

A Databank Resource for Pastoral Research: Detailed Descriptions of Chaplains' Visits with Patients

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SUMMARY

Papers by Chaplains John Gleason and John Ehman have identified the need for pastoral research conforming to professional norms of research, in order to achieve a disciplined study of religious experience by pastoral practitioners. Chaplains who are professional in their spiritual care practices study the findings of religious and pastoral research, test those findings in personal pastoral practice, further examine in detail their own practices, and share with colleagues through peer reviewed papers what they find helpful for improving the quality of the spiritual care they all individually provide. This collegial sharing of analyses of personal pastoral experience, however, requires that patient visits be described in a level of detail, consistent format, and unambiguous terminology if they are to be useful for the systematic evaluation and improvement of pastoral practices.

This paper outlines a method for developing detailed descriptions of patient visits in a consistent template or structure of relevant information, sufficient for enabling other colleague chaplains to replicate the essential characteristics of those patient visits, and thereby test and verify the effectiveness of those patient visit protocols for improving pastoral practices. These structured descriptions of patient visits would include a statement of the purpose of the visit for meeting a patient's spiritual needs, the information the chaplain had about the patient and the patient's needs when formulating the purpose of the visit, the themes and information the chaplain communicated to the patient in the visit, the planned sequence of the discussion with the patient during the visit, and the cues or indicators that enable the chaplain to judge how effective the visit had been in meeting the patient's needs. This approach is based on the methods used to verify the efficacy of cognitive behavior interventions in clinical trials conducted by clinical psychologists and as adjuvant therapy in other clinical studies.

This structured description method can be useful not only for use by experienced chaplains to specify their spiritual and pastoral care practices, but also for introducing CPE students to the systematic data description methodologies of pastoral research. A databank of patient visit descriptions

can serve pastoral researchers' systematic studies in many different ways, and can provide an empirical knowledge base for professional chaplaincy.

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INTRODUCTION

In his 2004 William Randolph Wycoff Lecture on pastoral research, John Gleason stated clearly the moral imperative of all clinical chaplains to involve themselves actively in religious and pastoral research. He challenged CPE supervisors to find ways to inculcate this involvement in research into the "Head and Heart" dialogue of clinical pastoral education. "Like it or not, ready or not, all clinical chaplains have a four-fold moral imperative: to stay abreast of Religious and Pastoral Research findings, to test those findings in the cause of improving our own quality of care, to further examine our practice, and to share what we find. Our professional colleagues from other disciplines have proclaimed that message to us." [ACPE Research Network Newsletter (Winter 2004), vol. 2, no. 2, §1]

John Ehman pointed out in the Spring 2003 ACPE Research Network Newsletter that the empirical usefulness and validity of research on institutional chaplains' patient visits will not be convincing unless what happens in those visits is specified in some reasonable level of detail. Consequently, the design of research studies will need a methodology for the more detailed specification of chaplain interventions, sufficient to enable other chaplains to replicate those chaplain interventions, and expressed in a consistent terminology defined for describing chaplain visits with patients and institutional clients in a relatively precise and unambiguous way.

The visit of a chaplain with a patient is the activity in which spiritual and pastoral care is delivered to an individual patient. Chaplains engage in many activities in hospitals and health-related institutions, as enumerated in the 2001 White Paper jointly developed by five chaplains associations. But the unique activity in which the chaplain's theological and psychological education, clinical skills, and personal commitment to the spiritual well-being of a patient are all brought to the service of an individual patient is the patient visit. Improving the quality and efficaciousness of patient visits, therefore, should be recognized as a professional priority for chaplains.

What is proposed in this paper is a method for enabling chaplains to share with one another their pastoral care experiences and their practices in patient visits that may be helpful for other chaplains to use. For this information to be useful, chaplains will need to describe their visits with patients in a consistent format and in a sufficient level of detail so that other chaplains would be able to understand what would occur in a similar patient visit, and be able to replicate a similar patient visit approach with other patients that have similar characteristics, problems, and comparable spiritual needs.

In addition, an arrangement for the convenient sharing of these detailed descriptions of patient visits among chaplains is needed. The periodicals in which chaplains publish their articles are well suited for many purposes supporting professional communication

among chaplains, but are not suited for the systematic accumulation of consistently structured detailed descriptions of patient visits. This paper offers suggestions for an arrangement that would provide a databank-like service for the storage and retrieval of patient visit descriptions.

Two Challenges for Professional Clinical Chaplains

“THE FUTURE: THE CHAPLAIN'S MORAL IMPERATIVE, by John Gleason

“For more than 75 years now, despite the work of the dedicated few Pastoral Researchers, most clinical clergy, rabbis, imams, lay caregivers, and others who work in correctional, mental health and general health care settings continue to minister in an essentially idiosyncratic way. We apply Head and Heart to the healing relationship as we see fit. We approach the client with our own unique styles. We resist any pressure toward critique or consensus about our daily practice.

“Like it or not, ready or not, all clinical chaplains have a four-fold moral imperative: to stay abreast of Religious and Pastoral Research findings, to test those findings in the cause of improving our own quality of care, to further examine our practice, and to share what we find. Our professional colleagues from other disciplines have proclaimed that message to us.” [ACPE Research Network Newsletter (Winter 2004), vol. 2, no. 2, §1] (John J. Gleason <j_mgleason@juno.com>)

“THE IDENTIFICATION OF PASTORAL CARE VISITS, by John Ehman

“One of the pressing issues today in pastoral care research is the specification of what chaplains *do* when they intervene in patient situations. If an intervention is poorly defined in research, the assessment of its effect must be at best tentative. Yet, the complex and subtle nature of pastoral care visitation does not lend itself to simple description, much less to rigid circumscription. . .

“Valuable research can well be done with interventions identified as broadly as "visit by a chaplain," but the demand for greater specificity is growing. There is an understandable desire among researchers to refine data collection, control for more variables, discover confounding variables, develop and validate specific measures, and lay the groundwork for reproducible results. . . .

“There are at least two operative questions here: How can we begin to focus in on the activities of chaplains so that there is both a reasonable specificity about interventions and a reasonable latitude for a chaplain's spontaneity in interaction with patients? Also, what interventions may help us to explore the contributions to health care that chaplains may provide either uniquely or especially well?” [ACPE Research Network Newsletter

THE HISTORICAL PATTERN OF MEDICAL RESEARCH

Chaplains are aware of the long tradition of research in the evolution of medical science and the medical profession. For centuries in the history of medicine, physicians carefully observed the symptoms and characteristics of the illnesses of their patients, and examined the degree of success of the various therapies that they applied in hopes of remedying specific classes of health problems. They sought to find recurring patterns in the illnesses of the patients they treated, and studied the physiological and biological sciences to develop theories for explaining the etiology of the different illnesses. They made notes on what they observed about the effectiveness of different therapies for specific types of illnesses, and shared their findings with other physicians in medical journal articles containing carefully written and detailed case studies along with comparative analyses. They described their observations of the therapeutic practices that seemed to help their patients, and developed hypotheses about why certain therapeutic practices were effective and others were not effective in helping their patients. The eponyms by which many illnesses, syndromes, and procedures have been named record the persistent work of the physicians who studied the patterns they found in the illnesses of their patients, and then published their findings in medical journals or books.

In the field of medicine, the sharing of physicians' observations of disease patterns and their findings on effective treatments was accomplished through articles in journals and in books. More recently, the scientific development of databases of shared case experience has contributed much information for the improvement of patient care. Editors of medical journals and managers of specialized database projects now require that contributions be made in specialized structured formats, in order to assure the completeness and consistency of the information, and to enable computer-based retrieval of relevant information for research.

