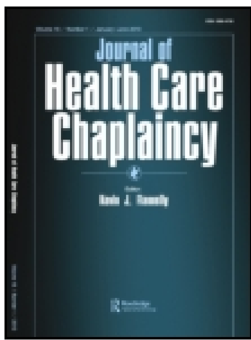

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Education for Professional Chaplains: Should Certification Competencies Shape Curriculum?

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The growing importance of professional chaplains in patient-centered care has raised questions about education for professional chaplaincy. One recommendation is that the curricula of Clinical Pastoral Education (CPE) residency programs make use of the chaplaincy certification competencies. To determine the adoption of this recommendation, we surveyed CPE supervisors from 26 recently re-accredited, stipended CPE residency programs. We found the curricula of 38% of these programs had substantive engagement with the certification competencies, 38% only introduced students to the competences, and 23% of the programs

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made no mention of them. The majority of the supervisors (59%) felt engagement with the competencies should be required while 15% were opposed to such a requirement. Greater engagement with chaplaincy certification competencies is one of several approaches to improvements in chaplaincy education that should be considered to ensure that chaplains have the training needed to function effectively in a complex and changing healthcare environment.

KEYWORDS chaplain certification, chaplain education, clinical pastoral education, healthcare chaplains

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INTRODUCTION

These are exciting and opportune times for healthcare chaplains. There is growing recognition of the importance of attending to the religious and spiritual concerns of patients and their loved ones. This is most evident in practice guidelines and consensus statements that include attention to spiritual needs and spiritual care in areas such as palliative care (e.g., National Consensus Project for Quality Palliative Care, 2013), intensive care (Davidson et al., 2007), and oncology (Pirl et al., 2014). Evidence of the positive impact of chaplain care on patient/family satisfaction continues to be reported (Johnson et al., 2014; Marin et al., 2015). Importantly, chaplains are increasingly recognized as the professionals with the expertise to address the spiritual needs of these patients and their loved ones (Puchalski et al., 2009).

These guidelines and this evidence also point to challenges for the training of professional chaplains. At a time of growing recognition of the important role of chaplains in the care of patients and families, there are no consensus guidelines for how healthcare chaplains should be trained and no organization exercising oversight for the development of such guidelines. In professional chaplaincy in the United States, the Association for Clinical Pastoral Education, Inc. (ACPE) is the organization with recognized authority for the accreditation of programs in which future chaplains are trained. However ACPE focuses primarily on process-oriented pastoral care education and its learning outcomes reflect its broader mission. ACPE has no guidelines for chaplaincy education curricula. Another organization is responsible for evaluating competence for certification as a health care chaplain, the Board of Chaplaincy Certification, Inc. (BCCI), which does its work on behalf of the Association of Professional Chaplains (APC). APC, along with other chaplaincy organizations, is responsible for developing standards of professional practice and certification, but currently exercises no oversight for chaplaincy education.

Historical and organizational priorities have led these two organizations to different approaches to assessing professional and pastoral competence. Clinical pastoral education (CPE) is a model of theological education focused on pastoral formation and pastoral reflection as well as pastoral competence. ACPE accredited training programs typically emphasize the personal development of the chaplain (personal and professional integration) and the process of transferrable learning. CPE curricula have historically been driven by a student-centered approach to learning and curriculum development. The professional chaplaincy organizations, while also valuing integration and process learning, place emphasis on chaplain competencies and outcomes-oriented chaplain care. The BCCI has developed competencies for board certification as a professional chaplain and APC has established standards of professional practice for chaplains reflective of these competencies (Board of Chaplaincy Certification Inc., Professional Chaplain Competencies).

While these organizations, and others (e.g., National Association of Catholic Chaplains, NACC, Neshama-Association of Jewish Chaplains, NAJC), have collaborated in developing common standards for chaplaincy certification, the absence of guidelines for chaplain education has left individual CPE curricula as the de facto norms for training healthcare chaplains. The limitations of this approach have not gone unnoticed. Australian CPE supervisor Keith Little (2010) described the limitations of the CPE action/reflection model as the foundation for the preparation of professional chaplains. He advocated for a curriculum that incorporated a propositional knowledge base to help prepare chaplains for effective functioning in an increasingly complex healthcare environment. As such, Little attended to the important distinction between CPE's focus on transferrable learning and the professional training model's attention to proficiency and expertise for a particular context. Massey (2014) and Tartaglia (2015) have also questioned the sufficiency of current models of CPE for training professional chaplains.

