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Education for professional chaplaincy in the US: mapping current practice in Clinical Pastoral Education (CPE)

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ABSTRACT

In light of questions that have been raised about education for professional healthcare chaplaincy, we examined the skills and knowledge Clinical Pastoral Educators believe students need to perform the essential tasks and responsibilities of a chaplain. At 19 recently re-accredited ACPE centers across the country, we asked educators about the knowledge chaplains need to be effective, the specific content areas they teach, and how didactic education is planned and organized within their programs. Beyond a focus on religious diversity, we found little consensus among educators regarding a core knowledge base that should be taught during CPE. While most respondents in our study recognize the importance of didactic education in preparing students to become chaplains, there is a lack of consistency in didactic curricula across programs. Our findings suggest the need for broader conversation and collaboration among educators, national chaplaincy organizations, and theological schools regarding the goals, priorities, and outcomes of CPE.

KEYWORDS

Chaplaincy education; CPE

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Linda Wilkerson, CPE Educator

Over the past decade, a number of scholars and leading practitioners have expressed concerns regarding how people who wish to become professional chaplains are educated (Cadge, 2012; Fitchett, Tartaglia, Massey, Jackson-Jordon, & Derrickson, 2015; Massey, 2014; Ragsdale, 2018; Tartaglia, 2015). Many of these concerns focus on healthcare settings where chaplains must navigate complex institutional dynamics as they work to meet the religious and spiritual needs of diverse patient populations. They also raise questions regarding the types of skills and knowledge that are required to be an effective

healthcare chaplain. How do people who want to enter this profession develop those skills and knowledge? Unlike other health professions, healthcare chaplaincy does not have a professional body that specifies a curriculum that must be offered or completed in order to sit for a licensing exam or other certification process. Rather, the educational requirements for board certification of the major professional chaplaincy organizations in the U.S. specify a master's degree in theology or pastoral care plus four units of Clinical Pastoral Education (CPE), a methodology for training people in spiritual care.¹

While consistency in clinical practice is an educational goal within a number of healthcare disciplines (Massey, 2014), people preparing for careers in healthcare chaplaincy encounter a mix of organizations as they complete education and certification requirements. In addition to receiving graduate theological education, students complete four units of CPE, but there are few specifications for what content must be covered in these units.² Assuring new healthcare chaplains have proficiency in a basic set of skills and knowledge rests on the board certification requirements and processes of a different set of organizations. Because the organization that accredits CPE centers, ACPE: The Standard for Spiritual Care and Education, is separate from the organizations that oversee chaplaincy certification, there are inconsistencies in the extent to which chaplaincy education programs are shaped by or have any engagement with the certification requirements. A 2015 survey of 28 educators from 26 CPE centers found that only 38% include substantive engagement with certification requirements in their residency programs; 23% report no engagement with or reference to the certification requirements in their educational programs (Fitchett et al., 2015). This lack of coordination and communication between different educational institutions and professional organizations that prepare people for chaplaincy careers has resulted in organizational gaps that make it difficult to know and evaluate what people are being taught across CPE programs.

In this study, we take up a question that has been posed to chaplain educators in the past, but not widely discussed (Little, 2010): Is CPE teaching people the substantive knowledge and skills they need to be competent chaplains? Traditionally, CPE has emphasized developing self-awareness and interpersonal skill through an action-reflection approach to education (Little, 2010). Several observers note this emphasis continues with little evidence of any efforts to revise chaplain education to focus on spiritual care that improves patient outcomes (Massey, 2014; Ragsdale, 2018). This tradition has meant less emphasis on specific bodies of knowledge that residents may need to be successful chaplains; that is, less emphasis on what is known in CPE as didactic education. N. Keith Little (2010) has observed that while the action/reflection method is excellent for understanding chaplaincy interactions, it does not facilitate the development of a "propositional knowledge" base related to facts, ideas, and theories. Without this base of foundational knowledge residents may leave CPE programs insufficiently prepared for the challenges they face in clinical settings such as how to meet the needs of diverse religious and non-religion populations (Cadge, 2012; Ragsdale, 2018), navigate changing health care systems (Massey, 2014), or address common ethical issues. Judy Ragsdale (2018), for example, argues that CPE's focus on personal integration needs to be changed to reflect current empirical research on how patients and families are

using religion/spirituality in their health care experiences, while Kevin Massey (2014) points out that CPE has not kept pace with the emphasis on patient-centered outcomes in the U.S. healthcare system.