The format or template for articles in the medical journals, for instance, is designed to provide the reader with enough information so that the relevance of an article's contents can be quickly assessed, and the completeness of the information in the article can be assured. Articles in medical journals typically follow the IMRAD format: Introduction, Methods, Results, and Discussion. The *Introduction* section states the objective of the research, and provides background information on the findings of relevant previously published research on the topic. The *Methods* section describes the research design, with sufficient detail to enable other researchers to design replication studies. The *Results* section contains fairly detailed descriptions of the findings of the study, and compares them with the assumptions and hypotheses that determined the design of the study. The *Discussion* section presents the author's interpretation of the results and their relevance usually suggests the applicability of the findings for practice. This section also draws conclusions from the findings and the limits of the research that

might be addressed in subsequent research. Within the *Methods* section in particular, editorial standards specify the full range of descriptive information needed to describe adequately the statistical design and sequence of activities that were followed in conducting the study; this section is intended to assure that the study can be replicated by other researchers.

Up to the present, there has been no comparable community effort of professional chaplains to develop a systematically validated body of knowledge on pastoral practices and their effectiveness in addressing the spiritual needs of patients. There have been many insightful books and articles published on aspects of pastoral practice, but they generally have lacked terminological precision and consistency. *The Dictionary of Pastoral Care and Counseling* published a decade and a half ago was a landmark in laying the foundation for the systematic development of knowledge. A beginning has been made.

The relatively few journals that have been the principal sources for the serious discussion of pastoral practices chaplains thus far have not established editorial standards that would assure completeness and consistency in the description of patient interventions for articles on pastoral practices. This is understandable, because there has been no parallel activity among chaplains to define what is needed for effective and efficient communication of pastoral practice descriptions at the level of detail that would allow replication. The task of professionally sharing what is discovered needs to be undertaken in a way that will allow comparability and the systematic accumulation of refined information.

THE HOSPITAL CHAPLAINCY PRACTICE CONTEXT

In the nation's hospitals, chaplains are very busy, with many demands on their time and attention. The work environment of a hospital is quite different from the academic environment of a university, which allows time for research and writing. The principal reason why chaplains do not publish many articles and engage in discussions of pastoral practice is the time pressure of the chaplain's working environment. As a result, little of the accumulated experience of chaplains finds its way into print. Physicians also have a work environment with many demands on their time and attention. They also find themselves under the time pressures of the hospital working environment. Yet physicians for centuries have written observations of cases they have encountered, and have systematically communicated their perceptions and experience with their colleagues. As a result they have built a vast literature that provides structured descriptions of their diagnostic and therapeutic procedures and findings. It can be argued that it has been as difficult for physicians to find the time to do this systematic observation and description of their diagnostic and therapeutic practices as it would be for chaplains to find the time to systematically write descriptions of their observations and findings concerning pastoral interventions with patients.

The pastoral care and hospital chaplaincy literature contains many case studies and many illustrative narratives of chaplains' experiences with individual patients. This literature is helpful for broadening colleagues' awareness of the scope of pastoral care

and spiritual concerns, but has lacked the specificity that would be helpful for identifying best practices in patient visits. Experienced chaplains who have contributed to this chaplaincy and counseling literature have written many partial descriptions of their patient interactions. Narrative models for describing experiences in patient interventions are not uncommon among chaplains. Indeed, chaplains learned the practice of writing verbatims and discussing patient visits in their clinical pastoral education internships, and these experiences carry over into their writings. What has not been done on a regular basis is the describing of these patient interventions in sufficient detail that would provide another chaplain with the information needed to replicate the intervention with another patient that had nearly identical needs for spiritual care. The descriptions of patient visits have lacked the level of specificity that would enable the patient visit's efficacious characteristics to be replicated by someone else, or to be compared systematically with the pastoral practices of other chaplains.

The pastoral and spiritual care experience of professional chaplains that would be particularly valuable would include detailed descriptions of the patient interventions that they have found to be particularly helpful in addressing recurring patterns of patients' spiritual needs. Although every patient visit is different in many respects, experienced chaplains identify fairly common patterns of problems among patients that they have encountered many times in the past. These chaplains have developed common but adaptable pastoral responses to these recurring patient needs. Professional chaplains know from their experience what themes and knowledge to share with patients when those categories of spiritual needs become clear in their visits with patients. Chaplains have learned by experience to switch the conversation in a patient visit to certain topics and lines of thought and reflection when certain characteristic patient needs are identified, and to steer the thinking of the patient toward appropriate considerations and reflections.

CURRENTLY AVAILABLE CHAPLAIN PRACTICE DATA

This accumulated experience of professional chaplains with distinguishable types of patient needs is sparsely reflected in the chaplaincy literature, but has not been readily available for systematic comparison and analysis. The preferred expressions and terminology used by chaplains to identify their practices in their articles and books are seldom explained at a level of detail to allow other chaplains to understand the precise characteristics of the practices. Without an unambiguous terminology for identifying pastoral practices, supported by clear and comprehensive definitions of the terms in the terminology, the imagination is left the task of visualizing what the author might mean.

Since there has been no systematic arrangement for accumulating and accessing detailed descriptions of pastoral practices and experiences, it is understandable that the development of sharable descriptions of pastoral practices has not become a recognized professional activity among chaplains. There also has been no career motive for a chaplain to do so. For example, the chaplains associations do not currently extend continuing education credits (CEUs) for the systematic research efforts that chaplains undertake and share with their peers. The professional chaplains who develop and communicate detailed descriptions of the pastoral practices that they have found

beneficial for responding to various spiritual needs of patients clearly are engaged in professional improvement efforts. Their pastoral expertise is deepened and broadened as a result of systematic effort of this sort. But the profession of hospital chaplaincy up to the present has not recognized this reality in a tangible way by conferring continuing education credit for this work.

Although many chaplains currently may be convinced that they do not have sufficient time to devote to developing structured descriptions of their experiences in pastoral care, if convenient arrangements were available for viewing the detailed descriptions of colleagues' pastoral practices, their thinking very likely would change. The examples of colleagues probably would be a sufficient motivator for a chaplain to develop a few structured descriptions of her or his preferred ways of responding to recurring patterns of patients' spiritual needs. In addition, the availability of a variety of detailed descriptions of colleagues approaches to different problems of patients would stimulate comparative analyses and a discussion of best practices in the chaplaincy literature.

Professional chaplains are quite familiar with the practice of writing verbatims of their visits with patients. In their CPE training they became proficient in writing verbatims and elaborating them with more details in discussions with their peers. In their pastoral practice, however, experienced chaplains normally have no reason or motivation to exploit this proficiency in writing verbatims of their visits with patients, and do not routinely develop case studies unless there is some special reason to do so. Chaplains do write articles that include some descriptive details of individual interactions and experiences with patients; but these descriptions are limited to the details or aspect of the patient visit that are sufficient to illustrate the themes and propositions they are presenting in the articles.

Up to the present there has been no practical and convenient way for individual chaplains to make a professional contribution to the body of shared knowledge specific to hospital chaplaincy. The development of structured descriptions of patient visits, and the collegial sharing of these descriptions so that common patterns and outcomes can be discovered through applied research, are the objectives goal addressed in this paper. The goal is to outline a practical way for chaplains to build a professional body of knowledge. Professional chaplains naturally have an interest in any initiative that holds promise for helping them refine and improve their pastoral and spiritual care for patients in the future. This ACPE Research Network structured descriptions initiative can best be understood as introducing practical arrangements for the observational and descriptive methods that have enabled physicians to build the body of knowledge of medicine. The collegial development and sharing of knowledge among physicians historically has shaped the evolution of medical knowledge and practice.

BUILDING A DATABANK OF PATIENT VISIT DESCRIPTIONS

Even though this project should be understood as providing an “infrastructure” for assisting clinical chaplains in systematically examining their pastoral encounter practices and sharing what they find is good practice, in accord with professional norms, the

project also can serve as a learning exercise for CPE students. There is no reason why CPE students could not also submit structured descriptions of their experiences in patient visits. The project includes the work of several CPE supervisors participating in the ACPE Research Network. They are participating in the development of the databank of detailed descriptions of pastoral encounters. These chaplains have introduced an assignment into their CPE units for the students to develop papers describing, in a common format, interventions they have had with patients that have been written up in verbatims, then discussed in the peer group and with the supervisor, and finally refined through pastoral reflection to identify the student's mature view of what would have been the ideal way to have conducted that original patient visit. These papers, called "Ideal Intervention Papers," are developed in accordance with the common structured template that is designed to capture all the relevant information that would enable another chaplain to replicate the visit.

