • Pause • Visits • Contact • Calls • Restriction	• Visits • Calls • Contact • Online	• Impact on contact and visits • Adoption of online platforms	Impact of the pandemic on pastoral activities	Captures the impact of the pandemic on pastoral activities
	The most obvious impact was social distancing. All of our services moved online, and we created a WhatsApp group for the church. My chaplaincy work in the hospital was paused for a moment due to lockdown, but I went back once restrictions were lifted.	• Visits • Contact • Calls • Restriction				
How did the pandemic impact those who receive your services?	When COVID happened, as I said, both churches went online and both churches were really happy to have found a way to worship together and join in zoom meetings. We were really talking more, and the two churches were able to connect through a virtual space. We were able to do all Bible studies online and meet with families on zoom.	• Visits • Contact • Calls • Restriction	• Online • Social media • Contact	• Transition to online environments • Adoption of social media	Impact of the pandemic on the community	Captures the impact of the pandemic on community

	So, I only know a little bit about the day-to-day life of the churches but from what I hear from the elders their gut reaction is that people are staying in close contact through social media and have maintained their habit of going to church online and had other things to do. Numbers of churches are starting to reopen.	• Social media • Online church • Reopen church • Close church				
How did you adapt to the changes that occurred during the pandemic?	In some ways, I didn't. I still call and email people, but we adapted socially distanced services in the chapel. Well, yes, the main difference has been socially distancing.	• Email • Calls • Social distancing	• Emails • Calls • Social distancing	• Adoption of technology to adapt to the pandemic • Health strategies to adapt to the pandemic	Adaptation by pastoral communities to the pandemic	Captures how the pastoral community adapted to the pandemic
	We have had to expand our team of staff and volunteers due to the sheer number of phone calls we receive. We have also started placing posters on bus stops and lampposts with tear-away phone numbers for women to take. We still work from the safe-house, and we have seen a steady increase in women coming to the building.	• Email • Volunteers • Posters • Calls • Social distancing • Safe house				
Were there any barriers that hindered effective adaptation? **a) Internal factors** **b) External factors**	Not really. I think the greatest barrier for me has been shutting off from work mode. When everything is at your fingertips it is hard to unwind. Although I work in a team, I am single and live with a flat mate, so there is nobody telling me to take a break.	• Shutting off • Unwind • Take a break • Overworking	• Struggles • Overworking • Technology	• Use of technology to adapt to the COVID-19 pandemic • Challenges affecting	Internal and external barriers to adaptation to the COVID-19 pandemic	Describes how the pastoral community adapted to the COVID-19 pandemic

	Yes, I have been struggling to get across who I am and what I am here to do. So much of pastoral care is based on relationship and although I have been able to make a few meaningful connections, the majority of my pastoral care has been cursory.	• Struggle • Connection • Relationships • Overworking		adaptation to the pandemic		
What was the most valuable lesson that you learned during this time?	The thing that I've learned is that we we really need to try to use all all means to connect with one another. So even if, you know, we can't meet, perhaps it is good to to keep on phoning people and because uhm, yeah, it's that that basic trust, so if people don't trust you, then pastoral care won't work and all you need is people to trust you a little bit and then they are willing to talk with you.	• Connection • Calls • Trust • All means	• Connection • Moral support	• Importance of moral support during the COVID-19 pandemic • Importance of connection during the COVID-19 pandemic	Lessons from the COVID-19 pandemic for the pastoral community	Describes the lessons that the pastoral community learned from the COVID-19 pandemic
	I think I am adding this that there should have been more support for pastoral caregivers, for example there should have been clear guidance on in person pastoral care meetings as it takes away the responsibility for me. I also wonder if we need maybe like a self-help group for pastoral caregivers something more where we were able to stop and yeah	• Moral support • Guidance • Meetings • Self-help groups				

	owning that we are all learning, we are learning.					
What does the future hold for pastoral care practitioners?	In some respects, it will go back to what it was like and pastoral care visiting people, but I want to set up a team of pastoral groups so it's not all on the shoulders of one person.	• Pastoral groups • Visiting • Teamwork	• Visiting • Support structures	• Importance of support structures • Preparation for future pandemics	Future of pastoral care	Captures the future of pastoral work and its impact for practitioners
	Pastoral care needs to reform. The pandemic revealed that the traditional support structures that we once depended on were already hanging by a thread, and we were not prepared for the challenges the pandemic brought.	• Reforms • Visiting • Support structures				

Figure 2 - Sub-themes and themes



The above figure offers a visual representation of the interconnectedness between each theme and sub-theme. Notably, each sub-theme and theme are distinct from one another, which is illustrated by the different colour codes. However, they depend on and are impacted by each other, which is illustrated by the circular design.

4.3 Theme One: Importance of pastoral care

Addressing the first theme revealed insights regarding the benefits of pastoral care to the community. The theme was addressed by assessing the responses to the first interview question, where participants were asked to describe what pastoral care entailed and its various benefits. From the responses, it was observed that the ministers provided pastoral oversight of churches to help them fulfil their mission to society. The Participant 1 stated:

> *"But basically, I have pastoral oversight of 11 churches by myself, so my role is to support churches to discover what their mission is and to help guide them to carry out their mission in their local communities."* (Participant 1)

The response indicated that the minister had pastoral responsibility for 11 different churches where they supported them in their mission to the local communities. Participant 2 corroborated Participant 1 where they revealed that they had pastoral oversight over two churches. Participant 2 stated:

> *"Okay, yes so, I am a minister of two churches in Birmingham. The big one is in the city centre and is a local ecumenical partnership with the Methodist church and the smaller one is in the outskirts of the city."* (Participant 2)

The response from Participant 2 indicated that the minister also provided supervision to two different churches in Birmingham, hence fulfilling an oversight function. Participant 3 identified views similar to those of Participants 1 and 2, who reported that they provided oversight to nine different churches. Participant 3 reported:

> *"I am a minister in a missional partnership of nine churches in greater Manchester. I have pastoral oversight which is somewhat managing a facilitating of the elders*

> *and may be a couple of the church secretaries nominated local leaders as they offer the day-to-day pastoral care to the churches and community."* (Participant 3)

The response from Participant 3 indicated that the minister provided oversight to different churches in Manchester. As such, the response indicated that ministers were playing key roles in supporting the church leadership in undertaking their responsibilities. The inference from Participants 1, 2 and 3 indicated that pastoral care was utilised in the management of churches in the UK, where leaders provided oversight and supervision for different activities. The ministers also ensured that the churches were able to undertake their mission to the community.

The second observation was that the ministers attended to the pastoral needs of the various community members. Participant 4 reported:

> *"In a funny sort of way, I am also a chaplain to students in Oxford University and I am a point of contact for students who need pastoral care."* (Participant 4)

The response from Participant 4 indicated that the minister provided pastoral care to individual university students. Participant 5 mentioned that the purpose of pastoral practitioners was to work in conjunction with the local community and offer help in projects and initiatives directed at improving the welfare of the people. Participant 5 indicated:

> *"I am the minister of two churches and so I have to provide pastoral care for both those two churches and pastoral care in conjunction with the elders and pastoral visits and do things like organising fundraising events, building work and applying for similar grants."* (Participant 5)

The assertions of Participant 5 indicated that the minister provided ministry services to two different churches. The views were corroborated by Participant 2, who reported that:

> *"I offer pastoral care to the local church congregation while engaging with the community as I do something with refugees and for PRIDE. The city centre church is very inclusive and has a ministry to the university, so I work in a team of ministers to support young adults and different groups."* (Participant 2)

The synthesis of the responses from the participants showed that pastoral work was utilised to engage with both the churches and the community. In this context, the ministers attended to the pastoral needs of different individuals, including young adults, refugees and members of the LGBTQ+ community. Moreover, the responses noted that pastoral care responsibilities extended to the oversight of other pastoral care practitioners, including, elders, church secretaries and local leaders. Therefore, apart from serving the community interests, pastoral care also meant attending to the needs of fellow practitioners.

Participant 11 reiterated the insights from Participant 2 and Participant 4 where they indicated that they provided care in the life journeys of different individuals. On this note, the Participant 11 stated:

> *"For me, pastoral care means journeying with people through life's ups and downs, being a non-judgemental presence and helping people work through the tough questions."* (Participant 11)

The observations of Participant 11 were corroborated by Participant 13, who posited:

> *"For me, being a pastoral carer is about being connected, whether on the phone or in person."* (Participant 13)

The responses of Participants 11 and 13 suggest that ministers supported each person based on their individual needs. Participant 5 additionally revealed that ministers were involved in undertaking activities and organising events. Participant 5 reported:

> *"Pastoral care in conjunction with the elders and pastoral visits, and do things like organising fundraising events, building work and applying for similar grants."* (Participant 5)

Pastoral practitioners were not only recognised caregivers but also included elders and local leaders, who undertook activities such as fundraising and building work within the society. As intimated by Participant 11, pastoral care involves the ministry of presence. Although Participant 13 shared similar views with Participant 11, the former emphasised the role of connection and strong relationships for improved pastoral care provision. Based on the observations of the participants, pastoral care was perceived as a way to support both individuals and social well-being.

4.4 Theme Two: Roles and responsibilities of the pastoral community

The second theme investigated the roles and responsibilities of the ministers, where they were asked to outline the different people to whom they provided services. From the responses, it was observed that the first responsibility was the management of the congregation of local churches and the community. Participant 19 stated:

> *“So, I am a pioneer minister based on a new housing estate in Lincolnshire. Essentially, my service is to the whole community. Our Sunday church services are in the school hall.”* (Participant 19)

The analysis of the response indicated that the minister’s responsibility was to the community and the congregation in the school hall. Participant 20 identified a similar finding as Participant 19 where they reported:

> *“The majority of my time is spent supporting my congregation and doing the rounds in the hospital.”* (Participant 20)

The evaluation of responses from participants 19 and 20 revealed that ministers were required to provide pastoral care to both their congregations and in wider contexts of the community and hospital.

Secondly, the responses showed that the ministers delivered care to the pastoral community with the support of the elders from the churches. Participant 1 reported:

> *“Well, I was inducted to the pastorate in the middle of the first lockdown to serve five of the 11 churches with another minister. I have been working with the local church elders to offer pastoral care through Zoom.”* (Participant 1)

The position of Participant 1 was corroborated by Participant 4, who reported:

> *"For the city centre church, we decided to give the elders a pastoral care update every other week and then the intervening weeks, we meet on Zoom to find out how people were doing."* (Participant 4)

The responses of Participants 1 and 4 revealed the interconnectedness between ministers and church elders in providing pastoral care. From the answers of Participant 1, it was deduced that pastoral practitioners in this context were responsible for ensuring the spiritual well-being of the vulnerable people in the churches. The strategy helped in the psychological health management of older adults and young people, hence promoting positive living even during the pandemic. The responses of Participants 1 and 4 attested to the need for coordination in administering pastoral care. Participant 1 argued that the village church was community-minded and action-oriented, which facilitated pastoral care among the congregation during the pandemic. Pastoral practitioners organised meetings and coordinated subordinate caregivers across the churches. Additionally, Participant 4 noted that church elders were required to provide reports on pastoral care engagements during the pandemic, and meetings happened virtually.

The third observation was that the ministers were also responsible to the community, where they provided services as chaplains in schools and hospitals and within board management, as revealed by Participant 11. Participant 11 reported:

> *"I am on the board of governors at the local school, I am on the chaplaincy team at the hospital, and I am a chaplain at the local care home."* (Participant 11)

The analysis of the response by Participant 11 showed that the ministers were required to provide pastoral services in different settings, including schools, the local community, and hospitals. Participant 16 reiterated the views of Participant 11, where they stated:

> *"I am part of a church in the Tottenham area who are working with local authorities to help women and families struggling with domestic violence. We have an inconspicuous safe house where women can come during the day to seek support. I lead a team of five staff and volunteers."* (Participant 16)

The evaluation of the response indicated that the participants were expected to adapt pastoral care to the needs of the community, such as caring for women and children struggling with domestic violence during the pandemic. Pastoral care practitioners were additionally tasked with ensuring the spiritual well-being of their recipients, including students within schools and patients in hospitals.

4.5 Theme Three: Impact of the pandemic on pastoral activities

The third theme elaborated on the impact of the pandemic on pastoral activities and the new challenges that the ministers experienced due to COVID-19. From the evaluation of theme one, pastoral work entailed supervision of church activities, attending to the pastoral needs of the communities, and helping the society in addressing different problems through collaboration with other caregivers. Theme two also showed that pastoral work was important for the congregation and the community. Therefore, addressing the third theme highlighted insights regarding how the pandemic affected the undertaking of the different services by the pastoral community.