In addition to Little's important critique other authors have proposed education for specific chaplain competencies or offered innovations for chaplaincy curricula. Hilsman (1997) described the need for CPE to develop new competencies for the emerging health care structures. Smith and Morgan (1998) called for bioethics training to be required in CPE programs. Two articles in the *Southern Medical Journal* addressed the training of health care chaplains. Ford and Tartaglia (2006) spoke to the development of standards for spiritual assessment, specific training in interdisciplinary care, and the emerging need for research education. McManus (2006) identified the lack of a single applied standard for training chaplains in the UK and urged the development of greater alignment between chaplain competencies and chaplaincy training. Recent calls for re-defining pastoral care in a postmodern age and the need for enhanced competency in spiritual and cultural diversity

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have implications for pastoral education training curricula (Anderson, 2012; Thorstenson, 2012). The importance of including research literacy as a component of CPE training has also been described (Fitchett, Tartaglia, Dodd-McCue, & Murphy, 2012; Tartaglia, Fitchett, Dodd-McCue, Murphy, & Derrickson, 2013).

In her study of healthcare chaplains, Cadge (2012) suggests the need to design chaplaincy education from scratch. She proposes a curriculum that would include topics such as healthcare administration, medical ethics, interfaith spiritual care, as well as research methods that would be taught by chaplaincy experts as well as educators in other healthcare professions.

Jackson-Jordon and Moore (2010) suggested that BCCI competencies be used as the basis for a CPE-based curriculum intentionally focused on the preparation for professional chaplaincy. Employing focused attention on BCCI competencies and mentoring by board certified chaplains, their program assists students in framing learning goals that meet both the BCCI competencies and ACPE outcomes. In addition, attempts to reconcile BCCI competencies and ACPE Level II outcomes have been developed and are available to programs considering integrating the two (Board of Chaplaincy Certification Inc., Crosswalks). In light of the issues that have been raised regarding chaplain education, the aim of this survey was to determine the extent to which ACPE residency programs were incorporating BCCI competencies into their curricula.

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METHODS

The CPE Programs

The study gathered information regarding their curricula from a sample of CPE programs with year-long, stipended residency programs that had recently been granted continued accreditation by the ACPE Accreditation Commission after a 10-year review. Selecting programs from this list permitted us to study programs with recently updated curricula which, we believed, were more likely to address the BCCI competencies than programs whose curricula had not been recently reviewed. The names of all CPE centers granted reaccreditation are published in the minutes of the ACPE Accreditation Commission that are publically available on the ACPE website. In the May and November 2013 meetings of the Commission 38 centers were granted reaccreditation based on a 10-year review. We examined the ACPE directory listings of these 38 centers to determine which centers offered a year-long program with a stipend. We found 32 programs that met these criteria. Of these, three programs that did not currently have a permanent supervisor were omitted from the project, leaving a sample of 29 programs. We successfully contacted and interviewed one or more supervisors at 26 of these programs (90%).

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The Interviews

One member of the study team contacted the supervisor listed in the directory for each program to describe the project, solicit their participation, and schedule a time for the interview. The interviews focused on three areas. The first area was whether BCCI competencies were addressed in the residency curriculum. For CPE curricula that addressed the BCCI competencies, we asked the supervisor to describe the methods, assignments, or other activities that addressed the BCCI competencies and when in the curriculum these activities occurred.

The second subject in the interview explored the supervisors' opinion regarding whether BCCI competencies should be included in CPE residency programs. This subject was included regardless of whether the BCCI competencies were addressed in the center's residency program.

The third area was the supervisor's engagement with the chaplaincy certifying organizations (APC, NACC, and NAJC). We asked if the supervisor was currently a member of one of these organizations or had been a member in the past. We also asked if there were any other CPE supervisors at this center (Associate or Full) and if so, how many of them were members of APC, NACC, and NAJC. We asked for the supervisor's opinion regarding whether CPE supervisors should also be required to be Board Certified chaplains. In addition, we inquired about the supervisor's familiarity with the BCCI competencies, whether he or she had served on any BCC certification committees in the past 3 years and if so, how many. These questions were included to help determine if engagement with the BCCI competencies in the residency programs reflected closeness or separation between ACPE, the organization that trains people for chaplaincy, and the organizations that certify chaplains. We concluded the interview by inviting the supervisors to share any other comments they had about whether CPE curricula should or should not address BCCI competencies.

The study interviews were conducted in the Winter/Spring of 2014. At two centers the interviews included two supervisors; thus, 28 supervisors from 26 centers participated in the study. Study team members did not conduct interviews with their own center.

Analysis

The main study question was whether a residency program had any engagement with the BCCI competencies. After review of the initial interviews we created three categories of curricular engagement with the BCCI competencies (See Table 1). Two members of the study team independently assigned a level of engagement with the BCCI competencies based on the interview reports. At this stage there was agreement for 21 of the 26 centers (81%). The differences for the remaining centers were resolved by a third member of the study team.

