PLACE-BASED CHAPLAINCY:

AN INTERFAITH APPROACHTO CHAPLAINCY TRAINING

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ABSTRACT

Laura Ritter: Place-Based Chaplaincy: An Interfaith Approach to Chaplaincy Training
(Under the direction of Helen Baroni)

Clinical Pastoral Education (CPE) claims to be an interfaith chaplaincy training program. However, what constitutes interfaith chaplaincy is not clearly defined in CPE literature. This study asks the question: "Does interfaith chaplaincy work?" In other words, "Can a person be trained to offer support to people from a range of religious traditions other than their own?" To examine this question, I interviewed thirteen professional chaplains and conducted three focus group interviews with a group of chaplaincy students in Hawaiʻi. I argue that, while CPE training effectively prepares students for a ministry of presence, it does not train students to function as religious experts. To succeed in an interfaith capacity, I suggest that chaplains need religious and socio-cultural education specific to the populations with whom they are working. My study concludes with a proposal for a place-based chaplaincy course which integrates an academic approach to religion with CPE's experiential training program.

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Preface

Leaning in toward his face, I turned my head to the right hoping to grasp a few of his words. Seeing my struggle to comprehend, he pointed to a plastic purple container on the crowded table next to his bed. After I handed it to him, he proceeded to open it with his one working hand. Inside was a little speaker cap which he placed on his trach. Little did we know that conversation would be the beginning of many that we would have until his death.

I met Mr. Lahui working as a hospital chaplain at the only trauma hospital in the Pacific. He had been in the hospital for over two months. On this day, his nurse had paged me to come to his room. Previously, my Catholic co-worker had been Mr. Lahui's primary chaplain, and I felt nervous that my own Buddhist orientation might not satisfy his hopes. Within a few minutes of our visit, he told me a story about receiving a message while walking on a mountain in Molokaʻi. He asked me, "Do you know that passage 'Look up! God is in the mountains'?" Not knowing what he was referring to, I responded, instead, by acknowledging that he must feel incredibly connected to the mountains that brought him face to face with God. That day, Mr. Lahui shared his memories from Molokaʻi where he spent 29 years of his life. His stories about visiting heiau and encountering spirits that protected his own were filled with what he called the sacred moments of his life.

I recall my experience with Mr. Lahui to illustrate a small glimpse into my work as a professionally trained chaplain. In that visit, Mr. Lahui and I forged a connection beyond what we both expected. I am a Zen practitioner. Mr. Lahui identified himself as *spiritual, but not religious*, however he expressed a strong faith in a Christian God. Our meetings had little to do with religion. Instead, in our many visits, we talked about his family, his childhood, and end-of-life concerns. I listened, validated and loved Mr. Lahui for accepting me so unconditionally into

his life. As life changing as our connection was, the purpose of this thesis is to take a step back and inquire from a scholarly perspective into the growing field of professional hospital chaplaincy. The academic questions about interfaith work that form the foundation of this thesis originated in my professional work. For example, consider my interaction with Mr. Lahui: Did our exchange constitute interfaith work? Or is there something more that chaplains can do to serve patients of a religion different than their own? I feel confident that Mr. Lahui would support me in this work.

Because this thesis focuses largely on chaplaincy training, I want to offer a brief background on my own. I began clinical chaplaincy training in New York City at a Zen center and finished four years later, in Kahului, Maui, with a Christian cohort. My unusual training path gave me unique insight into the chaplaincy profession which inevitably influences my academic work. I began my training with Trudi Jinpu Hirsch,[1] the first Zen Buddhist to be board certified by the Association of Professional Chaplains. Guided by her spiritual care philosophy, Hirsch asked her students to "join" their patients in their suffering. In other words, if a patient saw me as their sister, then she suggested that I offer them the companionship they were seeking; if the patient saw me as a devout believer, then I should allow that patient to see her faith reflected in me. She demanded that we look at impermanence, ours and others', head-on. In sum, Hirsch taught that there is no separation between Buddhist contemplative training and chaplaincy practice; from her perspective, the relationship between the patient and the chaplain becomes a means by which both can achieve awakening.

[1] Hirsch trained as a monastic with John Daido Loori at the Zen Mountain Monastery in Mt. Tremper, NY.

After completing two-intensive years training with Hirsch through the New York Zen Center for Contemplative Care (NYZCCC), I moved to Honolulu to participate in a chaplaincy residency program offered by Pacific Health Ministry, Hawai'i's only accredited chaplaincy training program. In this program, I was the only non-Christian student in a group of six students.[2] Through participation in this program, I expected to gain a deeper understanding of Christianity which could help me in my work. I assumed that my peers would discuss how their worldview supported them in chaplaincy work as my cohort group did at NYZCCC. It was something of a disappointment that my peers rarely disclosed their own religious experiences. Instead, my training at Pacific Health Ministry focused on the technicalities of spiritual assessments and peer group development. Thus, over the course of four years, I had two very different chaplaincy training experiences.

Both programs were accredited by the Association for Clinical Pastoral Education, the only organization approved by the United States Department of Education to accredit Clinical Pastoral Education (CPE) and as a result, both programs aimed at the same learning outcomes addressed by particular professional chaplaincy competencies. However, it seemed to me that neither program adequately addressed the interfaith aspect of hospital chaplaincy work.
At the NYZCC, our Buddhist-influenced training was highly self-reflective and focused on applying moment-to-moment awareness to patient relationships. As a result, I learned to engage my patients with a level of authenticity that allowed me to often directly inquire about their religion and worldview. However, I sometimes felt that I was not sufficiently versed in my patients' religions to support them with specific textual readings or theological insights. At

[2] This demographic is typical of the majority of chaplaincy training programs in the United States.

Pacific Health Ministry, perhaps due to the hospital's patient demographics, a mix of Christian and Buddhist for the most part, I became increasingly comfortable in offering multifaith improvisational prayer. However, I still questioned the depth of my understanding. I often felt that I was just scratching the surface of my patients' faiths. I knew that their beliefs and practices had rich histories of which I was unaware.

While it is true that professional chaplains to a great extent learn their professions in practice, it seems to me that there is a need for a more rigorous interfaith training, one that better prepares chaplains to engage religions other than their own. In this thesis, I take a deep look into clinical chaplaincy training and make some suggestions about improvements that might be made. My aspiration is that interfaith chaplains learn to use religious differences as a tool with which to engage and empower their patients. As we build the profession of clinical chaplaincy, my hope is that the beautiful intricacies of specific religious beliefs and practice are not lost in a web of generalized spiritual care.

Although I use pseudonyms and have omitted identifying details, the stories shared here are real and reflect heartfelt experiences and vulnerable moments. The kind and humble participation by my interviewees has made this scholarly inquiry possible. May this research be a positive contribution to interreligious scholarly work.

Introduction

For most Americans, the word "chaplain" evokes some very specific images.[3] The most likely image: a man, wearing a clerical collar, consoling family as he prays over a dead body. The general assumption, that the chaplain is the bearer of bad news[4] is still very much alive today. However, hospital chaplains do not just attend to the dying: they work alongside physicians, social workers, nurses, and behavioral health specialists as one part of a larger medical system. Their visitation notes are recorded in patient's medical records. Their expertise is called upon not only at the bedside, but also during ethics meetings, nursing rounds, and family meetings.

Today's hospital chaplains are typically hired directly by the medical center to which they are employed. They undergo years of clinical training and hold at least one masters degree, typically in divinity from a Christian seminary. Their clinical training, rather than focusing on rituals and theologies practiced by particular religions, looks at the cognitive and behavioral aspects of spirituality[5] and at the challenges of communication and spiritual assessment.

The following study was sparked by an increasingly urgent question: "Does interfaith chaplaincy 'work'?" Can a person be trained to offer support to people from a range of religious traditions other than their own? If so, what does that training look like? Specifically, can a

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[3] In her book *Ministry of Presence,* Winifred Sullivan writes about the influence that popular media has had on the public's image of "the chaplain". Winnifred Sullivan, *Ministry of Presence: Chaplaincy, Spiritual Care, and the Law* (Chicago: The University of Chicago, 2014).

[4] Patients' family members often talk about a feeling of anxiety that comes over them when the chaplain approaches them in the hospital. Their fear is that the chaplain has been sent to let them know that their loved one's death is imminent.

[5] Florence Gelo states that spirituality includes "cognitive, affective, and behavioral aspects." Florence Gelo, "The Role of the Professional Hospital Chaplain," In *Religion, Death, and Dying (Vol 1),* ed. Lucy Bregman (Santa Barbara: Praeger, 2010), 7.

chaplain connect with patients across religious differences to provide care that brings patients closer to their own religion?

In order to look into these questions, I interviewed a group of six chaplain students in Hawai'i. I also interviewed thirteen professional chaplains and two scholars who specialize in interreligious work. The students, as participants of a year-long chaplaincy program, were each placed at a clinical site where they worked full-time and covered on-call shifts. The clinical sites included a trauma hospital, two smaller local hospitals, a children's hospital and a retirement and assisted living center. The interviews were conducted in three one-hour-long sessions. On completion of their year-long residency, students receive three units of Clinical Pastoral Education (CPE). In order to be eligible for board certification by the Association of Professional Chaplains (ACP) a trainee must receive a minimum of four units of CPE and meet other stringent requirements.[6]

The ACP plays a prominent role in the development of chaplaincy as a profession. Not only was it the first organization for chaplains, it also set the standards for chaplaincy education. Today, many hospitals will only hire chaplains who are board-certificated by the APC. The APC began as a Liberal Lutheran group. Starting in the 1990's, it worked to diversify its approach and to certify chaplains on an interfaith basis. Nonetheless, the majority of participants in clinical pastoral education classes continue to be Christian. For instance, of the six residents whom I interviewed, only one claimed a non-Christian faith (Tibetan Buddhist). The other chaplain residents were Christian (Lutheran, Baptist, Disciples of Christ, United Presbyterian Church, and United Church of Christ). Of the thirteen professional chaplains that I interviewed all but one

[6] In addition to CPE, in order to be nationally board certified by the APC, chaplains must be endorsed by a religious body, have a Masters of Divinity or similar degree, complete a minimum of 2,000 hours of professional work, and go through an intensive interview process.

was CPE-trained. Four were Buddhists, six were Christian, one was Hindu, and two identified as secular humanists. Unlike the students that I interviewed, the religious distribution among the professional chaplains is not representative of a larger population trend. I met these chaplains through my own training, including scholarly and professional experience.

My thesis is divided into four chapters. In Chapter One, I focus on CPE educational goals. Specifically, I look at the standards that the ACPE has developed for each level of CPE education. In my analysis, I suggest that the APC standards create obstacles to interfaith learning. I also provide a brief background on the development of CPE and contextualize it within United States' religious history. In Chapter Two, I look at innovative ways that CPE-trained chaplains navigate multi-faith, clinical environment. In my discussion, I outline the aspects of CPE training that shape chaplains' approach to spiritual care. Chapter Three critiques CPE training. Here, I describe challenges that CPE students face working in an interfaith capacity and outline what I see as fundamental problems to CPE's current training program. In Chapter Four, I propose a *Place-Based Chaplaincy* course to addresses the pedagogical problems that I identify in Chapter Three. I present this proposal as a regionally-based pilot program set in Hawai'i. My intention is to integrate the successful aspects of CPE training (introduced in Chapter Two) with coursework that prepares students to work with religious populations specific to Hawai'i.

The limitations of my study are obvious. I would have preferred to interview more residents from non-Christian backgrounds, however the student population I worked with is representative of CPE programs on a national-scale. The range of religions that the chaplains refer to throughout my interviews is also limited, however it, also, reflects the patient population in Hawai'i. More than one example will refer to an intergenerational family that is mixed

Christian and Honpa Hongwanji Buddhist. It is important to note that although I conducted this study in Honolulu, Hawaiian religion is rarely mentioned. Many of the patients that chaplains work with in Hawai‘i may practice Hawaiian religion, however it is possible that these patients may not specifically mention their Hawaiian faith to because it has been integrated into their predominant religious identity.

I also need to make clear that I have not surveyed all CPE programs in the United States. It is possible that there are programs with interfaith training curriculum that I am unaware of and do not account for in my research. In order to improve this study, it would need a multi-year approach, with a larger interview pool, and more extensive research on CPE programs nationally. Conducting a cross-comparison of religious populations by region might help to differentiate components of CPE curriculum that can be applied nationally from those that need to be regionalized for effective interfaith learning.

On a final note, my original intention was to design an interfaith chaplaincy class designed to address the challenges that I outline in Chapter Three. However, because conventional CPE groups are predominantly Christian with one or two students from another faith tradition, they don't have enough religious diversity for in-depth interfaith learning. In addition, from my initial research, I learned that interfaith dialogue has been criticized as an ineffective method both in academic and social activist circles. In fact, some chaplains opted not to participate in my interviews because of the unsatisfying experiences they have had with interfaith work in the past. One scholar, who began an interfaith dialogue group in her town over ten years-ago, said that because "people are not comfortable saying what they feel" in interfaith groups they often "put on their best image" and as a result there are many opportunities for

misunderstanding.[7] She also claimed that interfaith language is born from the Abrahamic community. In an interfaith discussion, minority populations must either adapt to the language and ideology of the dominant group or they will be further alienated and likely to eventually leave the group altogether.

Through the interview process, I've become more aware of how deeply Christianity is embedded in American culture and especially our colloquial language. From experience, I have learned that criticizing chaplains for a lack of awareness about their own privilege is not productive; it does not help a chaplain to understand how they are minimizing non-Christian perspectives. However, I've also realized that such criticism on my part would only be hypocritical because of how strongly my own language, education, and ideology is deeply influenced by Christianity.

One Hindu chaplain that I interviewed described his own chaplaincy work as based on *Hindu models of pastoral care*. Although the term *pastoral* has Biblical roots, this chaplain explained that he hoped to help the chaplaincy profession "evolve and grow" from the "inside out."[8] This chaplain states:

> I actually don't push back against or [become disconcerted by] using titles like *chaplain* or using a phrase like *pastoral care*. It is not like I am unaware of the Christian roots of that terminology, but I also think that part of the story of chaplaincy and pastoral care is that the terminology is also evolving…and why not be a part of that process and help to redefine what people think when they hear the word chaplain?[9]

Similar to this interviewee, throughout this study I have chosen to use the word *chaplain,* although the word denotes a minister who works at a Christian chapel. As a professional, when I introduce myself as a chaplain, most patients immediately know that religion and death are

[7] Anonymous (professional chaplain) in discussion with author, September 13, 2017.

[8] Anonymous (professional chaplain) in discussion with author, February 20, 2018.
[9] Anonymous (professional chaplain) in discussion with author, February 20, 2018.

prominent aspects of my work. The alternative term *spiritual counselor* that is sometimes used in hospital and hospice settings vaguely communicates a nondescript role. The point of this thesis, however, is to critique, correct and bring clarity to the chaplain's potential as a religious expert who connects patients to the insights, strength, and refuge provided by their own religion or worldview.

Chapter One

Educational Standards for Chaplaincy Training

An Introduction to Clinical Pastoral Education

Every Tuesday morning at 8 am, the Pain and Palliative Care Team at Northern Hospital[10] gathers for what is called a "spiritual opening." The team is composed of three physicians, four nurses, and a social worker. Usually they come from several religious backgrounds; hence a sectarian prayer is inappropriate. The spiritual opening is offered by a chaplaincy student. Students may recite prayer or poetry, lead a guided meditation, or play a musical piece. The opening is intended to uplift the team and offer it a sense of peace. The team typically responds with appreciation. The student hopes that the appreciation indicates that the opening authentically touched a few of the team's members.

These chaplaincy students are receiving their training through Clinical Pastoral Education (CPE), an experiential program intended to prepare chaplains for work in professional clinical settings. CPE requires thirty-two hours of direct clinical experience for every eight hours of classroom time. Based on an action-reflection-action learning model, students directly engage with hospital patients, reflect on their patient interactions within the classroom setting, and, if necessary, revise their chaplaincy approach for subsequent patient visits. CPE hopes to help chaplaincy students develop a personalized approach to spiritual care that serves people of all cultures, social backgrounds, and spiritual orientations. It is not unusual for CPE students to have their first unsupervised patient visit within the first week of the training program. Often students begin CPE with a strong religious orientation; in the course of the program, they develop their spiritual care skills learning to respond skillfully and kindly to patients of different faiths.

[10] The Northern Hospital is a pseudonym.

Most major hospitals in the United States require that their chaplains have at least four units of CPE to be eligible for employment. The Association for Clinical Pastoral Education, accredited by the US Department of Education, oversees the certification of CPE programs. On their website the ACPE defines CPE as follows:

> Clinical Pastoral Education is interfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounter with persons in crisis.[11]

This definition raises the following questions: 1) What is interfaith chaplaincy? 2) Is CPE interfaith because a) it brings together people of different faith backgrounds, b) it places students in clinical settings where they will be working with people of faiths different than their own, or c) there is an interfaith learning component to the training that teaches students how to engage in interfaith interactions?

Within Clinical Pastoral Education there seems to be an assumption that because students of different faiths meet in the classroom setting and because students encounter patients whose religion differs from their own, the training inevitably qualifies as interfaith. Descriptions of CPE programs in academic articles rarely acknowledge, let alone problematize, the interfaith aspect of the training program. The following description of CPE illustrates the normative approach to clinical chaplaincy:

> Clinical Pastoral Education is understood here as a form of theological education that takes place not exclusively in academic classrooms, but also in clinical settings where ministry is being practiced and theological knowledge of the human condition is applied to people in need.[12]

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[11] ACPE: The Standard for Spiritual Care and Education, *Information for Prospective Students: Frequently Asked Questions*, https://www.acpe.edu/ACPE/_Students/FAQ_S.aspx (accessed March 19, 2018).

[12] Simon J Cradock Lee, "In a Secular Spirit: Strategies of Clinical Pastoral Education," *Healthcare Analysis* 10 (2002): 341.

CPE pedagogy assumes that the student's own theological perspective can guide them to work with the general populace. The term *theology,* implies belief in a deity and the ability to logically discuss one's beliefs. However, the fact that all religions are not theistic or creed-based goes unstated, bringing the interfaith component of CPE into question.

In 2002, the Department of Education required that the ACPE standardize its educational goals for CPE programs. In this chapter, I will analyze these goals to determine how they influence the interfaith component of CPE programs. I will also provide some historical information about CPE to offer insight as to why these particular standards were chosen. Finally, I will suggest some of the implications that these educational goals have on interfaith learning.

The History of Clinical Pastoral Education

Clinical Pastoral Education began in 1925 with the supervision of Anton Boisen who self-identified as a Presbyterian/Congregational minister. He worked as a hospital chaplain at Worcester State Hospital in Massachusetts. Boisen suffered from periodic schizophrenic psychotic breaks throughout his life. In fact, Boisen spent two years of his life as an inpatient in the Worcester State Hospital's mental health unit. However, rather than describing his illness and hospitalizations as tragedy, Boisen claimed the experience "served a purpose."[13] As a result of his self-directed therapeutic experiences in the hospital, Boisen believed that "certain types of schizophrenia could be understood as attempts to solve problems of the soul."[14] Because of his own healing experience, Boisen asserted that traditional Protestant approaches to chaplaincy,

[13] Allison Stokes, *Ministry After Freud* (UK*:* Pilgrim Press, 1985), 41.
[14] Robert D, Leas and John R. Thomas, "Association of Clinical Pastoral Education: A Brief History," *ACPE: The Standard for Spiritual Care and Education*, https://www.acpe.edu/pdf/History/ACPE%20Brief%20History.pdf (accessed on March 19, 2018).

based on preaching and scripture did not help those in spiritual crisis. He spent the remainder of his life developing a new approach to pastoral care.

Boisen's perspective was strongly influenced by early 20th century liberal Protestantism. Responding to a general disillusionment with classical Protestantism's intellectual theological stance, liberal Protestant pastors searched for alternative ways to engage with urban social problems. With the professionalization of law and medicine in the 1920s, theologians faced pressure to exhibit skills beyond sermons and oratory. Rationalization, science, and technological innovation conflicted with a ministerial style based in revelation provided by the impetus of the Word.