The first observation was the challenges encountered in undertaking pastoral activities such as conducting funerals, as detailed by Participant 1. Respondents argued that COVID-19 considerably limited pastoral care due to the absence of face-to-face contact. The pandemic made it impossible to be physically present in events, such as consoling

the bereaved. For example, Participant 1 indicated that the company of pastoral practitioners in places such as funerals was restricted. In particular, Participant 1 said:

> *"The big one was funerals and funeral visits while we were in lockdown. Under these circumstances, meeting face to face is important for pastoral care and I think planning a funeral was challenging."* (Participant 1)

Similar arguments were provided by Participant 13, who noted that they had been challenged in visiting the community. Participant 13 stated:

> *"Having been involved in pastoral care for 20 years, I believe in-person visiting is greatly different from anything we can do virtually, so I am looking forward to returning to face-to-face pastoral care."* (Participant 13)

The responses suggest that COVID-19 negatively affected pastoral care practicalities. As expressed by Participant 1, the pandemic limited the effectiveness of pastoral care for the most critical situations, as the practitioners could not offer services during the most demanding stages of the pandemic. Ordinarily, individuals would make personal visits for pastoral care; therefore, they faced challenges giving this mandate virtually.

Secondly, the responses indicated that the ministers were challenged in adopting technology and adjusting to the new normal to undertake their different responsibilities. The participants reported that it was not easy to deliver effective pastoral care using online platforms in the first instances when the COVID-19 pandemic struck. Participant 4 indicated resistance to change to online pastoral care. Participant 4 stated:

> *"I think for me, the major adjustment was technology, and I was very resistant to doing pastoral care online, and so that was a huge adjustment and it helped to have an ecumenical colleague invite me to, you know, show me the ropes and I found having conversations online was great, unique and connect with people."* (Participant 4)

The assertions of Participant 4 underscored the challenges that the respondents faced in adopting technology and were echoed by Participant 3, who posited:

> *"The main adjustment was to technology. In my previous role, I was a chaplain to young people in a motorcycle club and coming to Manchester had already meant doing pastoral care differently and when it came to COVID, also you're practising pastoral care in different ways."* (Participant 3)

The responses from Participants 4 and 3 reveal the pastoral care dynamics during the pandemic, especially with the adoption of technology and the shift of operations to the online platform.

However, Participant 2 asserted:

> *"Interesting, since we went into lockdown, everything went online. The city centre church found it easier to adapt than the smaller church who are not well connected."* (Participant 2)

The changes introduced due to the pandemic significantly affected how pastoral care was administered. As observed by Participant 4, pastoral care had been traditionally conducted in person through actual physical encounters rather than virtually. Adjusting to the new normal of online pastoral care sessions was challenging. In agreeing with

Participant 4, Participant 3 noted that technology was the primary element of adjustment in pastoral care during the pandemic.

A synthesis of the responses suggests that it was hard for the majority of pastoral care practitioners to comprehend the use of virtual pastoral care since it had never been commonly practised before COVID-19. The suspension of movements and the need for social distancing demanded that pastoral care take a new form without prior planning and pilot testing; thus, embracing virtual pastoral care presented a significant challenge to the practitioners.

A third observation was that the pandemic generated challenges with regard to coordination activities for pastoral work. The responses showed that the lockdowns and social distance directives separated the core of pastoral care such that most practitioners felt they were on their own in service. In this regard, Participant 10 noted that she thought her engagement in pastoral care activities during COVID-19 was an isolating endeavour. The Participant 10 indicated:

> *"It became very much a one-woman show. It felt like I did have the support of the elders, but most of it felt like it was down to me in enabling, you know, I would encourage people in the weekly newsletter to visit people who haven't been seen."* (Participant 10)

Similar views were presented by Participant 18, who observed that it was challenging to establish effective professional and personal relationships with fellow practitioners. Participant 18 noted:

> *“Due to the nature of my role, I haven't been able to make personal relationships with my colleagues because I am responsible for their pastoral care, which has made me somewhat anonymous. Nobody would know if something happened to me."* (Participant 18)

The responses from Participants 10 and 18 showed that COVID-19 significantly impaired the interpersonal relationships among pastoral care practitioners while they offered the needed services to vulnerable individuals in society. Analysing the views of Participant 10, the pandemic reduced the number of practitioners available to carry out pastoral care duties. Furthermore, many pastoral practitioners could not work in teams due to the restrictions, and there was a loss of contact with one another. Consequently, those who continued to practice were isolated and felt the burden of responsibility of maintaining the spiritual well-being of the people affected by the pandemic. The view was supported by Participant 19, who revealed:

> *“With social distancing, it has been challenging getting to know people. I tried to do something on Facebook live and Zoom, but it never gained traction.”* (Participant 19)

The evaluation of the responses reiterated that the pandemic led to isolation among practitioners due to the restrictions on communal activities and the limitations of the online meeting platforms.

Despite the negative effects of the pandemic on pastoral activities, such as the disruption to coordination efforts and foundational pastoral work, which involved one-on-one interactions, further examination of the responses revealed that numerous benefits were

reported in other cases. A case in point was the improvement of virtual pastoral services as advocated by Participant 14, who stated:

> *"I was already doing quite a lot online and through social media, but COVID basically ramped up everything. Before, our YouTube videos typically got around 30 views, but now we consistently get 150 views. We also started zoom bible studies and weekly games nights."* (Participant 14)

The analysis of the response revealed that the ministers were able to engage more with their audiences after the COVID-19 pandemic. As a result, bible studies on Zoom and weekly game nights were introduced to adapt to the challenges faced. Therefore, the pandemic boosted the pastoral services where audiences were reached and connections maintained via the use of technology.

4.6 Theme Four: Impact of the pandemic on communities

The evaluation of theme three revealed that the pandemic had adversely affected pastoral practice, where foundational face-to-face activities such as funerals and hospital visits were disrupted. Additionally, the ministers were forced to adopt technology in order to cope with the COVID-19 pandemic situation. Therefore, theme four investigated how the pandemic had affected the communities that received the pastoral services, including the congregations, boards, and patients in hospitals. From the responses, positive effects of the pandemic on the communities were identified, where the church leadership was able to reach more people through phone calls and virtual platforms. Participant 1 reported:

> *"Me and the eldership, I think as the church leadership, we have called probably called people more than we would have before and even people we might not call*

> *on a regular basis because of the pandemic. I have checked up on people a lot more than we would have to make sure everything is okay and that they have all the support that they need, groceries and things."* (Participant 1)

The inference from the response was that the pandemic made the receivers of pastoral care readily available for services via online platforms, making it easier for pastoral care practitioners to offer the necessary support. In agreement, Participant 2 observed:

> *"When COVID happened, as I said, both churches went online and both churches were pleased to have found a way to worship together and join in Zoom meetings. We were talking more."* (Participant 2)

The views of Participant 1 revealed that pastoral care during the pandemic was characterised by the sociological principle of reaching out and connecting with people in society to convey the idea that they are not alone in the struggles they face. The pandemic triggered a sense of concern among the pastoral practitioners and the served population; therefore, they responded enthusiastically. Participant 11 identified similar views and reported:

> *"Well, I have seen a shift in those asking to speak to me. Many more staff and volunteers are knocking on the chaplain's door, compared to before the pandemic."* (Participant 11)

The inferences from participants 1, 2 and 11 were that the pandemic led to increased availability of the communities to receive pastoral care. As such, the strategy likely promoted the extent of pastoral care among the church members. In support, Participant 2 noted that families responded positively to online provision initiated during the pandemic for pastoral support. The presence of online avenues to pastoral care provided an

opportunity and ample time for many people to share with the pastoral care providers. The pandemic increased the desire for pastoral care due to increased distress.

A second observation was that the pandemic led to improved technological literacy for the communities as they were forced to adopt new technologies to engage with the ministers. Participant 7 noted that the positive impact of the pandemic was that more people learnt to use technology to connect with pastoral care. Specifically, Participant 7 claimed:

> *"It is only that people can learn to use technology, and so that has been very positive. I think again those who didn't use technology use it even more now, and they are connected."* (Participant 7)

The argument of Participant 7 is consistent with that of Participant 12, who asserted:

> *"When the first lockdown happened, most people engaging with our content were from the church or students from the university. But now, most people engaging with our content have no prior connection to us."* (Participant 12)

The evaluation of the responses revealed that the pandemic increased the adoption of technology among communities who had an interest in pastoral care. Due to lockdowns, people discovered new ways of connecting, increasing the consumption of virtual spaces. The restricted movement led many religious and non-religious people to seek pastoral care through online social media platforms and telephone channels. Thus increasing communication technology literacy among pastoral care recipients. Moreover, COVID-19 triggered self-reflection among many people, increasing the desire to seek spiritual

guidance and emotional support in pastoral care programs. The responses re-emphasised pastoral care as a social program that was not restricted to religious people but accessible to all in society who required pastoral support. The new communication media allowed pastoral practitioners to identify and engage individuals needing emotional and spiritual support. Pastoral care practitioners assumed that all humans, whether religious or non-religious, faced similar struggles and, hence, needed to be given similar attention and avenues to access pastoral care programs, just like social programs. Thus, improved access to technology during the pandemic enabled pastoral care programs to reach more people, including those not affiliated with specific religious organisations.

Thirdly, negative effects were also observed among the populations where many experienced deaths due to the pandemic and cases of suicidal ideation, as reported by Participant 13:

> *"We experienced a number of deaths in the wider community, which had a huge impact on the churches. Six people were from a non-Christian background, and three were from Christian backgrounds. I also met with people who were suicidal and provided support for education staff and parents."* (Participant 13)

The response indicated that the pandemic caused negative consequences to the community members. Participant 16 supported the views of Participant 13, where they argued that other negative consequences arose from the pandemic, such as increased domestic violence. Participant 16 stated:

> *"Cases of domestic abuse incidents were more frequent and more extreme than before. Whereas before, there were ways for the survivors to distance themselves*

> *from their abusers, lockdown meant that they were stuck with their abusers 24/7."* (Participant 16)

The synthesis of responses from participants 13 and 16 indicated that the pandemic was associated with negative consequences, including high levels of domestic violence and death due to suicide and complications from infection. As such, the views indicated that the isolation due to the pandemic was generating adverse consequences for the communities who were unable to engage the ministers.

However, the pandemic resulted in concern and care for one another among the receivers of pastoral care. As noted by Participant 8, more people were frequently connected on social media, which was more effective than before when meetings were mainly on worship and fellowship days. Participant 8 explained:

> *"So, I only know a little bit about the day-to-day life of the churches, but from what I hear from the elders, their gut reaction is that people are staying in close contact through social media and have maintained their habit of going to church online and had other things to do."* (Participant 8)

The position of Participant 8 was reinforced by Participant 10, who pointed out that small churches cared for each other since the members lived nearby. Participant 10 stated:

> *"The small church, in a way, did what they always do, taking care of each other as they all live quite close to the church, but I think the physically able did more checking up on each other and taking care of each other."* (Participant 10)

Similarly, Participant 15 posited:

> *“Now people are phoning more, and I don't think that there was a huge amount of in-person visiting happening."* (Participant 15)

The responses suggest that interconnectivity and proximity to pastoral care are essential during pandemics like COVID-19. As reflected in the assertions of Participant 8, pastoral care during the pandemic did not require building big churches, synagogues or mosques but instead finding a way of reaching an audience and connecting with them in a way that helped to address their psycho-spiritual needs. Using social media to connect with people during online church programs revealed that pastoral care utilised the sociological principle of finding the most effective ways of interactions that enabled support to be given to a targeted group. COVID-19 created the need to care for each other due to a common societal challenge. Similarly, as suggested by Participant 10, while the bigger churches mainly relied on online pastoral care, the same was accomplished in the small church through doorstep visits. Pastoral care was linked to sociology in that it incorporated groups of people who had common interests and values and often resided close to one another. Thus, ministers and churches acted as social support networks.

Different groups adopted various ways of supporting each other during the pandemic depending on the population, technology availability and the preferred methods of pastoral care practitioners. Pastoral care receivers yearned for more services during the pandemic than before. Pastoral care relied on social interaction that, in this case, changed to phone calls as opposed to physical interaction due to COVID-19 containment measures. Technology and sociology were represented in the views, thus pointing to the role of technology in shaping social dynamics during the COVID-19 pandemic. Social

isolation increased due to the decline in face-to-face social interactions within the community, as intimated by a shift towards more isolated forms of interaction.