In light of these concerns about whether contemporary chaplaincy education is paying sufficient attention to propositional knowledge, in our study we asked how different educators bring didactic education into their teaching and curriculum development. We also examined a related question about whether there is a normative body of propositional knowledge that people entering healthcare chaplaincy should possess: Is there a core curriculum that should be taught across CPE programs? In her ethnographic study of chaplains working at “Overlook Hospital,” Wendy Cadge (2012) observed what appeared to be less than effective care for patients and families whose faith tradition was different from the chaplain’s own. Based on this research, Cadge argues that educating chaplains to enhance interfaith spiritual care should be one of the priorities in developing a reformed approach to chaplaincy education (Cadage, 2012). Chaplains need to know enough about different religious traditions, practices, or belief systems to be able to respectfully advocate for patients and families in hospital settings (Cadage, 2012; Ragsdale, 2018). Cadage also identifies research literacy and understanding the healthcare environment in which the chaplain works as other important components for chaplaincy education (Cadage, 2012). In light of these suggestions and other critiques of CPE (Fitchett, Tartaglia, Dodd-McCue, & Murphy, 2012; Massey, 2014; Ragsdale, 2018), our study focused on the extent to which the didactic education in the CPE programs addressed the topics of diversity, ethics, organizational behavior, trauma, and research. In addition to exploring these specific curriculum areas, we asked whether there are common bodies of knowledge people are being taught as they train for careers in chaplaincy, and if greater development and standardization of the didactic curriculum in CPE is needed to prepare students to work in clinical settings (Massey, 2014). This project was complimented by similar interviews with faculty teaching in chaplaincy programs in theological schools (Cadage, Stroud, et al., *in press*).

Methods

The data for this study come from interviews with 19 educators at 19 different ACPE centers across the country.³ We drew these 19 sites from 86 centers that had recently completed the reaccreditation and associated self-study process through the ACPE Accreditation Commission. This approach enabled us to study programs with recently updated curricula. Our purposive sample was created to reflect diversity in geographic locations and CPE settings. It included programs in hospital systems (9), academic medical centers (5), Veterans Affairs (VA) hospitals (1), counseling centers (1), hospices (1), a military medical center (1), and a community-based program (1). Fifteen of the sites included in the study had CPE residency programs and four were sites where CPE is offered without a residency component. At each site in our sample, we interviewed one educator who administers the CPE program. The study was approved by the Institutional Review Board at Brandeis University. All the participants provided informed consent. Participants who are identified in this report also gave consent for this.

All interviews were conducted by a trained qualitative researcher and followed the same semi-structured interview guide. The first section of the interview focused on the educators' personal backgrounds, the history and current demographics of the center where they work, and educator perceptions of the role of healthcare chaplains. The second part of the interview included questions regarding educators' views of the knowledge chaplains need, how didactics are planned and organized within their program, the didactic topics included in the curriculum, views of theological education, and the educators' hopes and concerns for the future of healthcare chaplaincy. Interviews lasted between 1 and 2 h and were audio recorded and professionally transcribed. Our research team analyzed the data inductively following the principles of grounded theory (Strauss & Corbin, 2008) and worked collaboratively using Atlas.ti software to develop a set of analytic codes and ensure that they were applied consistently across interviews. The focus of this paper is the educators' views of the knowledge chaplains need to be effective and the importance of specific didactic topics within the CPE curriculum.

Results

The role of didactics in CPE

In our conversations with educators, we found substantial variation in the emphasis they place on didactics. Some educators argued that the skills and knowledge chaplains need are inseparable while others believe it is more important for chaplains to learn relational skills than master particular areas of content. Although a few participants clearly aligned themselves with one of these two approaches to CPE, most educators expressed the view that learning both relational skills and propositional knowledge was important.

A strong commitment to didactics

Educators with the strongest commitment to didactics believe CPE residents need to be taught a core curriculum that includes specific bodies of knowledge and content. Rather than viewing the development of relational skills and didactic knowledge as competing priorities within CPE, they see them as complementary threads of chaplaincy education. Paul Robertson at Memorial Hermann clearly articulated this standpoint. "I think the skill base and knowledge base are really pretty well intertwined," Robertson explained. "I don't think you can have a skill base without the knowledge base [to] undergird that." He went on to provide examples related to curriculum on listening, grief, family systems, and conflict management, "I think you need to understand the theory of listening. Or understanding how to deal with grief—you have got to understand the theory... You have got to have some understanding of the theory before you really proceed to develop the skill set that is needed."