In his attempt to step away from traditional forms of ministry, Boisen looked toward science, specifically psychology, for inspiration. The clinical pastoral education program that he developed emerged as a response to the societal conversation between liberal Protestantism and the newly developing field of psychology.

Bonnie J. Miller-McLemore states:

> CPE was inspired, as Edward Thornton argues, both by the appeal of the "methods of medical education, psychology, and social work" *and* as a reaction "against the limitations of classical theological education." The sciences appealed because they presented a viable means to address this disenchantment. People turned to psychology not so much because they were caving into secular culture, as Holfield implies, nor because they sought "academic or scientific respectability" as Edward Farley asserts, but because they found in the sciences a powerful way to understand religious experience and healing (perhaps better at the time than that found elsewhere in theology).[15]

Boisen, who valued close and methodical observation of peoples' lives, presented a new form of pastoral theology that focused on the human experience and offered a social response to early 20th century societal problems.

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[15] Bonnie J. Miller-McLemore, "Revisiting the Living Human Web: Theological Education and The Role of Clinical Pastoral Education," *The Journal of Pastoral Care and Counseling* 62, nos 1-2 (2008): 8.

Dr. Richard Cabot, a physician at Harvard Medical School known as the "Father of Social Work,"[16] worked closely with Boisen during CPE's formative years. Under Cabot's direction, Boisen employed the case study model in his teaching and his pastoral care. By integrating information about the patient's family, their religious background, and personal development into pastoral care, Boisen prioritized the patient's experience over traditional theological positions.

Incorporating psychological theory into his ministry was not a stretch for Boisen. During his hospitalization, Boisen wrote a letter to a friend regarding Freudian theory. Boisen said:

> Freud's conclusions are so strikingly in line with those which I had already formed that it makes me believe in myself a little bit once more…Neuroses…Have a purpose. They are due to deep-seated conflict between great subconscious forces and the cure is to be found not in the suppression of the symptoms but in the solution of the conflict.[17]

However, unlike Freud, Boisen viewed the resolution of internal conflict as a deeply spiritual act. Barbara Howard explains that for Boisen, "salvation consisted in the resolution of the conflict through unification with that which is 'Greater-than-self', bringing inward peace and sacrificial cooperation in the process of evolution."[18]

Boisen's theological philosophy remains prevalent in CPE today. Just as Boisen found "opportunity" in his neuroses, CPE students are taught to spiritually assess how patients are "making meaning" of their illness. Subsequently, students then attempt to guide patients towards peace by addressing spiritual conflict in their lives. Boisen's pastoral approach resulted from his

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[16] Robert D, Leas and John R. Thomas, "Association of Clinical Pastoral Education: A Brief History," *ACPE: The Standard for Spiritual Care and Education*, https://www.acpe.edu/pdf/History/ACPE%20Brief%20History.pdf (accessed on March 19, 2018).
[17] Stokes, *Ministry After Freud,* 49.
[18] Barbara Howard, "Shifting Concepts of the 'Living Human Document," *New South Wales College of Clinical Pastoral Education* https://cpensw.com/wp/wp-content/uploads/2017/09/SHIFTING-CONCEPTS-OF-THE.pdf (accessed on March 19, 2018).

own experience of interacting with mental health patients over an extended time. Rather than teaching a particular set of skills, Boisen asked his students to directly engage with what he called the "living human document."[19] The premise that "pastoral identity" results from self-reflective clinical experience forms the foundation of CPE educational philosophy. This account of Boisen's history shows that a particular historical liberal Protestant theology continues to shape CPE today.

In summary, aspects of CPE's historical development form the cornerstones of the CPE training programs that I experienced both in New York City and Honolulu: 1) Close observation of people's lives gives rise to insights that cannot be gleaned from doctrine, spiritual or otherwise. 2) Learning arises from human relationships; CPE supervisors often suggest that students allow "their patients to be their teachers." 3) The chaplain seeks to understand the patient's worldview by attempting to understand how the patient "makes-meaning" of their life. 4) Patients have self-determination in how they "make meaning" of their illness.

Clinical Pastoral Education Goals as Defined by the ACPE

The Clinical Pastoral Education program sets students to master two levels of learning competencies. Students prove proficiency at each level by meeting a set of educational goals. In many CPE programs, students write weekly logs which illustrate, with clinical examples, their strengths and weaknesses in relation to these goals. In the following section, I will list the CPE educational goals, offer an interpretation of their meaning, and assess their implications for interfaith chaplaincy training.

For each learning level, CPE goals are listed under three separate categories: pastoral formation, pastoral competence, and pastoral reflection. (See Appendix A for the ACPE listing.)

[19]Miller-McLemore, "Living Human Web," 3.

"Pastoral formation" focuses on establishing the student's self-identity as a chaplain. "Pastoral competence" lists a few clinical skills, such as attentive listening, conflict resolution, and crisis management, which students are expected to demonstrate. However, overall, "pastoral competence" describes general administrative tasks that situate the chaplain as a professional within the hospital system. The third category, "pastoral reflection," prepares students to transition into a professional position where they will need to work independently. All three categories emphasize self-development, referred to as the "pastoral identity" of the chaplain.

The category titles "pastoral formation," "pastoral competence," and "pastoral reflection" have strong Christian connotations. The Latin word *pastor*, meaning shepherd, is used throughout Christian scripture. John 10:1 refers to Jesus as the good shepherd who tends to his flock, meaning that he cares for his people. Because the CPE category titles invoke such strong Christian imagery, I feel that they distract from the actual content of the goals. They do not help students to function successfully in an interfaith environment.

I suggest reorganizing the goals into five new categories that offer an alternative way to describe their function. The goals themselves use the text from the ACPE website, however they are re-categorized into five groups: (awareness and articulation, critique, administrative function, skills, and other) with titles that give another window into their specific purpose.

Awareness and Articulation

1. Articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry.
2. Identify and discuss major life events, relationships, social locations, cultural contexts, and social realities that impact personal identity as expressed in pastoral functioning.
3. Articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.

Feedback and Critique

1. Initiate peer group and supervisory consultation and receive critique about one's ministry practice.
2. Risk offering appropriate and timely critique with peers and supervisors.
3. Demonstrate self-supervision through realistic self-evaluation of pastoral functioning.
4. Use the clinical methods of learning to achieve one's educational goals.

Administrative Functionality

1. Demonstrate competent use of self in ministry and **administrative function**[20] which includes: emotional availability, cultural humility, appropriate self- disclosure, positive use of power and authority, a non-anxious and non- judgmental presence, and clear and responsible boundaries.
2. Establish collaboration and dialogue with peers, authorities and other professionals.
3. Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.
4. Demonstrate awareness of the *Common Qualifications and Competencies for Professional Chaplains.* Note: The ACPE Standards and Code of Ethics supersede these standards.

Skills

1. Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
2. Demonstrate competent **use of self**[21] in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self- disclosure, positive use of power and authority, a non-anxious and non- judgmental presence, and clear and responsible boundaries.[22]
3. Assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.
4. Provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspectives

Other

1. Recognize relational dynamics within group contexts.

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[20] I highlighted this phrase to emphasize why I placed it in this particular category.
[21] I highlighted this phrase to emphasize why I placed it in this particular category. The 'use of self' in chaplaincy is an acquired skill.
[22] This goal is listed twice because it pertains to two categories.

2. Demonstrate the integration of conceptual understandings presented in the curriculum into pastoral practice.
3. Initiate helping relationships within and across diverse populations.

Awareness and articulation, the first category, lists goals that encourage students to become more aware of the lens through which they perceive the world and how that lens influences their interactions with patients. The second category consists of *goals aimed* at giving and receiving *critique.* This section emphasizes that students must not only be able to receive critique, but that they must actively seek out critique by initiating consultation with their supervisors. In follow-up, they must then be able to use that critique to develop goals for further learning. The third category, *administrative function*, includes goals such as collaborating with "authorities and other professionals" and interpersonal skills such as forming clear and responsible boundaries that situate the chaplain as a professional within the hospital system. The *skills* category lists the few practical chaplaincy skills that are included in the educational goals and the *other* category identifies goals that did not easily fit in a category.

I further divided the *practical skills* categories into two distinct sets - those that are reflective and those that are active in stance. The reflective goals cannot easily be perceived or evaluated by others. This grouping includes: listening/attending, empathic reflection, cultural humility, emotional availability, positive use of power and authority, and a non-anxious, non-judgmental presence. The action-based skills include: conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.

The goals in the miscellaneous category have little in common except that they are all vague. It is not clear how these goals are to be interpreted. For instance, the phrase "helping relationships" does little to explain the chaplain's role as a spiritual care expert; rather, it obliquely challenges the chaplain to be everyone's companion. Similarly, "recognizing group

dynamics" does not clarify how a chaplain's work differs from that of any other professional in the clinical setting. The final goal, in the *other* category, states that the chaplain must "demonstrate the integration of conceptual understanding presented in the curriculum." However, CPE curricula vary from program to program and the ACPE does not identify the "curriculum" or the "conceptual understandings" to which this goal refers.

ACPE Educational Goals and Interfaith Training

Although the ACPE describes CPE as an interfaith program, none of the educational goals speak directly to interfaith work. The goals are written in language with such strong Christian connotations that if one were not already familiar with CPE, one might not be aware that it actually is an interfaith program. Two goals, seemingly intended to apply to interfaith learning, talk about "diversity." Although neither "religion" nor "spirituality" are mentioned, they *may* be implied under the umbrella term "diversity." In CPE level one, the student is expected to "initiate helping relationship within and across diverse populations" and in CPE level two, students "provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics without imposing one's own perspective."

Rather than listing skills required to work in diverse or interfaith environments, these two ACPE goals cloak the chaplain's role in ambiguity and suggest that the chaplain, as a generalist, serves the hospital and its patients in many capacities. While one level II goal refers to "social conditions" and "ethics" (which may help determine the quality of medical care that minority populations receive), the goal itself fails to give practical direction to students struggling within the limitations of their own cultural viewpoint and personal biases. In other words, it does not directly acknowledge the real obstacles that students will face in interfaith work. For instance,

the homeless often do not have family members to serve as proxy and advocate for their care. In cases where homeless persons have been intubated or declared brain-dead, hospital ethics teams (which often include chaplains) have met to consult on whether to end the patient's life. Any chaplain, who has not been trained to address their own personal biases may make a decision based on their preconceived notion about particular populations, rather than offering a more nuanced assessment of the situation actually at hand.

One goal succeeds to list characteristics that could help students navigate interactions with people of diverse backgrounds or identities. "Cultural humility," "positive use of power and authority," and "clear and responsible boundaries" are described as behaviors that "demonstrate" competency in ministry. However, in order to make the link between these qualities and interfaith chaplaincy, the CPE student must figure out for herself how these qualities can be mastered and manifested. Senior chaplains may role-model interfaith chaplaincy to CPE students or CPE students may receive feedback about their own interfaith skills from peers, but this is not required by the ACPE curriculum. Bottom line, the ACPE educational goals do not mention "interfaith" work, let alone mandate that it be standardized into their learning goals.

Analysis

In examining the goals, two themes stand-out that will set the background for later chapters. The first is the professionalization of hospital chaplaincy. Secularized hospitals require that hospital chaplaincy departments serve the needs of a broad patient population. Hospitals accredited by the US Joint Commission on Accreditation of Healthcare Organizations (JCAHO) create a demand for chaplains. Regulations stipulate that chaplains function in an interfaith capacity. As a result, in the 1990's, a distinct shift took place in chaplaincy training programs;

chaplains were to be prepared to work with patients of all religious backgrounds as well as with patients who claim no religion.

The second theme is that CPE educational goals prioritize self-development over skill training. CPE educational goals aim to legitimize the spiritual care profession by making chaplaincy relevant to all patients regardless of their religious orientation. However, because the learning goals emphasize self-awareness without providing explicit practical education in interfaith skills, CPE's self-development training may inhibit students from moving beyond a historically, normative Christian approach to chaplaincy.

Professionalization of Hospital Chaplaincy

Above all else, CPE teaches students to function professionally within medical institutions. Students must learn to explain their role as chaplain to patients, their family and hospital staff in a secularized setting. As Kerry Eagan points out in her book *On Living*, succinctly explaining a profession that is based on the premise of *presence* and *accompanying* others through illness can be an elusive task.[23] CPE encourages students to present themselves as an integral part of the medical care team. Using the spiritual assessment tool, chaplains provide information about the patient's spiritual or psycho-social background that is integrated into a patient's medical care plan.

Institutionally, hospital chaplaincy is supported by JCAHO. In 1998, JCAHO promulgated a standard that required hospitals to offer spiritual care as part of their patient services. Hospitals that support CPE training programs receive Medicare funding. Staff and

[23] Kerry Eagan, *On Living* (New York: Riverhead Books, 2016).

students involved in CPE training offer the hospital the spiritual care services needed to meet JCAHO's accreditation requirements.

The mandate that hospitals offer religiously-motivated services in a secularized setting was justified in vague terms. As Craddock Lee points out, "the only way chaplaincy could become a JCAHO standard was to be recast as 'spiritual care services,' a non-denominational, more importantly 'non-religious,' patient care strategy." Craddock Lee further states, "Consequently, a secularized professional practice is necessary to demonstrate the relevance and utility of spiritual care for all hospital patients, rather than restricting their applicability to explicitly religious patients."[24] Craddock Lee concludes that CPE serves to codify the chaplain's work and trains chaplains to function as "spiritual care" experts within the hospital system.

Like all other medical professionals within the hospital system, chaplains are required to 1) approach their work with a rational seeming problem-solving based methodology and 2) to quantify their work in order to prove that their services are a financial asset to the institution which they serve. The spiritual assessment methodology that is the primary focus of CPE training meets both of these demands. As mentioned previously, using the spiritual assessment, the chaplain identifies spiritual and psycho-social issues that the patient may be experiencing. The chaplain then offers spiritual care interventions to address the patient's concerns. The chaplain's spiritual assessment can be charted in an abbreviated form into the patient's medical record. The medical record both communicates the chaplain's recommendations to the medical team and quantifies the chaplain's contribution to patient care. This process seeks to legitimate the chaplain's position as a member of the interdisciplinary patient care team.

[24] Cradock Lee, "Secular Spirit," 340.

In addition to making chaplaincy services applicable to all patients throughout the medical system, CPE professionalizes hospital chaplaincy by distinguishing CPE-trained chaplains from pastors and other religious leaders who might visit the hospital to offer ministry to their parishioners. Craddock Lee explains that "Rather than being purely revelatory or intuitional, [CPE] is a routinized and systematic process that can be taught, evaluated and its providers tested and certified." The CPE educational goals are part of this process. One resident who has completed seven units of CPE said that the goals helped her to find "a way to articulate [her] competencies and to really understand what [her] skill set is" rather than "relying on her intuition" as her sole approach to spiritual care.[25]

In contrast with the pastor who proselytizes and the Catholic priest sanctioned to perform Anointing of the Sick, the CPE-trained hospital chaplain primarily listens to patients' experiences and in response offers a form of spiritual companionship. As one CPE trained hospice chaplain stated, "The majority of chaplaincy work is the ability to appropriately respond to people who are in crisis or in an emotionally volatile situation with compassion, with caring, with occasional words of wisdom."[26] When CPE trained chaplains facilitate a patient encounter, religion becomes a significant part of the conversation only when the patient makes it so.

The ACPE's Prioritization of Self-Development in Its Educational Goals

The ACPE educational goals list few tangible skills necessary for conducting interfaith chaplaincy. Instead, they focus on the personal development and self-growth of the chaplain. For instance, one of the program goals is for students "to articulate an understanding of the pastoral

[25] Anonymous (professional chaplain) in discussion with author, February 23, 2018.
[26] Anonymous (professional chaplain) in discussion with author, September 27, 2017.

role that is congruent with one's personal and cultural values, basic assumptions and personhood."[27] A pain and palliative care chaplain commented:

> Part of this training is very sincere in its effort for me to find my own orientation and define what it means…It is certainly held in very intentional regards here in my program now. In that authentic sense, [we ask ourselves] what is our own pastoral authority? How do you view yourself in your own belief system in order to offer care to people of all faiths and people of no faith at all?[28]

As this chaplain implies, in CPE there is an unspoken assumption that finding integrity in one's approach to chaplaincy involves making that approach inclusive to all patients. Students who are not interested on some level in expanding their self-awareness as a way to improve their chaplaincy skills often do not complete the program.

Challenged to articulate how their life experiences have helped shape their approach to chaplaincy, students must reach an understanding of how past events (including their religious upbringing) might influence their current work with patients. Cradock Lee claims that "modern hospital, spirituality increasingly refers broadly to the experiential integration of one's life in terms of one's ultimate values and meaning."[29] CPE educational philosophy suggests that in reflecting on and integrating past life experiences, CPE students confront the origins of their own spirituality and are "encouraged to find ways to make use of his or her story as a resource for ministry."[30]

CPE's emphasis on developing self-awareness is well-founded. Chaplains often work with patients and families that are facing the most vulnerable moments of their life. As expressed by one hospice chaplain, the chaplain's role is more often to sit with a patient in silence and

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[27] Focus group interview conducted (CPE students) on October 3, 2018.
[28] Anonymous (professional chaplain) in discussion with author, February, 22 2018.
[29] Maureen Muldoon and Norman King, "Spirituality, Health Care, and Bioethics," *Journal of Religion and Health* 34, no. 4 (1995): 347.
[30] Logan C. Jones, "Baptism by fire in clinical pastoral education: the theory and practice of learning the art of pastoral care through verbatims," *Reflective Practice* 7, no. 1 (2006): 138.

respond to the patient's emotional experience, than it is to offer advice or counsel. Rarely can a chaplain "fix" the "problem" at hand. Witnessing another's suffering without being able to help, but without distancing oneself from the pain requires self-awareness. A pain and palliative care chaplain explains:

> [In CPE] you find out who you are in relationship to the people you meet, what pushes your buttons and [find out how to be] comfortable in your own skin. To me that is a lifelong journey.[31]

Through group learning and clinical support, CPE aims, first and foremost, to encourage students to gain self-awareness. In order to be effective, the chaplain must continually confront her own fears and anxieties about illness, death, and other circumstances that she will face in the clinical setting.

As an educational tool, self-awareness can be useful for interfaith engagement. As an educational goal, self-awareness falls short if students are unaware of the larger epistemological framework within which they are functioning. In this regard, the ACPE's choice of language, such as "pastoral formation," is concerning, because it illustrates the organization's lack of awareness about its own exclusivity. If the organization does not hold itself accountable to building awareness about inclusiveness, how can its students be expected to develop beyond a normative Christian approach to interfaith chaplaincy?

Although the ACPE's emphasis on self-development may be a positive attribute to chaplaincy training, it forms an insufficient foundation for ACPE's interfaith educational philosophy. In the following statement Cradock Lee summarizes the traditional CPE learning philosophy:

> A significant part of the CPE paradigm is about the growth, not just of patients, but of chaplain residents themselves, the development of a chaplain's pastoral identity and, thus, his or her individual ministry…Becoming more aware of her calling, the CPE student improves her ministry to patients. By improving her ministry, she discovers her pastoral identity.[32]

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[31] Anonymous (professional chaplain) in discussion with author, October 30, 2017.
[32] Cradock Lee, "Secular Spirit," 352.

In these terms, CPE's developmental process can no longer be considered an interfaith approach to chaplaincy training. The fault lies in two unspoken assumptions: 1) that growth, predicated on self-awareness, inevitably leads to an ability to facilitate interfaith spiritual care and 2) that chaplains can be trained on the basis of their "calling." These assumptions lead to CPE-training that produces chaplains who may be self-aware in an individualistic sense, but who lack sufficient socio-cultural awareness and education to adequately serve religions that differ from their own. If these assumptions persist, CPE programs will tend to recruit primarily Christian students rather than a more diverse population of students that both reflects the patient population and is conducive to interfaith learning.