4.7 Theme Five: How the pastoral communities adapted to the pandemic

Theme five addressed the issues raised in theme three regarding the impact of the pandemic on pastoral communities. The findings in theme three revealed that the ministers were challenged in undertaking face-to-face activities due to lockdowns and isolation. Issues regarding the difficulties in adopting technology were also identified to have hindered their daily practice. Therefore, in theme five, the focus was to establish how pastoral communities adapted to the pandemic and the participants were asked how they had adapted to the changes that occurred during the pandemic. From the responses, it emerged that the ministers adopted alternative technologies such as telephone and virtual platforms. The shift ensured that they could reach individuals in need of their services. For example, Participant 1 posited:

> *"I guess we connected people more than we would have under normal times, and it was easier to get hold of people because everyone was at home. You know that if you ring someone, they will pick up rather than leave a message."* (Participant 1)

The perspective of Participant 1 was supported by Participant 2, who elaborated:

> *"In terms of the church, almost all of my pastoral care was provided virtually and on the phone. I continued to conduct hospital visits as a chaplain, albeit with far more restrictions and wearing PPE."* (Participant 20)

From the responses, Participants 1 and 20 revealed that pastoral care was more sustainable during the pandemic using phone calls and virtual platforms, which were readily available. The aspect of social connectivity was emphasised, which indicated that the congregation was more easily contactable.

Secondly, the findings suggested that the ministers were also concerned with the mental health problems which they faced due to the pandemic. Participant 1 indicated that mental issues were attributed to the long indoor hours:

> *"We were dealing with mental health to make sure we will stand well at the same time as helping others and also recognising those ups and downs of our mental health, which was at different stages at different times."* (Participant 1)

The response suggested that the ministers were facing challenges in coping with the pandemic, which led to mental health issues that were exacerbated by isolation and the challenge of engaging with their congregations virtually. Participant 2 supported the view by reporting that people became uncomfortable speaking on the telephone:

> *"People who were used to talking on the phone would talk well, but some people got really uncomfortable and from my side, it was difficult when people were upset because there would be a long silence."* (Participant 2)

The response from Participant 2 displayed that the ministers experienced problems in engaging with their congregations where they were not used to virtual interactions. In this context, the practitioners struggled to take care of themselves, meaning they had to acquire ways to maintain a positive psychological perspective during the pandemic

because the congregation depended on them. In addition, pastoral care practitioners had to adapt to a new mode of communicating with the people apart from the traditional in-person visits. Many ministers were expected to provide social media platforms and over-the-phone pastoral care to ensure adherence to the COVID-19 social distancing measures and regulations.

A third observation was that some ministers had to expand their pastoral care teams due to increased demand, as reported by Participant 16:

> *"We have had to expand our team of staff and volunteers due to the sheer number of phone calls we receive. We have also started placing posters on bus stops and lampposts with tear-away phone numbers for women to take."* (Participant 16)

The evaluation of the response indicated that increasing volunteers and staff was important to address the high demands of individuals who required support. Thus, pastoral care communities had to adapt to the increased pressures while also adhering to the COVID-19 social distancing regulations.

4.8 Theme Six: Internal and external barriers to adaptation to the COVID-19 pandemic

The focus of the sixth theme was to evaluate the internal and external barriers to adaptation to the COVID-19 pandemic. From previous themes, findings showed that challenges such as difficulties in utilising technology and social distancing affected the adaptation during the pandemic period. To better understand the barriers affecting adaptation, the participants were asked to elaborate on issues that hindered effective

adaptation. The responses revealed that a key issue regarded death due to the pandemic, as reported by Participant 5:

> *"The main thing is that we had quite a lot of church members die and mostly not from COVID, but they were at least five deaths, and I've taken more funerals than that."* (Participant 5)

The response from Participant 5 was that the pandemic, directly and indirectly, led to numerous deaths for the church members and the community. Participant 3 supported the views of Participant 5, as they also frankly stated:

> *"Impossible to say on the whole as COVID killed people."* (Participant 3)

The responses from participants 3 and 5 indicated that the deaths caused by the pandemic had a significant impact on the provision of pastoral care.

A second observation was that the pastoral practitioners identified burnout as a problem that challenged the adaptation to the pandemic. The burnout arose due to increased stress and the excessive workload during the pandemic period. In particular, participant 16 explained:

> *"Initially, with the first lockdown, fewer women were contacting us because of social distancing, and then suddenly it was a flood of calls and referrals for our services."* (Participant 16)

The assertion of Participant 16 was corroborated by Participant 7, who argued:

> *"So, I almost had burnout, and so I think the lesson is that a lot is going on internally, there's a lot of fear, there's a lot of anxiety, there's a lot of energy that goes."* (Participant 7)

The responses from Participants 16 and 7 suggest that pastoral practitioners' duties were constrained considerably by burnout arising from diverse factors. According to Participant 16, the restricted movement during the pandemic limited socialisation with support networks and meant that demand for care increased. Participant 7 highlighted that excessive energy expended responding to pastoral care calls during the pandemic contributed to burnout.

Thirdly, adaptation during the pandemic was constrained by individuals who were resistant to using alternative forms of pastoral care. In particular, Participant 2 noted that the problem was common among the smaller churches whose membership was mainly comprised of older adults. Participant 2 stated:

> *"So, the smaller church has been the most affected as they are more elderly with fewer resources, so they wanted to return as soon as restrictions eased."* (Participant 2)

The response indicates that age was a factor in how pastoral care was received during the pandemic. Participant 2 elaborated:

> *"But they had been struggling with wearing face masks and were frustrated that they couldn't meet for coffee. It was almost like they were having a break, but everything would go back to normal."* (Participant 2)

The position of Participant 2 was echoed by Participant 6, who claimed:

> *"Especially, pastoral care is best done in person as you're more likely to, to talk genuinely and it's a bit awkward when it's on the telephone to have long silence, but in person its easier."* (Participant 6)

The observations of Participants 2 and 6 implied that the churches with older congregations struggled to adopt new modes of pastoral care.

On the other hand, Participant 9 found conflicting opinions held by individuals in the same group. Participant 9 noted:

> *There were very different views as some people wanted in-person pastoral care while others thought they could go steady on face-to-face meetings.* (Participant 9)

Overall, the responses of the participants revealed that they faced barriers in their practice due to the difficulty recipients faced in adopting new forms of pastoral care. In particular, participant 2 noted that the smaller church had fewer resources, which implied that there was a correlation between attitudes and resources.

The fourth observation was that the ministers themselves reported difficulty adapting to technology to conduct pastoral care. Participant 11 reported:

> *"Well, it's slightly embarrassing, but I'm a creature of habit, and I have not been able to get the hang of live streaming my services or having Zoom meetings. I cannot see how pastoral care can be replicated through a screen."* (Participant 11)

The response indicated that the change to virtual platforms was ineffective in undertaking pastoral care. Participant 20 reiterated the views where they reported:

> *“At first, virtual pastoral care had an air of novelty about it, and I found more people engaging with the church than before. However, I soon found the limitations, as there is only so much that you can see on a screen or hear from a voice.”* (Participant 20)

The insights from Participants 11 and 20 were that there were negative aspects regarding the use of technology to facilitate pastoral activities. The lack of technological skills and the difficulties in changing user attitudes towards the technologies were observed to hinder the effective use of the tools to undertake pastoral work. The insights suggested that there was a need for training to use the technologies in conducting pastoral activities.

4.9 Theme Seven: Lessons from the COVID-19 pandemic for the pastoral community

Theme seven highlighted important lessons that were learnt by the pastoral community from the COVID-19 pandemic. The first lesson regarded the sharing of resources and diversification of responsibilities. Regarding sharing resources, Participant 1 pointed out that in the spirit of unity, it was important for the churches to work together in delivering pastoral care since some were not able to afford the technology. In this context, Participant 1 stated:

> *"We can share our resources, and 11 churches can work together to provide some form of an online church."* (Participant 1)

Similar sentiments were presented by Participant 19, who noted:

> *"I've learned that pastoral care takes many forms and involves the whole community. Yes, I had not thought about it, but my role would not be possible without the support of the community."* (Participant 19)

Moreover, the views of Participants 1 and 19 are corroborated by Participant 4, who indicated:

> *"I tried to introduce a system where we had pastoral visitors who weren't necessarily elders and see if we could make that adjustment to take the pressure off the elders and involve more people."* (Participant 4)

The responses affirm the need to share resources during pandemics like COVID-19 to lessen their impacts on pastoral care in communities. As argued by Participant 1, pastoral care is a common concept that is needed by all, so there is no need to segregate the services when anyone can join the online sessions. The responses also highlighted community support to facilitate pastoral activities.

The second lesson was the need to prioritise self-care among pastoral practitioners who faced unprecedented pressure on their personal health and safety due to the pandemic. It was recognised that effective pastoral care required informed self-care in order to care for others adequately. In this regard, effective time management was emphasised as an essential lesson. For example, Participant 9 noted:

> *"Personal one, to be really in control or use of time and not think you've got to be busy, and you got to be seen to be busy, and the second one is to stop trying to be people's rescuer."* (Participant 9)

The observations of Participant 9 are corroborated by Participant 14, who argued:

> *"Also, an important thing to learn as a minister is yes, you are in pastoral charge, but you do not need to get involved in every aspect of the life of the church."* (Participant 14)

However, while agreeing with the sentiments of Participants 9 and 14, participant 17 added a further dimension to the perspectives. Participant 17 noted:

> *"I think I am adding this that there should have been more support for pastoral caregivers; for example, there should have been clear guidance on in-person pastoral care meetings."* (Participant 17)

The responses presented by Participants 9, 14, and 17 emphasised the need for a holistic approach to pastoral care practitioners. Having a better self-understanding would contribute to eliminating potential barriers and difficulties associated with pandemics such as COVID-19. Personal care is as essential to pastoral care success and effectiveness as is practical experience. Participant 17 reiterated the need for greater guidance and support for pastoral practitioners to overcome the challenges and difficulties inevitable of pandemics.

A third lesson regarded hybrid church services that involved the use of technology and physical church services. Participant 1 reported:

> *"The need for hybrid worship so many people are connected to churches, but also, like every church, has to update how they work together. We can share our resources between each other, and 11 churches can work together to provide some form of online church but, recognising that some people may never walk into one of our buildings, but quite happy to join in the worship, Bible studies and gatherings online."* (Participant 1)

The response indicated that the adoption of a hybrid model of practice boosted the effectiveness of the church services and led more people to interact with the church. The view was supported by Participant 6, who reported:

> *"I think more people engaged with worship online, and all of the churches joined the same Zoom service…we had members of the Methodist Church and churches from across East Africa, people joined in, and it brought the Christian community closer together."* (Participant 6)

The insights from the responses of participants 1 and 6 were that the use of technology and the adoption of hybrid worship services were important to ensure the continuity of pastoral care. As a result, the churches received greater participation and delivered more services to both online and offline audiences.

4.10 Theme Eight: Future of pastoral care

The final theme investigated the future of pastoral care, where the ministers were asked to elaborate on how they perceived the future of the profession. From the responses, insights revealed that a reliance on technology to facilitate hybrid worship was paramount. Participants noted that online and telephone pastoral care sessions were already part of the system and were here to stay. For example, Participant 15 pointed out:

> *"Things are staying the same, so I will have to do the weekly newsletter, and the service is still live streamed, which is okay; I got used to it now."* (Participant 15)

Sharing the same sentiment as Participant 15, Participant 1 argued:

> *"We can learn from what we have done in the past, like reaching out to people, using hybrid worship, using telephones, or just finding a way to check on each other, is how we can grow our pastoral care."* (Participant 1)

The participants' responses revealed that future pastoral activities must be innovative and accept novel strategies to ensure successful care. The views were supported by Participant 20, who added that there was a need for the evolution of the profession. Participant 20 asserted:

> *"Pastoral care needs to reform. The pandemic revealed that the traditional support structures that we once depended on were already hanging by a thread, and we were not prepared for the challenges the pandemic brought. If we are not willing to take a critical look at ourselves and our profession, we will become obsolete."* (Participant 20)

The response indicated that the participants felt it was essential to adapt to the changes in technology in order to maintain their pastoral activities. From the perspective of Participant 15, future pastoral care should not only be dispensed through traditional in-person meetings but also via more use of virtual spaces. Supporting the position of Participant 15, Participant 1 recommended that pastoral care should adopt a hybrid model in order to expand the scope and reach of influence. The reflections of Participant 20 took the concepts further as they asserted that pastoral care must be reformed. Thus adopting

new identities and approaches, contributing to a deeper understanding of social dynamics and practices.