Other CPE supervisors are invited to introduce this "Ideal Intervention Paper" assignment into their CPE programs after the mid-point of the CPE units they are conducting. Electronic copies of students' Ideal Intervention Papers describing the revised versions of the patient visits can be sent to the Convener of the ACPE Research Network for inclusion in the databank. The databank's project manager can then package all the structured descriptions together and distribute them to supervisors participating in this pastoral encounter research databank program. After reviewing the combined set of the structured descriptions, the supervisors participating in the pilot program will discuss improvements to be made in the method as well as other refinements to facilitate ways to use the descriptions in research projects.

As this database grows from subsequent CPE units with the input of additional Ideal Intervention Papers, in accordance with the common structured description template, broader-based research studies can be undertaken. The availability of a database of these structured descriptions of chaplains' visits with patients could serve multiple purposes for the members of the ACPE Research Network and for all professional chaplains interested in substantive research on pastoral practices:

- Agreement could be forged on terminology for referring to specific chaplaincy practices within visits with patients and pastoral encounters in other settings.
- By describing the pastoral encounters in a consistent structured way, researchers will be able to analyze and characterize the variety of creative approaches that is available for specific types of spiritual needs and concerns of patients.
- Appropriate examples among these structured descriptions could be used in CPE education.
- CPE interns and residents in their second, third, and especially their fourth CPE units could develop studies and papers based on this database's examples of interventions with patients.

THE 'STRUCTURED DESCRIPTIONS' METHOD

An effective outline of the information needed for a detailed description of a patient visit (its structure) would include descriptions of the visit's purpose, the characteristics

and needs of the patient, the knowledge and information drawn on by the chaplain in communicating with the patient during the visit, the sequence of steps or phases within the visit, and the indicators the chaplain would pay attention to for sensing whether the visit had achieved its purpose. A five-part *structured description* for the specification of a chaplain visit is proposed in this paper as a reasonable level of specific information about a visit, which also will allow a reasonable latitude for a chaplain's spontaneity in interaction with patients. The level of detail would be that which would enable another chaplain to replicate the visit with other patients having similar characteristics and spiritual needs.

This proposed template of information for a structured description is derived from the research practices of clinical psychologists in specifying their experimental cognitive behavior therapy (CBT) methods for the purpose of conducting clinical trials to determine the efficacy of those specific therapeutic approaches. Cognitive Behavioral Therapists have validated the efficacy of a number of specific CBT interventions with patients through randomized controlled clinical trials. For these clinical trials, the psychologists have been required to describe in considerable detail not only the cognitive content of the information that they communicate to clients in the course of the CBT sessions, but also the sequence and structure of their sessions with the clients. They also specify the cues and patient reactions that they use as indicators during the sessions to guide their interventions and suggest the effectiveness of their approach in the sessions.

The level of detail and specificity that CBT researchers include in their structured descriptions of the CBT therapy sessions is that which is considered to be necessary and sufficient for enabling another therapist to replicate the counseling session with other clients. The replication, for valid scientific measurement of the effects of the CBT method, must present the same specific cognitive content but also must allow a reasonable latitude for the therapist's spontaneity in interaction with the research subjects as clients.

THE CLINICAL PASTORAL EDUCATION CONTEXT

CPE Supervisors who are members of the Research Network no doubt are already introducing their CPE students to current religious and pastoral research findings in their didactic sessions; and their group discussions offer opportunities for the students to consider how research findings relate to their experiences in visiting patients. John Gleason's challenge has been to go further and introduce CPE students to a systematic examination of their spiritual care practice, and then share in a professional way what is learned through this reflection upon their patient visit practices.

Currently there are efforts underway to include in CPE Units an exercise for each student to develop one structured description of an ideal patient visit, based on a verbatim developed by the student. These efforts provide a practical way for supervisors to introduce into the schedule of CPE student activities some level of systematic examination of professional practice, along with the sharing of findings with colleagues. Each CPE program has its own pragmatic issues, but in general all programs have limits on the time that students can devote to any exercise other than the prescribed CPE

processes. Usually it takes a while for CPE students to learn to use CPE procedures effectively in order to make progress toward their personal goals and the objectives stated in their contracts with the supervisor. The group discussion practices, the weekly reflections, the verbatims, and the individual sessions with the supervisor are dynamic learning experiences that enable students to make progress towards their stated goals and objectives. Developing rapport and mutual trust among the students in a CPE unit takes time, and the hours dedicated to direct contact with patients are the primary experiential activities that stimulate the dynamic growth of students' personal identities. These interactions with patients drive the other activities in the CPE process. These other activities are designed to help the student perceive and internalize the meaning of the "living documents" encountered in the patients. Therefore, from the pragmatic perspective of the limited time available, any effort devoted to the systematic examination of practice and the professional sharing of the results of this examination should build upon the existing processes of the CPE unit, rather than be separate activities.

The initiative for Ideal Intervention Papers with structured descriptions that is underway introduces systematic practice examination and professional sharing activities into the processes of CPE Units in a natural continuation of existing CPE procedures, using already developed verbatims as the starting point. The existing CPE practices of writing verbatims, and then discussing these verbatims in a peer group and in sessions with a supervisor, are the first phase of an examination of practice. In order to take full advantage of the observations and suggestions received from other students and the supervisor, in addition to self reflection on the pastoral intervention, a student will write a further reflection on an intervention in light of feedback received on the visit's verbatim, so as to capture thoughts for improving pastoral practice. This second-phase analysis is introduced to students as an assignment toward the end of a CPE unit.

THE CPE IDEAL INTERVENTION PAPER EXERCISE

In this particular method for responding to John Gleason's challenge, each CPE student would undertake an assignment to work carefully through the critique and suggestions received on one of the student's verbatims, and then write out the design of an optimal patient intervention. The structured description of the encounter would include the 'best practices' for that particular visit as synthesized and conceptualized by the student. This assignment for each student would provide an experience in examining the student's pastoral practice in a particular encounter with a patient, and then formulating what the student has learned about how best to provide spiritual care for a patient with similar needs. By using a standard format for writing the structured descriptions, students will learn to focus attention on accurately presenting pastoral care information in ways that other chaplains can understand and use. As the structured description is shared with other CPE programs in other institutions, students would also be able to experience participation in the larger world of professional chaplaincy.

The exercise, then, is for each student is to develop one structured description of an intervention with a patient that would include the student's synthesis of the suggestions received from the other students and the supervisor, along with the student's mature

reflection on the original encounter with the patient. This structured description will, in essence, present how the student would conduct the intervention if she or he could do it over again. The description of the intervention would therefore represent the student's articulation of a "best practice" in the context of the original encounter with the patient.

To be of professional usefulness, these structured descriptions of patient visit interventions will need to be detailed to the level of information that would enable another chaplain to replicate the intervention in another institution with another patient with needs and in circumstances similar to those encountered in the original intervention. It will include a description of the patient characteristics and needs that determined the purpose and best practice in pastoral care described for the visit. The structured description of the intervention with the patient would be designed to describe how another chaplain could plan a sequence of steps for replicating the intervention as a "best practice" for patients with similar needs, and should be sufficient to guide a chaplain or intern in another setting to conduct the model intervention.

The information contained in the structured description should include:

- The purpose of the intervention, based on the known needs of the patient
- What is known about the patient's characteristics and the patient's needs
- The cognitive content or information presented by the chaplain to the patient
- The sequence of steps or phases of the intervention
- The indicators considered to be evidence of a favorable outcome of the visit

For professional sharing of these pastoral practice experiences, students will provide the supervisor with electronic copies of the structured description papers. These electronic copies enable the supervisor not only to build a database of structured descriptions of patient visits but also to exchange them with other supervisors. The exchange of these structured descriptions among CPE programs would work as an effective, if quite basic, professional sharing of the examination of practice. Such exchanges can begin with the communication of the electronic copies of the students' structured descriptions to the ACPE Research Network's database of structured descriptions of patient visits.