Although CPE educational goals work to legitimize the spiritual care profession and make chaplaincy available to all patients regardless of their religious orientation, the goals are written in language that undermines their purpose. One professional chaplain, who was the first Hindu in his CPE training program explained, "It did feel very much like a Christian, or at best Judeo-Christian, or at best an Abrahamic framework where I constantly had to do my own translating to make it make sense for me." As with this students' experience, rather than being supported within an interfaith learning environment, students from minority religions have to accommodate CPE.

Craddock Lee suggests that words like "ministry" and "pastoral care" may function as a professional language that separates chaplains from psycho-social professionals in the medical setting. Quoting a professional chaplain Craddock Lee writes:

> In this setting you need to have some theory to describe what you do. Without it you get discounted, and you end up charting with psychological rather than theological language. Without being able to articulate spiritual services, chaplains are relegated to only religious patients, and as an afterthought.[33]

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[33] Craddock Lee, "Secular Spirit," 346.

Craddock Lee is claiming that as the ACPE transitioned its focus from "religion" to "spiritual care," professional medical chaplaincy had to retain a degree of autonomy. The ACPE's educational goals that ask students to articulate how their theology informs their ministry set the precedence for the language that signifies the chaplain's professional domain. However, the ACPE has chosen terminology that invokes a particular type of religious understanding and may limit the organization's ability to work with students and patients from non-Abrahamic backgrounds.

ACPE educational goals which ask students to "assess the strengths and needs of those served, grounded in theology" demonstrate an ignorance about religions and cultures that do not easily conform to a creed-based paradigm. Ultimately, "theological" presumes a belief in God. The underlying assumption that religion is about belief and the idea that chaplaincy engages one's belief as the solution to a perceived spiritual crisis may limit the profession's potential to serve. For example, how can an ACPE supervisor give theological guidance to a non-theistic or unchurched student? Similarly, how does a student use their theological foundation to relate to a patient from a non-theistic religion? The fact that the majority of the world's religions are not theologically based, but are enacted religions founded in a community's social ties, is not accounted for within ACPE education goals.

Although ACPE educational goals are not designed for interfaith work, many CPE-trained chaplains are finding innovative ways to work with patients within the demands of secularized medical environments. In the following chapter, I examine how CPE-trained chaplains navigate clinical settings. Drawing from my interviews, I look at chaplains' descriptions of their role and the values that they uphold. I suggest the population that CPE-trained chaplains best serve. And, I also discuss the touchstones of CPE training that have

influenced the shape of professional chaplaincy. In sum, I provide a picture of the CPE trained chaplain on-the-ground.

Chapter Two

CPE Training: The Practice of Presence

Introduction

Doing rounds one day on a medical surgery floor, I met a patient in her mid-forties who was recovering from a minor surgery. When I introduced myself, she asked me what chaplains do. That day my response was more brief than usual. I simply responded, "We listen without judgment. I'm really here just to hear whatever it is you might like to tell me about your life." In response, the patient started talking and didn't stop until forty-five minutes later. At the end of her sharing she said, "I've never told my story without anyone interjecting and telling me I should have done something differently. When you told me you just listen, I didn't believe you. Thank you so much for hearing me out."[34]

Although the APC educational goals fail to offer practical guidelines for students' interfaith development, on-the-ground CPE-trained chaplains are finding innovative approaches to chaplaincy care. In the following chapter, I look at: 1) Common ways that CPE-trained chaplains perceive and enact their role, 2) The patient population that CPE-training serves, and 3) Components of CPE training. By examining how CPE-trained chaplains approach chaplaincy in chapter 2, I will be able to critique the interfaith aspect of CPE training in chapter 3.

On the Ground: An Overview of The Chaplain's Work

When meeting with clinical chaplains, my primary question was, "How does one person work with people of so many different faiths?" One chaplain replied, "That is the essence of the training."[35] However, none of the chaplains directly answered my question, rather they gave an

[34] This is a personal story from my own chaplaincy experience.
[35] Anonymous (professional chaplain) in discussion with author, February 23, 2018.

overview of their work and, rarely, was religion mentioned. In the following section, I share some of the common themes that stood-out in the chaplains' descriptions of their work.

While some chaplains specialize in end-of-life palliative care, others work in out-patient oncology units and visit patients receiving chemotherapy treatments. Some are assigned to burn units, while others lead group therapy spirituality sessions for inpatient behavioral health programs.[36] Within the medical model, the chaplain signifies an area of human care that scientific interventions cannot fulfill. In the face of death, the chaplain represents another opportunity for patient care.[37] From a medical perspective, the chaplain attends to the patient's spirit, so that the patient can experience quality of life until she dies.

Many chaplains describe their role as a companion who "journeys" alongside their patients and accompanies them in the "unknown."[38] Whether that unknown be an incomplete medical diagnosis, an unanswerable existential question, or the inevitability of death, chaplains emphasize that they support patients facing uncertainty. As Tim explained:

> When [patients] hear that I am a chaplain they may consciously or subconsciously hand me things to solve like riddles, discrepancies, paradoxes. I once had a patient who simply said, "I am fifty and I am dying of cancer." It wasn't a question to me. It was just kind of a thing that he couldn't figure out. And so, I think it was my job to move into that space with him. This space of confusion and pain. What I like to call the desert. Kind of just sit with him in this desert. Explore it. And maybe find a way out.[39]

Just as Tim uses the image of the desert, Ellie draws on the image of a labyrinth:

> You go with someone on this path and you don't know where it is leading, but you just keep following it as best you can. So, I use the image of a labyrinth and I also use beginner's mind. Each visit is unknown and if I hold that beginner's mind it allows the unexpected to be more palatable or okay.[40]

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[36] This is not an exhaustive list of the areas in which hospital chaplains can specialize.
[37] Within the holistic care model, when the patient may no longer be cured, it is thought that the possibility for "healing" remains. Within this model, healing is defined as integration between body, mind, and spirit.
[38] Focus group interview conducted (CPE students) on October 3, 2018.
[39] Focus group interview conducted (CPE students) on October 3, 2018.

[40] Focus group interview conducted (CPE students) on October 3, 2018.

Tim and Ellie, like other chaplains that I interviewed, trust the chaplaincy process; when they enter the labyrinth with a patient they trust that they will both eventually find their way out. Although the medical model may introduce the chaplain as a solution to the "problem" of death, chaplains who are willing to simply explore with their patients without a fixed agenda function outside of the conventional problem-solution binary.

Other chaplains described their work as "bearing witness."[41] These chaplains emphasized that they create a space in which patients can express themselves freely. By bearing witness to the patient's circumstances, the chaplain brings a sense of awareness to the situation at hand. Emma explained:

> In my first year of seminary I had a really bad accident and I was in the hospital for a long time and there was no chaplain in Germany at that time and no support. People just always said things like "it will all be ok" or "It could have been worse" or "compare yourself with so and so" and I thought there must be a profession that can sit with those in darkness and crisis and just sit there and not tell them it all will be ok. …. I discovered there was clinical chaplaincy a profession that sits right there.[42]

In defining clinical chaplaincy as a profession, Emma describes the field's expertise as specific to people in "darkness." By "just sitting" there the chaplain does not attempt to preach or minister to the patient. The chaplain's intention is to bear witness to another's suffering and offer consolation through their presence.

Chaplains perceive their presence as an agenda-less act. In medical charts, professional chaplains often write that they "offered a compassionate, nonjudgmental presence." While this language may convey little to the lay person, within the chaplaincy field it conveys that the chaplain did not intervene. One hospice chaplain said quite literally, "My job is to get out of the way."[43] She further explained that many families successfully come together to care for their

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[41] The phrase has both Christian and Buddhist connotations. Here, it eludes to the power of *being with* another person in their suffering.
[42] Focus group interview conducted (CPE students) on October 3, 2018.
[43] Focus group interview conducted (CPE students) on October 3, 2018.

loved ones during their final hours and that her job is to stay in the background, so the family can step forward in care.

Other chaplains specifically talked about the harm that platitudes such as "God has a reason for everything" and "God doesn't give you more than you can handle" cause for people facing grief.[44] A few chaplains described *presence* as the concept of "giving space" to their patients. For instance, Jim said "I see myself as sort of a sounding board listener more than anything else - giving people space to share their stories. The doctors often don't have time for that."[45]

These chaplains share the value that compassionate presence, through the act of bearing witness, is more likely to relieve their patients' suffering than religious or spiritual dogma. In her book *Ministry of Presence*, Winifred Sullivan calls the act of presence a "deliberate rejection of utilitarian action."[46] Sullivan suggests that in individualistic societies, the chaplain's presence substitutes for family and community support. Sullivan states:

> In a simple sense, [the ministry of presence] is about not being alone. The chaplain offers herself as a sacrifice to the suffering brought on by a myriad of seemingly intractable modern ills and the prevalence of a sense of abandonment, including her own. But she also seeks to be in relationship, not just with the divine, but also with the client.[47]

Suggesting that modernity engenders a sense of abandonment, Sullivan presents the idea that the chaplain as well as the patient benefit from the connection that is forged.

In a globalized, transient community, chaplaincy care offers a sense of personalized, compassionate support to patients and family members who may have little connection to their religious or cultural roots. In general, chaplains agreed that their visits should be patient-guided

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[44] Anonymous (professional chaplain) in discussion with author, September 25, 2017.
[45] Anonymous (professional chaplain) in discussion with author, October 30, 2017.
[46] Sullivan, *Presence,* 185.
[47] Sullivan, *Presence,* 184.

rather than chaplain-centered. Chaplains trained in bearing witness to others' suffering may offer patients a sense of recognition and acknowledgement that they've never before experienced.

Some chaplains described specific skillsets to illustrate their work. One chaplain called his work "grief work" and talked about encouraging a patient's family members to imagine how they would cope after the patient's death.[48] He then explained that he approaches grief with a Buddhist family the same way as he would with a Christian family. Grief work, he described, is not religious, but about the emotional and logistical aspects for the surviving family member's day-to-day continuity.

Other chaplains also talked about offering tools to cope with grief and loss. One chaplain said:

> I might give some gentle guidance or reassurance about the nature of grieving or loss, or things that people can do to feel like they have some degree of control. Like how to help people talk to their loved one who is dying, on their death bed, non-responsive. Reassuring them that their loved one is likely still able to hear them and feel their presence.[49]

This chaplain also explained, from her experience, that guiding a patient through grieving "doesn't require [her] to be Christian or quoting scripture and it doesn't require [her] to be Jewish or Buddhist or of any faith tradition."[50] Grief work is considered to be a tool separate from religious or spiritual care.

Many chaplains emphasized that their work is about emotional responsiveness and that they are trained to work in an emotional realm. A hospice chaplain explained that during the dying process emotional pain and medical pain can get confused. As a result, sometimes patients

[48] Focus group interview conducted (CPE students) on October 8, 2017.
[49] Anonymous (professional chaplain) in discussion with author, September 27, 2017.
[50] Anonymous (professional chaplain) in discussion with author, September 27, 2017.

are being medicated for pain that can be more successfully addressed with other kinds of therapy. This chaplain said:

> So many people in our culture have never learned to process emotions. They have learned to distract themselves. If someone is facing a chronic illness, distractions are not going to work the way they worked the past.[51]

As result this chaplain views her primary role as preparing people for death by offering them tools to process their emotions associated with illness and loss.

Two other chaplains offered interesting perspectives on their role. One chaplain who spent many years working in a state mental health facility explained that "chaplaincy is about setting up scaffolding."[52] By this she meant her role is to help patients find grounding and stability amidst crises. One chaplain said that he sees his role as a liaison because "a lot of providers don't understand how little the family members comprehend."[53] This chaplain explained that although he does not comprehend all of the medical jargon, he is attuned to listening to cases differently than other medical professionals. He said that he often identifies when the patient needs further medical explanation and in turn, offers the medical team insight into the patient's cultural, social, and family dynamics

Multiple chaplains mentioned that they preferred not to work with people of their own faith. One chaplain said that he makes fewer assumptions about a patient when he is less familiar with their religion. This chaplain explained:

> As cliché as it is, *I think ignorance is a gift in the patient room* because if I meet a Christian patient, it easy for me as a Christian to assume things. What they mean by God or Jesus or any kind of doctrine and it is like I can't assume that, that is a big mistake. But, if I know they have a different religion than me, now I can be genuinely curious about who they are, what it actually means to them as well.[54]

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[51] Anonymous (professional chaplain) in discussion with author, January 18, 2018.
[52] Anonymous (professional chaplain) in discussion with author, September 25, 2017.
[53] Anonymous (professional chaplain) in discussion with author, February 21, 2018.
[54] Focus group interview conducted (CPE students) on October 3, 2017.

The chaplain who described her role as "setting up scaffolding" expressed that "she is less and less inclined to pray with people and do spiritual things" because she feels that chaplaincy is more effective when she is supporting the patient in other ways.[55] A chaplain who identifies as Evangelical explained that she preferred to work with people who claimed no faith at all because she found that non-religious patients were more open to talking about their lives and therefore more receptive to spiritual care.

When chaplains are supporting nonreligious and religious patients alike, they often attempt to identify what the patient deems most meaningful in their life. Maryanne talks about this chaplaincy approach:

> I am thinking it doesn't necessarily have to look like prayer or meditation or singing hymns. The question I think of at that point if they don't know where to go and they are a "none"[56]...is Where do you find love? What brings love into your life? What brings peace into your life? And that can look like petting a dog. That can look like taking a walk in the park. That can look like coloring. That can look like listening to Metallica. And because where are those open parts in you that lets love in and what does that look like?[57]

Although the patient may not identify as spiritual, when the chaplain identifies what the patient values, she is trained that meaning is the center piece of the patient's life. From this perspective, "spirituality" becomes equated with what the patient deems most meaningful in their life and therefore, theoretically, spiritual care can be introduced to a patient of any orientation.

Although the chaplains that I interviewed were from distinctly different religious backgrounds, they shared the idea that there was something common to humanity that transcended religious specificity. Maryanne described this in terms of "love" and "peace." Another chaplain said,

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[55] Anonymous (professional chaplain) in discussion with author, September 25, 2017.
[56] Upon admittance to the hospital, patients complete questionnaires that ask about their religious identity. If the patient does not affiliate with a specific religion, she may check the box "none".
[57] Focus group interview conducted (CPE students) on October 8, 2017.

> The true connection [between religions] is that we are all images of the divine. And, that transcends into interfaith because all traditions remain in the image of the divine - somewhere there is that piece. Buddhism definitely because we all have the Buddha nature, Christianity, Judaism, everything, Islam.[58]

Some chaplains, who work in an interfaith capacity, believe that their spiritual care theology transcends religious difference. For instance, a Catholic sister explained how she functions in an interfaith capacity:

> The one thing that I try to help people to see is that they are loved. Never in my life did I think that anybody could be unloved and when I met that person it was like wow. It just showed that he had no love. He didn't even know what love was….by the time that gentleman died, he knew that we were his family and that we loved him and took care of him so he could experience it. Until you have an awareness of what something is you can't be that yourself.[59]

Other chaplains emphasized that their work focuses on individual well-being and basic emotional needs shared by all human beings.

In summary, some chaplains described their work as being *presence*-based , others referred to it as the act of bearing witness. Chaplains named grief support and emotional responsiveness as important skillsets. One chaplain explained his role as a liaison, but however they chose to describe their job, chaplains agreed that cultivating their role took practice. For example, multiple chaplains explained that, from experience, they learned that platitudes meant to offer encouragement and assuage grief often send a grieving family deeper into isolation and despair.

In the following section, I will propose that because clinical chaplaincy, supported by the medical model, speaks to individualized spirituality rather than the dictums of a higher power, CPE-trained chaplains are prepared, above all else, to work with patients who do not identify with any specific religion. Not only is there a demand, among the American public, for a non-

[58] Anonymous (professional chaplain) in discussion with author, October 21, 2017.
[59] Anonymous (professional chaplain) in discussion with author, October 1, 2017.

religious type of care, but the medical model's focus on whole-person[60] care is actively transforming the chaplaincy profession. The net result being that chaplaincy is shifting gears toward becoming a field focused on human potential rather than religious care.

CPE: Spiritual Care Training Designed for Nones[61]

CPE-trained chaplains work with patients as spiritual care generalists.[62] Their training does not specifically teach chaplains to work within a patient's religious framework. However, it does give chaplains tools to assess and converse with the general patient population about how they find meaning in their life. The question then becomes, "Who is the chaplaincy profession serving?" I argue that, as a profession, hospital chaplaincy is a response not just to a changing pluralistic patient population, but to a technologically advanced medical system. In the following section, I look at the population that chaplains are serving and frame CPE within the larger academic conversation about the rising demographic of non-religious persons.

One chaplain I interviewed estimated that up to 50% of the patients she visited did not identify with any faith. Emma described her experience:

> [I call on a lot of] spiritual but not religious folks, who say we don't go to any church or temple, but we feel it inside. We go to the ocean we experience love and we are family. We do good. We feel connected, but not to an institutional concept.[63]

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[60] Whole-person care is considered to be a component of integrative medicine. It includes treatments that address the whole-person – body, mind, nutrition, movement and spirit. See Jenni Lyttle, "Whole Person Care," *Duke Magazine.* Oct-Sept, 2002, http://dukemagazine.duke.edu/article/whole-person-health-care (accessed January 15, 2018).

[61] People who answer "none" when asked what religion they affiliate with prefer not to identified with any religious category.

[62] Gelo defines spiritual care as "Care that is not connected to a specific religious tradition or heritage and seeks to express experiences beyond the material word and explanations for the ups and downs of living" (Gelo, "Role," 6). I specifically use the phrase "spiritual care generalist" rather than "spiritual care expert" because the chaplaincy field is promoting a service that caters to all patients, rather than an expertise that holds a specialized area of knowledge.

[63] Focus group interview conducted (CPE students) on October 3, 2017.

Emma's example of the category "spiritual but not religious" influences her approach to chaplaincy in two ways. First, she identifies "spiritual but not religious" as an all-inclusive category. Second, she distinguishes spirituality as an act of "connection" different from religion which connotes "institution." [64]

Not only has CPE training evolved to cater first and foremost to the Spiritual But Not Religious (SBNR) population, but CPE training attracts chaplains who are interested in exploring outside of the boundaries of their own religion's worldview. The training introduces a skillset based in attentive listening, critical self-reflection, a calm presence, and a non-judgmental frame of mind. As one chaplain explained, his role it to care for the basics of the human spirit, which she itemized as the need "to have meaning and purpose, to have a sense of belonging and community, and to love and be loved."[65] The students I interviewed specifically stated that they chose clinical chaplaincy over parish ministry because they wanted to have the opportunity to care for people outside of religious institutions. From their individual responses, it seems that for these students, the "sacred" exists in the moment-to-moment exchange with the patient, rather than in the act of referring to and expounding upon religious references.

In the past fifteen years, multiple scholars have written about Nones, people who claim no religious identity, as one of fastest growing identity categories in the United States.[66] Spiritual

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[64] Religion is commonly thought of as institutional while spirituality is considered to be the experience of what one values as sacred. Professor Ramdas Lamb states: Generally speaking, the term spirituality today has to do with an inner experience of something sacred that is disconnected with, or at least unbounded by, sectarian religious dogma or identity.

[65] Anonymous (professional chaplain) in discussion with author, on October 30, 2017.

[66] In her book, *Belief Without Borders,* Linda A. Mercadante claims that "during the 1990s the number of "Nones" began to rise exponentially until now it is considered the fastest growing "religious group" in the nation." She also states that "in 2012, 20% of Americans identify as Nones." Linda A. Mercadante, *Belief Without Borders: Inside the Minds of the Spiritual But Not Religious,* (New York: Oxford University Press, 2014), 4.

But Not Religious can be considered one sub-classification under the category None. Scholars have various perspective on the origins of the SBNR movement. In the following paragraphs, I refer to four scholars' perspective in order to examine CPE-training within a larger academic conversation.