A second observation was the need for the ministers to receive support when undertaking their pastoral activities. According to Participant 4, there was a declining trend in the number of ministers available to offer pastoral care, especially after the pandemic. Participant 4 stated:

> *“But as the number of ministers per church declines, more and more pressure is being placed on fewer ministers to offer pastoral care to more people.”* (Participant 4)

The observations of Participant 4 are corroborated by Participant 5, who suggested a practical solution to the situation. Participant 5 asserted:

> *"In some respects, it will go back to what it was like and pastoral care visiting people, but I want to set up a team of pastoral groups and visitors, so it is not all on the shoulders of one person."* (Participant 5)

According to Participant 4, the current provision of pastoral care has become untenable, and the quality of pastoral care will deteriorate in the future. This view was shared by Participant 5, who proposed the creation of additional pastoral care teams to assuage the increasing shortage of personnel.

A third observation was that some ministers demonstrated uncertainty and were not sure how the future would pan out for pastoral care. Participant 3 concisely reported:

“Who knows?” (Participant 3)

The response indicated that some ministers were uncertain about the future. Participant 6 could not make a conclusive projection because of changing ministries hence still adjusting. Participant 6 explained:

> *"I guess the truth is I'm not sure yet, and because I changed my ministry during COVID, I am not quite sure how and what I should change. Currently, I am coping with the changes that are coming to my ministry with prayer."* (Participant 6)

Similarly, Participant 13 described the future as tentative by stating:

> *“Very experimental, try new things, small bits, slow steps, then big steps in the direction of the Holy Spirit. With a series of small steps building momentum, you carry on with the experiment."* (Participant 13)

The implication of the statements by participants 6 and 13 is that they viewed the future of pastoral care with uncertainty.

However, the views of Participants 6 and 13 were contradicted by Participant 12, who added that they perceived the future to be optimistic. Participant 12 revealed:

> *“I'm quite optimistic, to be honest. More young people are engaging with pastoral care than ever before.”* (Participant 12).

The insights indicated that there were observable differences among practitioners regarding the perceptions about the future of the pastoral profession.

4.11 Summary

The evaluation of the findings in this chapter exhibited that pastoral care was important for the congregation and community, where it ensured pastoral needs were met. The ministers also collaborated with the non-religious community to undertake different activities in the society. However, the pandemic adversely affected pastoral work, as foundational activities were disrupted, including visiting the sick in hospital and in-person in congregations. The findings also revealed that more people were distressed and experienced mental health problems due to the pandemic activities. A positive consequence of the pandemic was that the ministers were in a position to provide pastoral care to more people via virtual platforms.

Further insights revealed challenges, including burnout and a lack of adequate resources, which negatively impacted the effectiveness of pastoral care. The arguments identified the need for support to be provided to the ministers in order to guide them in handling their allocated work. Significant lessons were also drawn from the pandemic, which the participants felt would help improve the effectiveness of pastoral care in terms of delivery methods and outcomes. A case in point is the use of hybrid technologies to facilitate pastoral services.

Chapter Five: Discussion

This chapter synthesises and discusses the findings from the study in relation to the impact caused by the COVID-19 pandemic and lockdowns. The research questions addressed the concurrent and subsequent implications of the pandemic. Results are considered with respect to the benefits of pastoral care during the pandemic and the future of pastoral care following lessons from the pandemic. Relevant theories and practical implications are presented.

5.1 Pastoral care benefits during COVID-19

The second research question investigated the benefits of pastoral care during the COVID-19 pandemic period. In order to address the question, it was important to identify insights regarding the perceptions on the nature of pastoral care, perceptions on the roles of pastoral practitioners, and the perceived benefits of pastoral care.

5.1.1 Perceptions of the nature of pastoral care

The first interview finding was that pastoral care was regarded from a religious perspective whereby ministers of religion assumed the role of practitioners and attended to the psychospiritual needs of congregations. Furthermore, pastoral care services to the surrounding community were noted to be primarily administered by ministers. The results implied that the church had taken the central role in committing to offering pastoral support to its members and the entire population. The view suggests that the practices and values of the church align with the principles of pastoral care, which include advice, counselling, consoling, and other forms of care. The finding is consistent with that of Del Castillo et al.

(2020), who showed that the church in the Philippines provided pastoral care to the congregation, homes, and healthcare facilities during the pandemic. The result was also similar to that reported by Egargo and Kahambing (2021) and Afolaranmi (2020b), who noted that the church's role in pastoral care provision during the pandemic was a practical guidance and counselling tool that enhanced optimism among individuals. In that respect, the participants' perception in this research may have been attributed to proximity to church-based pastoral care during the pandemic. From a theoretical perspective, the perception of pastoral care as accustomed to the church fulfils the claims of the role theory (Kelle, 2019). The fact that the church is associated with pastoral and admonishing activities has automatically led people to believe that church ministers are pastoral care practitioners.

Moreover, the church ministers have welcomed the role expected to lead in pastoral care provision, especially during difficult times like the pandemic. The interview results identified that church-organised ministry teams accomplished the role of pastoral care to the community, refugees, young adults, and different groups. The result suggests that pastoral care requires coordination to ensure that those who need pastoral care and those who provide the care are connected effectively and efficiently. The implication is that the social structure permits this type of service to be rendered by religious leaders. Pastoral care services are primarily associated with the need to enhance the spiritual and emotional well-being of individuals and are more associated with the activities carried out by ministers.

However, inconsistent views were offered by de Diego-Cordero et al. (2022), showing that pastoral care is perceived as a more general term and encompasses all activities to improve the psychological well-being of patients and the general community. The observations imply that pastoral care may be more related to counselling services that support the recovery of individuals from emotional turmoil. Coordination and role setting are crucial aspects of pastoral care, and they enhance social interactions in the community. The observations can be explained by the role theory, which is described by Lit et al. (2021) as considering that the actions of individuals are dictated by the role they play in society. Their social interactions influence the role played by pastoral care givers; hence, the knowledge of social context is a crucial requirement in defining human patterns as set out in the role theory in relation to the considerations of Kelle (2019). In other words, the expectations about the role of pastoral practitioners are shaped by their social interactions. The role theory could also be taken in the current context to mean that the role of individuals influences their duties, rights, and behaviours. Thus, the role played by pastoral care providers is influenced by their assigned roles and responsibilities in the communities, which in turn influences the outcomes of pastoral care.

The other study finding noted that pastoral care entailed supporting various initiatives and development projects for individuals and the community. The result implies that pastoral care is a holistic means of attending to people that covers spiritual inspiration for psychological peace and pursuing life ambitions and objectives. In the context of COVID-19, pastoral care programs involved creating initiatives to address individuals' spiritual and mental health needs to alleviate their anxiety and fear related to social exclusion,

high infection, and increasing mortality rates. Evidence showed that the practitioners engaged in fundraising, building work, and applying for grants. Therefore, it is a matter of positive mental health and the community's growth. The obtained finding also reflects the submission by Ariffin et al. (2022), who established a connection between pastoral support and self-efficacy.

Further, Wells et al. (2021) and Best et al. (2022) denoted that there is a sense in which pastoral care is linked to social support. Although the literature was only focused on psychotherapy, the current findings have provided the additional understanding that social support includes facilitating general welfare initiatives among the people. From the theoretical angle, the observation can be explained using the relational frame theory (RFT), in which behaviour change is related to perceived stimuli (Ahlqvist and Uotila, 2020). Specifically, in this case, the pastoral practitioners could discern the atmosphere brought about by the pandemic concerning the increase in those needing help and support. Consequently, beyond providing the normal counselling care model, pastoral practitioners also responded to the people's financial, health and social needs. The finding indicates that pastoral care involved a broad range of activities during the pandemic. In this regard, pastoral care enhances the community's general well-being and is not necessarily limited to strengthening and facilitating the emotional recovery of sick individuals. It covers the need for activities to improve an individual's overall quality of life to enhance positive health outcomes. Moreover, the observation that pastoral care entails supporting various initiatives and development projects for individuals and communities could be observed sociologically, which examines how communities, individuals and

institutions collaborate in addressing social issues, as enumerated by Wampold (2019). The view implies that pastoral practitioners facilitate the emotional recovery of individuals to enhance personal well-being.

5.1.2 Perceptions of roles of pastoral practitioners

During the pandemic, the practitioners interviewed revealed that pastoral care revolved around watching over the welfare of the congregations depending on the specific area of assignment or jurisdiction. The focus was to ensure the positive mental well-being of the recipients as the sorrow of COVID-19 spread. Pastoral practitioners planned their work during the pandemic to try to reach out to everyone under their care. Therefore, since people could not meet physically as in the pre-COVID era, more effort was required to ensure the effectiveness of the pastoral process. The results implied that pastoral care practitioners had the role of consoling those who were bereaved and encouraging those affected by the pandemic to be emotionally and spiritually healthy during the challenging COVID-19 period. The finding is consistent with that of Rosales (2020) and Rosales (2021), who acknowledged that the role of the Catholic Church during the pandemic was exhibited in providing pastoral care to the members through virtual events. Furthermore, the findings regarding the role of pastoral caregivers in the congregation echo the submission by Afolaranmi (2020b), who reported that the churches in Nigeria were also accountable for the spiritual soundness of the congregants during the pandemic, which facilitated the use of online platforms for meetings and fellowships.

However, Wampold (2019) reported inconclusive evidence regarding the responsibility of pastoral care practitioners to non-churchgoers during the pandemic. Nevertheless, from a theoretical perspective, the finding aligns with role theory in which church ministers guide congregants to offer pastoral support as well as play leadership roles (Wampold, 2019). Hence, pastoral practitioners provide social support, promote social support networks as well as maintain the well-being of individuals.

In regard to the theoretical concepts, the result can be explained from the relational frame theory (RFT), which considers that individuals change their behaviour in relation to the prevailing stimuli, as explained by Abbot (2020). Pastoral practitioners ensure that the individual actions of pastoral care receivers are shaped by activities presented to them. During the pandemic, pastoral practitioners were responsible for enhancing the provision of pastoral care and improving the ability of pastoral care receivers to cope with the prevailing circumstances and the challenges posed by the pandemic.

The second finding indicated that the pastoral practitioners were responsible for organising meetings and coordinating the activities of their teams. While this suggests that there were different levels of pastoral care during the pandemic, the weakness is that the revelation is limited to the church context. Nonetheless, pastoral practitioners organised elders into groups and assigned them pastoral care responsibilities. The arguments are reinforced by Afolaranmi (2020b), Rosales (2020) and Rosales (2021), who observed that applying the devolved strategy promoted pastoral care support to all congregational members. Pastoral care practitioners had the role of facilitating pastoral

care programs by seeking funds and acquiring the equipment needed to improve the online delivery of pastoral service. The ability to give and receive reports helped organise solutions to problems arising, leading to improved quality and effectiveness of pastoral care during COVID-19. The finding is consistent with Johnston et al. (2022), who noted that ministers reported increased demand for pastoral care among their congregation despite the lockdowns and other COVID-19 restrictions. The strategy meant a need for more pastoral practitioners, thereby the justification for the devolved and delegation model practice revealed in this study. The actions of pastoral practitioners were in response to the increasing demands as the pandemic continued to unfold. The outcome is presented by Egargo and Kahambing (2021), who indicated that religious-based pastoral care during the pandemic saved many from suicidal thoughts and attempts. The pastoral practitioners in this context were responsible for the continuous response of the church to provide fellowship meetings and counselling sessions online and via telephone. The described role still falls under the premises of role theory since, as spiritual guides, the pastoral practitioners were expected to play the lead role in the entire care program (Barnes-Holmes et al., 2020).

The terror management theory comes into play since the underlying duty of pastoral practitioners is to prevent excessive negative thoughts associated with the events of the pandemic, thus increasing the motivation of the recipients (Wolfe and Tubi, 2019). Based on the current findings, the context of their professional duties widely influenced the testimony of the participants.

