"A reformation in CPE deserves our thoughtful attention:"
A Response to Tartaglia's Proposal on Chaplaincy Education

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I appreciate the opportunity to read Alexander Tartaglia's essay and provide a response. I am an ACPE supervisor directing a chaplain residency program at a large pediatric medical center, Cincinnati Children's Hospital, and I am a qualitative researcher. Tartaglia's essay provides a thoughtful ethical assessment of clinical pastoral education (CPE) as the primary provider of chaplaincy education. He finds traditional CPE processes insufficient to prepare healthcare chaplains given the changes currently happening in healthcare. Tartaglia offers a two-year residency curriculum beginning with traditional CPE in the first year. The second year would expand the CPE paradigm, having the CPE supervisor coordinate an educational experience focused specifically on equipping healthcare chaplains. He situates his call for the reformation of CPE as a parallel to the reformation in theological education CPE provided from its inception in the 1920s. He acknowledges the recent critiques offered by sociologist Wendy Cadge[1] and hospital administrator Kevin Massey.[2] Tartaglia is one of several CPE supervisors developing curriculum components for CPE in an effort to better equip hospital chaplains,[3] and he is the first to call for a reformation of CPE. I commend Tartaglia's courage as well as his scholarship.[4]

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Tartaglia makes several excellent points. Clarifying the definitions of both chaplaincy and spiritual care are long overdue. His call for clarifying both the approach to spiritual assessments and a way to evaluate outcomes also strikes me (along with many others) as essential needs in chaplaincy right now. His perspective that CPE can be responsive to the context in which the program is situated makes excellent sense. The congregation-based CPE program I directed twenty-five years ago had a very different curriculum than our chaplain residency CPE curriculum at Cincinnati Children's Hospital. Attending to context is not new to CPE; our process education programs can and should be related to the ministry placement context.

Tartaglia makes a worrying claim: "This ideological discrepancy accompanied the formative years of CPE with the education vs. therapy debate continuing to the present." A perceived focus on personal growth at the expense education for pastoral care in CPE may also contribute to Massey's comment that a shift in CPE should include "minimizing self and personal practice in favor of demonstrated practice patterns associated with improved patient outcomes."[5] Tartaglia's sense that CPE is in some cases focused more on therapeutic gains for the student than on education for ministry may be finding support in a current study by CPE certification commissioners. I am working with a small group of ACPE supervisors to identify behaviors by the supervisory candidate, either in their written or recorded materials or in the committee appearance itself, that have influenced certification commissioners to vote to grant, or deny, certification at the associate supervisor level. Several of the twenty-eight commissioners interviewed fault supervisory candidates who don't help their CPE students apply insights gained in CPE to their practice of pastoral care. If some supervisory candidates aren't being guided to help their CPE students understand how increased self-awareness may be used to improve their practice of ministry, this is another indicator that Tartaglia's call for a reformation of CPE is timely.

My primary critique of Tartaglia's essay has to do with the omission of religion as a primary component of his call for reform and his curriculum. Cadge points out that many medical center staff members assume the role of the chaplain has to do with providing religious support regardless of the patients' and families' religious traditions.[6] I wonder whether we have done a poor job of conveying that CPE students are not to impose their religious beliefs on others and that chaplaincy and CPE supervision have emerged as professions primarily focused on providing and developing providers of presence and relationship.[7] I believe the reason CPE seeks to develop these

abilities is to equip the chaplain to create a space to explore the beliefs that aid or hinder coping, finding strength, and making decisions in the throes of medical/psychiatric crises. For people of faith, these beliefs are often religious and, as such, are the unique realm of focus for the chaplain. My research has primarily been in the area of CPE supervisory education, but last year I completed a qualitative longitudinal study of twelve Adolescents/ Young Adults (AYA) that explored how they used religion/spirituality in the process of receiving hematopoietic stem cell transplants (HSCT, also known as Bone Marrow Transplant or BMT).[8] The other members of the research team were the head physician for BMT, a long-time nurse coordinator for BMT, and the chaplain for BMT at the time of the study; all of us serve at Cincinnati Children's Hospital. We were all surprised at the depth of religious experience conveyed by these patients in the qualitative interviews. Here is an excerpt from that article:

> Two members of our research team have been chaplains with pediatric HSCT patients; neither had heard in routine pastoral care of the depth of religious experience that participants conveyed in the context of responding to interview questions. This may be a failure of skill on the part of the chaplains or a result of chaplains' seeking to provide emotional support and neutralize faith differences[9] or for some reason yet to be determined. . . . Our study suggests that more assertive exploration of how AYA patients understand and use their faith will be meaningful for the patients and helpful for the health care team.[10]

The nurse and the physician both read the interviews for the analysis process, and both commented on how helpful it would be for the chaplain to bring this kind of information to the team. Both had been and continue to be very welcoming of chaplaincy. They said they had never heard the depth of their patients' religious experience they encountered when participating in this research study.

Another religion/spirituality research study, this one with fifteen parents of children newly diagnosed with cystic fibrosis, found that every one of the participants affirmed that "the fact that they were 'given' this situation by God was interpreted to mean that they would be able to 'handle it.'"[11] As a chaplain who had previously discounted the phrase "God never gives us more than we can bear" as a type of denial, I had to reconsider the strength this belief apparently provided these parents.