Robert Fuller, author of *Spiritual, But Not Religious,* makes three claims about the SBNR category. He states: 1) Spiritual experiences connect a person to the "non-visible" world, 2) The SBNR movement influences the "churched" as well as the "unchurched," and 3) Psychology complements SBNR trends.[67] Fuller states:

> It is important to distinguish unchurched spirituality from secular interests. It is not sufficient for beliefs or practices to function like a religion for us to consider them spiritual. Many secular activities meet some of the social and psychological needs often associated with religion (providing a sense of meaning, fostering inner satisfaction, building community) … but they lack a distinctively spiritual quality.[68]

Fuller claims spirituality occurs when a person experiences a connection between their attitudes, ideas, lifestyles or practices to something beyond the visible world. CPE-trained chaplains aren't necessarily making the same distinction. For instance, if a patient talks about the freedom they experience while riding motorcycles, the chaplain may use this topic as an initiating point to discuss the topic of freedom in other areas of the patient's life. From there, the chaplain might ask the patient specifically how their sense of freedom is being affected by their hospitalization. Whether the patient considers motorcycle riding a spiritual act is not the chaplain's primary concern. CPE trains chaplains to work within the SBNR paradigm and employ its ideology, that life is imbued with meaning, regardless of the patient's self-identification. This paradigm shift is significant. SBNR actually negates the necessity to find meaning through religious practice or belief implying the loss of religion's relevance.[69]

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[67] Robert Fuller, *Spiritual But Not Religious*, (New York: Oxford University Press, 2001), 8.
[68] Fuller, *Spiritual*, 8.
[69] Jeff Wilson, e-mail message to author, March 26, 2018.

We may go beyond this. SBNR doesn't simply suggest that life is imbued with meaning—by negating the necessity of finding meaning through religious practice or belief, it trivializes them. So SBNR results in the loss of religion's relevancy, potentially making it harder for chaplains to call upon religious resources for assistance

Fuller theorizes that "unchurched spirituality is influencing the general American population including people who belong to mainstream religious organizations."[70] Claiming that we have become a nation of "seekers" of spiritual experience, Fuller further explains that many people associate spiritual beliefs with "issues that arise in everyday life, such as reducing stress, keeping healthy, or sustaining optimistic attitudes."[71] Perhaps, in the United States, unchurched spirituality has paved the way for chaplains trained in the SBNR paradigm. The chaplains that I interviewed meditate with patients, play music for patients, and create labyrinths on hospital grounds. As Fuller suggested, activities like these can positively affect patients, regardless of their religious orientation.

Finally, Fuller claims that unchurched spiritual traditions are compatible with the field of psychology, because they speak to the act of looking within to find peace and connection to a broader Universe. Fuller specifies that spiritual self-reflection relates to a desire to reach one's "full human potential" by finding "God within."[72] As a result, he claims that "unchurched religious traditions prepared popular audiences to see a deeper, spiritual significance in theories concerning our untapped psychological potentials."[73] The chaplains that I spoke with admitted that clinical chaplaincy can be very similar to social work and counseling. Through experience, chaplains learn when they have traversed into territory that is beyond their expertise. Chaplains commonly refer patients to psychologists when further support is needed.

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[70] Fuller, *Spiritual*, 9.
[71] Fuller, *Spiritual*, 124.
[72] Fuller, *Spiritual*, 124.
[73] Fuller, Spiritual, 124.

Leigh Eric Schmidt, author of *Restless Souls*, takes another approach toward understanding the origin of the SBNR movement. Schmidt claims that the United States' liberal Protestant roots are responsible for the ideas that Nones share today. He claims that "religious liberalism" is based on the following qualities:

> "Individual aspiration after mystical experience or religious feeling," "the valuing of silence, solitude, and serene meditation," "the immanence of the transcendence – in each person and in nature," "the cosmopolitan appreciation of religious variety as well as unity in diversity," "ethical earnestness in pursuit of justice-producing reforms," and "an emphasis on creative self-expression and adventuresome seeking."[74]

All of these qualities, describe a worldview shared by a majority of CPE-trained chaplains. If we take Schmidt's theory as plausible, then it is possible that the basic ideology of the spiritual care assessment, that individuals' lives are "imbued" with "meaning and depth," comes directly from liberal Protestant theology.[75] If that is the case, it is important to recognize that the SBNR category may not be as inclusive as commonly assumed and that CPE-trained chaplains could overlook the needs of patients who identify with religions, such as Shinto and some forms of Buddhism, that are not based in a meaning and belief-based conceptual framework.

Whether SBNR is a phenomenon that originated independently of America's religious institutions, as Fuller suggests, or it is an outcrop of liberal Protestant thinking, as Schmidt discusses, the most significant implication of the SBNR movement on chaplaincy remains the same; chaplains work with patients first and foremost as individuals. Viewed as isolated entities, patients are not assessed as part of a religious and cultural network. In fact, religious institutions offer a sense of connection, belonging, and community to people's lives. The loss of religious institutions as support networks can lead to people on a perpetual search for fulfilling lives.[76]

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[74] Leigh Eric Schmidt, *Restless Souls: The Making of American Spirituality*, (San Francisco: HarperCollins, 2005), 12.
[75] Schmidt, *Restless*, 12.
[76] Jeff Wilson, e-mail message to author, March 26, 2018.

Linda Mercadante, author of *Belief Without Borders,* claims that formerly this was not the case. She explains that "spirituality was about piety" and "not divorced from communal faith identity."[77] I question if chaplains are less likely to account for a person's family, history, or cultural reality when working with patients outside of a religious framework.

On one hand, some patients find it liberating to be acknowledged outside their familial context. In fact, patients often share their personal experience with the chaplain only when their family is outside of the room. However, on the other hand, the lack of a familial and cultural context can limit the chaplain's work. For instance, some cultures prefer that family members, rather than the patient, receive the patient's medical diagnosis. In the case of chronic illness, families fear that if their loved-one knows their prognosis they may be more likely to die. Without the patient's familial and cultural context, the chaplain may not only offer inappropriate care, but may also be impeded from providing the deep-rooted support that communal ritual offers.

Winifred Sullivan looks at chaplaincy from yet another angle. Sullivan "portray[s] the chaplain and her ministry as a product of legal regulation and as a form of spiritual governance."[78] In her book, Sullivan explains that while religion is considered a private matter, spirituality is legally protected as a basic "human need."[79] Sullivan, evocatively argues:

> The US chaplain, in particular, has come to instantiate the peculiar and shifting religious terrain framed by the religion clauses of the First Amendment to the US Constitution; she operates at the intersection of the sacred and the secular, a broker responsible for ministering to the wandering souls of a globalized economy and a public harrowed by a politics of fear-while also effectively sacralizing the institutions of the contemporary world.[80]

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[77] Mercadante, *Belief,* 4.
[78] Indiana University or Bloomington, *Department of Religious Studies Biography Page,* http://indiana.edu/~relstud/people/profiles/sullivan_winnifred (accessed January 15, 2018).
[79] In her book *A Ministry of Presence,* Sullivan writes about a legal case that determined that spiritual care is a basic human need..
[80] Sullivan, *Presence*, XI.

From a legal perspective, the SBNR paradigm is the gateway for professional chaplaincy in a secular world. Chaplains, as spiritual counselors, work for hospitals, schools, and prisons fulfilling a basic human need - care for the human spirit.

Mercadante presents a fourth perspective on the origin of the SBNR movement. Mercadante claims that Nones do, in fact, have a shared belief system that justifies their rejection of religious affiliation and that rather than hearing a desertification of belief from Nones, Mercadante believes that Nones represent the formulation of a new set of principles. Mercadante claims that the "separation of [religion from spirituality] is more a rhetorical device than a true divorce."[81] From Mercadante's perspective, the distinction between religion and spirituality is merely a function "to get out from under the external constraints of authority."[82] However, the shift in power has been significant resulting in "a proliferation of alternative spiritualities outside religious sponsorship [and] alternative or complementary health practices outside scientific medicine."[83]

The authoritarian shift to which Mercadante refers also applies to the chaplaincy field. The chaplain, rather than embodying the traditional role as a representative of God, now abides by a new set of rules defined by the medical team. Rather than having a clerical authority overseeing them, most chaplains report to a hospital administrator who is not trained in religious or spiritual care. Ultimately, in order for the chaplain's position to be retained and respected, the chaplain must prove their worth as necessary for patients' medical well-being.[84] As a result, chaplains are beginning to function within a totally different capacity.

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[81] Mercadante, *Belief,* 6.
[82] Mercadante, *Belief,* 6.
[83] Mercadante, *Belief,* 6.
[84] One chaplain explained: "Studies show that when they do patient surveys there is a high correlation between positive outcomes and people who received spiritual care." Anonymous

Each of these scholar's perspectives has different implications for chaplaincy training. From Fuller's perspective, chaplains trained to work with spirituality can assist religious and non-religious patients to cope with the day-to-day challenges of their hospitalization. If the SBNR movement is an offshoot of liberal Protestantism, as Schmidt proposes, then chaplains need to be particularly cautious of dismissing religious and non-religious persons who do not fit within a "meaning-making" paradigm. Sullivan's legal critique implies that professional chaplaincy must be based in a SBNR paradigm in order to be validated by the US constitution. Mercadante's theory, which categorizes the distinction between religion and spirituality as a rhetorical device, suggests that the question is not whether chaplains are religiously or spiritually trained, but "who is determining the principles by which the field is abiding?"

In this chapter I propose that CPE-training caters to Nones and most specifically the SBNR population. In the following section, I will examine the foundations of chaplaincy training to examine how chaplains are trained to work with a non-religious population. However, perhaps the most significant shift in the chaplaincy field is not a move from religion to spirituality, but an authoritarian shift from the church to science, so that the principles that the chaplain is abiding by are in alignment, first and foremost, with the medical field.

The Touchstones of CPE Training

The medical system allots chaplains a level of creativity and autonomy that many medical professionals are denied. Chaplaincy stands out starkly against every other profession in the hospital. Unlike doctors, nurses, and social workers, the chaplain is not restricted by time constraints. Because work with the human spirit cannot be codified or standardized, the chaplain

(professional chaplain) in discussion with author, on Feb 23, 2018) Gelo writes about scientific studies that demonstrate the benefit of spiritual support for hospitalized patients. Gelo, "Role," 8.

inhabits a liminal space. The chaplain's main tool, much of the time, is simply her raw humanity.[85] CPE training is intended to train clinical chaplains to exhibit an expertise that creates space for patients from many different faith backgrounds to express and reflect-on on their hospitalization and their health within the greater context of their life. In the following section, I will look at the spiritual assessment, the practice of presence, and the verbatim,[86] as touchstones of chaplaincy training.

The Spiritual Assessment

In interviews with CPE trained chaplains and CPE students two aspects of their training stand out. The first is the spiritual assessment, the tool that guides chaplains to discern what patients define as most meaningful in their life. As, Eric Hall, explained, "The chaplain, as a solo practitioner, enters patients' worlds with the desire to help individuals to make sense of and find meaning in what they are experiencing."[87] Within CPE pedagogy, the question of "meaning" is assumed to be applicable to all patients regardless of their religious orientation. Craddock Lee argues that from a professional viewpoint *meaning* "constructs a discourse of contemporary relevance, a convincing narrative within the institution, that can preserve a space for modern religiosity – rendered less threatening and more universal by the label "spiritual."[88] The question of *meaning* is considered to be an inclusive form of inquiry.

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[85] Brian Walton, "Spiritual Care at The End of Life: The Chaplain as A Hopeful Presence," *British Journal of Psychology* 4, no. 1 (2014): 140.
[86] For more information on the verbatim see Chapter Two page 47.
[87] Rev Eric Hall, "Gaps In Chaplaincy Profession Still Ring True," *News From Healthcare Chaplaincy Network.* Health care Chaplaincy Network, https://www.healthcarechaplaincy.org/news-events/entry/gaps-in-chaplaincy-profession-still-ring-true.html (accessed on November 1, 2017).
[88] Craddock Lee, "Secular," 353.

The focus of the spiritual assessment lies on two pivotal questions, "What does a patient find most meaningful in their life and how is this patient making-meaning of their hospitalization?" In her book *On Living,* Kerry Eagan discusses the value of this inquiry:

> Every one of us will go through things that destroy our inner compass and pull meaning out from under us. Everyone who does not die young will go through some sort of spiritual crisis, where we have lost our sense of what is right and wrong, possible and impossible, real and not real. …This process of making or finding meaning at the end of life is what the chaplain facilitates. The chaplain doesn't do the work. The patient does. The chaplain isn't wrestling with the events of a life that don't match up with everything you were taught was true, but she won't turn away in fear, either. She won't try to give you pat answers to get you to stop talking about pain or shut you down with platitudes that make her feel better but do nothing to resolve the confusion and yearning, you feel.[89]

Ultimately, Eagan claims that the chaplain, through a trained style of inquiry, creates a space for the patient to grapple with existential concerns. Rather than being rooted within a culturally shared belief system, as is the case with religion, "meaning making" is based on an individual's personal experience. Individuality, rather than society, determines what is most meaningful in a person's life. I propose that this approach of relating to the human experience is not universal nor eternal, rather it is a social construct typical of contemporary American and European society.

In interviews, I found that each chaplain uses the spiritual assessment uniquely. Many chaplains talked about using the assessment to emotionally attune themselves to patients and make connections between one's emotional state and her spiritual beliefs. For example, Breann explained that a patient's emotions are often tied to a particular theological belief or understanding of God, and that patients' theological interpretations impact how they experience grief, shame, and guilt.[90] Another chaplain said, "I am assessing for [my patient's] emotional state. Are they in despair? Are they distressed? And, if so, then we can look at past experiences of overcoming adversity."[91] This chaplain emphasized that he "brainstorms ways to be creative

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[89] Eagan, *On Living*,18.
[90] Focus group interview conducted (CPE students) on October 8, 2017.
[91] Anonymous (professional chaplain) in discussion with author, February 21, 2018.

with people and connect with the good stuff in their life during a difficult time in the hospital."[92] Another chaplain explained that her way of assessing patients is by "getting them to tell her a story," so that she can determine "the heart of the problem" that the patient is experiencing.[93] This chaplain explained:

> [The patient's] story is going to tell me something. It is going to tell me where they are. Usually the first thing I ask is "How are you doing right now?" Really specific. That might go into, "How did you sleep last night? or What brought you into the hospital? Do they have family, do they have friends? What is [their] faith? How is that a factor?[94]

From this chaplain's perspective, *how* the patient tells their story offers insight into the kind of care the patient needs.

Pedagogically, CPE training attaches two significances to the meaning-making approach. First, meaning-making applies to the general population and takes precedence over religiously-based connection with a patient. Secondly, chaplains emphasize that the "meaning-making" approach is patient led. Theoretically different than the pastor who represents a direct link to a specific theology, the clinical chaplain builds-on the patient's own connection to meaning in their life. One student, Marty, stated:

> When I got here, I thought that it was important [to have knowledge of my patient's religion]. But, what is it - over the last two months now? It is nice to know, but I am so fascinated especially, with the age group that I am working with, how many people don't themselves know or did this at one point in their life, but are doing something else and I am finding that the meaning making seems to come more out of my being interested in what is important to them rather than what it is important for me to know.[95]

Marty's comment highlights that the meaning-making approach to chaplaincy seems especially conducive for working with patients who no longer identify with their birth religion or any religion at all.

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[92] Anonymous (professional chaplain) in discussion with author, February 21, 2018.
[93] Anonymous (professional chaplain) in discussion with author, February 21, 2018.
[94] Anonymous (professional chaplain) in discussion with author, February 23, 2018.
[95] Focus group interview conducted (CPE students) on October 8, 2017.

The Practice of Presence

The second area that I identify which defines CPE training is learning the practice of presence. It is through the act of presence that chaplains learn to: 1) position themselves as spiritual figureheads within hospitals, and 2) learn to *create a space* where patients can feel comfortable enough to talk about the existential questions that they are facing in their life. In the clinical setting students learn how to actively listen, how to be supportive without trying to fix the patient's situation, how to respond compassionately to grief, and how to remain emotionally steady in the face of anger and rage.[96] All of these actions can be considered outcomes of the practice of presence.

In order to be successful, the chaplain must be trained to become aware of her own emotional experience within the patient room, so that she doesn't react to a patient out of her own anxiety or other personal projections. When hospital staff experience a traumatic event in the hospital, such as caring for patients who are victims of violence, the chaplain is expected to care for the staff. In reference to this role, one chaplain explained: "there is a notion that somebody is able to walk into a room and for everybody [in that room] to feel peace" because of the quality of presence that the chaplain embodies.[97]

One chaplain gave an example of a patient visit where he encountered a lot of anger when working with a non-verbal patient. This chaplain felt that the patient's family was selfishly keeping the patient alive at the cost of the patient's own well-being. In order to be present with the patient in this circumstance, the chaplain had to face his own anger about the situation. This student summarized his experience as a CPE student:

> This past year of my CPE unit was really about presence. The power of presence and the question was throughout the whole unit is my presence enough? Because the patients that I saw were (I hate the word

[96] Jones, "Baptism," 129.
[97] Anonymous (professional chaplain) in discussion with author, September 27, 2017.

> "non-responsive" because it is not really true) they were non-verbal and all forms of dementia or intubated, so it was really one sitting with presence. I think for me when we walk into a room there is a lot going on. You have your guides, they have their guides, there is Spirit in the room, there is God in the room, I think that is part of what we have been trained to do to be present to what's in that connection.[98]

According to this chaplain, students can be trained to become aware of both the relational and subtle energetical dynamics in a patient room.

Many students talked about a beginner's state of mind as a tool for cultivating presence in their clinical work. One resident, said, "I use 'don't know mind' which is kind of like 'beginner's mind' but it helps me to come in with a beginner's presence to the situation and to allow the patient to guide what happens in the room." Ellie's remark prompted Tim's comment about how he finds its helpful when a patient's religion is different than his own. In order to become aware of the assumptions that they make, students learn to step out of an authoritative state of mind. Emma notes that "along with knowledge and skills and passion there is a not knowing and humility."[99] The chaplain's willingness to sit next to the patient, more like a companion than a professional, is a distinct choice that denotes a dynamic that is different from all other relationships that the patient will experience with clinical staff.

The chaplains also talked about authenticity as key component of *presence*. In order to find their authenticity, students engage in exercises that put them face-to-face with their own vulnerability. In one program, students created a timeline representing their life story. They then shared this graph with their peers explaining the significant life events that they have experienced. In another, CPE supervisors lead students through a visualization where they imagined having a debilitating chronic illness that slowly took away their ability to function and

[98] Anonymous (professional chaplain) in discussion with author, October 21, 2017.
[99] Focus group interview conducted (CPE students) on October 3, 2017.

communicate. A chaplain described another exercise where she sat knee to knee with a peer while engaging in ongoing eye-contact. The chaplain who participated in this activity said:

> The idea of being able to hold space and not have to fill it. Wasn't that the greatest learning curve? The exercise of just looking in someone's eyes. That was breaking a wild pony, but when we got it, it changed everything.[100]

In the process of these exercises students learn how to feel their own emotions without necessarily acting upon them, so that when they experience an anxiety provoking patient visit they are able to allow the patient's experience and emotions to take precedence over their own.

The Verbatim

Some CPE supervisors describe CPE as a process that "links the mind and the heart."[101] The mind that is adept in spiritual assessment joins the heart that learns vulnerability through the act of presence. The verbatim is a written encounter of the patient and chaplain interaction and it is the primary modality for learning in the CPE classroom. Verbatims require that students learn both the practice of spiritual assessment and the vulnerability necessary to be present with a patient through harrowing times. Different than a medical case study, the student rather than their supervisor chooses the scenario that she will present in her verbatim.[102] The student must explicitly state why she chose the given case and how it influences her goals for future chaplaincy practice.

In the verbatim, the student uses the spiritual assessment tool to gain insight into the patient's interpretation of their hospitalization. For the first step of the assessment, the chaplain identifies the root of the patient's spirituality by determining what the patient deems as most meaningful in their life be it their family, their home, religion, or nature. The chaplain then

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[100] Anonymous (professional chaplain) in discussion with author, October 16, 2017.
[101] I heard this phrase from multiple CPE supervisors when I was a CPE student.
[102]Because chaplaincy learning is an inward experience the supervisor will not necessarily know in what ways the student is being challenged unless she discloses the information.

assesses the obstacles preventing the patient from connecting with their sense of meaning. In the final part of the assessment, the chaplain addresses ways in which the patient may utilize internal and external resources to reconnect with their spirituality.