Linda Wilkerson at Parkland Health and Hospital System shared the view that relational skills and didactic knowledge are intertwined. Referring to herself as a "big proponent of the knowledge base," she explained her goals for CPE:

I want people to come out of Parkland certainly knowing who they are and being able to work out of their authentic selves. But I also want them to be skilled. I want them to know how to do spiritual care with people... I think we have a pretty good mix of learning about oneself, but also coming out of this program with a knowledge and skill base to care for people.

She later reflected on the experience of students beginning their residency, “From the moment they get started, it is just relentless, the needs of people — the psychological and emotional and spiritual needs that people have. You can’t get very far without learning some skills and developing a good knowledge base.”

Roy Myers made similar arguments regarding the need for chaplains to acquire knowledge in particular areas in order to develop skill sets but focused on theology and personality theory. In addition to being anchored in a “really good external theologian,” Myers observed, “I think that a clear understanding of how humans function is important as well ... I’m not so much wedded to a particular school of thought, but I do think that if I don’t understand how people are and how people work, I’m not sure if I can really assess their needs.”

Four educators underscored the knowledge chaplains need to successfully navigate particular healthcare settings, including understanding the different roles, rules, and the chaplain’s place within the larger system. According to Shawn Mai, you need a “working knowledge” of the healthcare setting because “part of integrating into teams [with other healthcare providers] is being able to speak their language.” Robert McGeeney was more specific:

You need to be able to read a medical chart. You need to be able to do medical record documentation in such a way that it doesn’t get you in trouble. You need to be able to do interdisciplinary consultations. [You need to know] how to call somebody or how to respond if they call you.

Misti Johnson-Arce argued chaplain interns must quickly develop a basic understanding of relevant medical terminology. In her hospice CPE program, a doctor comes during the first week of orientation to begin familiarizing residents with pain management, common terminal diagnoses, and the types of medicine that are used for treatment and why. “They technically need to learn very quickly some of the medical terminology,” Johnson-Arce explained. “And what does that mean in a family? And eventually, what’s going to happen to this person? They need to know those things.” Speaking from their experiences across different hospital and hospice-based CPE systems, educators like Mai, McGeeney, and Johnson-Arce believe that learning the norms, policies, vocabularies, and procedures of an institution is just as critical to providing spiritual care as developing relational skills. Focusing on large healthcare institutions, Wilkerson summarized these views when she observed, “Our students have to come out being able to speak to the institutions in a language they understand.”

A weak commitment to didactics

Although less common, a few educators explicitly resisted prioritizing didactic content in their CPE curriculum. Educators with a weak commitment to didactics expressed the belief that relational skills are more important than knowledge. “I resist that pedagogical banking model of outcomes for CPE education, that there is a core curriculum that

should be learned by everybody leaving a unit of CPE or a year residency,” Mark Tabbut explained. Expressing the tension that some educators experience when trying to prioritize both didactics and relational skills, he reflected, “We certainly need to bolster our content and things that we teach chaplains. No argument there, but I don’t want to lose the genius of CPE, which is helping students integrate that personal and professional competency.” Tabbut went on to argue that while you may assign a book on grief or another topic, if residents do not have the skills to integrate that knowledge into their chaplaincy practice, they will not progress with it. He expressed concern that when residents struggle with the “relationship piece” they may want to secure themselves with substantive knowledge rather than working on important interpersonal issues.

Koshin Paley Ellison rejected the term didactics outright. Laughing, he responded, “Well that is very funny because I don’t believe in didactics. I don’t even believe in the word actually because I feel like everything is very relational.” For Ellison, the most important goal is teaching students how to be physically present to others through a focus on meditation training, posture, and practicing how you walk into a room to meet patients. Although he does not embrace the terminology, Ellison explained his teaching focuses on experiential learning and “mini-didactics around essential aspects of spiritual assessment, diversity, or different kinds of illnesses, different kinds of conditions, and spiritual bypassing.”

In some cases, rather than directly challenging the importance of didactics within CPE, educators turned conversations about knowledge and content back to a discussion of relational skills, personal development, self-awareness, deep listening, and narrative. While these educators may agree didactic education is important, they had difficulty talking about the types of knowledge chaplains need or how they include it in their CPE curriculum. When asked about the knowledge base chaplains need, one educator continued to focus on personal knowledge and narrative:

I’m betting on story. How do you understand your story? One of the things I find that effective chaplains do is they understand their story. And what that means is we are steeped in the art of listening... We need to be grounded in narrative... When we enter a room, we’re trying to figure out how to help a person help us help them. That is what we’re trying to figure out. How am I to help you, help me, help you?