TABLE 1 CPE Residency programs' level of engagement with BCC competencies ($n = 26$)

None 23% (No mention of competencies or BCC certification in the curriculum)

Introduced 38% (The competencies and/or BCC certification are introduced but initiative for any further engagement with them is left to the students)

Comments

- Information included in the CPE Handbook such as a list of the competencies or the website
  for one of the chaplaincy certifying organizations
- Curriculum includes one or two didactic seminars that introduces the competencies and/or process of chaplaincy certification
- Curriculum includes students participating in a webinar about chaplaincy certification

Substantive 38% (The curriculum has required, multiple points of engagement with the BCC competencies and/or the process of chaplaincy certification)

Comments

- Curriculum content intentionally created to prepare students for competencies
- Multiple didactics describing the competences
- Use of the competencies in writing and processing verbatims; use competency verbatim checklist
- Engage competencies in refection on verbatim
- Write and present early drafts of required certification papers
- Mock certification committee sessions
- Each student (or interested students) have chaplain mentors available with whom they can discuss the process of board certification and/or competencies

The project was reviewed by the Advocate Health Care IRB that determined the project was a quality improvement activity and not research involving human subjects as defined by the Department of Health and Human Services (DHHS) and Food and Drug Administration (FDA) regulations and that, as such, IRB review and approval was not required.

RESULTS

As can be seen in Table 1, the majority of the residency programs (76%) were engaging the BCCI competencies, but there was substantive engagement in only 38% of the programs. Examples of how the residency programs engage the competencies in their curricula are also shown in Table 1.

The supervisors we interviewed reported a range of opinions about whether CPE residency programs should be required to engage the BCCI competencies. As is shown in Table 2, a majority of the supervisors (59%) felt this should be required. A small proportion of the supervisors (15%) felt, often strongly, that the residency programs should not be required to address the BCCI competencies. A similar small proportion of supervisors (15%) were uncertain about requiring residency programs to address chaplaincy certification competencies. For them it appeared to be a new idea about which they were unsure. Several of the supervisors (11%) did not agree with requiring all CPE residency programs to address the certification competencies, but

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TABLE 2 CPE supervisors' opinions about whether attention to the BCC competencies should be a required part of a residency curriculum ($n = 27$)*

Yes 59%
Comments
- We are preparing people for professional chaplaincy. That's what they are here for. It should be the focus of the outcome of a successful residency.
- It's a no brainer. The competencies and standards should be seamless with each other.
- The competencies should be included. The emphasis can vary depending on the context and student goals. Their center has received positive evaluations from their students regarding this aspect of their curriculum.
- Students have shown interest and the supervisor plans to integrate more in the future.

No 15%
Comments
- If I thought they were important I would address them. I don't think they should be included.
- It is dangerous to teach to the test and not cover the underlying theory.
- The mission of CPE extends beyond chaplaincy certification. CPE is process oriented and should remain so.
- Residents have enough work addressing Level I & II Outcomes. It would be burdensome to expect students to keep track of competencies too. There is no time in their schedule or energy to throw in the BCC competencies.
- Keep the educational program and certifying body separate. Supervisors should teach to the ACPE outcomes and not comment on APC competencies. That would place the supervisor in role of gatekeeper and potentially threaten the supervisory alliance.
- Addressing CPE Outcomes prepares students for BCC competencies.

Uncertain 15%
Comments
- I'm uncertain about whether CPE should teach to the competencies. I'm old school. Supervision is helping students 'develop the art of pastoral ministry.'

An option for interested students 11%
Comments
- The BCC competencies should not be a required element in the curriculum. If a student has BCC certification as goal it is translated into a learning goal for the residency.

*The response to this question was missing for one supervisor.

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thought it should be an option for residents whose career goals included professional chaplaincy. The comments the supervisors made regarding this question are shown in Table 2.

The responses to this question included several comments about whether there should be more or less collaboration between ACPE and the chaplaincy certifying organizations. Regarding more collaboration, one supervisor commented, "It is very important that the curriculum address the competencies. Hopefully in the future the two organizations can do more things together and become more efficient about how they work together." The same sentiment was expressed by another supervisor who said, "It is good to be intentional about the assessment of curriculum items addressing the BCC. [There] should be a relationship between both [sic] organizations. We probably need to be more intentional about how

TABLE 3 How many CPE Supervisors[a] are Board Certified Chaplains?