A TEMPLATE FOR THE STRUCTURED DESCRIPTIONS

The template for the specification of interventions with patients described below is a pragmatic first step in identifying the best ways of specifying chaplain visits in greater detail. Specifying professional practice patterns in some detail should permit more precise identification of differences in chaplains' practices and reduce ambiguities in the terms used to describe them. A chaplaincy practice pattern is more than a list of activities and types of interventions with patients. Each of the activities or interventions with patients in a specific practice pattern can be identified by its purpose, what is known about the spiritual condition and needs of the patient, the information or cognitive content communicated to the patient in the visit, the structure or sequence of steps in the visit, and the observable indicators or cues by which the outcome of the visit may be recognized as successful or less than successful.

I - The Purpose of the Activity: Each of the types of chaplain interventions with a patient would be categorized by its purpose. Interventions designed for achieving the same purpose belong in the same general category of intervention. Some examples of *purpose categories* would be patient visits for spiritual assessments, discussion of advance directives, responding to a referral from a nurse or clinician, discussion of end of life issues, performing a religious rite or ordinance, spiritual counseling, providing spiritual support when a patient has received bad news, conveying a message from the patient's congregation or pastor, etc. As with any activity, the key issue is whether the purpose of the activity is achieved. The purpose of the intervention distinguishes the visit from other kinds of visits, defined in terms of their different purposes. Interventions intended to achieve the same general purpose, of course, can differ operationally by the other three characteristics: structure, cognitive content, and outcome indicators.

II - The Characteristics, Problems, and Needs of the Patient: The purpose of the patient visit is determined by the needs of the patient as known before the visit. Spiritual assessments will provide information on the characteristics and problems of the individual patients. From this information the chaplain will identify the most appropriate purpose for a follow-on visit. The structured description should contain sufficient information on the characteristics and needs of the patient to enable other chaplains to form a profile of the patient, so that patients with similar profiles would be candidates for replication of the patient visit outlined in the structured description.

III - The Cognitive Content of the Communications Involved in the Visit: The topics that the chaplain is prepared to discuss or explain in the visit with the patient, and the conceptual framework used in assessing the patient's responses in the interaction, represent the cognitive content of the chaplain's communication with the patient, in order to achieve the purpose of the intervention. Some purpose categories can have very well-defined cognitive content, such as a visit for discussing advance directives. Other purpose categories can have much broader cognitive content, drawing on the extensive pastoral experience of the chaplain. An intervention in a particular category of purpose may well have cognitive content that differs from chaplain to chaplain, based on a chaplain's denominational background, education, experience, and specific objectives for the patient visit resulting from previous visits to that patient.

IV- The Structure or Sequence of Phases in the Visit: The structure includes the component parts of the visit and the sequence of steps involved. There is no assumption that the steps would be rigidly adhered to in practice. The steps would provide the "plan" which the chaplain takes into the encounter with the patient. As the encounter progresses, the chaplain may depart from the plan as alternative opportunities for achieving the purpose are perceived. The ways in which a chaplain intervention for a particular purpose category would go about achieving that purpose are likely to vary, depending on the responses of the patient and the chaplain's experience-based understanding of how the interaction with the patient is progressing toward the desired outcome.

V - The Indicators of the Outcome Achieved in the Visit: The specification of the indicators of the outcomes achieved in the visit should be stated in concrete operational

terms. The outcome achieved will be compared with the outcome intended in the purpose of the visit. The statement of the outcomes should be in terms of the observable indicators that the outcome has or has not been achieved, or by the measures by which the intervention would be rated as successful, less than successful, or not successful in achieving the purpose of the patient visit. The purpose of the visit is specified in a general categorical way; the outcome, however, should be specified in terms of observable concrete facts that can be verified empirically. We would expect different chaplaincy practice patterns to define the intended outcome of a chaplain's intervention for a particular purpose category of visit in a way that is consistent with the chaplain's theological, philosophical, and psychological education and pastoral experience.

Other Supplemental Comments (optional): The five dimensions of information described above may not be sufficient for an accurate and complete structured description of the patient visit. The topics of conversation between the chaplain and the patient may evolve in different directions for many reasons, and the structured description cannot anticipate the reaction of the patient. Even though a verbatim is used as the starting point for a structured description, the chaplain or CPE student cannot assume that the patient would respond in the same way if the visit were replicated. This supplemental comments section of the structured description may offer some observations or suggestions for handling the unexpected reactions of the patient that might occur.

For each type of visit defined by its purpose, the topics of conversation between the chaplain and the patient may evolve in different directions for many reasons. The different ways in which the chaplain attempts to achieve the purpose of the visit will vary based on the chaplain's background, training, experience, and interests, as well as the background, experience, and interests of the patient. The orientation, experience, and faith community background of a chaplain very likely will influence the specific ways in which an intervention is conducted. A chaplain is expected to adjust and adapt the conversation to the patient, and to select for discussion the specific topics in the cognitive content that match the disposition and background of an individual patient. There are many ways in which the chaplain may adapt the content of the discussion to the patient's viewpoints in order to achieve the purpose and the desired outcome of an intervention.

What this five-part template intends to accomplish is not to put constraints on a chaplain's resourcefulness in addressing the needs of an individual patient, but to describe the general patterns that a chaplain has developed through education and experience for handling patient visits in specific purpose categories. The template is intended to make explicit the implicit "plan" that the chaplain has in mind at the entry point to the intervention. For purposes of research, a patient visit must have sufficient specification in order to be replicated by other chaplains. The five-part template outlined above offers one approach to providing a specification that can enable another chaplain to conduct patient visits according to the same design, even though there will be adaptations within that design.

FUTURE RESEARCH MADE POSSIBLE

The availability of a databank of structured descriptions of patient visits will open up a variety of different research projects that can be envisioned. For example, successive chaplain visits to the same patient have a cumulative and synergistic effect that also needs to be defined and specified. A research program will seldom focus on just a single chaplain visit, but will be concerned with the effectiveness of the sequence of chaplain visits to the same patient or institutional client, with the sequence understood as an integrated system of interventions. Just as the individual visits need to have detailed specifications and descriptions of the purpose of the visit, the characteristics and needs of the patient, the cognitive content, the structure, and the indicators of the outcomes achieved, so the sequence of visits also will need to be identified in terms of its overall purpose -- the purpose that cannot be achieved by a single visit, but only by the synergistic effects of the individual visits that make up the sequence. What may be called a *chaplaincy practice model* would link together specified interventions in order to achieve synergy and a cumulative benefit for the patient that no individual intervention, by itself, could.

A chaplain's practice model would consist of the framework of chaplain visits that a chaplain would put together to achieve a desired overall result for patients that fit certain patterns of characteristics and needs. Just as the individual interventions in a chaplaincy practice model can be grouped and distinguished by their individual purposes, by their structures and cognitive content, so the structure of the sequence of interventions, and the cumulative cognitive content of the individual chaplain visits, should be identified in research designs. Within a chaplaincy practice model for obtaining a particular result, the purposes of the individual chaplain visits can be recognized as interdependent, with the purposes of each visit being seen as intermediate purposes, with each visit in the sequence preparing for and laying the groundwork for the next visit in the sequence. The individual visits in the sequence, therefore, are intermediate steps toward the overall purpose. The sequence of visits, or chaplaincy practice model for an overall result, is a purpose-based group of interventions.

The further question then becomes how the detailed operational description of each of these individual chaplain visits in the sequence can be combined in a specification of a chaplaincy practice model for a particular desired result. Also, for any given chaplaincy practice model that specifies the purpose categories of interventions to be combined in a sequence of visits, there can be significant variability in the structure, cognitive content, and criteria for measuring outcomes, not only between different chaplains, but also in the practice of an individual chaplain. The specification of this "model" sequence of chaplain visits may need to be accomplished in a way different from merely combining the detailed operational descriptions of the component chaplain visits. But practical experience in specifying individual chaplain visits will be needed first before decisions can be made about what will be the best way to specify a purpose-based sequence of interventions, or *chaplaincy practice model*. The method of specifying chaplaincy interventions described above may be considered a first step toward developing a consensus among professional chaplains on how to specify chaplain interventions with patients.