When considering educators who expressed a weaker commitment to didactics, the examples of Tabbut and Ellison also illustrated a contradiction. We found that while some educators expressed a weak commitment or even rejection of didactics in the interview this view was not always reflected in their center’s CPE curriculum. At Tabbut’s hospital, for example, their accreditation materials described didactics about spiritual assessment, medical ethics, grief and loss, enneagram, family systems, behavioral sciences, bioethics, and spiritual care research. This contradiction may point to the lack of consensus around didactic content not only across sites, but within them.

A shift in thinking as the profession of chaplaincy develops

In our study, the data did not suggest a common set of factors that led CPE educators to value didactic learning. However, some educators described a broadened focus from the personal formation of individual students to teaching residents how to effectively provide care for patients and staff. As Anke Flohr pursued opportunities for

professional development and gained exposure to new areas of research, she began incorporating a stronger focus on didactic content and research literacy at her CPE center. “I probably started off being more on the counseling side, the self-integration and self-awareness, and I have learned so much throughout the years,” she reflected, “Now I am promoting a different approach of much more evidence-based healthcare approach, and I hope I encourage our students as well so that we are much more, at least research literate.”

Some educators were motivated by the leadership of other chaplains as they reconsidered their approach to CPE. Jo Anne Morris credited Judy Ragsdale’s work as an important influence (See Ragsdale, Hegner, Mueller, & Davies, 2014; Ragsdale, Orme-Rogers, Bush, Stowman, & Seeger, 2016; Ragsdale, Steele-Pierce, Bergeron, & Scrivener, 2012):

I’m going to tell you what has shifted in my thought process quite a bit in the education of students and continues to [do so] ... What helped me articulate this better was working with Judy Ragsdale and reading some of the research that she has done.

Like Flohr, Morris described moving from a more singular emphasis on self-awareness and narrative to a concern for the other areas of knowledge chaplains need in a hospital setting. “I’m going to say it bluntly,” Morris quipped, “I feel like I’m violating the therapist part of me in saying this, but it ain’t all about you ... The reason I’m concerned about you knowing about yourself is because you are the primary resource you have for doing ministry and I don’t want you to get into the way of that.” These comments suggest that for some educators the decision to place a greater emphasis on didactics in CPE may feel like a violation of their own training and professional socialization. For Morris, the question is now: “How do the students utilize themselves as a resource for assessing the spiritual, religious needs of other folks, and find and secure the resources to attend to those needs within the scope of practice within the hospital setting?”

Most important didactic topics

When we asked educators about the most important didactic topics they cover in their curriculum, they generated a long list of topics as evident in Table 1. Despite this diverse range, responses did cluster around several areas. More than a quarter of participants prioritized topics related to death and dying, mental health, and diversity, while just over 20% focused on addiction, conflict, geriatrics, enneagram, ethics, and personality development. Stronger patterns emerged when we asked educators to tell us about particular areas of didactic education.

Specific curriculum areas

In addition to asking educators to talk about the most salient didactic topics within their CPE curriculum, we asked educators about five specific areas that scholars (Cadge, 2012) and others have identified as important to current chaplaincy practice: diversity, ethics, organizational behavior, trauma, and research.

Table 1. Most important didactic topics.

General topic	Specific topics mentioned	Count
Grief, Loss, & Care at End of Life	Grief & Loss, Advance Care Planning & Advance Directives, Death and Dying, Adult and Child Death, Infant and Perinatal Loss, Delivering Bad News	9
Trauma and Abuse	Trauma, Abuse and Sexual Abuse, Crisis, Domestic Violence, and Moral Injury	7
Understanding Illnesses & Illness at Various Life Stages	Specific Illnesses and Conditions, Alzheimer's Disease, Dementia, Elder Care, Geriatrics, Pediatrics	8
Self-Assessment: Personality and Learning Style	Enneagram, Myer-Briggs Type Indicator, Kolb Learning Style Inventory	6
Diversity	Diversity (Religious, Sexual Orientation, Cultural Humility, Intercultural Communication)	5
Ethics	Bioethics, Ethics, Clinical, Professional	5
Mental Health	Mental Health Issues, Depression, Suicide Prevention	5
Addiction	Addiction, Alcoholism, Chemical Dependency, Opioids	4
Conflict	Conflict Management and De-escalation	4
Family Systems Theory	Family Systems Theory, Marriage and Family Therapy	4
Personality Development	Personality Theory and Development	4
Hospital Chaplaincy	Hospital Chaplaincy, Staff Care, APC Competencies	4
Group Dynamics	Group Theory, Group Dynamics	3
Listening	Listening, Reflective listening, Teach Egan's <i>Skilled Helper</i>	3
Knowledge about Healthcare		2
Leadership Skills	Leadership Skills	2
Neuroscience	Neuroscience, Emotional Regulation	2
Social Issues	Social Determinants of Health, Systemic Injustices	2
Spiritual Assessment	Spiritual Assessment and Spiritual Bypassing	2
Research	Research	1