The verbatim presentation is a self-reflective exercise for the student. In addition to the spiritual assessment, the student writes about her assumptions and feelings upon encountering the patient, the internal thoughts she had throughout the visit and analyzes the interpersonal dynamics between herself and the patient. Students are allotted 60 – 90 minutes to review their verbatim with the class. In the process, they must be receptive to self-analysis and critique from their peers. According to Jones, the purpose of the verbatim is "to begin the process of identifying the attitudes, values and assumptions" that determine the students approach to spiritual care and to reflect on how the student's choices impact the patient's experience.[103]

CPE learning theory often uses the image of the "wounded healer"[104] to illustrate the link between a chaplain's potential and their personal stories of challenge and struggle. The verbatim review is a group process that exposes students to the vulnerability that they will face in the clinical setting. This moment of self-exposure occurs during the verbatim presentation when the peer group shifts focus from the patient to the student. Jones explains:

> [In her verbatim presentation] the student may indicate he or she wants to learn more about the grieving process. However, this learning is not just on a theoretical level. More often than not, the patient's grief touches the student's own grief. It is then the student's own experience of grief and loss becomes the focus of the learning.[105]

In front of her peers, the student is asked to reflect on the experiences and beliefs that caused her to respond to the patient the way she did. The ultimate goal of this process is for the student to learn how she can use her experience of grief and loss to sit with a patient in theirs.

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[103] Jones, "Baptism," 129.
[104] Henry Nouwen's *The Wounded Healer* is commonly referred to in CPE courses.
[105] Jones, "Baptism," 135.

One chaplain referred to "modern chaplaincy as its own tradition"[106] and another described clinical chaplaincy as a newly developing field. In truth, spiritual care for the ill and dying is by no means a new concept. Yet, as spiritual care converges with the medical model in secular environments, clinical chaplaincy becomes an innovative field and the language that chaplains use appears to be a marker of a new professional niche. Winnifred Sullivan writes:

> Hospital chaplains now describe their work as founded in understanding illness as creating a crisis of meaning for patients, one that demands specialized care, "meaning" being somehow a new catchall and universal vessel for the leftover business of naturalizing enlightenment philosophies and scientistic naturalism.[107]

Sullivan points out that "meaning" has replaced religion as the chaplain's point of inquiry. The chaplain's role is to assist the patient to discern what makes their life meaningful.

Clinical chaplaincy training prepares students to be present with patients by bringing them in touch with their own vulnerability. CPE training intends to prepare students to work with patients in any area of the hospital, as well as with patients of any religious conviction. One professional chaplain explained that "the experience of the CPE process should be transformative where you become more and more open."[108] Chaplains will invariably face resistance when encountering certain scenarios. Some chaplains talked about struggling with witnessing the suffering caused by physical deformation in hospital burn units, others described that working with patients on the neurology unit was particularly challenging.

Vulnerability training serves multiple functions. It invites personal authenticity. It brings students closer to the loss of personal identity that many patients experience when hospitalized and it encourages students to encounter their own mortality. Students' self-expectations of this CPE-training are high. Many students expressed that they feel they should be able to see a

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[106] Anonymous (professional chaplain) in discussion with author, February 21st, 2018.
[107] Sullivan, *Presence,* 125.
[108] Anonymous (professional chaplain) in discussion with author, February 21st, 2018.

patient's human totality and that the chaplain's expertise lies in their ability to perceive an individual's characteristics within the larger framework of their human spirit.

A New Vision of Human Care

Struck by some chaplains' suggestions that clinical chaplaincy is a new field, I began to explore the idea. What I have found is that CPE training is both shaped by and shapes the medical system. As I have proposed, not only are CPE chaplains trained specifically to serve Nones and the SBNR population, but also when examining CPE, it becomes clear that the training itself focuses on human, rather than religious or even spiritual care. In this section, I look at some of the ways that the medical system has shaped clinical chaplaincy and how in turn CPE training addresses humanity rather than religion.

In an environment where science has replaced divinity, death is viewed as a failure of medical technology. When the patient is told that there is nothing more that physicians can do, the chaplain is called into the room. However, unlike the family pastor who a century ago visited families at home, the professionally trained hospital chaplain does not represent one particular religion or even necessarily speak about religion at all. Instead, her role is to offer generalized spiritual care that personalizes the depersonalized medical environment.[109]

I suggest that clinical medical chaplaincy is changing the field so that the chaplain no longer represents religion or perhaps even spirituality, but potential. Within the hospital, the CPE-trained chaplain role models an alternative to succumbing to death as a failure. Accompanying patients and family members into the unknown the chaplain offers presence amidst loss and crisis. Thus, the chaplain represents the potential to accept grief, the potential to

[109] Gelo writes about the "unintended consequence of the depersonalization of the medical environment." Gelo, "Role," 6.

die well, and the potential for the patient to realize their most authentic-self. In essence, CPE trained chaplains follow the general SBNR practice of honoring the "divinity" within.

The clinical chaplain's role is determined by the medical model's need to preserve a sense of humanity within in an ever-advancing scientific and technological environment. When asked if she felt that CPE training was more about caring for humanity than it is about religion or spirituality, one chaplain commented, "I think there are some basic needs we all have. I think there is a need to have meaning and purpose in life and some kind of connection."[110]

The medical system's influence on the chaplain's role is apparent from the "whole-person care model" used by the medical team. Gelo, who claims that the hospital chaplain is the "specialist of whole-person care," explains that this model encourages the medical team to recognize that dying "involves looking beyond matters of the body."[111] She then denotes five components of whole-person care. Gelo states,

> Whole-person care helps the dying to (a) advocate for participation in their own treatment and decision making that represents their highest values and beliefs, (b) to maintain and deepen social and loving relationship – seeking closure and making amends, (c) conduct life review, (d) make meaning out of suffering and to feel hopeful and at peace with oneself, and (e) enjoy living and prepare for a good death.[112]

With these tasks identified as the chaplain's specialty, it evident that the chaplain's role is about human care, much more than it is about religion or even spirituality.

In addition, to being the "specialist of whole person care," the chaplain has also become a representative of the "good death." The "good death"[113] is constituted by 12 guidelines to make sure that physicians and other health care professionals actively communicate with the dying.

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[110] Anonymous (professional chaplain) in discussion with author, October 30, 2017.
[111] Gelo, "Role," 12.
[112] Gelo, "Role," 12.
[113] Gelo, "Role," 10.

These principles includes phrases like "to be able to retain control over what happens" and "to have control over who is present and who shares the end".[114] On one hand these guidelines are clearly designed to empower patients who are presented with life-prolonging technologies, but on the other hand they suggest that a patient and their family can determine the course of a patient's life until the very end. Thus, the chaplain who was traditionally the mediator between death and the afterlife has become the medical team's broker for a "good death."

In a problem-solving medical environment, where death is the enemy, at first glance the chaplain appears to be another solution. Gelo frames the chaplain's role in just that way. She states, "Cure is the eradication of illness; healing is the possibility to be restored to wholeness of mind, body, and spirit, even as death approaches, and to die well by bringing closure to life."[115] Gelo illustrates that death itself is secularized. Under the influence of the medical model, *death* becomes a project in and of itself. The implication being that, by turning one's attention to *dying well*, one can maintain control until the very end. However, the chaplains that I interviewed presented an alternative; absorbed into the medical system, chaplains appear to be role modeling a new way of approaching care for the dying. Because they are trained to walk alongside their patients into the "unknown" and because, in the face of crisis, they prioritize presence over resolution, some CPE-trained chaplains may be slowly changing the medical system's conceptualization of human care. The result of bringing attention to how patients die has ultimately brought more attention to how patients live. The chaplain's role is now about helping individuals to feel empowered to grow and change amidst their illness with the hope that they will reach their potential to embrace the remainder of their life fully.

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[114] Gelo, "Role," 10.
[115] Gelo, "Role," 4.

Chapter Three

Obstacles To Interfaith Learning In CPE Program Design

> My attitude and priority for the patient is really to get them in touch with their spirituality regardless of what their faith actually is and if that means this patient is Jewish I would hope that as a result of my visit this person in more in touch with their God more than anything.[116]

Introduction

The CPE-trained chaplains that I interviewed clearly intend to support patients within their own faith tradition; as Tim stated, he hopes to put a patient "in touch with their God." However, because CPE chaplains are not trained as religious experts but as spiritual generalists, their work with patients on the basis of religion becomes problematic. Alex expresses the type of attitude often cultivated in CPE training: "Whichever patient I am with, they matter, not me. And so, whatever they happen to believe, I am there to support them in any way I can."[117] While this attitude positions the hospital chaplain to converse with a broad patient population, I argue that it does not prepare students to serve patients religiously. CPE training focuses on preparing students to make a spiritual connection with a generalized population and downplays the religious and cultural specificities that influence how a patient experiences religion in their life. CPE students need further training in order to be able to work with patients in a religious capacity. In this section, I problematize CPE's training approach. I question whether one student can be trained to work with all patients regardless of the patient's religious orientation and I challenge the premise that a one-size fits all approach to chaplaincy training is an effective inclusive methodology.

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[116] Focus group interview conducted (CPE students) on October 3, 2017.
[117] Focus group interview conducted (CPE students) on October 10, 2017.

The residents that I interviewed expressed interest in engaging with patients from all religious backgrounds, however CPE-training does not devote specific attention to interfaith skill development. Rather, it seems to assume that chaplains will inherently develop interfaith skills through practical experience. Some of the professional chaplains that I interviewed conveyed insecurity about their effectiveness in interfaith contexts. Emily shared her concerns:

> With religions I don't know well, I am pretty insecure and I am hoping I create some kind of soothing moment for them. Some joining. At that point it feels like it is just about witnessing and for that person to not be alone. I would like it more if I had more education. The interfaith component…I feel very unprepared for situations where it is like my mind and my heart don't match. I need more information to be my best self. It lends to that feeling that I wasn't trained in that space between the head and the heart. It was just the heart, just dive in, but sometimes I do feel like having a skill or being able to navigate…. sometimes patients need the chaplain to take on authority.[118]

Emily explains that her head and her heart are not congruent as a way to describe what was lacking in her own training. While the presence that she offers her patients may be highly beneficial, it is not necessarily religiously supportive. Emily identifies that her training taught her how to trust her heart, but at the same time she suggests that further information (about specific religions) would make her a more effective chaplain.

Tim offered a specific scenario to explain his struggle with interfaith chaplaincy. In his example, he met a palliative care patient who wanted to convert to Christianity. As a Christian who knew little about his patient's religion, Tim felt that he was on precarious moral ground:

> I had a recent case where I felt like I was walking on egg shells not because the patient was sensitive to my chaplaincy, but because of my own grappling with what it means to work in the interfaith context. The patient…grew-up Buddhist but his wife grew-up Christian and they were both like yeah, we both want to be Christian. So, I find myself struggling because I am Christian and I guess I could provide you with resources because they are like "How do we pray and such?" And, it is like okay, "I could provide you with Psalms and what not." At the same time, I wonder how do I do that while respecting his years as a Buddhist? How do I hold that at the same time?[119]

Tim's integrity is evident. His desire to account for the patient's Buddhist past is admirable, and Tim's self-analysis skills may be attributed to the CPE training that he has received. However,

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[118] Anonymous (professional chaplain) in discussion with author, October 16, 2017.
[119] Focus group interview conducted (CPE students) on October 10, 2017.

Tim could clearly benefit from developing tools to address situations like the one he described. Because Tim just relocated to Hawai‘i (specifically for CPE training) and knows little about Buddhism, he does not have enough information to formulate knowledgeable questions for further inquiry into his patient's religious background.

The three scenarios described above introduce what I see as CPE's fundamental problems. Alex described that she "supports [patients] in any way that [she] can." While Alex's intentions may be well-founded, the generality and ambiguity of such a broad-minded approach to chaplaincy limits her ability to function as an expert in her field. Secondly, Emily is not the only chaplain that I interviewed who expressed a lack of confidence in working in an interfaith capacity. A large part of CPE training is focused on developing important humanist communication skills, however the skill-development needed to work religiously is lacking. Thirdly, Tim's example brings up an important point about the potential for religious inequity in an interfaith exchange.

Structural Downfalls of CPE Training

Before looking at each of these problems in turn, there are some structural pitfalls that limit CPE training's capacity to prepare students for interfaith work that need to be addressed. First, CPE pedagogy is based on an experiential, group process. Peer critique plays an essential role in the students' development over the course. Unfortunately, the lack of religious diversity within a typical CPE cohort severely limits the type of feedback that peers are able to offer one another. Secondly, as far as I have determined, CPE training does not have any curriculum specifically designed for interfaith learning. The two CPE programs that I attended approached the question of interfaith chaplaincy in different ways, neither of which actually trained students to religiously serve patients from a tradition different than their own.

In general, CPE programs are not diverse. The majority of them, which I will refer to as "conventional" CPE programs, describe themselves as interfaith. However, a typical cohort is made-up of students from various denominations of Christianity and one student from a non-Christian tradition. As I described in Chapter One, ideologically, conventional CPE programs are influenced by liberal Protestantism.

A second-type of CPE program is religiously specific. I interviewed one chaplain who trained at the Jewish Theological Seminary (JTS) in New York City. In his cohort, there were two non-Jewish students including himself. The training that I did at the Zen Center for Contemplative Care in New York City is another example of a non-conventional CPE group. It attracts students who are interested in Zen Buddhism, although they may have little experience as Zen practitioners. These specialized CPE groups receive the same accreditation as conventional programs. Non-conventional programs do not necessarily create a more diverse cohort than conventional CPE; they often attract students with similar experiences and ideologies. Like conventional CPE, these cohorts tend to share a similar worldview making it difficult for peers to recognize one another's personal biases.

In my interviews with both chaplain residents and professional chaplains, I came across what I identify as a dilemma in CPE training design. I directly asked my interviewees if clinical pastoral education prepared them to work in an interfaith context. Of the chaplains who felt that CPE could have better prepared them, most (like Emily) suggested that more knowledge about diverse religious beliefs and death and dying rituals would have enhanced their ability to function across religious boundaries.

Perhaps in response to such feedback, certain CPE programs offer students didactics on a diverse range of religious traditions. The chaplains that I interviewed who were in classes with

interfaith didactics critiqued this approach to interfaith learning. For instance, in a presentation on Buddhism, Jeanine was informed about Buddhist mourning rituals, but she was not informed that rituals differ between Buddhist lineages. The first time that Jeanine worked with a Buddhist family she expected them to chant sutras and was embarrassed when the family said they were unaccustomed to such a practice. In this case, because the didactic provided a little bit of insufficiently detailed knowledge, it proved unsuccessful.

Breann also participated in a CPE program that offered didactics on different religions. She found that such study was a distraction to her development as a chaplain. Breann explained:

> During my first unit, we had this whole didactic, a number of them, on serving Muslim patients and Buddhist patients and non-religious patients…It was kind of overwhelming like, "Oh gosh, I don't know all of the things!" and "How can I? What if I?" It was very overwhelming. I very much started feeling like I needed to do a lot of research and read a lot of books and it was in that first CPE unit, that towards the end of it, I was like – "I don't need to know any of that! That does not make me a better chaplain necessarily." It really comes down to what is important for [the patients]. Where are they finding love and hope and joy and a lot of that despite humanity's need to categorize themselves?[120]

Breann's example points to the fact that the evolving field of professional chaplaincy has a distinct choice to make about how the field develops and the role that religion will play in the care that chaplains offer. Breann's comment also brings up the point that the United States is one of the most religiously diverse countries in the world[121] and that it is logistically impossible for one program to cover all the religious denominations, sects, and lineages that a chaplain may encounter.

Spiritual Care: An Ambiguous Approach to Chaplaincy Training

CPE chaplains function as spiritual generalists, however hospital patients, staff, and many chaplains themselves continue to consider their role as the hospital's religious experts. The phrases that chaplains use, such as "ministry of presence" and "a compassionate, non-anxious

[120] Focus group interview conducted (CPE students) on October 10, 2017.
[121] According to Gelo, the United States has a greater number of religious groups than any other country. Gelo, "Role," 5.

presence," to describe their work further create a sense of ambiguity about the field. Chaplains themselves express the stress that can result from ambiguous expectations; because in a secular hospital environment they are assumed to be able to serve all patients, chaplains often feel a great deal of pressure to be versed in all religions - an impossible task.

Patients can experience the repercussions of the training that chaplains receive. A patient expecting definitive spiritual direction from the hospital chaplain may be thrown-off when their chaplain offers generalized spiritual care; some patients may benefit from a more authoritative chaplaincy style. Tim, a chaplain on a pain and palliative care team, talks about how, if he were a patient, he would want direction from the chaplain:

> [If I were a patient] I may not be ready to clearly disclose what I am going through. I may trust the person (i.e. the chaplain), but I would really need to rely on the chaplain's expertise in just seeing who I am because…some patients like to self-diagnose themselves...so I might do that I am not sure…But on some level, it is like how accurate can a patient be…I would really appreciate it if the chaplain saw those things in me with whatever dialogue we had.[122]

Tim, who is well aware of the complexity of the decision-making processes that patients and families face when the end-of-life approaches, acknowledges that some patients may need a chaplaincy approach that reaches beyond a ministry of presence to one that offers structured guidance.

In the hospital, when patients face dire circumstances, religion is not an abstract experience; the hospital is the exact place where people are most likely to rely on religion. The problem is that, with a CPE based approach to chaplaincy, religion (one of the most useful tools for people at the end of life) can be lost in a generalized web of spiritual care. Chaplains may be able to connect with patients on a general level, but they are not necessarily trained to

[122] Focus group interview conducted (CPE students) on October 10, 2017.

facilitate religious rituals or work with patients from non-creed-based traditions whose religiosity is based in lived experience.

Religious practices offer generational continuity that can be especially supportive at the end of life. In rituals, families find comfort and patients can receive support that guides them toward death. Chaplains who are immersed in specific religious knowledge offer nuanced patient care. For example, as mentioned previously, Breann noticed that her Christian patients' emotions are often tied to a particular theological belief or understanding of God. Without this type of religious-specific insight, individuals may still find comfort from the chaplain's presence, however the effectiveness of the chaplain's care may be limited.

Chaplaincy training programs can explore the issue of why religious-specific care should not be overlooked. Supervisors can initiate discussions with their students by posing questions such as: "What do religious communities offer patients?" "What purpose might religious practices serve in a hospital setting?" "What type of experiential knowledge might a patient receive from participating in ritual?" Although the answers to these questions cannot be fully explored here, I will offer a brief statement based on my own experience working as a chaplain.

Religious participation can counteract the feelings of loneliness and isolation that are pervasive in modern life[123] and often amplified in a hospital setting. Community religious groups offer patients and their families logistical and emotional support that is significant; in Hawai'i, not only do religious communities financially rally to collectively meet the expenses that a hospitalized family member may incur, they also offer endless hours of companionship, counsel, and emotional assurance. I've also met many hospitalized patients who aren't part of a

[123] In his book *Bowling Alone,* Robert D. Putnam writes the isolation that many Americans face as a result of changing social structures. Robert D. Putnam, *Bowling Alone* (New York: Simon & Schuster, 2000).

local religious community yet receive a deep sense of belonging from their religion; these patients recognize that they are participating in a shared practice or belief system that reaches beyond their individual life. Perhaps most importantly, religious practices, from a range of traditions, offer a modality through which a person can experience relief from the fear about losing one's individual identity before death - an act that can be essential to alleviating existential suffering at the end-of-life. These practices contrast with *Spiritual But Not Religious* ideology that tends to focus on an individual's well-being. In a scenario in which patients have received a chronic diagnosis and will not improve, there comes a point when acceptance of disease and a letting go of the need to retain one's own "well-being" must occur in order for the patient to experience a sense of peace.

The Need For A Critical Perspective in Clinical Training

CPE does not offer a critical analysis of the topic of religion itself. In CPE training, most students work with the assumption that religion is a homogenous field. In academia, we know that religion is a social construct that changes over time, and that religion is informed by multiple factors including culture, place, politics, economy, ethnicity, and history. Because CPE pedagogy does make such factors explicit, students' assumptions about what constitutes religion are not challenged and the history of religion as a category (devised by European intellectuals) to study humanity is not discussed.