Appendix A:

From the ACPE Research Network Winter 2004 Newsletter

On-Line Newsletter Volume 2, Number 2
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Edited by Chaplain John Ehman, Network Convener

1. Excerpts from "Pastoral Research" by The Rev. John J. Gleason, DMin --The William Randolph Wycoff Lecture of the Department of Pastoral Care of the Lehigh Valley Hospital and Health Network (Pennsylvania), delivered February 27, 2003

[Editor's note: The full text of this lecture, including an account of the author's own course of research and its role in his ministry and the development of his Four Worlds Model of Spiritual Assessment and Care, is available directly from the author at easternacpe@aol.com.]

INTRODUCTION: TENSIONS AND DEFINITIONS

...In healthcare environments of excellence..., clinically trained chaplains are valued members of the medical treatment team because of the skills we bring and because of the values we hold in common with medicine and allied health disciplines: enhancing the health and well-being of the patient as a unity of body, mind and spirit within a unique family and cultural system. At the same time, it can be accurately said that we chaplains do our work on someone else's turf. We are persons of the spirit laboring among persons of science. The scientists, specifically the medical doctors, are in charge and rightfully so. With support and input from other members of the treatment team, patients and families, the medical scientists make the difficult life-and-death decisions and are held accountable for the outcomes of those decisions.

Thus eyebrows are raised when words representing spirit and science are placed together in a phrase like "Pastoral Research." This pairing of words may even be perceived by some as a contradiction-in-terms. Put metaphorically, this is tension between Head and Heart, a condition seen by my professor of psychology of religion and mentor, Samuel Southard, as the central problem of American religion. But the tension is centuries old.

Galileo Galilei (1564-1642) pointed his 20-power telescope to the sky and found sunspots, the four largest moons of Jupiter, and other things that did not mesh with accepted theological beliefs about perfectly round heavenly bodies, an Earth around which they all orbited, and so on. For his discoveries Galileo received a sentence of life imprisonment for heresy. To obtain a license to practice medicine in 1566 doctors were required to swear that they would stop seeing a patient on the third day unless (the patient) had confessed all sins and had a confessor's statement to prove it. Violations

were punished by permanent removal from the practice of medicine.[1] Little wonder that from then until now there have been scientists who would like to explain all the mysteries by empirical inquiry over against the faithful who fervently believe in spiritual forces immeasurable by any meter.[2]

In the midst of this ongoing tension between Head and Heart, John L. Florell, a pastoral counselor, identifies two kinds of Pastoral Research: "*empirical studies* which examine actual events of care and counseling (and human problems to which they are addressed); and *theoretical studies*, which analyze or construct the concepts and images which define the problems and guide the practice of pastoral care and counseling." Florell goes on to identify the three most common methods of gathering information in pastoral care and counseling: case studies, correlation studies, and experimental studies.[3]

Medical science is built exclusively upon experimental studies, but according to Florell experimental designs are not the only way pastoral care can legitimately expand its knowledge base (and I most certainly agree). In that more expansive sense, my own definition of Pastoral Research is *the disciplined study of religious experience by pastoral practitioners toward increased effectiveness in ministry* within the larger context of Religious Research (i.e., work conducted by persons representing many disciplines: theology, medicine, nursing, psychology, psychiatry, sociology, and so on).

The goal of this presentation is to examine the past, present, and future of Pastoral Research, including the chaplain's moral imperative to examine practice and to share what is found....

THE PAST: THE PIONEERS

The first pastoral practitioner to formulate and study the tension between Head and Heart in American religion is probably the last one you would have thought. It was none other than Jonathan Edwards (1703-1758), remembered as the fiery preacher of "Sinners in the Hands of an Angry God" and not for his ability to stand apart from what he was doing and view it with clinical insight. Almost everything that Edwards thought or observed was committed to his notebooks, which he then used as a basis for analysis in his ministry.[4] He was troubled that many persons could name an idea but not be in contact with the feeling that the idea signified, and therefore were lost among meaningless signs in a state of disassociation. In Edwards' view the understanding of the Head must become the sense of the Heart. In other words, integration was in order. So he intentionally preached to stir feelings, and he was effective enough to help launch a revival, the First Great Awakening, in 1740s New England. His work with converts was reported in what Southard has called the primary clinical study of religious experience in America, "A Treatise Concerning Religious Affections."

Both the theory and the method of Pastoral Researcher Edwards were vigorously opposed by the Head-only people of the day, the learned clergy. To them, a correct understanding of confessions of faith was sufficient for church membership or ordination. Emotional expressions of religion were to be made in private. But there could be no argument that

Edwards had provided the first model for the use of empiricism toward better understanding in matters of the spirit.[5]

The religious tension between Head and Heart was again critically examined at the turn of the 20th century by William James (1842-1910), described by Jacques Barzun as America's most original thinker since Edwards. From his studies, physiologist-psychologist-philosopher James, in his Gifford Lectures of 1901-02 (published as *Varieties of Religious Experience*), granted the Heart a deeper and more powerful role over the Head within the individual. "The unreasoned and immediate assurance is the deep thing in us; the reasoned argument is but a surface exhibition. Instinct leads, intelligence does but follow" (p. 73). But in the study of religious experience, as in any study, "To understand a thing rightly we need to see it both out of its environment [i.e., Head] and in it [i.e., Heart], and to have acquaintance with the whole range of its variations" (p. 35). *Varieties* examined the transformative experiences of encounters with the divine that were the privilege of great religious figures, and thereby established a two-category spiritual assessment schema of *once-born* and *twice-born*. [6]

Along with William James at the turn of the 20th century, G. Stanley Hall, Edwin D. Starbuck, George A. Coe, Edward S. Ames, J. H. Leuba and others engaged in the empirical study of religious consciousness, with emphasis upon religious conversion. However, this new academic discipline, the psychology of religion, was quickly eclipsed by the rising popularity of psychoanalysis and later, behaviorism. Its concerns were for the most part incorporated into religious education, the philosophy of religion, pastoral psychology, and sociology, but there has been a steady stream of scholars writing on the subject to the present, including Orlo Strunk, Jr., G. Stephens Spinks, E. R. Goodenough, Paul W. Pruyser, William A. Sadler, Jr., Robert H. Thouless, Wayne E. Oates, Heije Faber, Geoffrey E. W. Scobie, H. Newton Malony, Raymond F. Paloutzian, Andre Godin, and Kenneth I. Pargament.

Anton T. Boisen (1876-1965), a Presbyterian minister who was convinced that his own psychotic episodes had religious significance, dedicated his life to the study of "living human documents" (those suffering from mental illness) in the cause of understanding the meanings and messages (Head) of those experiences (Heart). In so doing, Boisen became a founder of the Clinical Pastoral Education (CPE) movement when as a chaplain he brought the first four seminarians to Worcester State Hospital for training in the summer of 1925.

A major contribution of Boisen to Pastoral Research was the adaptation to theological education of the medical case method that had just been developed by another founder of clinical pastoral education, Richard C. Cabot, MD. For Boisen, the desired effect was to get seminarians to pay careful attention to life experience (Heart) toward integration in their theological formation (Head). Boisen joined Cabot in his call for a clinical year for all seminarians so that they could address, case by case, the relationship between functional mental disorders and religious experience. Boisen also called for "some plan for encouraging high-grade research work on the part of pastors in the field, comparable to what medical [scientists] are doing." [7]

...As the CPE movement matured toward its present form, the strong emphasis on the application of clinical findings to the day-to-day work of ministry using the verbatim record of pastoral care--instituted by Russell Dicks (1906-1965), a Methodist chaplain educator at Massachusetts General Hospital--at the expense of depth studies and theological perspectives, was a considerable disappointment to Boisen.[8] Charles E. Hall (1919-2000), the first executive director of the Association for Clinical Pastoral Education, Inc. (ACPE), titled his book on the history of CPE, *Head and Heart*, and wrote in his introduction: "...I discovered an overarching theme of the CPE Movement: an attempt to integrate the messages of the head and the heart. CPE developed out of dissatisfaction with the intellectual assumptions of systematic theology separated from religious experience and dissatisfaction with ministry based on that separation." [9] In that separation, the movement relied heavily on psychology, was strongly influenced by psychoanalysis, and as already noted, became focused nearly exclusively upon the day-to-day chaplain-to-patient action via the verbatim (Heart) to the near total exclusion of the depth studies, empirical research, and the theological reflection (Head) deemed so important by Boisen.