Diversity

We found a focus on caring for diverse populations is part of most CPE programs in both formal and informal ways (see [Table 2](#)). Depending on the center this could include religious diversity (including care for those without traditional religious affiliations), racial/ethnic diversity, and diversity in sexual orientation and gender identity. While educators addressed multiple forms of diversity, they emphasized religious diversity most frequently. Educators provided specific examples of the books they include in their curriculum and usually adopted one of three approaches to teaching about diversity. The most common approach, taken by nine educators, was teaching about particular religious traditions. In this model, guest speakers, often staff members or community religious leaders, were invited to share their religious traditions with residents. “I think one of the things that we recognize is that we can’t teach people everything there is to know about every patient’s background and faith,” Emily Viverette said. “... What we hope we’re teaching students is how to learn what they need to learn moving forward.” Recognizing these limitations, Viverette invites a Catholic priest, a Jewish rabbi, and a Muslim imam to talk about spiritual care with different populations. She also asks a local African American clergy person to come and discuss ministry and bereavement with African American families, and facilitates conversations about ministry with immigrant populations.

Five educators took a different approach to incorporating diversity into formal curriculum by emphasizing cultural competence and one combined the two. (One educator had sessions on cultural competence as well as specific religious traditions.) Instead of focusing on particular religious traditions or sub-groups, these educators emphasized

Table 2. Curricula for specific topics.

Curricula on diversity	Count
Teach principals of diversity theory, focus on different types of diversity (race, religion, sexuality, gender, gender identity)	13
Teaching about diverse religious traditions (e.g., invited speakers)	10
Teaching about sexual orientation	5
Students learn from each other, diverse patients, staff and supervisor, hospital setting	7
Develop cultural competence (cultural humility, awareness, recognition, intercultural communication)	6
Assign specific books	3
Include a focus on systemic injustice	2
Curricula on ethics	
Discuss bio-ethics, health care ethics, clinical ethics, medical ethics, or professional ethics	16
Observe ethics consultations or committees	4
Assign books and articles, attend ethics journal club, complete online ethics modules	3
Ethics issues included in verbatims and case studies	2
Participate in mock ethics committee	2
Teach intensive medical ethics curriculum (6 months)	1
Curricula on trauma	
Teach trauma related topics (e.g., trauma theory, trauma-informed care, crisis and emotional regulation, crisis ministry, moral injury, PTSD, intervention techniques)	13
Assign trauma-related readings or documentaries (M Epstein, <i>The Trauma of Everyday Life</i> (2014); Resilience: The Biology of Stress and the Science of Hope (documentary, KPJR Films, 2016)	2
Include in verbatims	1
Not included, need to do more, connect to outside resources for further specialization if interested	5
Curricula on research	
Teach research literacy (e.g., expose students to current research in the field, students read and analyze recent journal articles, develop research questions, learn how to do literature reviews, attend journal clubs including APC Webinar Journal Club)	11
Residents complete a research project or teach a research-based didactic	2
Not part of curriculum, need/plan to do more, resistance to research among staff or students	9
Curricula on organizational behavior	
Teach leadership skill (transformational leadership, resilient leadership), organizational behavior, management, administration	7
Include students in administrative consultations, reviews, and multidisciplinary rounds	4
Assign readings on leadership or organizational behavior (JM Kouzes and BZ Posner, <i>The Leadership Challenge</i> (2017), W Bridges and S Bridges, <i>Managing Transitions: Making the Most of Change</i> (2017), B Duggan and J Moyer, <i>Resilient Leadership</i> (2009)	3
Teach systems or systems theory	4
Include in verbatim	1

the importance of cultivating attitudes of cultural humility, awareness, and recognition of how culture may influence interactions between chaplains and patients. This “cultural competence” is not about learning the content of different religions or cultures, but the cultural dynamics and assumptions at work in interactions that take place while providing spiritual care. As Wilkerson explained:

We do a lot around cultural competency... We do learning about cultures and religions that are different from the ones that we're a part of, but we do more learning around what do I need to be aware of? What is happening culturally in this visit? What are the cultural aspects that I need to pay attention to here? We help our staff frequently. As they're working with a patient that they have deemed as very difficult, the chaplain is often the one who is saying, “Hey, pay attention to these things.”