A student's definition of religion can inhibit their ability to grasp how an individual experiences religion in their own life. Spiritual assessments designed to identify how patients make meaning of their illness may work well with patients from creed-based traditions, but they exclude patients who do not relate to a cognitive meaning-making perspective. A Buddhist

priest, trained in CPE, described why a spiritual assessment based on meaning-making is not applicable to Buddhist patients. He explains:

> The Buddhist worldview isn't about that sense of making meaning of your suffering. It is about dealing with suffering and looking at 'Who are you now?' 'Who are you in this moment?'[124]

In order to make interfaith inquiries, students must first be encouraged to deconstruct their ideas about what religion *is.*

If the practice of upending one's expectations of religion and stepping into religious territory that feels different from one's own forms the foundation for interfaith learning (as I suspect it might) then students who represent a minority tradition within their CPE cohort might receive the most in-depth interfaith training. When I asked students to give examples of their interfaith chaplaincy experiences, Ellie, the only student to represent a religious minority in her cohort, gave an example of immersing herself in her patient's religion. Ellie explained:

> I was offering prayer and then in the middle of the prayer [the patient] chimed in and it was a really different experience for me just about how to do prayer. By chiming in "Jesus is coming" and in praising Jesus as I was praying (and so I as a Buddhist was okay with it) but I just allowed her to express. Then her meaning of the experience through my prayer [was that] certain miracles had happened. So that was interesting cause that is not necessarily a part of my tradition, but she expressed that there were miracles that were happening through the prayer.[125]

Ellie's experience stood-out in comparison to other students, because she was the only one who crossed a religious border to enter into another's worldview. The other students, in accordance with CPE training, tended to avoid religious difference by searching for commonalities with their patients. Rather than addressing the patients' religion directly, students tended to work with patients based on their psycho-social experiences.

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[124] Anonymous (professional chaplain) in discussion with author, March 16, 2018.
[125] Focus group interview conducted (CPE students) on October 3, 2017.

Ellie's experience demonstrates the potential for students to re-educate themselves about religion as a category of human experience. One CPE supervisor, who trained many international students, talks about his approach to gaining a closer understanding of another's experience.

> Learning to stand on the boundary between cultures involves…understanding a different culture as a mirror in which to see the reflection of one's own culture. Standing on the boundary involves stepping back and looking at one's culture as if seeing it for the first time…For example, we may be able to see the difference between the extreme individualism of American culture as compared with the family and community orientation of many other cultures: *e.g.* Asian, African, middle Eastern, and southern European cultures. If, for instance, a student comes from a culture that is concerned with each person's role and function in a kinship system (or an educational or commercial enterprise) and not with individual feelings and emotions, the student may have little awareness of his or her personal feelings and little ability to recognize or express feelings. An emphasis on sharing feelings with peers and with the supervisor may seem quite alien to such a student.[126]

Similarly, if a chaplain, in Hawai'i approaches an elder by directly asking her questions about her belief system without taking time to orient themselves to that patient's cultural or religious background, chances are that the chaplain will make little headway in offering care to the patient. CPE students need to be educated to deconstruct their own religious worldview in order to initiate interfaith inquiry. I suggest that the practice of crossing religious borders and stepping into religious territory that feels different than one's own forms the foundation for interfaith learning.

In Chapter Four, I propose integrating an academic approach to religion into CPE's experiential learning process, so that students develop a conceptual framework that can support them in interfaith work. At the very least, educating students that religion is a culturally-rooted, constantly evolving phenomena could significantly improve students' preparation for working in diverse religious environments. Rather than underplaying religion (as seems to be the current approach to spiritual care) objective religious knowledge might empower chaplains to inquire more actively into patients' religious experiences and worldviews.

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[126] Homer L. Jernigan, "Clinical Pastoral Education With Students From Other Cultures: The Supervisor's Role," *The Journal of Pastoral Care* 54, no. 2 (2000): 142.

The Problem of Promoting a Universal Approach to Spiritual Care

When I conducted my focus group interviews, the residents had been at their worksites for six weeks. Only one of the residents originated from Hawai'i; all of them had received training on the mainland. I was particularly interested in hearing if the residents, when recounting their experiences thus far, would comment on social, cultural, and religious factors specific to Hawai'i. I found that the chaplain trainees I interviewed tended to acknowledge religious identities (of both chaplain and patient) with little awareness of how sociocultural factors might shape their work.

A spiritual generalist approach to chaplaincy does not concern itself with religious and cultural detail; it attempts to reach beyond religion to engage common human needs. Based on this premise, one resident complimented his peer's experience working with a family:

> Despite the religious difference, I am remembering the two sons that came up to you… It felt like they trusted you enough to tell you some very deep things, "My cooking killed my dad." And the second one, "I am okay. I am okay. But how do I move on from here?" It was like this real ambivalence. I don't want to be here, but I am okay. But it felt like those two connections transcended religious differences.[127]

This universal approach to chaplaincy training prepares students to make moving, heart-felt connections with patients and family members. It suggests that if a patient trusts and confides in a chaplain, further religious expertise on the chaplain's part may not be necessary.

A universalist approach to chaplaincy training prepares students to work with human commonality, rather than religious specificity. The downside of this approach is that students are not trained to account for how a patient's socio-religious background influences their experience of religion. As a result, students tend to make generalized assumptions about their patients' religious experiences based on their own worldview. Marty exemplifies a lack of awareness about her own religious biases that is not uncommon within the chaplaincy field:

[127] Focus group interview conducted (CPE students) on October 10, 2017.

> The other struggle that I am having is with the elder Buddhist population that doesn't have any idea of what I mean [when I introduce myself as the chaplain]. [They] don't even seem to relate that there could be any spiritual connection between us… [They say] "Well, I am Buddhist, there is nothing, unless you are Buddhist too, there is nothing you can help me with." And, I think that is really sad because these people are mostly by themselves. They have outlived their family and they have nobody. And here I am extending myself in an earnest way and they are just like "No, there is nothing you can do for me you are not Buddhist" so that is something I don't know how to meet.[128]

Marty assumes that her skills will benefit Buddhist elders; however if her religious ideology is limited to a creed-based perspective, she may in fact have little to offer. Marty misses out on the opportunity to consider this populations' life experiences and she fails to take into account what a visit from a white, Christian chaplain might represent to them. Instead, she presumes that these Buddhist elders are lonely and does not consider that they may actually feel fulfilled in their life and worldview.[129]

Chaplains need to critically assess how their conceptualization of religion is influenced by their own cultural norms; if they do not, they may subtly marginalize members of minority religions by wrongly assuming that they are embodying spiritual inclusivity. Robert G. Anderson writes about how acknowledging religious difference has posed an ongoing challenge even within CPE programs themselves:

> Acknowledging the diversity of religious backgrounds in training groups has posed an important challenge and corrective to religious and cultural assumptions embedded in the CPE context. A search for an interfaith or universal base of common or inclusive beliefs, sometimes sought as a basis for common worship, instead often promotes prevailing values or rituals that stem from a dominant Christian cultural context. Rich diversity can be lost in the quest for common ground.[130]

To ensure accountability in chaplaincy training programs, two factors must be considered. First, we must make explicit the role that Christianity has played in American culture, and how that has shaped the common understanding of what religions *is*. Because Christianity is so socially dominant, we do not see certain ways that it influences our lives.

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[128] Focus group interview conducted (CPE students) on October 10, 2017.

[130] Robert G. Anderson, "Spiritual/Cultural Competency: Methods in Diversity Education," *Journal of Pastoral Care and Counseling* 6, no. 4 (2012): 2.

Although the role of chaplain is evolving to serve a more diverse population, patients perceptions of the chaplain's role may be colored by its history of proselytization. In order to build programs that can successfully train interfaith professionals, chaplaincy needs to critically assess how it presents itself as a professional field. Breann addresses some of the obstacles that chaplains currently face as they strive to work in interfaith environments. Breann explains:

> One thing that just stuck out to me that was very prevalent in the Bay area and in Berkeley, specifically, and not necessarily specifically with Buddhist patients, but patients with all different kinds of disaffected Christians or lapsed-Catholics and that kind of thing - the word "chaplain" was very off putting and kind of screamed Christian which is why then that program adopted you know "I am Breann with Spiritual Care." So "spiritual care" was the kind of operative way we would introduce ourselves.[131]

Patients' reactions to chaplains can reflect negative individual religious experiences, as well as the disruptive manner in which religion has often played-out on a societal level.

Second, we must understand the difference between a patient's spirituality and their religious socialization. In certain hospital scenarios, focusing on an individual's spirituality without taking into account their religious socialization and cultural background, may prevent the chaplain from understanding the family dynamics that often arise under the crises of hospitalization. For instance, some Asian cultures prefer that the family rather than the patient receive the patient's medical prognosis. In this way, the family protects the patient; if the patient were to receive a poor prognosis, the family's concern is that she may lose her will to live. A well-trained chaplain will serve as a liaison by educating the patient's medical team about the family's worldview. Chaplains who lack religious cultural training will not be able to adequately address many of the religious issues that arise in the face of complicated medical scenarios such as the choice to remove a loved one from life-prolonging technology.

[131] Focus group interview conducted (CPE students) on October 10, 2017.

In an effective interfaith training program, a student like Marty might be given specific place-based, cultural knowledge that could help her look beyond her limited perspective and guide her in her work. For example, she could be taught that: 1) In some cultures, social familiarity needs to be established before direct, personal communication can occur. 2) People who identify with religions that focus on practices rather than beliefs may not see how they could benefit from a chaplain unless that chaplain is trained to embody their worldview and religious orientation.

The weaknesses of CPE's approach to interfaith training are likely more visible in religiously diverse places like Hawai'i. Worldviews that do not account for other worldviews,abecome apparent when minority populations reach a critical mass. In certain regions of the United States, it is likely that chaplains simply do not encounter enough religious diversity to realize the foundational inadequacies of their interfaith training.

In the following chapter, I propose a chaplaincy training course designed to address some of the issues that I have raised in this chapter. Because religion is a regional phenomenon and interfaith interactions in Hawai'i will look very different than those in say, Decatur, GA (where the CPE headquarters is located) my class proposal is designed specifically for Honolulu. Hawai'i offers a unique opportunity to study interfaith chaplaincy training; it is the only state that does not have a religious majority.

The course that I've designed is distinct from other CPE courses for several reasons. A place-based pedagogy informs the assignments and in-class activities developed for the course. I ask students to question their assumptions about interfaith chaplaincy and explore the skills necessary to work with a patient of a worldview different from their own. In order to support my students' inquiry, I've included an academic approach to religion in my proposal. My hope is

that I've created a course blue-print that CPE supervisors in other regions might use to develop their own interfaith program.

Chapter Four

A Place-Based Chaplaincy Proposal

Introduction

Working as a chaplain on a cardiac-recovery unit, I met a Christian woman in her 50s who urgently asked me to tell her more about her father's Buddhist religion. Her father had recently undergone open-heart surgery. She was concerned that the life-prolonging technology that was keeping her father alive might influence his journey through the *bardos.* Specifically, the daughter asked me if her father's soul might get caught in a sustained "hell-realm" if he was not allowed to die naturally. Later that day on a general admissions unit, I received a referral to a Christian Tongan man who was at risk for dying from gangrene. Doctors recommended his foot be amputated, however he explained that he would rather die than burden his family as a disabled man. These are just two examples of interreligious and intercultural chaplaincy in one major Honolulu hospital; they exemplify the type of scenarios that chaplains are required to work with on a daily basis.

In this chapter, I propose a CPE training class designed for interfaith learning in Hawai'i.[132] I suggest that place-based training that is regionally and culturally specific needs to be integrated into nationwide clinical pastoral education programs. In order to function as interfaith experts, chaplains need to be educated about the religious practices and beliefs of the people that they are likely to work with. Without a sufficient amount of information, chaplains simply cannot knowledgably inquire into a religion different than their own.

Because it is not feasible for CPE programs to cover all of the religious groups a chaplain may encounter in the United States, localized trainings aimed toward meeting the religious needs

[132] See Appendix B to view a complete syllabus.

of particular regions should be developed. By including regionally-focused didactics, presented by community clergy and professional chaplains, a training program may be able to address diversity within and across religions in a particular locale. For example, in Hawai'i, it is common for the elder generation of a family to be Buddhist and for their first generation American-born children to claim Christian identities. Therefore, chaplains working in Hawai'i must be trained to traverse between the generation's worldviews.

Through a generalized spiritual care framework, conventional CPE programs train chaplains to address the needs of all clinical patients, religious and non-religious alike. However, in order to work in an interfaith capacity, students must have at least a basic education that orients them to religions with which they are unfamiliar. Interfaith training must guide students to step beyond a generalized framework by teaching them how to temporarily step outside of their worldview and inquire into traditions different from their own.

Religion provides frameworks for encountering and experiencing life's biggest mysteries – who we are, where we come from, why we are here. In chaplaincy, the answers to these mysteries are not as important as the inquiry. Chaplains create a space from which their patients can gaze or step into the unknown. Approaching religion primarily as a belief-system and a mechanism with which a person "makes-meaning" of their life restricts a chaplain's ability to support patients across diverse traditions. Rather, if religion as Ninian Smart says "mobilize(s) the feelings and wills of human beings,"[133] then the chaplain's role is to encounter religion as it is enacted in a person's life. How an individual relates to their religion when faced with unexpected crisis or chronic illness forms the foundation for the chaplain's inquiry. It is then the

[133] Ninian Smart, *Worldviews: Crosscultural Explorations of Human Beliefs* (New Jersey: Prentice Hall, 1995), 1.

chaplain's job to engage the patient by offering support that answers to the patient's lived experience and resonates with their tradition.

CPE's approach to spiritual care has changed chaplaincy. CPE-trained chaplains don't preach; they listen. Rather than proselytizing, CPE-trained chaplains strive to offer compassionate care. However, the interfaith aspect of CPE training is fundamentally flawed if it is based on the assumption that exposing students to people of faiths different from their own constitutes interfaith learning. Chaplaincy training that does not adequately address interfaith skill-building undermines the chaplain's potential to interact with patients on the basis of their religion. Religion functions as a vehicle that offers community support, age-old traditional wisdom, and insight into life's biggest questions. It should not be overlooked for the sake of developing a generic approach to spiritual care.

In this chapter, I will further explain what I mean by a place-based approach to chaplaincy. I will then describe my proposal in two sections: First I will look at the components of CPE that are working and suggest alterations to make them more appropriate for an interfaith context. Second, I will suggest new curriculum for CPE.

Why A Place-Based Program?

In the interviews I facilitated I noticed several obstacles to interfaith learning. Some I observed and others chaplains stated directly to me:

1) Chaplains believe that they need to be able to serve and meet the needs of patients from all religions including patients who claim no religion. Yet, most chaplains talk about religion as a fixed concept informed by a Christocentric point of view. Students are not aware that religion is a constantly evolving social construct strongly influenced by culture, history, and politics of place.

2) Students may be aware of some of the differences within their own faith tradition, such as the differences between Christian denominations, but students seem to have little knowledge about the vast religious variation that exists within religions outside of their own. For instance, one hospital chaplain explained that in her CPE training she learned that ritual-chants are performed for deceased Buddhist patients. However, she was not informed that the type of ritual conducted varies widely from lineage to lineage and that in fact some lineages do not perform chanting rituals at all.

3) CPE training is universal; students are given a generalized approach to work with patients and that approach is expected to meet the needs of all patients independent of their geographic location. However, many CPE students relocate for their training. CPE pedagogy assumes that students learn about the populations that they are working with directly upon patient encounter. As a result (for example) a student working in Detroit, where there is a large Hindu population, may be completely unaware of the differences between a Brahman priest and a bhakti devotee.

4) Students are uneducated about the intersection between culture and religion. Specifically, students were unfamiliar with the idea that one's cultural identity, rather than their religious identity, may motivate them to perform religious acts. Or conversely, for example, one student talked about feeling conflicted when working with a patient who was culturally Buddhist, but wanted to learn more about Christian faith. This student wanted to acknowledge the patient's Buddhist background before granting his request to "convert" him to Christianity, but was not sure how to do this or if it was appropriate.[134]

[134] Focus group interview conducted (CPE students) on October 20, 2017.

5) Most of the students that I interviewed exhibited "pluralistic attitudes" meaning that they were "open-minded, tolerant, and compassionate."[135] Yet, CPE's approach to religious inclusivity through "meaning-making" is not critiqued within the classroom setting. There seemed to be little awareness that a "meaning-making" approach to spiritual care may actually limit who chaplains can serve.

6) CPE's strength is teaching students how to assess an individual's needs, yet students also need to be well-informed that in many cultures societal needs take precedence over an individual's experience. For instance, in Japan, there is ritual called Mizuko kuyō, that is performed to appease the spirit of an unborn child. In his research on the ritual, Jeff Wilson shows that in Japan Mizuko kuyō is designed with the whole community in mind; it frees the community from the threat of a haunted spirit. In contrast, in the United States, similar rituals for deceased or unborn children tend to honor individuals' grieving processes.

While my end goal is for students to develop interfaith chaplaincy skills, my approach is not to tackle the interfaith problem head-on. Rather, I propose that CPE is supplemented with a regionally focused chaplaincy education. As Kosmin and Lachman state, research shows that in the United States religion is a regional phenomenon:

> When we refer to the geography of American religion, we are really speaking about social rather than physical scenery. Certain locations and habitats attract certain types of people, and religion is an activity practiced in groups. Elements of fashion and camaraderie are present in the practice of religion in a specific time and place, and this reinforces a cultural status quo.[136]

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[135] Scholar Jeff Wilson names the qualities - "inclusivity," "tolerance," "open-mindedness," and "compassion for others" – as attitudes supportive of pluralism. Jeff Wilson, *Dixie Dharma* (Chapel Hill: The University of North Carolina Press, 2012), 150.

[136] Barry A Kosmin and Seymour P. Lachman, *One Nation Under God* (New York: Crown Trade Paperbacks, 1993), 50.

In the interviews I conducted, chaplains also talked about religious regionalism. For example, Breann described how different her experience is working with Christian patients in Honolulu than it was working with Christian patients in Berkeley. Breann explains:

> My experience so far [in Honolulu], it feels very Christian to me and I came from the Bay area in Berkeley. And, so actually I am finding most difficulty or attention with my Christian patients. Just in terms of the theology - that almost feels like an interfaith experience for me right now. Because it is not just we are all Christian. It is this umbrella term.[137]

Tim talks about how certain religions are prevalent in particular regions.

> I did my chaplaincy in central New Jersey and the vast majority of patients I ministered to were white mainline Protestant or African American Pentecostal. Those two groups were very dominant and every once in a while, we would have Hindu or Muslim or Jewish patient and that is pretty much how we thought of interfaith. Coming [to Hawai'i], and maybe it is how this discussion is couched, it feels more like it is going to be more Christians and Buddhist. At least, that is my perception of what interfaith might mean.[138]

While it is true that regions tend to differ based on their religious dominance, it is also true that how religions influence one another in a region varies. As Jeff Wilson writes:

> In the historiography of American religion, regionalism and pluralism have often been conceptualized as enemies locked in a struggle: either America is a collection of discernibly different cultural and religious regions – diverse between regions but not within them – or it is a homogenous blur of national diversity, where everything is mixed up and nowhere is all that different from anywhere else. All regions are more diverse than they once were, but pluralism differs both in degree and in meaning among different parts of the country.[139]

In his study of Buddhism in America, Wilson illustrates that religious diversity manifests differently from region to region. As Tim pointed out, the type of interreligious dialogue that occurs in central New Jersey will not look the same as interreligious dialogue in Honolulu.

For chaplaincy training, not only is regionalism significant (students must be trained to work with a region's particular populations), but so is pluralism because it accounts for how religions coexist in a place. As Emma explains, the face of chaplaincy changes depending on the region that the chaplain is working in:

> I found my years in Toronto a much stronger focus on religious diversity. There was a rabbi chaplain and imam chaplain at the time. But the patients were Muslim, Orthodox Jewish, which hardly I see in Hawai'i

[137] Focus group interview conducted (CPE students) on October 3, 2017.
[138] Focus group interview conducted (CPE students) on October 3, 2017.
[139] Wilson, *Dixie Dharma,* 12.