Robert B. Reeves, Jr. (1910-2002), a chaplain from 1954 to 1974 at The Presbyterian Hospital in the City of New York (now New York Presbyterian Hospital-Columbia Presbyterian Medical Center), brought Pastoral Research a giant step toward the present. In the mid-1960s he was asked by an eye surgeon colleague to see a patient who, six days after detached retina repair, had not begun to heal. Reeves discovered that nearly every close relationship the patient had ever known had become poisoned. On his second visit she "poured forth an almost incredible tale of bitterness, hatred, fear, and guilt." The morning following, the surgeon called Reeves to tell him that overnight the patient had caught up in her healing--her eye was as it should be at that time. Shortly thereafter Reeves and his colleagues obtained a grant and began researching the impact on healing of pastoral interventions with other ophthalmology patients.[10] Reeves and his investigative team found that interventions by the chaplain positively correlated with high acceptance and rapid healing on the part of detached retina surgery patients.[11]

Florell's replication studies with 150 orthopedic surgery patients[12] and Mills' work with 100 open-heart surgery patients[13] also showed a high correlation between acceptance and healing. Unfortunately, there were no further studies based on the work of Reeves, Mason, Florell, and Mills after 1975. The next nine years (1976-1984) produced only a few Religious Research studies directly addressing pastoral care and healthcare per se. One, Yates, et al., reported in 1981 that significant benefits were found in pain reduction and sense of well-being among advanced cancer patients with religious commitment and associated religious activities.[14] This was the calm before the surge of attention to culture-wide matters of spirituality and holism in health care.

THE PRESENT: BURGEONING INTEREST, EXPANDING LITERATURE, AND SOME HAZARDS

Pastoral Research in the present is a picture of burgeoning interest, expanding literature, and hazards for the practitioners of pastoral care. One trigger for this explosion of interest

was the publication in 1972 of Archie L. Cochrane's book, *Effectiveness and Efficiency*, in which he addressed the inattention of the medical profession to the specific effects of their practices. As a result, careful attention to *outcomes* became the byword as a matter of professional responsibility, first for medicine and inevitably for all allied health disciplines. Today the Cochrane Collaboration is a worldwide voluntary project of health care professionals in forty groups that review what physicians report about their practice of medicine.[15]

A second stimulus to the new interest in religion and health was the dawning of the Age of Aquarius: the sexual revolution, the culture's discovery of holistic health, and the increasing popularity of individual spirituality vis-a-vis organized religion. The stage was being set for a dramatic paradigm shift that would soon see the rise of patients' rights, the new psychiatric perception of religion as a part of health (not pathology), the inclusion of spirituality in medical school curriculums and research in seminary curriculums, and careful attention to clinical spiritual assessment. Yet another factor (and perhaps the most powerful of all) was economics: the rapid acceleration of U.S. health care costs and an accompanying urgency in employing cost containment measures.

Amidst this roiling sea of change, a new round of studies directly addressing pastoral care, spirituality and healing began to appear, primarily undertaken by Religious Researchers from many disciplines, not clinical clergy Pastoral Researchers.

In 1985, Chu and Klein found that encouragement of inpatient schizophrenics in prayer and worship contributed to lower readmission rates among 128 African American patients.[16] In 1988, ...[Randolph Byrd] found therapeutic effects among coronary care unit patients who were the beneficiaries of intercessory prayer offered from outside the hospital,[17] ...and Richard B Osmann found that hospital staff benefited significantly in stress reduction from pastoral care, with accompanying savings to the institution.[18] Elisabeth McSherry and her associates in the VA system published findings in 1989 indicating that the special spiritual needs of spinal cord injury patients resulted in slower care without an adequately staffed hospital-based chaplain team,[19] and in 1990, Pressman, et al., found that religion as a source of strength and comfort was significantly related to post-operative ambulation status and inversely correlated with level of depression in elderly women with hip fractures....[20]

Two 1992 studies are noteworthy. In one, outcomes for 200 men readmitted for depression an average of six months after initial evaluation indicated only one of 17 variables predicted lower rates of depression: the variable of religious coping.[21] In the other, seven study modules take the reader through research studies from the scientific literature that focus on religious commitment and its impact on health and mental health. Findings strongly suggested that religious commitment was negatively correlated with suicide rates, alcohol and drug abuse, juvenile delinquency, divorce rates, depression, and general psychological distress. Regular church attendance was positively correlated with lower mortality rates and with fewer incidences of heart disease and emphysema. Certain other religious commitment measures were positively correlated with reduced hypertension.[22]

In 1993, Benor reported that of 155 published works on spiritual healing, more than half showed significant results, and several such results were statistically significant.[23] In that same year the co-author of the seven study modules just noted, David B. Larson, MD, noted that "a growing number of studies demonstrate that spiritual commitment is associated with clinical benefit for both mental and physical health status. Results are so consistently positive and so contrary to prevailing academic ideas that we believe that the mental and physical health professions may be on the verge of a transformation in perspective in the next few years." [24] John W. Ehman has noted that Larson's words proved to be accurate and timely. In 1993 there was "a significant jump in the number of Medline-indexed articles on spirituality..., a jump that has been well-sustained ever since." [25]

By 1996, I had personally accumulated 90 listings in my own unpublished annotated bibliography, "Spiritual Care and Health," and could readily access over 300 studies that directly correlated spiritual involvement and interventions with wellness and with disease prevention and suicide prevention. The next year clinical psychologist and professor Kenneth I. Pargament classified some 250 studies in five categories of religious coping in his comprehensive book, *The Psychology of Religion and Coping*. [26] With respect to the ratio of Religious Researchers to Pastoral Researchers, I could recognize the name of only one Pastoral Researcher in those 250 Religious Research reports: that of Larry VandeCreek.

...However, within this rising tide of Religious Research-generated data, a narrow stream of dedicated, low-visibility Pastoral Researchers--Board Certified Chaplains, professors of pastoral care, pastoral counselors and CPE educators--has been steadfastly encouraging and engaging the Head in Pastoral Research in the midst of the Heart-only resistance of their colleagues: Samuel Southard, H. Newton Malony, Orlo Strunk, Jr., Merle R. Jordan, James L. Travis, III, Margot Hover, Larry VandeCreek, W. Noel Brown, John W. Ehman, William E. Johnson, Paul Derrickson, and George Fitchett, to name a few. In so doing, these Pastoral Researchers carefully and skillfully maneuver among very real hazards. Those hazards include pop spirituality, the co-opting of the care of souls by other disciplines, the temptation to allow other disciplines' definitions of research to drive their work, and other disciplines' agendas to dominate....

In her 1994 Foreword to *Research in Pastoral Care and Counseling*, Chaplain Margot Hover acknowledged that this small but determined corps of Pastoral Researchers is gaining momentum. Increasing numbers of chaplains and pastoral counselors are turning to quantitative and qualitative research methodologies to pinpoint such cost-effective relationships as the correlation between pastoral visits and length of hospital stay or the frequency of use of pain medication. [27] More chaplains are submitting proposals to institutional review boards. Chaplain residents are increasingly required to undertake research projects. And a widening array of Doctor of Ministry programs emphasizes careful research toward practical applications. [28] Yet much work remains to be done.

THE FUTURE: THE CHAPLAIN'S MORAL IMPERATIVE

For more than 75 years now, despite the work of the dedicated few Pastoral Researchers, most clinical clergy, rabbis, imams, lay caregivers, and others who work in correctional, mental health and general health care settings continue to minister in an essentially idiosyncratic way. We apply Head and Heart to the healing relationship as we see fit. We approach the client with our own unique styles. We resist any pressure toward critique or consensus about our daily practice.