Yet, the views gathered from the findings on the part of pastoral practitioners differ from those given by Del Castillo (2021). The restrictions brought about by COVID-19 limited the availability of pastoral care, which seemed to suggest that the responsibilities undertaken by pastoral practitioners were impeded during the period, as can be observed from the closure of churches and the limitations of social gatherings and physical meetings. Despite the inconsistent evidence, it is generally accepted that the avenues available, such as virtual meetings, were utilised by pastoral practitioners to provide emotional well-being to the community in general and patients in particular.

5.1.3 Benefits of Pastoral Care During COVID-19

A significant benefit of pastoral care provision during COVID-19 was the possibility of more extensive outreach. The receivers' availability for pastoral care sessions was greatly enhanced since the majority of recipients were at home and had access to telephone or internet services. In that respect, the implication is that during the pandemic, many interruptions, such as work and other commitments, were reduced, facilitating the availability of people for pastoral care. These findings are reinforced by Heidari et al. (2020) and Chan et al. (2022), who reported that recipients of pastoral care accessed pastoral support through online platforms during the pandemic. The mode of communication, which was online, ensured that people could meet without necessarily travelling. The attendance of pastoral care sessions was no longer limited to physical spaces, unlike in the pre-COVID era, and internet access was the only limiting factor.

Additionally, according to the interviewed practitioners, many pastoral phone calls were made during the pandemic, and these calls were successful because there was a certainty that the receivers were at home. In this regard, pastoral care aligns with the sociological concept that places significance on interaction and communication. The sociology aspect of pastoral care can be explained using the relational frame theory (RFT), which emphasises that human behaviour is closely linked with interactions with one another (Ahlqvist and Uotila, 2020). Moreover, the obtained result is consistent with Carey et al. (2020), who affirmed the significance of online pastoral care services during the pandemic. Hence, pastoral care entails finding ways of promoting relational values in society, such as compassion and empathy, to ensure cohesion and resilience in overcoming different challenges that emerge.

Even so, Drummond and Carey (2020) noted that the virtual experience was unusual for clients and care practitioners, especially in the first stages of the initial lockdown, thus contradicting the above assertions. The interviews revealed that some recipients and practitioners struggled to adjust to the virtual environment; hence, it took time to adopt new methods of pastoral care. Nonetheless, the pandemic led to the rapid reception of virtual pastoral care for many receivers. From a sociological approach, Wampold (2019) reported that social connectivity affects pastoral care outcomes, indicating that external factors influence social interactions. From a theoretical aspect, the observation can be explained by the relational frame theory (RFT), which considers that social interactions can have an influence on behavioural change, as discussed by Barnes-Holmes et al.

(2020). The explanation suggests that the effectiveness of pastoral care during the pandemic was altered by limitations in social interactions.

In spite of that, the behavioural change observed in the adoption of technology in enhancing social interactions can be considered to have facilitated pastoral care outcomes. The findings are corroborated by Abbot (2020), who reported that understanding social interactions by individuals and the changes brought about by social changes influences the ability of individuals to adapt to changes and effectively improve social interactions. The effectiveness of pastoral care during the pandemic can be considered from the RFT, which means that outcomes in pastoral care were dependent on the ability of pastoral care practitioners to enhance interactions with pastoral care receivers.

The findings indicate that offering pastoral care during the pandemic gave the receivers a sense of care and concern for one another. For the smaller churches, those living nearby could check on one another within the safety guidelines, whereas the larger churches mainly relied on online connections. The events of the pandemic produced, within the people, values of compassion and empathy in that everyone contributed to the pastoral support of one another. Therefore, the current study findings showed that pastoral care during the pandemic enhanced self-reflection among individuals on how they could support each other. The result pointed to improved unity within communities during the pandemic. The result aligns with the work of Tang et al. (2022), who established that pastoral care came from colleagues during the pandemic, provided there

was a communication channel. The observation is consistent with Sahay and Wei (2022), who acknowledged the effectiveness of interpersonal pastoral care on a peer-to-peer level. The responses of the interview participants confirm that during the pandemic, pastoral care provision was not limited to trained practitioners. Instead, the receivers were in a position to provide peer-to-peer encouragement and support, supplementing the efforts of the pastoral care practitioners. Thus, pastoral care receivers were mainly impacted positively by pastoral care during the pandemic. The view suggests that the receivers quickly adjusted since pastoral care was crucial to their survival during the pandemic.

Anyhow, Palma et al. (2021) argued that telehealth pastoral care provided during the pandemic did not meet the expected outcomes among pastoral care receivers. Most patients and those in emotional breakdowns indicated feeling lonely and abandoned, pointing to the ineffectiveness of the available platforms in offering holistic pastoral care. Therefore, the pandemic negatively affected pastoral care reception, limiting healthcare outcomes. It must be noted, nevertheless, that sociologically, pastoral care provided social support to individuals during the period of the pandemic (Drummond and Carey, 2020). This observation is significant because sociology recognises the social support networks that have a contribution to the well-being of individuals (Wolfe and Tubi 2019).

Moreover, from the theoretical viewpoint, the findings can be understood from the crisis management model that has been explained by Levers et al. (2022) as applicable in offering support to communities to enhance social support and improve the outcomes of

pastoral care. Thus, the management of crises should take into consideration the need for social support by individuals during COVID-19 without dependence on physical pastoral care provision. Furthermore, pastoral care providers should enhance the ability of pastoral care receivers to improve self-reflection among individuals to increase care outcomes.

The other result was that pastoral care during the pandemic increased technology literacy among pastoral care receivers. Before the pandemic, there had been little concern about using communication technology on a large scale to receive pastoral support; hence, few people cared to learn how the applications worked. However, the Internet and virtual communication software became necessary during the pandemic, and more people learnt how to connect to pastoral care sessions in rural and urban areas. The unprecedented challenges of the pandemic gave rise to individuals who were more technologically literate and better equipped. The finding reflects the positions of Finiki and Maclean (2020) and Drummond and Carey (2020), who reported that applications such as Zoom, Facetime, Webex and Skype were used for pastoral care sessions; hence, the receivers had to be conversant with the respective operations.

Further, the finding is consistent with Vandenhoeck et al. (2021), who noted that digital technologies were applied for pastoral care during the pandemic, hence the necessity for individuals to transform to digital communication. Indeed, the pandemic caused psychological issues but, at the same time, promoted the acceptance of virtual communication technologies in society. The aftermath is an increased engagement in

social media post-lockdowns. The pandemic expanded the horizon of pastoral care and introduced a completely new dimension of applying technology in pastoral care provision. Technological literacy was improved, which continues to be relevant following the pandemic restrictions.

5.2 Future of pastoral care following the lessons from COVID-19

The third research question investigated the future of pastoral care following the lessons from the COVID-19 pandemic. The question was addressed by examining themes regarding the strategies to improve pastoral care and findings on the future of pastoral care services during the pandemic.

5.2.1 Strategies to improve the provision of pastoral care

The participants shared the lessons from providing pastoral care during the COVID-19 pandemic, which revealed that the period was full of innovations that profoundly altered the perceptions of pastoral care practitioners. The first finding was the lesson concerning sharing church resources to facilitate pastoral care. In the event of difficulty and scarcity, such as the pandemic, pastoral care should be all-inclusive in that equipment is shared with those in need. Pastoral care requires much support during a crisis as some areas become overstretched and unable to cope. The findings are echoed by Adeli et al. (2020), who stated that resource organisation was limited due to the short notice of the pandemic. This implies that there was a lack of readiness to share critical resources for pastoral care since the pandemic had erupted suddenly. In this regard, pastoral care providers should be readily prepared to join forces for pastoral support during challenging times without

consideration of boundaries. According to de Diego-Cordero et al. (2023), some countries were poorly resourced for the pandemic, which was reflected in low levels of pastoral care provision in the healthcare facilities. The same was observed in the current study, as the use of online pastoral care attracted people from various communities and backgrounds. In this regard, sharing is a part of pastoral care support for the population.

The second lesson learnt by pastoral care practitioners concerned personal health achieved through self-care. The amount of work involved in the pandemic caused pastoral care practitioners to be worried about their mental well-being and stability. The finding indicates that pastoral care practitioners have a double role of looking after the people and self. The two must be balanced for effective pastoral care and support. In this research, the fact that some practitioners learnt the significance of self-care and addressed this through proper planning was a notable achievement. The finding echoes that of Sahay and Wei (2022), who highlighted the peer-to-peer pastoral support among nurses during the pandemic. The result shows that there were increased levels of psychological pressures among the workforce responsible for pastoral care. Thus, interpersonal pastoral support demanded attention. In the current investigation, pastoral care practitioners interpreted this as a significant aspect of self-care.

Furthermore, the centrality of self-care justifies the previous results by Prazeres et al. (2021) and Roshani et al. (2023), who observed that healthcare workers exhibited increased levels of anxiety and fear when administering care during the COVID-19 pandemic. Similarly, pastoral care practitioners had to ascertain how to address these

mental health challenges for personal safety. Consequently, by prioritising their own self-care, the pastoral care personnel could sustain themselves to provide care to the public. In this way, the pandemic highlighted the need to enhance the availability of emotional care to pastoral practitioners in order to reduce their emotional burnout and improve the general quality of health outcomes.

The other lesson provided by the participants was the urgent necessity to create a well-established support plan for pastoral care providers. The trend stemmed from the confusion witnessed at the start of the pandemic when there was no specific guideline for pastoral care providers. The implication is that there is a need for an emergency response plan for the pandemic dedicated specifically to pastoral care. The need for pastoral care has been witnessed to increase in the case of serious predicaments, such as the COVID-19 pandemic, which makes the service a core part of human survival and productivity during times of crisis. The finding reflected that of Pai et al. (2020), who noted that accessing the patients for pastoral care services during the pandemic was challenging since the emphasis was on medical response. Further, Parveen et al. (2021) and Asgari et al. (2022) indicated that nurses showed low competence in delivering pastoral care during the pandemic, which was attributed to a lack of prior training. Due to these challenges, it will be necessary to create a crisis policy that provides clear guidance to practitioners, including early training, support, preparation, and interventions.

The other finding was that pastoral care practitioners adapted by accepting and practising new modes of communication. The pandemic meant the closure of all potential

gatherings, hindering face-to-face care sessions. Therefore, participants reported embracing the telephone and the Internet to deliver pastoral support. Practitioners convinced the people to join in services and sessions online or via phone calls because there were no other alternatives. The finding is consistent with the observation by Carey et al. (2020) and Winiger (2023), who reported an increase in the use of ICT for pastoral care provision during the pandemic. The view demonstrates that pastoral care practitioners faced the changes of the pandemic by adapting to alternative means of connecting to the audience.

In spite of that, not all people welcomed the new developments, especially among the older adult population. Pastoral care practitioners faced challenges in meeting the goals of pastoral care through virtual communication platforms. The view is consistent with the argument of Drummond and Carey (2020) that some clients found exclusive virtual pastoral care uncomfortable. Nevertheless, the findings revealed that pastoral care practitioners were patient and tolerant, accommodated awkward situations and ensured that pastoral care was accessible to all people. Hence, this demonstrates that the majority of practitioners were prepared to tackle obstacles and promote participation in pastoral care sessions.

5.2.2 The Future of Pastoral Care Based on Lessons Learnt During COVID-19

The findings presented the main perspectives for the future of pastoral care practitioners. The trends are in agreement with the experiences and lessons learnt from the pandemic.

The implication is that times of crisis reveal valuable lessons that can help improve or advance care provision. The first result was that future pastoral care provision would feature the wide use of technology for sessions. Online platforms and telephone conversations have become part of the pastoral care community. Hybrid systems would be adopted whereby both physical meetings and online sessions would be used to deliver pastoral care. These findings are corroborated by Finiki and Maclean (2020), Drummond and Carey (2020), and Carey et al. (2020), who reported that the pandemic transformed the mode of pastoral care provision from traditional physical meetings to virtual internet platforms. The majority of people have adapted to the new normal and will be able to benefit from the ubiquity of virtual pastoral care in the future. The finding is also consistent with Afolaranmi (2020b), who acknowledged that online sessions for pastoral care were practical. Online pastoral care is likely to persist due to the specific advantages of convenience and effectiveness in reaching out to many people at once. From a sociological perspective, experiences are effective in the creation of new identities and approaches that have a significant contribution towards the enhancement of social dynamics. Considering the sociological aspects of pastoral care, the results can be explained using the relational frame theory (RFT), which considers that individuals tend to change their behaviour based on their perceived stimuli. Past observations have an effect on the perceptions of stimuli, which influences the adoption of pastoral care practitioners. The finding is consistent with Ahlqvist and Uotila (2020), who explained that the cognition ability of individuals is dependent on the ability to develop relational skills. In the current context, relational skills development can be considered to depend on the ability of individuals to change behaviours.