The third approach to teaching about diversity was less formal and more experiential. A number of educators explained that although they include diversity in CPE curriculum, the most meaningful learning about different backgrounds takes place informally among staff or residents in their program. One educator talked about the important influence of students who are agnostic and humanist while another explained that

having students from different denominations is a strength of his program because “they learn it from each other.” Some centers are able to tap into the diversity of their own staff and faculty. “Our department has been a place of welcome for all kinds of diversity,” Tabbut explained. “Whether that is around age or theology or religion or sexual orientation ... We’ve learned over the years that diversity can be in your supervisor. It can be in [your] peer group. It’s certainly with the staff and the patients.” Yuko Uesugi also believes one of the strengths of her CPE program is students’ exposure to diversity on multiple levels: “Diversity of patients, diversity of staff members, diversity in any way you can think of it—in class, social background, faith affiliation, you name it. More than what we do, the uniqueness and strength of [our center] is the critical context that these students are exposed to.”

Educators in diverse urban settings emphasized the experiential learning that takes place as residents work with patients of different nationalities, religious traditions, and racial/ethnic backgrounds. “I would say that sometimes it has been in a more formal way and sometimes it has been more baked in,” explained Mai who works at a center in the Midwest that serves a large Muslim population. Working in a religiously and culturally diverse major metropolitan area in the South, Robertson teaches the principles of diversity theory and tries to lay some foundational knowledge of particular religious groups. At the same time, he recognizes that the curriculum “can’t cover every group” and balances the tension between “How much of that [learning] is curriculum based? How much of that [is] experiential based?”

While the majority of educators in this study drew on one or more of these three approaches to teaching diversity, a few shared how difficult it is work with students whose awareness of people with different backgrounds than their own is extremely limited. Some educators commented that many of their white conservative Protestant male students have had little exposure or training in world religions. “When they come here,” explained Johnson-Arce, “they’re going to encounter people that are not like them, and so they have to know some basics to be respectful and sensitive, and know when to ask, ‘How can I help you with that?’ Not assume that everybody would want what I would want.”

Ethics

Like diversity, teaching about ethics is part of the curriculum at most of the centers. As outlined in [Table 2](#), the majority of educators report discussing bio-ethics, health care ethics, clinical ethics, medical ethics, or professional ethics as part of CPE curriculum. Residents are taught basic ethical principles and theories in healthcare such as non-maleficence, autonomy, and fidelity and have the opportunity to identify potential ethical issues during verbatims. At four of the CPE centers, residents gain more experiential knowledge by observing ethics committees or consultations. Robertson explained that with guidance and mentorship, residents may participate in family meetings or ethics committee meetings with patients. Sometimes students are confronted with ethical dilemmas during residency and come forward to discuss these issues with educators. Kenneth Blank was one of two educators who set up mock ethics committees in his classroom. He asked his students to deliberate as if they were part of the first ethics

committee at the University of Washington in 1962, debating who should have access to a limited number of dialysis machines.

Trauma

At most CPE centers, educators address trauma through curriculum on trauma theory, trauma informed care, or intervention techniques (Table 2). Not surprisingly, the type of CPE center played a significant role in how educators thought about addressing trauma. Roy Myers at the U.S. Army CPE System Center outlined a well-integrated curriculum on trauma, including two courses, Combat and Medical Ministry and Emergency Medical Ministry, which introduce residents to tactics, techniques, and procedures for responding to different types of trauma situations, including witnessing violence firsthand. Working at a hospital in a major metropolitan area with two trauma centers, Robertson explained that trauma seminars are well integrated into the curriculum. Trauma chaplains are dedicated to providing resources to respond to trauma and student orientation includes a focus on triaging, trauma, and teaching residents the basics of crisis ministry. Educators are intentional about debriefing with students after their first weeks in the program and provide ongoing mentorship. “I teach that there are four patients in every room,” shared Robertson. “It has been an old cliché. There is the patient, the sick person, the patient’s family... the staff is often affected and you are going to be affected.”

Three educators said that while they offer a strong curriculum on grief, they would like to deepen their focus on trauma. Although her hospital does not have a trauma center, Carrie Buckner talked about the need to recognize trauma when working with people experiencing mental health or chemical dependency crises. Morris drew attention to the secondary trauma residents may experience as they are exposed to other people’s traumatic situations and expressed the hope that she can be more proactive in addressing this topic earlier in the program. At Parkland, Wilkerson explained chaplains respond to every level one trauma and many level two and three traumas. “I think we probably do a really really good job on grief theory, and a mediocre job on trauma theory,” she reflected, “I think that is an area we could improve.”