Board certified chaplain	Supervisors interviewed ($n = 28$)	Supervisory colleagues in the department ($n = 33$)	Total ($n = 61$)
Yes	18 (64%)[b]	27 (82%)[d]	45 (74%)
No	10 (36%)[c]	6 (18%)	16 (26%)

[a]CPE Supervisors or Associate Supervisors only.
[b]APC $n = 13$, NACC $n = 2$, NAJC $n = 1$, In process $n = 1$, APC & NACC $n = 1$.
[c]Includes one supervisor who is an APC member but not a Board Certified Chaplain.
[d]Includes 4 in the process of becoming Board Certified Chaplains.

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we address the competencies." A contrasting opinion was expressed by a supervisor who said, "It doesn't make sense for another organization to develop our standards for education."

Because we thought residency programs' engagement with the BCCI competencies might reflect the degree of connection or separation between ACPE and the professional chaplaincy organizations, as noted earlier, the interviews included a number of questions about the supervisors' engagement with the chaplaincy organizations. As shown in Table 3, nearly two thirds (64%) of the supervisors we interviewed were members of one of the chaplaincy organizations. When their supervisory colleagues were included the proportion increased to 74%.

Two themes emerged in the comments the supervisors made about this topic. The first was about the cost of belonging to both ACPE and to one of the chaplaincy organizations. Several supervisors said the additional cost was the only reason they were not members of a chaplaincy organization. One of the supervisors had been a member of one of the chaplaincy organizations until his/her department ceased paying those dues. In contrast one of the supervisors reported that if his center did not pay his professional chaplaincy dues he would be willing to do so himself. The second theme related to departments that required their CPE supervisors to also be Board Certified chaplains. At three different centers, the supervisors reported that just as it was a requirement for chaplains in their department to be Board Certified so it also was for the department's CPE supervisors. One of those supervisors also reported that for any new Supervisory Education Students in their department who were not Board Certified becoming certified was the first thing they were required to do in their supervisory education. Again, in response to this question several supervisors commented on the need for closer cooperation between ACPE and the professional chaplaincy organizations.

In the interviews we also asked supervisors for their opinions about whether CPE supervisors should be required to be Board Certified chaplains. As can be seen in Table 4, a majority of the supervisors (58%) said this should be a requirement. About one in four of the supervisors (27%) were

TABLE 4 Supervisors' opinions about whether CPE supervisors should be required to be BCC ($n = 26$)*

Yes 58%
Comments
- Supervisors should always have a context for providing pastoral care on a regular basis to be able to relate that developing experiences to students.
- Believes supervisors who are training people for chaplaincy should be BCC; if supervising in other contexts then not needed.
- It is important. It is hard to teach something that you are not proficient in and keep practicing and improving your own skills in.
- Yes, it is a best practice. If we are going to advocate for people to be chaplains in a hospital context we should be a member of APC or NACC or other chaplain organization.

Ambivalent, not mandatory, it depends 27%
Comments
- He supports certification and thinks it is a good idea for VA supervisors and chaplains to hold a certification (ACPE, APC, NAVAC, etc.) but would be reluctant to require chaplain certification for supervisors, in part due to multiple fees attached to multiple certifications[a].
- I'm on the fence on that. ACPE supervisors should be extended BCC parity; should not have to become BCC.

No 15%[a]
Comments
- Too many organizations to belong to. The two organizations should examine somehow combining.

*Two supervisors had no opinion.
[a]Two supervisors, one who said it should be required and one who said no, both mentioned that the cost of being both a certified supervisor and a certified chaplain was a problem.

ambivalent about making Board Certification a requirement for CPE supervisors. A small proportion of the supervisors (15%) were clearly opposed to this idea. For one of them the issue was again related to costs. A large majority of the supervisors (86%) told us they were familiar with the BCCI competencies. While 26% of the supervisors had served on a professional chaplaincy certification committee in the past 3 years, the majority of the supervisors (63%) reported they had not.

DISCUSSION

Survey

Although the majority of CPE supervisors supported the concept of incorporating BCCI competencies into CPE curricula, the study found a range of opinion on the importance of their inclusion. A strong theme in the interviews favoring the incorporation of the competencies was one of advocacy for the needs of students, with the majority of supervisors supporting their inclusion in the curriculum for students whose career path includes professional chaplaincy. Supervisors who took this position expressed a sense of obligation to provide experiences that would prepare students for future

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appearances before a chaplaincy certification committee. This theme is consistent with the student focused tradition within CPE.