On the other hand, some participants also predicted a shortage of pastoral care practitioners for future encounters due to possible deaths and withdrawal from ministry because of the pandemic. The COVID-19 pandemic affected practitioners' ability to provide care since they were at the forefront of responding to societal needs. Therefore, there may be a need to recruit more people to fill in the gaps to sustain reasonable work distribution and avoid overloading a few individuals. Vandenhoeck (2021) similarly revealed that in the wake of the pandemic, some chaplains were sent home or assigned other administrative duties, such as policymaking, which interfered with their capacity to deliver pastoral care. The finding reflected the arguments of Galbadage et al. (2020), who showed that pastoral care was deprioritised at the beginning of the pandemic, as illustrated by an increasing trend of downsizing pastoral care practitioner staff. In that respect, the prediction of personnel shortage for future pastoral care provision is justifiable. But, the projections based on this study mean an action plan can be initiated to salvage the situation.

Conversely, some of the participants interviewed were unsure of the future of pastoral care based on the impacts of COVID-19. The pandemic brought about mixed reactions among individuals, blurring vision as some pastoral care practitioners preferred addressing issues as they arose and avoided pre-emption. The finding resembles that of Szilagyi et al. (2022), who suggested that the pandemic negatively affected the self-efficacy of chaplains in hospitals. The view exposed that the chaotic pandemic scene was confusing for some pastoral practitioners, thus leading to the inability to determine what

to expect in the future. Further, Khalesi and Pourmohammad (2022) indicated inadequate knowledge about the COVID-19 disease among pastoral care practitioners. The study helps to explain the reason behind some practitioners' inability to fathom the future of pastoral care despite personal experience during the pandemic. The future of pastoral care practitioners following the COVID-19 pandemic will be revealed over time; hence, the subject invites further exploration. Nevertheless, the findings identify that the future of pastoral caregiving hinges on the ability of pastoral practitioners to adapt to the changing landscape and the ability to cope with emerging challenges to pastoral care provision.

5.3 Summary

Based on the examination of the findings and their comparison against previous literature, insights revealed that pastoral care was essential during the pandemic period where it helped the community cope with the diverse problems they faced. However, lockdowns and social distancing measures affected the delivery of pastoral services. To cope with the new normal, ministers were forced to adopt new technologies, although some were hesitant to use the tools. Receivers of pastoral care were sometimes opposed to the online mode of pastoral care provision during the pandemic. The view meant that there was difficulty encountered in balancing the needs of the practitioners and receivers. Overcoming challenges for pastoral practitioners to address pastoral care needs during the pandemic was crucial. Sociology is closely related to pastoral care as it pertains to social change and social interactions. Thus an important lesson learnt in the pandemic is that the ability to adapt to social changes will be imperative for the future of pastoral care.

Chapter Six: Recommendations and Conclusion

This chapter integrates the study findings and the critical lessons learnt are considered with respect to the relevant theories. The implications and limitations of the research are also presented. Recommendations for theory and practice plus pastoral care improvement strategies are proposed.

6.1 Critical lessons

The findings of this study generated four critical lessons learnt during the pandemic that are essential to enhancing the effectiveness of future pastoral care strategies to limit the negative impacts of pandemics of similar magnitudes on the provision of care. The first lesson was the need to diversify the provision of pastoral care to improve effectiveness and outcomes. The second is the importance of self-care management in improving the effectiveness of care provision. The third highlights the need to support pastoral practitioners. The final lesson points to the essence of continuing technology usage for the future of pastoral care provision.

6.2 Implications of the study findings

The study has nine implications. The first implication is the ability to inform pastoral care practitioners concerning the different challenges that arose from the COVID-19 pandemic. With such information, pastoral practitioners can identify the main strategies to respond to such challenges as experienced by other practitioners. Therefore, the study shows that new skills and knowledge in providing pastoral care to support communities and individuals during and after times of crisis can be developed and enhanced.

Moreover, the perspectives gained from pastoral care practitioners are significant in increasing the theory of pastoral care and expanding the literature on how it can be employed in different contexts. Thus, the study findings are significant in the potential development of new forms of care and support during crises, hence supporting pastoral care practitioners' efforts during such times and enhancing care effectiveness.

Furthermore, the results may additionally facilitate partnership and collaboration among the various care professionals to enhance outcomes on psychological and mental care provision related to care delivery. Such partnerships could improve care outcomes by establishing a system of shared care provision to patients and individuals needing psychological and mental health support. From interdisciplinary collaborations, healthcare practitioners can refer individuals to pastoral care services when necessary, thus recognising the role of spirituality in overall well-being. In this sense, the study findings can enhance the provision of holistic care that addresses spiritual and psychological needs, improving care outcomes.

The study findings may also be crucial for faith-based institutions and communities to support their congregants during times of crisis, similar to the COVID-19 pandemic. The present findings highlight the positive implications on the response of pastoral practitioners to unique circumstances created by the pandemic.

In large, the findings can improve policy creation on the provision of pastoral care in healthcare delivery and likewise influence the change of pre-existing policies, but this does not suggest that all policies must change as a result of the findings of this study. Nonetheless, new policies can positively shape and strengthen psychospiritual health outcomes during novel times, such as the COVID-19 pandemic. With the adoption of appropriate policies, the study can contribute to the development of healthcare provision.

Additionally, the evidence generated by this study can contribute to the literature on the field of research, thus enhancing literature development that future researchers and professionals can use to enrich their research and practice. In this way, the study provides a foundation for further studies to strengthen evidence creation. The study may further be important in setting out the need for training and community outreach to improve focus on pastoral care needs. In this regard, the study will improve the psychospiritual support provision available to distressed individuals by detailing the importance of pastoral care provision. With the justification of pastoral care provision, the study will also enhance support and address mental health well-being, especially in times of turmoil such as the pandemic. Thus, the study will enhance the justifications for psychospiritual care provision and improve knowledge development in this study area.

A culminating implication of the study is that it is a resource to enhance knowledge of pastoral care, including the different pastoral care techniques, which can be employed during a crisis. Thus, it may expand knowledge of the field of pastoral care and improve understanding of the diversity of the profession.

6.3 Strengths and limitations of the study

The methodology utilised in the study provided clear strengths in addressing the research aim and questions. The purposive sampling method enabled thorough scrutiny of participants in accordance with the inclusion criteria, ensuring only the most suitable candidates were selected. As Galvin (2015) posited, limiting the area of focus allows for a more in-depth engagement with the research participants compared to studies conducted on a wider geographic scope. Therefore, by concentrating the research on a specific target population, the research objectives and interview questions could be precisely articulated to the participants, leading to results that are not only relevant but also credible in various contexts throughout the UK. Likewise, employing the phenomenological design ensured that results were based on the lived experiences of practitioners, elevating the quality of the findings. Consequently, the data collected was comprised of detailed individual testimonies rather than organisation-based information. In addition, the use of semi-structured interviews as the data collection instrument allowed participants to express themselves fully, thus achieving in-depth knowledge of the topic.

Limitations were encountered during the course of the study despite the positive observations made. The first limitation relates to the study's restricted scope, which considered the pandemic’s impact on pastoral practitioners but did not analyse the effect on other support services affiliated with pastoral care. The depth and breadth of data obtained may, therefore, not uncover all the aspects of pastoral care during COVID-19. This limitation could be attributed to the lack of association of pastoral care as a sub-

section of healthcare provision, which should be studied alongside other healthcare aspects.

Another limitation concerns the potential for sampling bias that may hinder the representativeness of the population of care practitioners included in the study (Slocum et al., 2022). The research explored pastoral care practice in a general sense but was not able to broaden the field of participants. In particular, participants were drawn from the UK; hence, they might not represent the broader pastoral care population entirely.

The data obtained through interviews may also involve biases associated with self-reported data, limiting the accuracy of observations made (Slocum et al., 2022). A related limitation was the subjective nature of personal experience, making it difficult to ascertain the true impact of the pandemic on pastoral care due to diverse individual beliefs and practices. Consequently, limitations associated with the management of the diverse opinions obtained from the participants involved in the study were taken into consideration.

Additionally, the current study experienced constraints of time and financial resources, which reduced the amount of data that could be collected and analysed within the available period of study. These constraints may have reduced both the quantity and quality of data obtained. Thus, the long-term effects of the pandemic on pastoral care provision may not be fully understood due to the limited period in which the study was carried out.

Furthermore, the study encountered challenges due to the lack of literature related to the research topic, which made it difficult to accurately consider the influence of other external factors, such as public health measures, government regulations and community dynamics. Similarly, there was limited data to attain a pre-COVID baseline from which the observations could be compared. This limitation made it an insurmountable problem to obtain the observations of the trends from which conclusions could be drawn.

It is crucial to underscore that these limitations were identified during the research, and the study took the necessary steps to facilitate rather than adversely affect the investigation's results. Thus, the data obtained can still be regarded as reliable for drawing conclusions. Moreover, the limitations faced in this study can be explored in future studies. For example, the application of diverse samples and mixed methods in data collection can be utilised. Likewise, the data diversity can be increased, improving the generalisability of the study findings.

6.4 Recommendations

6.4.1 Recommendation for theory

Four recommendations for theory have been made to shape pastoral care provision during situations such as those experienced during the COVID-19 pandemic.

One of the recommendations is the need to carry out longitudinal studies that track the impact of COVID-19 over a prolonged period. It will be possible to observe valuable

insights into the long-term effects of pandemics on pastoral care and ascertain adaptive measures that can be adopted. The extended studies may also contribute to the development of evidence-based interventions and policies. Future researchers can conduct a comparative analysis across a broader range of geographical contexts, religions, cultures, and theology to better understand the various aspects of pastoral care.

Secondly, a comparative analysis will also enable the examination of the differences and similarities that can improve the understanding of factors that influence the approach to pastoral care. Future researchers may also consider carrying out analyses into the perceptions of technology integration into pastoral care and the ethical considerations related to applying such digital tools in pastoral care provision. Such studies will be critical in understanding the long-term effects of the pandemic on pastoral care as it relates to the strategies adopted in practice.

Thirdly, future studies could capture interdisciplinary collaboration between various care-provider actors, including mental health professionals, nurses, and pastoral care practitioners. Interdisciplinary studies can be expected to enrich the knowledge available on care's psychological, social, and spiritual dimensions. The studies may be critical in understanding the roles of the various practitioners in the provision of healthcare, including pastoral care. The study recommends the investigation of the differences in response in case of future pandemics of similar magnitudes on the provision of pastoral care. The studies may establish an understanding of more effective ways pastoral

practitioners can react to such situations to minimise any negative influence or adverse mental health outcomes.

Finally, future studies could examine the development of an understanding of the effective ways through which pastoral care influences patient outcomes in various healthcare settings. An understanding of how pastoral care can form part of healthcare may be established. Future studies also need to consider ways through which pastoral care practitioners can enhance their emotional well-being. Such studies will aid in making recommendations for the best care approaches that could develop policies for improving care outcomes.

6.4.2 Recommendation for practice

Five recommendations for practice have also been made to shape pastoral care provision during situations such as those experienced during the COVID-19 pandemic.

Firstly, there is a need for pastoral practitioners to develop the adoption of technology learning in care provision to enhance preparedness and response. Technology confidence can be improved through enhanced training and experience. In this way, virtual platforms can be normalised in pastoral care provision while incorporating telehealth technologies to ensure continued access to pastoral care services. The study further recommends that training and skill development programs should be introduced among pastoral care practitioners to address the unique needs and concerns of individuals that arise from pandemics of the magnitude of COVID-19. Digital literacy

should be enhanced to improve the ability of pastoral care practitioners and receivers to continue with pastoral care services even during times of crisis. Digital literacy among both practitioners and receivers of pastoral care will be critical in enhancing the outcomes in patient care settings.

Secondly, pastoral care practitioners must establish community outreach and education on using virtual technologies to address mental health challenges and offer pastoral support, especially during physical and social interaction restrictions. Such outreach and education can enhance better responses during pandemics to reduce the negative influence on mental health and psychospiritual needs. Educational material can be developed to guide the adoption of such technologies and enhance positive outcomes regarding care provision.