Research

A third of educators reported teaching research literacy to students during residency (Table 2). In the most robust examples, students read and analyze recent journal articles, develop their own research questions, and complete literature reviews on relevant topics. Two CPE centers included in this study have research chaplains, and at one of them the residents complete a 20-h research literacy seminar series. At four other centers, residents attend journal clubs, discussing research articles that are relevant to providing spiritual care. Three programs simply incorporate research literacy into other curriculum elements (e.g., verbatims).

When asked about the place of research in CPE curriculum, a number of educators discussed the challenges of teaching research literacy. At four centers, research is not a part of the curriculum. Johnson-Arce described the challenges her program faces in incorporating research because of the demands on her students’ time, “Unfortunately, research has been a weakness here. We don’t have any funding for that and research is

done really on their own time. When the staff chaplains take the class they still have to try to keep up their visits, you know?”

Three educators explained that they do not do much around research, but are planning to do more in the future. “That is our growing edge,” explained Mai. “Pretty much across the board, in our faculty there is not a lot of experience in research.” McGeeney recognized that as research literacy becomes more important to professional chaplaincy, his program will need to do more. “We throw [in] a little bit of research stuff,” he explained, “It’s not my strength so it’s probably one of our weakest areas, but we’ve been trying to have them do some research literacy as we were moving forward... trying to figure out how to put that in, especially since it looks like there will be a [CPE] outcome in the future.” Robertson emphasized, “We’re committed to trying to figure out what to do... I don’t think every chaplain necessarily has to be involved in doing research, but I think we all ought to be drawing upon research for our evidenced based practice.” Three faculty members at his hospital are actively trying to increasing their own research literacy and developing a plan for better incorporating research into the residency program in the future. “We are committed to doing better,” Robertson explained. At other centers, educators have encountered resistance to focusing on research among staff chaplains, and some groups of students.

Organizational behavior

When we asked educators about organizational behavior, fewer curriculum patterns emerged (Table 2). While educators who work in large hospital systems recognized the importance of understanding organizational behavior and administration, how these topics were incorporated into formal curriculum varied widely. Five educators focused on the importance of developing leadership skills among residents, and talked about the specific texts they use such as Kouzes and Posner’s *The Leadership Challenge* and Bridge’s and Bridge’s *Managing Transitions*. Wade Rowatt, for example, teaches a course on transformation leadership, which includes a focus on developing administration skills such as drafting budgets, time management, and handling organizational conflict. McGeeney explained how surveys of their alumni helped educators recognize the need to include leadership training in their curriculum, “Our alumni basically said that almost everybody leaves, becomes the coordinator, director, boss, ends up in leadership, and we’ve provided no leadership training.”

Four educators reported giving residents the opportunity to observe organizational processes at their hospitals first hand. Uesugi requires residents to attend multidisciplinary rounds once a week for each assigned clinical unit, which exposes them to the distinct cultures and hierarchies of different units. When there is student interest, Viverette helps second year residents organize opportunities to shadow a board-certified chaplain at another hospital and talk with them about the administrative aspects of their profession. Wilkerson asks residents to take turns attending the “morning huddle” with the CEO and directors of the hospital as they discuss everything that did not go well the previous day, whether it is a medication error or missing paperwork. This gives them a chance to “see the bigger scope of the organization” and reflects her belief that residents must learn to communicate effectively in the context of a large health care

organization. She worries that current training does not prepare people to be effective chaplaincy managers in the future:

We [need to] prepare [chaplains] to understand and speak the language of the institutions that they're a part of... They go to work in these big institutions and they just don't have, sometimes, the skills. They don't understand how to read a balance sheet. They don't understand how to talk some of the financial language... How do I do a cost benefit analysis? How do I explain to the institution what they're getting for their money? So I think we have a lack of preparation in that area.

Discussion and conclusion

We found diverse views among educators regarding the role of didactic education in CPE programs. Most shared the belief that CPE needs to balance a focus on intra- and interpersonal skills with propositional knowledge, but held different perspectives on what and how this content should be taught. Educators with the strongest commitment to didactic education argue that CPE residents need to be taught a core curriculum focused on specific bodies of knowledge that will enable chaplains to do their jobs effectively. However, even within this group there was no consensus regarding what that curriculum should include beyond a focus on religious diversity. While most educators see the value in teaching about the specific topics we addressed in interviews – diversity, ethics, trauma, research, and organizational behavior – there was considerable variation in how educators understood and approached each curriculum area.