Like it or not, ready or not, all clinical chaplains have a four-fold moral imperative: to stay abreast of Religious and Pastoral Research findings, to test those findings in the cause of improving our own quality of care, to further examine our practice, and to share what we find. Our professional colleagues from other disciplines have proclaimed that message to us. As plenary speaker at the College of Chaplains' annual conference in 1987, the VA physician cited above, Elisabeth McSherry, MD, made an impassioned and urgent plea for clinical chaplains to engage their Heads in research-based spiritual assessment and more precise pastoral responses, lest they be overrun and outdated by the increasing demands of cost containment and measures of cost-effectiveness throughout the U.S. health care delivery system.

In so doing, McSherry was echoing another strong voice, also from a non-chaplaincy discipline (clinical psychology) in the person of Paul W. Pruyser, who had in 1976 appealed to all pastors to reflect on their special heritage and use its theoretical foundations and practical applications to the fullest extent. He included clergy as professionals when he wrote, "The first duty of any professional is to achieve clarity about the problems brought for the sake of guiding the interventions (to be contemplated). If (the professional) does not fulfill this duty, he (or she) is a charlatan, albeit perhaps a very 'nice' one-whatever his (or her) shield proclaims him (or her) to be." Pruyser went on to liken such to the old-fashioned patent medicine vendor selling one vial of liquid as the remedy for "seventy-eight known diseases." [29]

That call has continued to come from within by our clergy colleagues as well. Edwards and Boisen have been joined by their professional progeny in urging full engagement of the Head in the work of the Heart through Pastoral Research. Six years before Pruyser published *The Minister as Diagnostician*, Boston University School of Theology professor of psychology of religion Orlo Strunk, Jr. said in his address to the joint conference of the ACPE and the American Association of Pastoral Counselors in 1970, "Just as clinical pastoral education provides raw data for the psychologist of religion and consciously reminds (one) of these data, so too must the psychologist of religion confront the clinician with the necessity of sharing insights in styles acceptable to others besides himself (or herself) and (other) clinicians. And the clinically oriented must learn to do this in terms of the other's criteria as well as (one's) own. If this does not take place, a great deal of clinical knowledge becomes private or at least fraternalistically secret, driving deep wedges between endeavors which ought to be in creative dialogue." [30]

Samuel Southard's 1976 book *Religious Inquiry* was addressed to all clergy, not just pastoral specialists. The first chapter was entitled "Research Is Your Business" and therein he set forth his thesis, which is also mine. "Research in religion is a natural and required part of religious experience and life in the church." In that same paragraph Southard promised "to provide guidelines and examples for research that will be appropriate in the church and manageable by professionals who have no advanced training in statistics or other quantitative methods." He went on to suggest and describe the practicality of reviews of documents, sample surveys, field observation, area analyses, and focused interviews.[31]

The most recent and perhaps the sharpest wake-up call has been sounded by Larry VandeCreek, who views the lack of empirical research as a sign that we pastoral clinicians are not "pulling our weight as a profession in this scientific age." He says, "We have been unable to put the capstone in place. That is, we have not built an empirical research tradition which tests our observations and theories. That, I believe, makes us morally culpable. As members of our respective organizations we have been too ready to make a living on existing, borrowed insights and practice patterns, and not ready enough to test our own insights. Consequently, we can legitimately be seen in the scientific world as a 'do nothing' profession which has failed to make a contribution to knowledge in a scientific age." [32]

GETTING STARTED

Regarding the moral imperative to further examine our own practice, I propose these steps toward greater professional responsibility and accountability.

First, become familiar with the literature. To begin that daunting task I would point you toward the master compiler of materials of importance to clinical ministry and Pastoral Research, W. Noel Brown. In every quarterly issue of *The Journal of Pastoral Care and Counseling* since the Spring of 1999, Brown has included a current list of Pastoral Abstracts excerpted from his own data base, The Orere Source. (You may even subscribe to bi-monthly newsletters from The Orere Source by writing to Box 362, Harbert, MI 49115-0362.) Brown also has published a list of suggested readings, "Current Contents in the Literature of Interest to Pastoral Care," grouped under the following headings: The Cochrane Collaboration, Chaplains (and Others) Urging the Development of Outcomes-Based Chaplaincy, Articles Reporting Outcome-Oriented Results of Care, Intervention Methods Being Used, and Papers about Research that Have Implications for Pastoral Care.[33]

Second, review suggested how-to formulas for the conduct of Pastoral Research. The best plain-talking source for ministry in general, including the local church, synagogue and mosque that I have ever seen is Samuel Southard's book, *Religious Inquiry: An Introduction to Why and How* (Nashville: Abingdon, 1976). The best discussion of quantitative vis-a-vis qualitative Pastoral Research can be found in *Research in Pastoral Care and Counseling*, by Larry VandeCreek, Hilary Bender and Merle R. Jordan (Journal of Pastoral Care Publications, 1994).

Third, pay attention to your own need to go deeper into some aspect of ministry. This need could be created by the necessity for demonstrating the efficacy of pastoral care in your own clinical setting. Or it could be a matter of simple curiosity. Why does this or that seem to happen in my ministry? Is there a pattern? If it's a good thing, how can I help make it happen more often? If it's not a good thing, how can I minimize the chances of it happening? And so on.

Fourth, partner with your ministry colleagues and your Pastoral Research colleagues via existing networks. Most major professional pastoral care associations have a research committee or network that meets during the annual conference. My primary professional organization, the Association for Clinical Pastoral Education, Inc., has the ACPE Research Network.... Also partner at your institution with your allied health colleagues who have technical research knowledge. Talk about your ideas and invite feedback with all of these people, but don't yield too easily to the ideas of others that may move you away from your original agenda just because you deem them to be more expert or more powerful in some way.

Fifth, and critically importantly, be sure to get the proper support and authority from within your own system to proceed in pursuit of answering your research curiosity or otherwise meeting your research agenda. Learn the workings of your internal research on human subjects' board as a part of your networking efforts, as well as the leanings and biases of other decision-makers in your organization.

Finally, develop a carefully thought out project design including realistic outcomes sought, timelines, and so on. An excellent step-by-step resource for this process is the VandeCreek, et al. title already mentioned, *Research in Pastoral Care and Counseling*....

NOTES [re-numbered from the original manuscript to follow sequentially in this edited version]

[1] Morton T. Kelsey, *Healing and Christianity*. N.Y.: Harper & Row, 1973. p. 212.

[2] For more detail on the historic interactions of science (Head) and religion (Heart), see Chapter 2 of *Research in Pastoral Care and Counseling*, VandeCreek, et al., JPC Publications, 1994.

[3] John L. Florell, "Empirical Research in Pastoral Care and Counseling," *Dictionary of Pastoral Care and Counseling*. p. 354.

[4] Samuel Southard, *Religious Inquiry: An Introduction to the Why and How*. Nashville: Abingdon Press, 1975. pp. 36-37.

[5] Samuel Southard, "The Head and the Heart in Clinical Training," Address, William S. Hall Psychiatric Institute, Columbia, SC, April 29, 1971.

[6] William James, *The Varieties of Religious Experience*. N.Y.: Mentor, 1958.

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- [17] R. C. Byrd, "Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population," *Southern Medical Journal*, 81(7), 1988. pp. 826-829.
- [18] Richard B. Osman, "Ministry to Hospital Staff and Its Effect on Hospital Operating Costs," *The Tie*, College of Chaplains, September/October, 1988. pp. 8-9.
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- [21] Harold G. Koenig, et al., "Religious Coping and Depression in Elderly Hospitalized Medically Ill Men" *American Journal of Psychiatry*, 149, 1992. pp. 1693-1700.
- [22] David B. Larson and Susan S. Larson, *The Forgotten Factor in Physical and Mental Health: What Does the Research Show? An Independent Study Seminar* funded by The John Templeton Foundation, 1992.
- [23] Daniel J. Benor, "Healing Research: Holistic Energy, Medicine and Spirituality." *Research in Healing*, Vol. 1. Munich: Helix Verlag GmbH, 1993.
- [24] David B. Larsen, et al., "A Paradigm Shift in Medicine Toward Spirituality?" *Advances*, 9(4), 1993. pp. 39-49.
- [25] John W. Ehman, e-mail message, February 10, 2003.
- [26] Kenneth I. Pargament, *The Psychology of Religious Coping*. N.Y.: Guilford Press, 1997. pp. 407-464.
- [27] Margot Hover in Larry VandeCreek, et al., *Research in Pastoral Care and Counseling*. Journal of Pastoral Care Publications, Inc., 1994. p. x.
- [28] Joan E. Hemenway, *Inside the Circle*. Journal of Pastoral Care Publications, Inc., 1996. p. 119.
- [29] Paul W. Pruyser, *The Minister As Diagnostician*. Philadelphia: Westminster, 1976. pp. 10, 58.
- [30] Orlo Strunk, Jr., quoted in John J. Gleason, Jr., *Growing Up To God*. Nashville: Abingdon Press, 1975. p. 9.
- [31] Samuel Southard, *Religious Inquiry*, op. cit., pp. 17, 29-30.
- [32] Hemenway, op cit., p. 120.
- [33] W. Noel Brown, *Ibid*. pp. xv-xx.