A theme in the comments of the supervisors opposing the incorporation of the competencies focused on the primary missions of the different organizations. This sentiment acknowledges that the goals of CPE are simply not, by design, the goals of the chaplaincy organizations. This opinion focused on the broader educational mission of CPE as clinical training for pastoral care. Supervisors who expressed this view sought to preserve the soul of CPE as a process oriented, student centered enterprise with learning goals focused on individual student needs that integrated personal and professional development. The strongest voice holding this position felt that the learning covenant between supervisor and student needed to be maintained and would be compromised if supervisors' were to address in any evaluative sense an individual student's progress toward certification. This perspective points to a potential conflict of interest issue to be addressed in any future conversation and collaboration among the pastoral care organizations.

Limitations

One limitation of the study is the assumption that more recently re-accredited programs are more likely to incorporate the BCCI competencies. This remains untested and may affect the degree to which centers that were interviewed were representative of ACPE accredited residency programs. Another possible limitation lies in the evidence to support the incorporation of the BCC competencies in residency curricula. These findings were self-reported and were not corroborated by an examination of the centers' curricula. As such, they are subject to self-report bias leading in this case to potentially socially desirable responses.

Future Considerations

This study serves as a kind of "sense of the house" vote among CPE supervisors regarding their evolving opinions about chaplain education. CPE supervisors generally approve of a stronger relationship between CPE residency curricula and BCCI competencies, though they hold varied opinions on how this should be approached. This finding may well provide a starting point for discussion toward greater consensus on this issue.

Beyond the findings of this study, a question for the chaplaincy profession is whether designing CPE residency curricula around the certification competencies is an effective way to educate people for professional chaplaincy or whether it is time for a fresh look at education for professional chaplaincy. Massey (2014) attempted to describe how the existing structure of CPE units could be adapted to deliver fuller propositional knowledge supporting outcome-oriented chaplaincy. Responses to this suggestion ranged

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from arguing for the status quo to acknowledging the need for a continuing conversation on reforming chaplaincy education (DeLong, 2014; Greene, 2014; Vaughn, 2014). Alternatively, Wendy Cadge (2012) has suggested that future chaplaincy training not be organized on the existing platforms. Rather, she proposed academic formats such as dedicated Masters level degrees focusing on chaplaincy knowledge and skill. She also suggested that "chaplaincy leaders might consider whether the time has come for professional licenses like those required of medicine and nursing" (Cadge, 2012, p. 207). This model is not dissimilar from other allied health professions such as physical therapy and occupational therapy where accrediting bodies for educational programs remain separate from certifying or licensing bodies, yet remain in dialogue with those groups in order to ensure that educational curricula provide the knowledge and skill development required to meet external standards (American Occupational Therapy Association, Accreditation, 2011; Commission on Accreditation in Physical Therapy Education, CAPTE Accreditation Handbook, 2015).

The merit in investigating licensure for chaplaincy is that standards of professional competency, propositional knowledge, and objective outcome-oriented clinical practice could be identified and tested through methods currently employed by other professional licensures and the question of who may train chaplains and how they may train chaplains becomes tangential. Organizations and programs would then be free to train chaplains in different ways, and best practices in chaplain education could be identified by the proportion of a program's graduates who achieve licensure. Such a change in the landscape would encourage CPE and other potential training models to engage in research that demonstrated the effectiveness of their educational program.

Proposals for a fresh look at chaplaincy education also share a critique of the lack of demonstrable, outcome-oriented competencies in the present approach to chaplain certification. Massey (2014) describes how the current BCC certification process largely depends on written and oral self-reporting of competencies with no process for independently evaluating and verifying a chaplain's competencies. This circularity in how chaplains are trained and how chaplains are evaluated results in chaplains being evaluated in ways similar to how they are trained, namely employing largely subjective and self-reported data, which points to the need for a different balance between self-awareness and skills based competencies to be applied to both the education of students and the evaluation of certification candidates. Were one to take a blended idea of the proposals to this point, perhaps chaplain training would be best suited to large medical centers housed within academic settings where a mixture of clinical experience and the resources of the academic institution could be combined to create an educational experience that incorporates both student centered self-reflective practice during clinical experience and tangible modules of classroom

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and didactic instruction. Alternatively, chaplain certification could take on a context specific focus with overlapping but distinct training and examination for competent practice in different clinical settings such as acute care, hospice care, and long term care.

CONCLUSION

The emerging opportunities for integrating spiritual care into patient-centered care require that professional chaplains are equipped with the best education possible. Advancing education for professional chaplaincy requires a lively conversation among knowledgeable and interested parties willing to dispassionately scrutinize the strengths and limitations of the current models. Such a dialogue would benefit from a willingness to envision approaches that may either incorporate existing structures or depart entirely from them. That conversation can engender recommendations for pilotable concepts that could be implemented in partnership by the professional organizations to compare and contrast alternative approaches.

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