The findings of the study should be interpreted in light of its limitations. These include the small sample size, which limits the ability to generalize these findings across all or most CPE educators. Our interviews inquired about didactic curricula for five content areas identified in the literature on chaplaincy education. Selecting other topics may have revealed other foci of didactic education in these programs. Another limitation is that the findings rely primarily on educators' self-reports. While we did compare educators' responses with curriculum materials in their CPE center handbooks, future research should include closer examination of the curriculum descriptions in these documents.

Our findings underscore a number of challenging questions for CPE educators and national chaplaincy organizations. In addition to the different approaches to didactics among educators in this study, we found conflicting opinions regarding the direction of CPE and the role of national chaplaincy organizations. Although we did not ask about it specifically, some educators shared their belief that these organizations have clearly articulated the need to integrate skills and knowledge through board certification, while others argued they have not done a good job defining the knowledge base needed for chaplaincy. Flohr pushed back against the idea that board certification competencies are focused primarily on skills, arguing that ACPE and certification guidelines integrate theory, professional practice and a working knowledge of psychology, sociology, and other disciplines. In contrast, Rowatt believes ACPE “nationally has not done a good job of defining our knowledge base” and needs to delineate a body of knowledge as part of its standards. Other educators warned of the risks of overloading CPE curricula. Drawing attention to the multiple ACPE standards and objectives that already exist, Wilkerson

lamented, “there is more to teach than you can teach in a year of residency.” She went on:

Within ACPE, we have a huge number of standards and objectives. I want to say, “Don’t add even one more because we’re already at capacity. There is only so much you can teach in a year.” It may behoove us to sit down and ask ourselves: what are the priorities? Instead of always trying to do everything – be everything to everyone – what are the critical things that a person should learn in the CPE residency?

Acknowledging the diversity of views regarding chaplaincy education and who should determine its content, we encourage educators to engage in a broader conversation regarding the goals and priorities of CPE. Historically, educators have resisted ACPE providing too much direction regarding the content of their curriculum, arguing they need flexibility to design their curricula around the unique needs of their students and institutional context. While a few educators we interviewed shared this view, others were open to ACPE defining key areas of knowledge and establishing a core curriculum for chaplains. Because ACPE is separate from the organizations that oversee chaplaincy certification, this conversation must include participants from those organizations.

In recent years, there have been several calls to replace existing chaplaincy education platforms (Cadge, 2012) and develop alternative models of chaplaincy training (Massey, 2014; Tartaglia, 2015). A number of the educators in our study pointed to weaknesses in the seminary education of their students (Cadge, Fitchett et al. 2019) and some asked whether part of the preparation for careers in chaplaincy should take place in theological schools. Other proposals that have been explored include a second year of CPE residency or fellowships and specializations that will enable chaplains to prepare for work in specific clinical contexts. Our study reveals the challenges presented by the diversity of CPE educator views and practices related to didactic education for chaplains. It also points to the importance of taking into account existing curriculum patterns, current ACPE standards, and chaplaincy board certification requirements in debates over where chaplaincy training should take place and what organizational bodies should determine its content.

If, as Keith Little argued for nearly 10 years ago, mastering a body of proposition knowledge was required for the professional education of chaplains we can see from the findings of our study that CPE educators are far from agreeing on what that knowledge should be and whether they want to be the ones to teach it. Nonetheless, the need for chaplains who are well-prepared to provide outcome-oriented spiritual care in our complex healthcare environment is growing. CPE educators, along with colleagues in theological education and the professional chaplaincy organizations, need to define this body of knowledge. Furthermore, as we suggest in an additional paper from this project (Cadge et al., *in press*), they also need to examine how they can best collaborate to teach it.

Notes

1. The role of CPE in chaplain education varies across different countries. It plays a key role in the US, Canada, Ireland and Australia. It does not exist in the UK and plays a minor role in the Netherlands. This variation in chaplain education across national contexts is an important topic for future study.

2. The four required units of CPE do not have to be completed as a year-long CPE residency program but 80% of people applying for board certification in 2017 with the Board of Chaplaincy Certification, Incorporated (BCCI) had completed such a program (George Fitchett unpublished).
3. We focus on ACPE-accredited CPE centers and educators because they continue to provide the majority of clinical training for healthcare chaplaincy in the United States. Further, ACPE is the only specialty accrediting body recognized specifically for the oversight of CPE.

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