> these groups. There were Sikhs present. Hindus played a much bigger part of the ministry. It was a different type of ministry. Here I find it much more overall spiritual. People getting along in the Aloha ways. I don't have these requests to send me the Orthodox rabbi, while in Toronto as part of the team, we had to have all of those religious representatives in the hospital all the time because of the patient population.[140]

In Toronto hospitals, religious patients require religious experts that can cater to specific religious needs. However, according to Emma's explanation, in Hawai'i, religions tend to interact more fluidly; the commonalities that they share are expressed in a general sense as spirituality. Thus, the way that chaplains function in Toronto is very different than in Honolulu.

The place-based pedagogy that I am proposing complements CPE learning theory which asks chaplain students to inquire into how their life story – their birthplace, upbringing, education, and significant relationships – influence their approach to spiritual care. Specifically, I ask students to discern how the region that they are working in influences their patients' religious and spiritual experiences. I propose curriculum that exposes students to the socio-cultural, religious, and historical dynamics of the place they are in. Laurie Lane-Zucker offers a useful definition of place-based education:

> Place-based education might be characterized as the pedagogy of community, the reintegration of the individual into her home ground and the restoration of the essential links between a person and her place. Place-based education challenges the meaning of education by asking seemingly simple questions: Where am I? What is the nature of this place? What sustains this community?..[Students] become a part of the community, rather than a passive observer of it.[141]

By immediately contextualizing a patient's experience, a place-based approach to chaplaincy degeneralizes spiritual care because the chaplain tailors their approach for the population with which they are working.

Ultimately, CPE's approach to inclusivity negates religious difference. One form of

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[140] Focus group interview conducted (CPE students) on October 3, 2017.
[141] Middlebury Interactive Languages, *Connecting Communities: The Importance of Culture in Digital World and ELL Instruction,* https://secure.edweek.org/media/middleburyinteractive_final_pdf.pdf (accessed on April 5 2018).

spiritual inquiry cannot resonate with all religions. Pluralism and inclusivity involve a deep acknowledgement of and appreciation for religious difference. A place-based approach to chaplaincy requires that chaplains learn about the socio-cultural, historical, and environmental differences that shape a population's particular experience of religion. Chaplains must connect with patients through the place-based circumstances that inform their lives.

A place-based approach to chaplaincy also addresses some of the challenges that I identified for chaplains working in an interfaith context. First, it allows chaplains to shift their perspective. Rather than approaching religion solely as a creed-based institution, students can engage with a patient's specific life circumstances and reach a more nuanced understanding of how religion influences their life.

For instance, in Honolulu, I visited with a first-generation American Evangelical daughter who explained to me that she did not know how to honor her mother's religion. Her mother was a Buddhist, specifically from the Honpa Hongwanji lineage, who immigrated to O'ahu to work on a plantation. Because the daughter defined religion as a belief system, she could not identify how Buddhism, a non-creed-based tradition, influenced her mother's life. However, when I asked the daughter to tell me about her mother, she described her mother as a person who loved to garden, who treated others kindly, and who lived a recognizably peaceful life. Through our conversation, the daughter realized that her mother's religion was enacted through the way that she lived her life.

Secondly, some students struggled to understand the interconnection between religion and culture. Examining a patient's relationship to religion outside of the socio-cultural context of their life minimizes important social connections and experiences that shape how that patient experiences and conceives of religion. Personally, as a chaplain resident I struggled when I was

requested to perform what the chaplaincy department called a "Hawaiian" blessing. "Hawaiian" blessings were most often requested by hospital staff after a particularly grueling period, such as when an unanticipated number of traumatic illnesses or deaths had occurred on a hospital floor. For this blessing, I was trained to use Holy Water, salt from Kalaupapa, Molokaʻi, a koa bowl, and palm leaf. The ritual, which involves sprinkling water with the palm leaf throughout a hospital unit, was intended to clear away harmful presences. I often explained that the koa bowl symbolized strength and the palm leaf fortune, but these elements significant to Hawaiian culture represent much more than I was able to articulate. Although this blessing did seem to lift-up staff morale, it did not feel deeply rooted in any particular tradition. In fact, I felt as if I was appropriating aspects of Hawaiian religion, which at the time I knew very little about.

If students are educated about the religious and cultural details of a region, then the history of the people in that place also becomes relevant. As part of my place-based class, I want students to understand how colonization, annexation and Hawaiian resurgence have influenced Hawaiian spirituality and the people who live here. I also want students to see that Hawaiʻi is a meeting ground for transnational communities. In their clinical work, students have the opportunity to observe the type of religious convergence that occurs here.

In my class proposal, I have designed specific in-class activities and assignments to ground students in a sense of place. Every week there is a guest presentation either from a professional chaplain based in Hawaiʻi or a local community religious leader. I've scheduled a field trip to Waianae Comprehensive Health Center for students to learn about health and healing from a Hawaiian perspective. Students must also write a verbatim about an experience with a patient from a religion (other than mainline Christianity or Buddhism) that is prevalent in certain regions in Hawaiʻi such as LDS, Jehovah's Witness, or the Tongan Seventh Day-Adventist

community. Students are also required to do their own fieldwork. This will be comprised of ten interviews with religious leaders based in Hawai'i. The interviewees must represent three denominations of Christianity, three lineages of Buddhism, three interviews with Native Hawaiians, and one interview with another religion of their choice. At the end of the course, students must compile their research into an interfaith handbook which emphasizes how each interviewee's religious perspective is shaped by the place in which they live.

Successful Aspects of CPE Education

Although CPE's interfaith training needs to be redesigned, there are aspects of the CPE program which can serve as stepping stones for interfaith learning. CPE chaplains are well trained in a ministry of presence. Meaning they know how to be with a patient who is suffering without trying to fix the situation at hand. The chaplain trained to listen stands out in a fast-paced, technologically advanced medical environment. One chaplain explained that when he is "fully present for a patient's suffering" and "when [he] listens to [his patients], not just their words, but to what is not being said" then he is able to "glean" insight into their life.[142] Chaplains skilled at bearing witness, engaging a non-judgmental state of mind, and offering a compassionate presence can be truly supportive to patients facing illness and death.

In the medical setting, the services that CPE trained chaplains offer are in demand. First-off, as I described in Chapter Two, not only are CPE students trained to work within a secularized setting, but they are also prepared to work with the country's growing SBNR population. Secondly, the spiritual assessment, which serves as a tool with which the chaplain can make recommendations, integrates the chaplain into the interdisciplinary care team. Thirdly,

[142] Anonymous (professional chaplain) in discussion with author, March 16, 2018.

the chaplain offers emotional and spiritual support to hospital staff by reminding the medical care team that when death occurs it is not a failure, but a natural part of life.

In the curriculum that I propose, conventional aspects of CPE training, that is, the verbatim self-assessment and interpersonal relations dialogue, remain as a core component of the curriculum. These activities contribute positively to chaplains' development. They train chaplains to face personal challenges, make them aware of when they are at risk for projecting their own needs onto a patient, and help them to learn how to rely on their own internal resources as support. Overall, the chaplains that I interviewed illustrated insight into how their behavior and perspective can influence a patient's experience.

In my proposal, I do make some changes in order to make the curriculum more applicable to interfaith learning:

1) I ask that each student facilitate one verbatim discussion. This is typically the role of the CPE supervisor. From experience, I've noticed that a supervisor's tradition influences her approach to the verbatim process. For instance, my Zen CPE supervisor focused on the details of the relationships between the patient and the chaplain. She would point out when we were withdrawing from a patient and ask what emotion we were experiencing in that moment. On the other hand, my former Presbyterian CPE supervisor encouraged me to articulate the theology which informed my ministry. Coming from a non-theistic tradition, this was a challenging task. If students take turns facilitating verbatim discussions, then they can gain insight into how different traditions approach care.
2) Students are given few guidelines when choosing scenarios for their verbatim presentations. In my proposal, I ask students to cover the following topics in order to

make the verbatim process geared toward learning about the interfaith skills that will be necessary for chaplaincy in Hawai‘i: 1) An intergenerational family of multiple religions or a family with internal religious conflict 2) An experience with a patient from a religion (other than mainline Christianity or Buddhism) that is prevalent in certain regions in Hawai‘i such as LDS, Jehovah's Witness, or the Tongan Seventh-Day Adventist community.

3) In my interviews, when students described a ministry of presence, they referred to concepts from various religions such as Beginner's Mind, "sitting with other's in darkness," and the wounded healer. However, it was not clear if the students knew about the religious history of the practices to which they were referring. In order to make CPE's ministry of presence training pertinent to interfaith education, I assign a group project which asks students to research and present contemplative practices from various traditions.
4) I suggest that CPE peers learn to engage one another as interfaith resources.[143] During my focus group interviews, I sensed that chaplain students don't often disclose their religious perspectives with one another. To aid in this process, I ask students to keep a weekly journal that reflects on how their theological beliefs and worldview are impacted and challenged by patient encounters. This project is intended to prepare students to take more risks when participating in class discussions and when giving peers feedback during self-assessment presentations.

[143] During a focus group interview conducted on October 24, 2017, CPE students said that they often do not feel safe enough in the group setting to share their personal beliefs. For my proposal, creating an environment where students can talk about their religious beliefs and experiences is essential. Group covenants, ground rules, and the supervisor's facilitation skills can help to create a supportive environment.

Assignments Designed to Support Interfaith Learning

In my syllabus, in addition to a place-based learning pedagogy, you will notice that I am specifically trying to immerse students in experiential activities that teach them about the religious populations specific to Hawai'i. At the same time, I incorporate lessons that offer an academic analytical framework from which students can expand how they conceptualize religion and interfaith chaplaincy. These lessons include: 1) Workshopping the definition of *interfaith chaplaincy;* 2) Analyzing the definition of *religion;* 3) Researching religious concepts related to illness, death and dying; and, 4) Lecturing on specialized topics and assigning specialized in-class activities. In this section I will expand on why I have chosen each of these activities and what they entail.

Workshopping the Definition of Interfaith Chaplaincy

During the first week of class, I designate two class sessions to a workshop designed to define interfaith chaplaincy. I do this for two reasons. First, in my research, I found a lack of unanimity about the definition and purpose of interfaith chaplaincy. As I had already seen in scholarly research on interreligious dialogue, the residents' responses illustrated that the word "interfaith" could be interpreted in many different ways. One interviewee posed the question, "Do we need to agree on our definition of interfaith chaplaincy?" In response to this question, agreement is not necessary or preferred, however the ambiguity around the topic needs to be acknowledged and analyzed. The workshop is intended to unpack how each student defines interfaith chaplaincy and to look at students' assumptions about what constitutes religion. It is also intended to directly address the mistaken assumption that interfaith chaplaincy occurs organically when two people of different faiths converse.

My goal is for students to learn to work with religious difference. Interfaith practice begins by learning how to inquire into a religion different than one's own. However, I observed that for most of the residents that I interviewed, difference is perceived as a divisive factor rather than a point from which a productive encounter ensues. For example, in some encounters, the residents bypassed the topic of religion, circumventing difference altogether. Tim who relocated to Honolulu from New Jersey recounts one of his first experiences with a Japanese Buddhist family:

> The patient was dying, and I met with her husband a number of times, but the topic of Buddhism definitely never came up. Nor did I ever mention God. I guess what was impactful about it was that I thought there would be some sort of clash between the two. It is like, 'Oh we are going to draw lines,' but I noticed in that particular experience at least it wasn't that way. I could freely do what I usually do with even a Christian patient.[144]

In another encounter, a resident acknowledged religious difference so distinctly that she referred the patient to a clergyperson of the patient's own faith. Only one chaplain described an experience during which she actually entered into the other's worldview via prayer. As we build the profession of clinical chaplaincy, my hope is that students are taught about the history and framework for various religions as a foundation for religiously diverse work, so that the beautiful intricacies of specific religious beliefs and practice are not lost in a web of generalized spiritual care.

Redefining Religion

While CPE successfully exposes students to a model that prioritizes practical experience over theological ideology, CPE students could benefit from broadening their conception of what constitutes religion. The fact that CPE training defines religion from Protestant informed theology limits its capacity to train non-creed based chaplains and to train chaplains to serve

[144] Focus group interview conducted (CPE students) on October 3, 2017.

patients from non-creed based traditions. In my interviews, I noticed that students identify a patient's religion, but do not necessarily account for how a patient's culture influences their religious identification and experience. I propose exposing chaplaincy students to an academic study of religion to expand their perspective.

In particular, I suggest addressing two misconceptions about religion that are deeply embedded in mainstream American culture. The first misconception is that religion is universally defined by belief; in fact, there is a huge range in the way that cultures conceive of and relate to religion. The second misconception is that religion expresses individuality; in many parts of the world, including areas of the United States, religion is a communal act. Coming from a broader lens less inhibited by their incomplete definition of religion, students can turn their focus to validating the lens through which their patient sees the world.

To expose students to an academic approach to religion, I will familiarize them with Ninian Smart's seven dimensions of religion. As Smart states, "The modern study of religion helps to illuminate worldviews, both traditional and secular, which are an engine of social and moral continuity and change."[145] If students begin to understand that religion as a classifiable field of study is a relatively new social construct common to American and European society, students may begin to unlock the fixity with which they approach the subject.

Smart's model illustrates that religion is much broader than a belief-based system informed primarily by doctrine, scripture and ritual. In his model, the ethical and legal, experiential and emotional, mythic and narrative, social and institutional, and material and cultural aspects of religion are included as well. Students will practice applying Smart's model to particular religious scenarios. The case studies provided will illustrate that religion is actualized

[145] Smart, *Worldviews,* 1.

through legal frameworks, institutional structures, and personal narratives. In their analysis, students will find that religion is much more than a system of beliefs, but also expresses how individuals and communities approach life, conceive of reality, and communicate with others.

Chaplaincy training may also benefit from using Smart's term *worldview*. Smart explains that *religion* often concerns the truth of one's own faith, however the term *worldview* can denote "what people feel, the ideas they have, [and] the structures of belief of their society."[146] In attempts to be inclusive, CPE incorrectly emphasizes "meaning-making" as a universal aspect of all religions. However, Smart's *worldview* orientation may be more productive and less imposing; every patient has a worldview which informs the life that they lead.

An Interfaith Approach to Religious Concepts Related to Illness, Death and Dying

If interfaith chaplaincy is based in the ability to inquire into a religion different than one's own, students need to learn the basic language that denotes important religious concepts. Language can restrict or enhance our ability to enter another's worldview. To address this challenge, I've designed a field-based research assignment. Students are expected to conduct ten interviews with religious leaders based in Hawai'i.

In order to develop their interfaith skills, I've created a list of themes that students must inquire about in their interviews. The themes that I chose (resolution, coming to terms with illness, saying goodbye, afterlife, hospital ceremony, grief practices, principles to live by, concepts of healing, multicultural communication, caring for medical staff, medical ethics, and closure) are intentionally not religious terms. However, they can be interpreted religiously. To illustrate, when I asked a Honpa Honwanji Buddhist priest how we would define *healing,* he replied:

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[146] Smart, *Worldviews,* 2.

> If we live in accordance with the truths - the truths of impermanence, the truths of interdependence, the truths of being embraced by the universe and if we can accept our changing nature, that this moment will never come again. That this life will never come again. That who I am now is not permanent. And so, can I find some comfort or find an awakening in knowing that I am not only my illness? That illness is part of me. That illness is not something that is in opposition to me. I am not necessarily battling the illness but how do I come to be in relationship with the illness?[147]

I chose these themes based on 1) reoccurring conversations I had with hospital patients; 2) the emotions that patients often face when they are diagnosed with a serious illness; and, 3) the range of responsibilities that the hospital chaplain holds. The idea is that by using these themes in their research, students will explore how various traditions encounter illness, death, and dying.

Students will compile their completed research by making an *Interfaith Handbook* which identifies, compares, and contrasts the key religious principles, terms, and concepts that their interviewees used when talking about illness, health, and dying. For another example, consider the theme *resolution*. Christians may talk about atoning for sin, while a Buddhist might speak about karma, and a Hawaiian might describe Ho'oponopono, a practice of forgiveness. If students approach these themes from the perspective of a particular religion, rather than trying to translate them to their own, then they will form a foundation for interfaith chaplaincy.

Specialized lecture topics and in-class activities

In my class design, I lecture as one way to bring an analytical perspective to chaplaincy work. In most CPE courses, lecture is not a component of the class; however I believe that students need more information about the religion, population and region they are working with in order to succeed in interfaith interactions. In addition to lectures on weekly themes, specialized lecture topics will include *Ninian Smart's Model of Worldview Analysis, September 11th and Interfaith Dialogue, Regionalism,* and *SBNR: The Growing Shape of American Religiosity. Ninian Smart's Model of Worldview Analysis* will provide students with an analytical

[147] Anonymous (professional chaplain) in discussion with author, March 16, 2018.

framework from which they can broaden their perspective on what constitutes religion. The second specialized lecture is intended to give a recent history (starting with September 11th, 2001) of interfaith dialogue in the United States. The lecture on *Regionalism* will illustrate that interfaith work can develop out of a regionalist approach that accounts for the historical, culture and socio-economic factors of a place. My fourth lecture, titled *SBNR: The Growing Shape of American Religiosity,* describes how conventional CPE training meets the needs of the growing SBNR population. I will problematize this trend by discussing the complications that result from focusing on spirituality and religion as an individual's choice rather than a culturally embedded social practice.

A large portion of the in-class activities are geared to address what I feel is one of the chaplain's most important roles - supporting medical staff. One workshop on *Spiritual Openings* is specifically designed for students to learn how to facilitate reflective and inspirational presentations for staff. Because the chaplain will be presenting to people from a range of faiths at one time, students will explore how to create a substantive opening ceremony that reaches a wide audience. Another workshop on *Integrative Medicine* looks at the chaplain's role within a holistic health framework. In this framework, the chaplain's role is often seen as one who can reduce stress or bring a sense of peace to the patient. While these skills are useful, I want students to problematize the chaplain's role as a member of the holistic healthcare team.

Through roleplays, students will practice debriefing medical staff, participating in family meetings and supporting the medical team during ethics cases. Debriefings occur after an especially tragic event or an unusually complicated medical case. In a debriefing, the chaplain facilitates a staff-wide discussion during which people share their experiences and concerns. A debriefing is intended to allow the staff an opportunity to process their emotions around a

particular case. Family meetings occur when the patient's interdisciplinary team (physicians, social worker, and chaplain) meet with the patient and their family to present difficult medical choices. This may be removing a patient from life-support or deciding to forego other medical treatments. In these conversations, the patient's quality of life becomes a topic of discussion. The chaplain assists the team to discern how the family and patient define quality of life. In ethics cases, chaplains hold a specialty role, which is to hear out all sides and opinions on a case. The chaplain must empathize with staff (who may be experiencing moral distress), but they must also educate the medical team on the patient's perspective. For instance, in the case of a Jehovah's Witness who is rejecting a blood transfusion, the chaplain can explain to staff that from the patient's perspective receiving a blood transfusion is a fate worse than death; it leads to disfellowship and being cut-off eternally from the divine.

Chaplains can visit with ten patients on a busy day (or more if they are on-call) and witness ongoing trauma throughout their day. How chaplains find resilience and motivation to do their work is often deeply rooted in their relationship with their personal tradition. Specifically, I ask students to do two presentations that talk about how their tradition supports them in their work. In one, students contextualize their life-story focusing on the experiences that brought them to chaplaincy. In the other, students present a text, ritual, or practice that they personally draw on for support in their work. For instance, one chaplain explained that she does *metta* practice for a few moments before entering a patient's room. For her, this practice serves to clear her energy from previous visits and prepares her focus for the patients that she will meet. The purpose of these presentations is two-fold. First, with peer support, students will reflect on how their personal faith tradition and communication style influences their ability to connect with patients across traditions and generations. Secondly, by hearing how their peers engage their

tradition to support them as a chaplain, students will gain unique insight that may inform them in interfaith encounters.