Thirdly, advocacy and social justice are recommended to aid in recognising and addressing social, economic, and systematic inequalities observed during the pandemic, which led to disparities in pastoral care services. Thus, pastoral care practice should form a core aspect of healthcare to improve care outcomes and overall well-being.

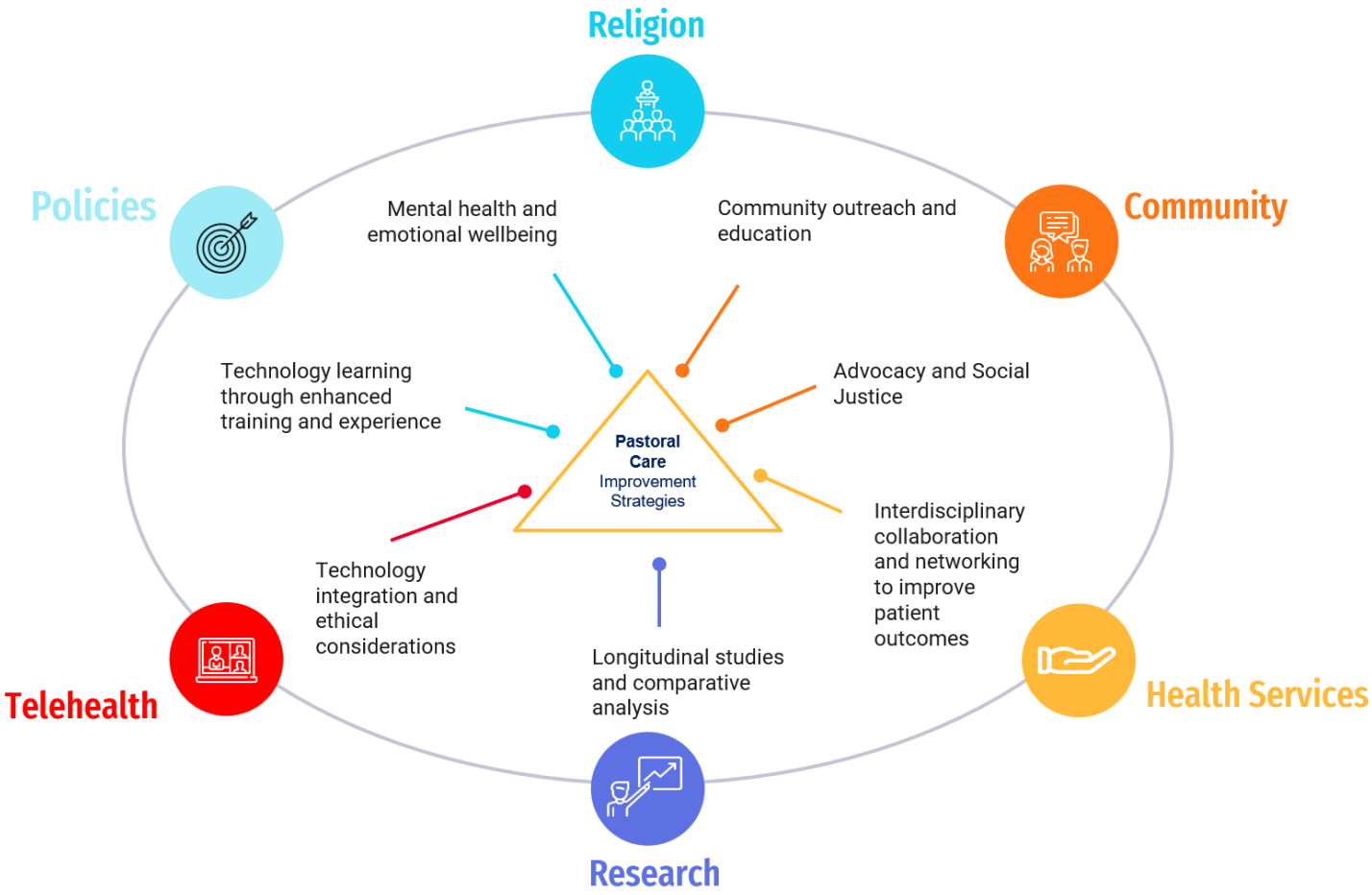
Fourthly, collaborations and networking should be increased among pastoral care practitioners to foster best practices and support mechanisms that can be utilised in times of turmoil. Collaborations and networking should be established by creating local networks, organising virtual conferences, and sharing resources and opportunities to improve the exchange of ideas and experiences. Hence, forming collaborative

partnerships among the various professionals in care settings with pastoral care practitioners will enable healthcare providers to offer comprehensive care in times of need, such as the COVID-19 pandemic.

Finally, it is crucial to recommend the provision of emotional and mental health support among pastoral care practitioners to improve the emotional well-being of those providing pastoral care. Strategies that can be adopted to enhance emotional well-being include providing empathetic listening, appropriate resources, and validation. Adopting such strategies will aid pastoral care practitioners in navigating the challenges and stressors experienced in difficult times, such as the pandemic in the extent and magnitude of COVID-19. Self-care and support strategies must be prioritised to reduce burnout and fatigue among pastoral care practitioners. Such a strategy will ensure that pastoral care practitioners engage in regular self-care activities, access peer support, and prioritise personal well-being to be able to maintain resilience even amid challenging times.

Figure 3 - Pastoral care improvement strategies

The following figure displays a framework that includes and demonstrates the pastoral care improvement strategies which can be implemented during times of crisis and in normal times.



6.6 Contribution of the research to knowledge and concluding remarks

To recapitulate, the study presented in this thesis has extended the evidence base by showing the effect of the COVID-19 pandemic on the practice of pastoral care practitioners. The research addressed the challenges of providing pastoral care during the COVID-19 pandemic, strategies for improving pastoral care provision during times of crisis, and practitioners' perspectives regarding practice adaptations during the pandemic.

The investigation revealed that both religious and non-religious people sought pastoral care via online platforms, showing that the care model reduced barriers to pastoral care access. However, the unprecedented demands on pastoral care practitioners and the attitudes of some care receivers negatively affected the quality of care provided during the pandemic. Moreover, certain demographics and individuals had difficulties using or accessing the technologies to benefit from alternative forms of pastoral care. Therefore, although pastoral care practitioners adapted to the pandemic by adopting technology to interact with care receivers, the lack of support and resources restricted the scope of the care they could provide. Thus, the findings augment the limited evidence showing that the outbreak of COVID-19 adversely affected pastoral care provision due to increased demand for care while restricting physical access to care providers.

These novel and important findings can be added to previous studies that comprehensively analysed the health needs of care receivers. In this regard, the current research extends the contribution of existing literature as it considers the impact that the

pandemic has had on the pastoral care practitioners themselves. The suggested framework can be integrated within the current initiatives to enhance interdisciplinary collaboration between pastoral care practitioners and other healthcare providers, such as nurses and mental health professionals, to ensure efficient and effective support to individuals who request pastoral care. Moreover, the framework can be utilised to develop strategies to improve pastoral care practice by promoting technology adoption and training practitioners to ensure they can better respond to the demand for telehealth services. Additionally, the suggested improvement strategies can contribute to the adoption and normalisation of systematic mental health support for pastoral care practitioners during periods of heightened stress and pandemics. Overall, the framework provides a flexible structure that can be adapted and employed in a way that benefits both pastoral care practitioners and receivers during times of crisis and normality.

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Appendices

Appendix 1 – Qualitative Semi-structured Interview Questions

Questions to gain insights into what pastoral care entails and its importance.

- Can you please explain what pastoral care entails, and why do you think that pastoral care is important?
- Do you think that pastoral care should only be considered within the context of religion? Why or why not?
- Who do you provide your services to?

Questions to provide an understanding of the impact of the pandemic on pastoral care.

- How did the pandemic impact your work? Did you encounter new challenges?
- How did the pandemic impact those who receive your services?

Questions to provide insights into how practitioners adapted to the pandemic era.

- How did you adapt to the changes that occurred during the pandemic?
- Were there any barriers that hindered effective adaptation?
    a) Internal factors
    b) External factors

Questions to generate recommendations for long-term adaptation strategies.

- What was the most valuable lesson that you learned during this time?
- What does the future hold for pastoral care practitioners?

Appendix 2 – Interview Invitation Email

Dear Invitee,

My name is Jacob Bali. I am a United Reformed Church minister and a doctoral student at the University of West London. I am emailing you to kindly invite you to participate in an interview as part of a doctoral research study that I am conducting titled: **The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK**

The intention of the study is to gain perspectives from pastoral caregivers in the United Kingdom on how their practice has been impacted by the COVID-19 pandemic.

Participation is completely voluntary, and you may withdraw from the study at any time if you wish. The study is completely anonymous and your identity information will not be disclosed within the study.

If you would like to participate in this study, please read the Information sheet attached, then sign and return the Consent Form via email by 1st March 2023.

If you have any questions, please do not hesitate to contact me by responding to this email.

Thank you for your time.

Kind regards,

Rev. Jacob Bali

Appendix 3 – Participant Consent Form

Project Title: The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK

• I have fully read the previous page which contained information about the study and have had the opportunity to ask any questions that I may have had.

• I understand what is being proposed.

• I understand that my personal involvement and my particular data from this study will remain strictly confidential. Only researchers involved in the investigation will have access.

• I have been informed about what the data collected in this investigation will be used for, to whom it may be disclosed, and how long it will be retained.

• I understand that the data resulting from my participation may be used for purposes of publications and/or presentations, and that no personal identifying information will be used for these purposes.

• I hereby fully and freely consent to participate in the study which has been fully explained to me.

• I understand that I am free to withdraw from the study at any time until the researcher's dissertation is submitted, without giving a reason for withdrawing.

• I agree to take part in the study.

Signed_____ Date_____

Appendix 4 – Information About this Study

Title: The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK

We would like to invite you to participate in an investigation. In order to help you to understand what the investigation is about, we are providing you with the following information. **Be sure you understand it before you formally agree to participate**. If you would like any clarifications before you start, please contact us using the details below.

What is the purpose of this study?

The purpose of this study is to gather information from Pastoral Caregivers about their personal experience of pastoral care during the COVID-19 pandemic.

Why have I been asked to take part?

You have been invited to participate in this study as a Minister who is currently employed in the United Kingdom.

Why am I being included?

You are being included because you are aged 25 years and above and are healthy mentally and physically.

If you have medical, psychosocial or emotional problems please do not participate in this study.

Do I have to take part?

It is up to you to decide. If you would like to take part, we will then ask you to sign a consent form before participating. You are free to withdraw at any time, without giving a reason.

What will happen if I take part?

If you decide to take part, you will be asked to sign a consent form and take part in an approximately 30-minute interview, which will be audio recorded.

The data resulting from your participation may be used for purposes of publications and/or presentations, but no personal identifying information will be used for these purposes.

What do I get for taking part?

The main benefit will be educational. As the impact of COVID-19 upon pastoral care has not been studied in depth in the UK, this pioneering experience and evaluation may contribute to the better practice of pastoral care in the future. Furthermore, this study may encourage pastoral caregivers and healthcare professionals to have greater consideration of the extent and limitations of the role and influence of pastoral care.

There are no risks associated with this study, however, if you feel like discussing the research further you can contact the principal researcher or the supervisor. If you feel upset about any issues discussed during the interview, you can contact the counselling service as provided in the Debrief sheet.

What will happen if I begin the study but then no longer wish to take part for any reason?

If you withdraw from the study, all data and information collected from you will be destroyed. Please note that you are free to withdraw for any reason at any time. You also have the right to not answer/skip specific questions if you wish to do so.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Data will only be made available to the research team directly involved in this study. All identifying documents will be destroyed in accordance with the UWL Research Data Management Statement.

You can request to review the interview transcript.

Who has reviewed the study?

Our research has been looked at by an independent group of people, the School Research Ethics Panel to protect your safety, rights, wellbeing and dignity.

Further information and contact details

For general information about this research and/or further information about this study, please contact:

Researcher: Revd. Jacob Bali - 21474836@student.uwl.ac.uk
Supervisor: Prof. Raffaella Margherita Milani - raffaella.milani@uwl.ac.uk
Supervisor: Prof. Anne Manyande - anne.manyande2@uwl.ac.uk

Thank you.