Research-informed chaplaincy, at least in my limited experience, suggests attending more carefully to the specific faith beliefs of the patients and

families we are serving. Cadge's study of 150 healthcare providers, including twenty-three staff chaplains and sixteen chaplaincy directors,[12] makes this argument with painful eloquence. Tartaglia does not reference an excellent article by Cadge and Emily Sigalow (a lecturer in Near Eastern and Judaic Studies) describing how chaplains negotiate providing care for patients of faith traditions different from their own.[13] One method is neutralizing, which is using language intended to provide care but not address specific religious content. The other method is code switching, in which the chaplain, while acknowledging her/his own faith tradition, cares for the patient using concepts from the patient's faith. For the past few years, Cincinnati Children's has welcomed a large number of Muslim patients from the Middle East. We have a department of twelve excellent staff chaplains, Christian and Jewish, and the learning curve we faced in caring for Middle Eastern Muslim patients has been steep. We are in the process of amending our CPE curriculum to intentionally address faith practices and beliefs from a wide variety of faith traditions. Professional healthcare chaplains need expertise in a wide variety of religious traditions as they provide or facilitate the provision of care to patients, families, and members of the healthcare team. Inevitably, members of faith traditions will not always practice their faith traditions according to formal dictates of the faith. Emerging research suggests that chaplains need the ability to assess patients' understanding of faith and help the healthcare team know how that faith is informing the patients' coping and decision-making.

Finally, Tartaglia's point that some CPE supervisors of hospital residencies are emphatically opposed to addressing the twenty-five competencies for Board Certified Chaplaincy in their curriculum invites reflection. If we in ACPE do not meet the needs of chaplaincy certifying bodies—Neshama: Association of Jewish Chaplains, the National Association of Catholic Chaplains, and the Association of Professional Chaplains—we may be sowing the seeds of our own destruction. Trace Haythorn, Executive Director of ACPE, and Marc Medwed, ACPE Program Manager, agree that "it would be conservative to estimate that of the 8500+ units certified annually at least 90% are completed in clinical settings."[14] While no doubt a lot of those are single unit students meeting seminary requirements, if a path other than CPE is created to prepare professional chaplains, ACPE will lose a major reason for establishing CPE centers in medical and psychiatric hospitals. One of the basic skills in CPE is working with feedback. Tartaglia's call for reformation in CPE deserves our thoughtful attention.

NOTES

1. Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press:,2012).

2. Kevin Massey, "Surfing through a Sea Change: The Coming Transformation of Chaplaincy Training," *Reflective Practice: Formation and Supervision in Ministry* 34 (2014): 144–52.

3. George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers* (Minneapolis: Augsburg Fortress, 1993); M. Susan Nance, Kenneth E. Ramsey, and J. Anthony Leachman, "Chaplaincy Care Pathways and Clinical Pastoral Education," *Journal of Pastoral Care & Counseling* 63 (March-June 2009): 11–14; John J. Gleason, "A Professional Spiritual Care Knowledge Base: Boon or Bane?," *Journal of Health Care Chaplaincy* 192 (2013): 45–53; Paul Derrickson and Angelina Van Hise, "Curriculum for a Spiritual Pathway Project: Integrating Research Methodology into Pastoral Care Training," *Journal of Health Care Chaplaincy* 161, nos. 1–2 (2010): 3–12.

4. Tartaglia has already demonstrated impressive leadership in engaging the context of healthcare in relationship to the processes of CPE. Tartaglia and colleagues' CPE program at the Medical College of Virginia is revolutionary in its combination of an accredited CPE program with an accredited Master of Science in Patient Counseling.

5. Massey, "Surfing through a Sea Change," 148–49.

6. Cadge, *Paging God*, 129.

7. Ibid., 93–97.

8. Judith R. Ragsdale, Mary Ann Hegner, Mark Mueller, and Stella Davies, "Identifying Religious and/or Spiritual Perspectives of Adolescents and Young Adults Receiving Blood and Marrow Transplants: A Prospective Qualitative Study," *Biology of Blood and Marrow Transplantation* 208 (2014): 1242–47.

9. Wendy Cadge and Emily Sigalow, "Negotiating Religious Differences: The Strategies of Interfaith Chaplains in Healthcare," *Journal for the Scientific Study of Religion* 52, no. 1 (2013): 146–58, doi: 10.1111/jssr.12008. This reference was misquoted in the article as another article by Cadge, but this is the correct reference.

10. Ragsdale et al., "Identifying Religious and/or Spiritual Perspectives," 1246–47.=

11. Grossoehme D. H., Ragsdale J., Wooldridge J. L., Cotton S., & Seid M. "We Can Handle This: Parents' Use of Religion in the First Year Following Their Child's Diagnosis with Cystic Fibrosis." *Journal of Health Care Chaplaincy* 2010: v. 163/4, 95–108. This quote is on p. 101.

12. Cadge, *Paging God*, 209–29.

13. Madge and Sigalow, *Negotiating Religious Differences*.

14. Personal communication to author, Jan. 18, 2015.