Conclusion

In their book *Bowling Alone,* Putman and Sullivan suggest that modernity engenders a sense of abandonment. Winifred Sullivan suggests the same. I frame CPE as response to humanity's need for personal care in a nation with a rapidly growing SBNR population. First and foremost, CPE prepares chaplains to acknowledge their patients' suffering and offer emotional support. Through their presence, chaplains bring awareness to the value of a patient's life; such an act cannot be overstated. However, to become an interfaith training program, CPE has many obstacles to overcome.

Within CPE pedagogy there seems to be a fine line between transcending religious difference and unduly dismissing it. In the mistaken interest of inclusivity, CPE's approach to spiritual care overlooks religious difference. As a result, from the student's perspective, religious orientation appears to be an obstacle, rather than an opportunity for relating to a patient's life. Ideally, CPE students practice engaging interreligious dialogue and chaplaincy practices in the classroom. However, multiple students that I interviewed expressed that they withhold their personal beliefs from their peers. Although CPE cohorts are not religiously diverse, CPE training programs could still be improved if supervisors learn to facilitate discussions and activities that allow each student's unique religious perspective to be expressed. In such an environment, students could potentially engage one another as resources for interreligious inquiry.

Under the guise of generic spirituality, chaplaincy is at risk for becoming secularized. By training chaplains to assess patients on the basis of how they make meaning of their life, CPE bypasses the religious nuances that shape a patient's lived experiences. The cost of a generalized

approach to spiritual care approach is the perpetuation of a chaplaincy field that unintentionally privileges a Liberal Protestant framework and risks undermining the experiences of patients from other religions.

If training courses teach students to broaden their conceptualization of religion, then chaplaincy education can maintain the compassionate, witnessing presence that CPE emphasizes, while simultaneously integrating cultural and religious specificity into the course. Introducing academic curriculum into CPE programs might create an environment that allows students to wear a more objective lens when inquiring about a patients' spiritual life. Students who are educated about the socio-cultural, ethnic, and environmental aspects of religion may have increased flexibility to enter patient-chaplain dialogues without needing to validate their preconceived notions about what religion is. Supporting CPE students with a college level World's Religion course could offer students baseline information about how to hold multiple religious perspectives as an approach to inquiry across religious boundaries.

Hospitals place chaplains in the role of mediator, asking them to bridge the gap between medical care and human care. In this position, the chaplain becomes the broker of a good-death. Although the term "good-death," often used by palliative care teams, is well intended, it creates expectations that a patient should have a sense of personal resolution and wholeness before death. Placing expectations on death is a precarious practice. Rather than being trained to stand on the brink between medicine and secularized human care, the chaplains' expertise should be concentrated on navigating the moments when one's wellbeing can no longer be maintained and resolution is no longer possible.

By offering guidance in the face of debilitating illness and death, religion provides a place of refuge amidst life-changing realities. It is precisely at the precipice of death that one's

religion is most likely to come forth. Religious rituals and practices are designed exactly for the purpose of carrying a person from a place of despondency into the unknown. As a result, we are at a substantial loss if chaplains are no longer able to meet patients on religious ground. Without well-versed interfaith chaplains, patients will lose an opportunity to connect with the historically rich practices that are grounded in cultural memory and generations' of practical experience.

In order to be a successful interfaith program, CPE needs to train students to work regionally. Not only do students need to be well informed about the religious population with which they will be working with, but they also need to understand how people of different worldviews interact within the region where they are located. Research into regional religious demographics could further support CPE interfaith program development by providing data that motivates CPE supervisor and students to be prepared to work with the populations that they will meet. Regional research could also help to differentiate the aspects of CPE curriculum that can be applied universally from those that need specialized regional design.

Because Hawai'i has no ethnic majority and high religious diversity, it offers an excellent environment for piloting an interfaith training program. For future work, I suggest implementation of the *Place-Based Chaplaincy* program that I have proposed here. The activities and assignments that I have designed need to be tested and tweaked with students in clinical practice. Although the patient populations with whom chaplains work may change throughout their career, my hope is that through this course they will gain the inquiry, observational, and practical skills necessary to momentarily step inside their patients' worldview and lived experience.

Appendix A

CPE Educational Goals as listed by the ACPE

(The following page is taken from the ACPE website https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/standards-311-312-outcomes-of-cpe-level-i-level-ii-programs)

Standard 311 Outcomes of CPE Level I

The curriculum for CPE Level I addresses the fundamentals of pastoral formation, pastoral competence and pastoral reflection through one or more program units. At the conclusion of CPE Level, I, students are able to:

Pastoral Formation

311.1 articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry.

311.2 identify and discuss major life events, relationships, social location cultural contexts and social realities that impact personal identity as expressed in pastoral functioning.

311.3 initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Pastoral Competence

311.4 risk offering appropriate and timely critique with peers and supervisors.

311.5 recognize relational dynamics within group contexts.

311.6 demonstrate the integration of conceptual understandings presented in the curriculum into pastoral practice.

311.7 initiate helping relationships within and across diverse populations.

Pastoral Reflection

311.8 use the clinical methods of learning to achieve one's educational goals.

311.9 formulate clear and specific goals for continuing pastoral formation with reference to one's strengths and weaknesses as identified through self-reflection, supervision, and feedback.

Standard 312 Outcomes of CPE Level II

The curriculum for CPE Level II addresses the development and integration of pastoral formation, pastoral competence and pastoral reflection to a level of competence that permits students to attain professional certification and/or admission to Certified Educator CPE. The Certified Educator's final evaluation will include a statement attesting to the competence demonstrated at the time of the evaluation.

Progression into Level II requires a level of competency in the Level I outcomes that permits the student to be building upon those competencies and no longer needing to address them as primary learning objectives. This is established through the Certified Educator's judgment documented in the written evaluation (cf. Standard 308.8.2).

At the conclusion of CPE Level II students are able to:

Pastoral Formation

312.1 articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.

Pastoral Competence

312.2 provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspectives.

312.3 demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.

312.4 assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.

312.5 manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.

312.6 demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self- disclosure, positive use of power and authority, a non-anxious and non- judgmental presence, and clear and responsible boundaries.

Pastoral Reflection

312.7 establish collaboration and dialogue with peers, authorities and other professionals.

312.8 demonstrate awareness of the Common Qualifications and Competencies for Professional Chaplains. Note: The ACPE Standards and Code of Ethics supersede these standards.

312.9. demonstrate self-supervision through realistic self-evaluation of pastoral functioning.

Appendix B

Place-Based Chaplaincy
Fall 2018
Monday and Wednesday, 8am – 12 pm

Professor: Laura Ritter
Office Sakamaki B310
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Office Hours: Mondays and Wednesday 2pm – 4pm

Course Description: *Place-based Chaplaincy* is a pilot course designed to train chaplains to work with the religious and cultural populations specific to Hawai'i. Over a sixteen-week period, students will meet twice a week for four hours. The exploratory question, "Does interfaith chaplaincy work - can a person be trained to offer support to people from a range of religious traditions other than their own?" forms the pedagogical design for this course. Unlike other CPE programs, students will be exposed to an academic approach to religious studies. The goal is for students to broaden their perspective on how religion is defined, enacted, and conceptualized by the people of Hawai'i.

On the syllabus you will see themes for each week. These themes (resolution, coming to terms with illness, saying goodbye, afterlife, the grieving process) illustrate a cycle people often go through when they receive a serious diagnosis. Lectures, guest presentations and in-class discussion will be shaped by these weekly themes. In their clinical work, using these themes, students will be asked to explore how various traditions encounter illness, death, and dying. For example, Christians may talk about atoning for sin as an aspect of resolution, while a Buddhist might speak about karma, and a Hawaiian might describe Ho'oponopono, a practice of forgiveness.

During class activities, which include workshops, case studies, verbatims, and interpersonal dialogues, students will examine and reflect on their clinical experiences in Oahu's hospitals. With peer support, students will critique how their personal faith tradition and communication style influences their ability to connect with patients across traditions and generations. The importance of accounting for historical, cultural, and socio-economic factors in interfaith work will be emphasized. The chaplains potential role as a facilitator for ethics cases will also be explored. For their capstone project, student's will create an interfaith handbook based on in-person interviews that they have facilitated with religious leaders in Hawai'i.

Student Learning Objectives
Regionalism and Religious Literacy

- Students can identify the major religion's in Hawai'i and demonstrate an ability to compare and contrast the popular lineages within each religion.

- Students can describe spiritual concepts specific to Native Hawaiians and how those concepts might be pertinent when working with patients and staff in a medical setting.
- Students can identify religions (other than mainline Christianity or Buddhism) that are prevalent in certain regions in Hawai‘i such as LDS, Jehovah's Witness, or the Tongan Seventh Day-Adventist community and understand any unique religious needs of these communities.
- Students can synthesize their research to create a spiritual care handbook for chaplaincy in Hawai‘i.

Interfaith Spiritual Care Practices

- Students can develop a definition of "interfaith chaplaincy" that can be used to explain their work to patients and care providers in the medical setting.
- Students can analyze religious perspectives with a multi-disciplinary lens.
- Students can identify worldview's applicable to Abrahamic, Dharmic, and Indigenous traditions.
- Students can demonstrate communication styles specific to particular cultural groups in Hawai‘i.
- Students can employ interfaith skills when working with families that have intergenerational religious differences and internal religious conflict.
- Students can develop an interfaith approach to their "ministry of presence" which includes the ability to facilitate contemplative practices from a range of religious traditions.

Interfaith Care in the Medical Setting

- Students can demonstrate the ability to facilitate spiritual openings, debriefings, and reflection/stress reduction sessions for hospital staff.
- Students can articulate the concept of "healing" from a multi-faith perspective.
- Students can identify and develop approaches for engaging in ethical scenarios where there is disagreement between the medical team's recommendations and a family's religious practices.

In Class Activities

Roleplaying: Roleplays will be on cultural communication practices, debriefing medical staff, and supporting patients and staff during ethics cases. Students must prepare for role-plays in advance by choosing a scenario from their own clinical work that could be used in class.

Case-Studies: During case study activities, students will be presented with scenarios that challenge their interfaith skills, up-end normative definitions of religion, and offer complex socio-cultural situations. Students will then break into small groups to discuss how they would approach each case. Students will apply Ninian Smart's model of worldview analysis to their case study analysis.

Verbatims: Verbatim presentation dates will be assigned on the first day of class. In addition, each student will be asked to facilitate one verbatim discussion. Students need to choose a

particular facilitation style that speaks to their tradition. For instance, when reviewing a patient-chaplain interaction, a Buddhist trained student might pay-close attention to the relationship between the patient and chaplain, while a liberal Protestant student, in their facilitation, may focus more on how the patient is making-meaning of their illness.

Workshops: Workshops are a combination of mini-lectures, group readings, small-group discussion, and student presentations. Workshop topics will include *Defining Interfaith Chaplaincy, Integrative Medicine, Ceremony Practicum* and *Spiritual Openings.*

Presentations: Students will prepare short presentations throughout the course. Presentations are intended for students to become resources for one another. Presentations do not need extensive pre-class preparation. They are intended to be personal dialogues with peers about one's own insights, beliefs, and experiences.

- Group presentation: Contemplative practice
  For this presentation, the class will split into two groups of four. The presenting group will lead the class in four contemplative practices that represent different religions or different lineages/denominations within a tradition.
- Individual presentation: Personal narratives
  In narrative style, students will share their own life-story and specifically what brought them to chaplaincy.
- Individual presentation: Personal tradition
  Students will present a text, ritual, or a practice that personally supports them as a chaplain.
- Individual presentation: Capstone Project, Interfaith Chaplaincy Handbook
  Students will present their fieldwork. During this presentation students must explicitly state how they chose to organize the information they gathered. Particular attention should be paid to comparing and contrasting concepts across and within religious traditions.

Guest Visits
Every week there will be at least one visit from a professional chaplain or community religious leader. This component of the course is intended to truly ground students in place-based learning. Speakers will focus specifically on their work with populations in Hawai‘i and weekly themes will be included in their presentation. There will also be presentations by a hospice organization, a medical ethics committee, and chaplain residents.

Interpersonal Relations Dialogue (IPR): IPR is a defining aspect of conventional CPE curriculum. In this activity students examine how they are working with one another to enhance individual and group learning processes. For the first discussion, students will create a covenant to establish confidentiality, accountability, and respectful communication practices.

Key Assignments

Verbatims:

Verbatims are a core component of the CPE learning process. Students will be expected to write and present three verbatims in the classroom setting. Each presentation will be 60 mins.

Verbatims must cover the following topics:

1) An intergenerational family of multiple religions or a family with internal religious conflict
2) An experience with a patient from a religion (other than mainline Christianity or Buddhism) that is prevalent in certain regions in Hawai‘i such as LDS, Jehovah's Witness, or the Tongan Seventh Day-Adventist community
3) A challenging patient encounter that includes one of the weekly themes

Journal:
Students will keep a weekly journal. The journal should be a log that 1) Tracks students experiences with patient visits; 2) Reflects on students' theological beliefs and/or worldview and how their perspective is changing or being challenged by patient encounters; 3) Engages the theme for the week.

Field Research and Interfaith Chaplaincy Manual:
Students are expected to conduct 10 interviews with religious leaders based in Hawai‘i. The interviewees must represent 3 denominations of Christianity, 3 lineages of Buddhism, 3 interviews with Native Hawaiians, and one interview with another religion of their choice. The questions that students ask the interviewees must be based on weekly class themes (resolution, coming to terms with illness, afterlife, etc.) Using key concepts, themes, and ideas from their interviews, students will develop an interfaith handbook. At the end of the semester, they will present their handbook discussing key components from their interviews and explaining their reasoning for how they organized their manual.

ASSESSMENT

The course will be pass or fail. I will evaluate students based on 1) Self-Assessments; 2) Class participation; 3) Verbatims; 4) Mid-term Exam; and 5) Interfaith Chaplaincy Handbook. In CPE, progress is measured by the student's willingness to grow and change, her ability to reflect on worldviews other than her own, and her capacity to critique and improve her own chaplaincy skills.

Self-Assessment:
Students will write 1-3 paragraphs on their strengths and weaknesses as they pertain to each SLO. Students are encouraged to illustrate their responses with examples from their clinical work and fieldwork interviews. Three SLO assessments will be submitted throughout the course. **Due Dates: August 30th, October 23rd, November 29th.**

Class participation:
The quality of what a student says and how well they listen determine the value of their participation. Because CPE is a group learning experience, students may challenge their peers, but must communicate in a manner that appreciates differences in opinion and approach. Creating a supportive atmosphere for the group's learning is valued over individual success or

competition. Students are expected to use journal writing as preparation for participation in Interpersonal Relations Group (IPR), workshops, and case studies. During roleplays, students will be expected to offer role play scenarios based on of their own clinical experience. Participation is also based on a willingness to participate in roleplays.

Students may choose to opt out of certain discussions or activities if needed for personal reasons. However, in this case, students must give the class an explanation for their decision and be willing to discuss how and if they wish to receive support from their peers.

Verbatims: Verbatims will be evaluated for thoroughness. I expect the written verbatim to be complete. If any section is left blank, the student will need to clearly articulate why she made this choice. Students must illustrate that they have reflected on the patient encounter and clearly articulate in their verbatim what they hope to learn by presenting it to the class. Finally, students must be open to receiving feedback from their peers. At the end of the verbatim discussion, the students will briefly summarize what aspects of the peer group critique they have found most helpful for their future work.

Exam: Students will have one midterm take home exam. The exam will be passed out on **Oct 4th** and returned on **Oct 11th**. Students will be given Ninian Smart's model of worldview analysis and be asked to apply it to three minority religious groups in Hawai'i. Students will then write a one – two-page essay on how the exercise influenced the way in which they define religion.

Interfaith Handbook: The purpose of the interfaith handbook is to expose students to community religious leaders as well as to broaden students understanding of how various religions perceive illness, healing, and death. For their field interviews, students will script questions based on the course's weekly themes. Students may choose how they compile and present their research. The only requirement is that they compare and contrast the weekly themes across religions.

CLASS SCHEDULE

Week 1: Introduction

Aug 21st: Introduction
Opening Ceremony
Workshop – *Defining Interfaith Practice*
2nd Year Students' Presentation

Aug 23rd: Introduction Continued
Workshop – *Defining Interfaith Practice*
Community Religious Leader Presentation
IPR

Week 2: ***Resolution***

Aug 28th: Lecture - Resolution
Guest Chaplain Presentation
Verbatim

Group Presentation – *Interfaith Approaches to Contemplative Practice*

Aug 30th: Lecture – *Ninian Smart's Model of Worldview Analysis*
Community Religious Leader Presentation
Verbatim
Group Presentation – *Interfaith Approaches to Contemplative Practice*
(*SLO Assessment Due)*

Week 3: *Hawaiian Spirituality and Healing*
Sept 6th: (8-hour class) Waianae Comprehensive Health Clinic

Week 4: Coming to Terms with Illness
Sept 11th: Lecture – *September 11th and Interfaith Dialogue*
Verbatim
Role play - *Communication Styles*
Case study

Sept 13th: Lecture - Coming to Terms with Illness
Verbatim
IPR
Community Religious Leader Presentation

Week 5: *Coming to terms with illness*
Sept 18th: Lecture
Verbatim
Presentation - *Personal narratives*

Sept 20th: Community Religious Leader Presentation
Verbatim
IPR
Presentation - *Personal narratives*

Week 6: *Saying Goodbye*
Sept 25th: Lecture – Saying Goodbye
Guest Chaplain Presentation
Verbatim
Guest Presentation - *Hospice of Hawai'i*

Sept 27th: Lecture
Verbatim
Case study
IPR

Week 7: *Afterlife*
Oct 2nd: Lecture - Afterlife
Community religious leader

Verbatim
IPR

Oct 4th: Lecture
Verbatim
Workshop: *Spiritual Openings*

Week 8: ***Ceremony in a Hospital Setting***

Oct 9th: Lecture – Ceremony in a Hospital Setting
Verbatim
Guest chaplain presentation
Workshop: *Ceremony practicum*

Oct 11th: Lecture
Verbatim
Case study
IPR
(Take home exam assigned)

Week 9: ***Grief Practices***

Oct 16th: Lecture – Grief Practices
Verbatim
Field work progress update

Oct 18th: Lecture
Verbatim
IPR
Community religious leader
(Take Home exam Due)

Week 10: ***Concepts of Healing***

Oct 23rd: Lecture – *SBNR*
Verbatim
Presentation: *Personal Tradition*
Workshop: *Integrative Medicine*

Oct 25th: Lecture – Concepts of Healing
Verbatim
Presentation: *Personal Tradition*
Guest chaplain presentation

Week 11: ***Principles to Live By***

Nov 6th: Lecture – Principles to Live By
Verbatim
Self-Assessment Feedback
(SLO Assessment Due)

Nov 8th: Lecture - *Regionalism*
Verbatim
Community Religious Leader
IPR

Week 12: ***Multicultural Communication***

Nov 13th: Lecture – Multicultural Communication
Verbatim
Workshop: *Ministry of Presence*

Nov 15th: Role-play: *Multicultural Communication*
IPR
Workshop: *Ministry of Presence*

Week 13: ***Caring for Medical Staff***

Nov 20th: Lecture – Caring for Medical Staff
Verbatim
Role-play: *Debriefing*

Week 14: ***Medical Ethics***

Nov 27th: Lecture – Medical Ethics
2nd Year Students Presentation
Verbatim
Guest Hospital Ethics Team Representative

Nov 29th: Verbatim
Role-play: *Family Meetings*
IPR

Week 15: ***Medical Ethics***

Dec 4th: Lecture – Examples of Ethical Scenarios
Verbatim
Role Play: *Medical Ethics Scenarios*

Dec 6th: Community religious leader
Verbatim
Self-assessment
(SLO Assessment Due)

Week 16: Closure

Dec 11th: Lecture - Closure
Field research presentations

Dec 13th: Field research presentation
IPR
Closing ceremony

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