Appendix 5 – Research Data Management Statement

As a student undertaking a research project, I understand that I am responsible for the following:

- Not collecting data prior to ethical approval.
- Maintaining accurate records of the methodologies used and the results obtained throughout the research project.
- Ensuring research data is kept in a manner that is compliant with legal obligations, the Research Ethics Code of Practice and the University Data Protection Policy and where applicable the requirements of funding and professional bodies.
- Ensuring backups of data and documents are made and updated at regular intervals during the research project.
- Ensuring anonymisation of research data containing personal information at the point of collection where possible. Where personal data cannot be anonymised, all identifying information must be removed from working files and kept separate in locked filing cabinets/files or secure password protected electronic folders. Working files must not contain identifying information.
- Transcribing all video and/or audio data using codes or pseudonyms for the identification of individuals.
- Ensuring the storage of confidential or personal data, particularly special category research data is treated with care and is made accessible only to authorised persons. Electronic folders containing personal data will be password protected. Electronic folders containing special category data will be encrypted **and** password protected. This relates to information concerning a subject's racial or ethnic origin, political opinions, religious beliefs, trade union activities, physical or mental health, sexual life, or details of criminal offences.
- Ensuring secure physical storage of personal and/or sensitive personal data in lockable cabinets.
- Not re-using data for a different purpose unless separate ethical approval is given.
- Ensuring secure disposal of research data in accordance with legal, ethical, research funder and collaborator requirements.
- Unless otherwise required, disposing of research data after the following periods
    - to be destroyed once marks are ratified by the Assessment Board
    -
    - after 10 years or five years after publication whichever is the greater.

Name: Jacob Bali

Application ID: 21474836

Project title: **The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK**

Appendix 6 – Debrief Sheet

Title of Project: **The Impact of COVID-19 on the Practice of Pastoral Care Practitioners in a Religious Setting in the UK**

Name of Researcher: Jacob Bali

Thank you for taking part in my study to investigate the experience of pastoral caregivers in the United Kingdom. This study aims to explore the role of pastoral caregivers and evaluate how pastoral care has been influenced during the COVID-19 pandemic period.

The data will be analysed to help gain different perspectives regarding how the practice of pastoral care has been impacted by this crisis and any changes that may need to be made.

Please do ask if you have any further questions regarding the study or interview.
Please also let me know if you wish to withdraw from the study at any time.

If you feel like you would like to speak further about any of the topics covered in the questionnaire, please contact:

Researcher: Revd. Jacob Bali - 21474836@student.uwl.ac.uk
Supervisor: Prof. Anne Manyande - anne.manyande2@uwl.ac.uk
Supervisor: Prof. Raffaella Margherita Milani - raffaella.milani@uwl.ac.uk

Or externally, you can seek further advice from the Churches Ministerial Counselling Service (CMCS): www.cmincs.net

Appendix 7 – Table 3 – Analysis of interviews to identify codes

The table details some of the codes identified in the analysis process.

Respondent	Interview response to question: Can you please explain what pastoral care entails, and why do you think that pastoral care is important?	What is taking place?	Who are the identified actors?	What roles do they play?	Where is the activity taking place?	How is the activity taking place?	Possible Codes	Justification for the codes
P1	"Basically, I have pastoral oversight of 11 churches by myself, so my role is to support churches to discover what their mission is and to help guide them to carry out their mission into their local communities."	Dialogue on the aspects of pastoral care and its importance	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister provides support to churches to discover their mission and guide them to fulfil their ministry within the local communities.	• Oversight • Support • Guide • Conduct • Mission • Local communities	The pastoral work involved the provision of oversight, supporting, and guiding the churches to ensure they achieved their mission.

P2	I offer pastoral care to the local church congregation while also engaging with the community as I do something with refugees and for PRIDE. The city centre church is very inclusive and has a ministry to the university, so I work in a team of ministers to support young adults and different groups.	Dialogue on the aspects of pastoral care and its importance	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister provides support to churches to discover their mission and guide them to fulfil their ministry within the local communities. The minister engages with the community and refugees. Minister works in a team of clergy to support young adults in university	• Offer • Support • Guide • Conduct • Engage • Inclusive • Local communities	The pastoral work involved the provision of oversight, supporting, and guiding the churches to ensure they achieved their mission. The ministers also revealed that the form of care was important to support refugees and university students.
Respondent	**Interview response to question:** **Do you think that pastoral care should only be considered within the context of religion? Why or why not?**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**

P4	It is a yes/no answer, and we will see. Both churches gained new members and a couple students joined us and we have had a few transfers from other churches as people have moved during the pandemic.	Dialogue on whether pastoral care should only be considered within the context of religion.	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister interacts with community and church members to address their problems.	• Importance • Pastoral care • Students' welfare • Community Welfare • Non-church members	The codes elaborate on the benefits of pastoral care beyond the context of religion.
P11	The short answer is yes, but I don't think it should be limited to religion. I was a school chaplain when I was home in Australia and pastoral care was very important for both the students and staff. I found this to be the same in the UK, I am on the board of governors for the local school, and a common topic is about the pastoral care of the students.	Dialogue on whether pastoral care should only be considered within the context of religion.	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister interacts with community and church members to address their problems.	• Pastoral care • Students' welfare • Importance • Staff welfare	The codes elaborate on the benefits of pastoral care beyond the context of religion.
Respondent	**Interview response to question: Who do you provide your services to?**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**

P11	I am on the board of governors at the local school, I am on the chaplaincy team at the hospital, and I am a chaplain at the local care home.	Dialogue on who the ministers provide their services to	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environme nt	Minister engages with different members of society	• Board of Governors • Chaplain • Local care home	The codes identify the different stakeholders that the ministers provide services to in the school and surrounding community.
P19	I am a pioneer minister based on a new housing estate in Lincolnshire. Essentially, my service is to the whole community. Our Sunday church services are in the school hall.	Dialogue on who the ministers provide their services to	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environme nt	Minister engages with different members of society	• Minister • Chaplain • Community services	The codes identify the different stakeholders that the ministers provide services to in the school and surrounding community.
Respond ent	**Interview response to question: How did the pandemic impact your work? Did you encounter new challenges?**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**

P16	The pandemic has been extremely challenging. Initially with the first lockdown, there were far fewer women contacting us because of social distancing, and then suddenly, it was like a flood of calls and referrals for our services.	Dialogue on how the pandemic impacted pastoral work and the different challenges encountered	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister spoke about the impact of the pandemic on their work and the challenges they faced	• Social distancing • Fear • Contact • Calls • Referral for services	The codes elaborated on the challenges that the ministers faced due to the pandemic and the impact that was faced.
P20	The most obvious impact was social distancing. All of our services moved online, and we created a WhatsApp group for the church. My chaplaincy work in the hospital was paused for a moment due to lockdown, but I went back once restrictions were lifted.	Dialogue on how the pandemic impacted pastoral work and the different challenges encountered	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Minister spoke about the impact of the pandemic on their work and the challenges they faced	• Social distancing • Fear • Online • Pause • Visits • Contact • Calls • Restriction	The codes elaborated on the challenges that the ministers faced due to the pandemic and the impact that was faced.
Respondent	**Interview response to question: How did the pandemic impact those who receive your services?**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**

P2	When COVID happened, as I said, both churches went online and both churches were really happy to have found a way to worship together and join in Zoom meetings. We were really talking more, and the two churches were able to connect through a virtual space. We were able to do all Bible studies online and meet with families on zoom.	Dialogue on how the pandemic impacted those who received services from the ministers	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister speaks about the impact of the pandemic on the delivery of church services.	• Visits • Contact • Calls • Restriction	Codes describe the impact of the pandemic on the delivery of church services.
P8	So, I only know a little bit about the day-to-day life of the churches but from what I hear from the elders their gut reaction is that people are staying in close contact through social media and have maintained their habit of going to church online and had other things to do. Numbers of churches are starting to reopen.	Dialogue on how the pandemic impacted those who received services from the ministers	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister speaks about the impact of the pandemic on the delivery of church services.	• Social media • Online church • Reopen church • Close church	Codes describe the impact of the pandemic on the delivery of church services.

Respondent	Interview response to question: How did you adapt to the changes that occurred during the pandemic?	What is taking place?	Who are the identified actors?	What roles do they play?	Where is the activity taking place?	How is the activity taking place?	Possible Codes	Justification for the codes
P11	In some ways, I didn't. I still call and email people, but we adapted socially distanced services in the chapel. Well, yes, the main difference has been socially distancing.	Dialogue on how the ministers adapted to the changes that occurred during the pandemic	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister spoke about how they adapted to the changes that occurred during the pandemic.	• Email • Calls • Social distancing	Codes describe how the ministers adapted to the changes that occurred during the pandemic.
P16	We have had to expand our team of staff and volunteers due to the sheer number of phone calls we receive. We have also started placing posters on bus stops and lampposts with tear-away phone numbers for women to take. We still work from the safe-house, and we have seen a	Dialogue on how the ministers adapted to the changes that occurred during the pandemic	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister spoke about how they adapted to the changes that occurred during the pandemic.	• Email • Volunteers • Posters • Calls • Social distancing • Safe house	Codes describe how the ministers adapted to the changes that occurred during the pandemic.

	steady increase in women coming to the building.							
Respondent	**Interview response to question: Were there any barriers that hindered effective adaptation? a) Internal factors b) External factors**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**
P12	Not really. I think the greatest barrier for me has been shutting off from work mode. When everything is at your fingertips it is hard to unwind. Although I work in a team, I am single and live with a flat mate, so there is nobody telling me to take a break.	Dialogue on the barriers that hindered effective adaptation both internally and externally	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister spoke about the barriers that hindered effective adaptation both internally and externally.	• Shutting off • Unwind • Take a break • Overworking	Codes described the barriers that hindered effective adaptation both internally and externally.
P19	Yes, I have been struggling to get across who I am and what I am here to do. So much of pastoral care is based on relationship and although I have been able to make a few meaningful connections, the majority of my pastoral care has been cursory.	Dialogue on the barriers that hindered effective adaptation both internally and externally	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	The minister spoke about the barriers that hindered effective adaptation both internally and externally.	• Struggle • Connection • Relationships • Overworking	Codes described the barriers that hindered effective adaptation both internally and externally.

Respondent	Interview response to question: What was the most valuable lesson that you learned during this time?	What is taking place?	Who are the identified actors?	What roles do they play?	Where is the activity taking place?	How is the activity taking place?	Possible Codes	Justification for the codes
P2	The thing that I've learned is that we we really need to try to use all all means to connect with one another. So even if, you know, we can't meet, perhaps it is good to to keep on phoning people and because uhm, yeah, it's that that basic trust, so if people don't trust you then pastoral care won't work and all you need is people to trust you a little bit and then they are willing to talk with you.	Dialogue on the most valuable lesson that the ministers learned during this pandemic time	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Ministers spoke about the most valuable lesson that the ministers learned during this pandemic time.	• Connection • Calls • Trust • All means	Codes identified the most valuable lessons that the ministers learned during this pandemic time.

P17	I think I am adding this that there should have been more support for pastoral caregivers, for example there should have been clear guidance on in person pastoral care meetings as it takes away the responsibility for me. I also wonder if we need maybe like a self-help group for pastoral caregivers something more where we were able to stop and yeah owning that we are all learning, we are learning.	Dialogue on the most valuable lesson that you learned during this pandemic time	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Ministers spoke about the most valuable lesson that the ministers learned during this pandemic time.	• Moral support • Guidance • Meetings • Self-help groups	Codes identified the most valuable lessons that the ministers learned during this pandemic time.
Respondent	**Interview response to question: What does the future hold for pastoral care practitioners?**	**What is taking place?**	**Who are the identified actors?**	**What roles do they play?**	**Where is the activity taking place?**	**How is the activity taking place?**	**Possible Codes**	**Justification for the codes**
P5	In some respects, it will go back to what it was like and pastoral care visiting people, but I want to set up a team of pastoral groups and visitors so it's not all on the shoulders of one person.	Dialogue on what the future holds for pastoral care practitioners	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Ministers spoke about what the future holds for pastoral care practitioners.	• Pastoral groups • Visiting • Teamwork	Codes describe what the future holds for pastoral care practitioners.

P2	Pastoral care needs to reform. The pandemic revealed that the traditional support structures that we once depended on were already hanging by a thread, and we were not prepared for the challenges the pandemic brought.	Dialogue on what the future holds for pastoral care practitioners	Ordained Minister of Religion	Minister was involved in delivering pastoral care in the UK	The setting is within a church environment	Ministers spoke about what the future holds for pastoral care practitioners.	• Reforms • Visiting • Support structures	Codes describe what the future holds for pastoral care practitioners.