Appendix B:

From the ACPE Research Network Spring 2003 Newsletter

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Edited by Chaplain John Ehman, Network Convener

Thoughts on the Identification of Pastoral Care Interventions for Research by Chaplain John Ehman, Network Convener

One of the pressing issues today in pastoral care research is the specification of what chaplains *do* when they intervene in patient situations. If an intervention is poorly defined in research, the assessment of its effect must be at best tentative. Yet, the complex and subtle nature of pastoral care visitation does not lend itself to simple description, much less to rigid circumscription. Every pastoral care researcher faces a tough question on this score, whether the project at hand is to assess pastoral care itself or to include a chaplain as a methodological component in data collection: How might it be possible to "pin down" the variables of a chaplain's actions without constraining the very dynamic by which chaplains work in relationship with patients?

Valuable research can well be done with interventions identified as broadly as "visit by a chaplain," but the demand for greater specificity is growing. There is an understandable desire among researchers to refine data collection, control for more variables, discover confounding variables, develop and validate specific measures, and lay the groundwork for reproducible results. This may be in part a function of a general drive in the field of spirituality and health toward quantitative, empirical, interventional studies; but it is also merely a function of the drive of the research enterprise for ever-increasing clarity.

Perhaps the most ambitious descriptive research to date in this area has been an extensive Australian study by Gibbons, G., Retsas, A. and Pinikahana, J.: "Describing what chaplains do in hospitals" [*The Journal of Pastoral Care* 53, no. 2 (Summer 1999): 201-6], but the conclusions of that study are highly thematic in nature (e.g., "promoting spiritual transcending," "promoting spiritual intactness," and "enacting ministry") and as such have not easily been applicable for subsequent interventional research.

Last year, a very practical list of pastoral care interventions was published in a somewhat surprising source: *The Journal of Nursing Administration* 32, no. 1 (January 2002): 20-4. In "The spiritual dimension of holistic care," Bonnie W. Duldt, a nurse with three years of experience as a volunteer lay chaplain in a Virginia hospital, enumerates 27 services and activities of pastoral care departments. Among those she identifies are: conduct formal services, pray with patients and families, [conduct] blessing and naming ceremonies for stillborns, conduct support groups, remain with critically ill patients/families, take family [members] to the morgue, visit patients hospitalized for over five days, and listen to patient/family concerns. While such a list may seem

unremarkable to chaplains, it hints at the sort of *mid-range* level of specificity of interventions that can be practical foci for research--these are widely practiced actions that begin to *locate points of pastoral impact*.

An extensive listing of chaplains' functions and activities was also part of the 2001 White Paper published by the ACPE and other organizations, "Professional chaplaincy: its role and importance in healthcare" [ed. by VandeCreek, L. and Burton, L., *Journal of Pastoral Care* 55, no. 1 (Spring 2001): 81-97; available [on-line](#)]. That list is ordered according to ten headings, highlighting such functions as: [providing] a powerful reminder of the healing, sustaining, guiding, and reconciling power of religious faith; providing supportive spiritual care through empathic listening, demonstrating an understanding of persons in distress; designing and leading religious ceremonies of worship and ritual, and acting as a mediator and reconciler for those who need a voice in the healthcare system. The listing is very descriptive and indicates the wide spectrum of chaplains' functions, but with regard to an identification of interventions for research, it accomplishes only a preliminary step.

Duldt is primarily interested in identifying pastoral care actions and services that can be incorporated into the practices of other health care professionals, and the White Paper is intent upon interpreting the importance of chaplains for health care. However, what of actions and services which chaplains may offer either uniquely or especially well? Might we be able to identify a reasonably specific list of those actions/functions, to the end of identifying interventions for use in research? This could help to further, among other things, research that explores the unique value of pastoral interventions [possibly along the lines of such studies as VandeCreek, L., Pargament, K., Belavich, T. Cowell, B. and Friedel, L., "The unique benefits of religious support during cardiac bypass surgery," *Journal of Pastoral Care* 53, no. 1 (Spring 1999): 19-29]. For the purpose of encouraging dialogue on this matter, a short listing is submitted below for discussion by members of the Network. There are at least two operative questions here: How can we begin to focus in on the activities of chaplains so that there is both a reasonable specificity about interventions and a reasonable latitude for a chaplain's spontaneity in interaction with patients? Also, what interventions may help us to explore the contributions to health care that chaplains may provide either uniquely or especially well?

- special capacity--both traditional and legal--for hearing patients' confidential information
- discussion of theological concerns in light of theological education
- worship leadership in light of special training and practice
- leadership in situations of religious diversity, in light of special training and experience
- response to persons in spiritual crisis, in light of special training
- spiritual assessment, drawing on intensive professional experience with spiritual issues
- special vantage for networking with religious communities in support of patients
- interaction with implicit valuing of spirituality (as a function of the chaplain's very profession)

- representation of a "pastoral ethic" (which may engender a unique sense of safety on the part of the patient), involving: respect and understanding, supportiveness, moral sensibility, fairness and justice-mindedness, concern for relationships, and integrity based upon devotion to ideals and a "higher power"
- interaction based on "pastoral authority" often allowed or imputed to clergy as "representatives of God" or as "holy or pious people," with special implications for: issues of forgiveness and issues of guilt/shame, provision of rituals (e.g., sacraments or end-of-life rituals), prayer leadership, issues of death/dying/loss and transcendent meaning, prophetic capacity (including moral advice), and discussion of spiritual experiences (personal experience and appropriate language)

Responses on this matter will be printed in a future edition of the Newsletter, including thoughts by supervisors about how they help CPE students understand what they do in terms of the language of "interventions" and comments by researchers on the relationship of intervention specificity to methodological usefulness.

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Appendix C:

(Placeholder for John Gleason's Account of the Development of Structured Descriptions in a hospital-based CPE Program)

John Gleason's Exemplar Proof of Concept Project

An Ideal Pastoral Intervention Paper

In an extended CPE Unit at St. Vincent Hospital in Indianapolis, Jan - Apr 06, John Gleason is undertaking a research initiative with the CPE students. The students, toward the end of the Unit, will be developing papers with *structured descriptions* of patient visits, describing the students' ideal pastoral interventions.

The exercise is for a CPE student, toward the end of a Unit, to rework one of the student's verbatims into a structured description of an 'ideal' intervention with a patient. A verbatim record of pastoral care that has already been presented to peer CPE students and to the CPE supervisor will be rewritten to incorporate their feedback toward a "best way." The 'ideal' aspect of the description would be the outcome of the CPE student's reflection on the critical comments and suggestions the student received in the review of the verbatim in group discussion and with the supervisor. The 'structured description' would be designed to provide all the information to enable another chaplain to replicate the intervention. Papers will be presented in the CPE peer group and then submitted to the ACPE Research Network for inclusion in a database for comparative analysis and, eventually, identification of "best practices."

This exercise, in the final weeks of a CPE Unit, is designed to give the students experience in research, as suggested in the Winter 2004 and Fall 2005 Newsletters of the ACPE Research Network. This approach was discussed at the 2005 Research Network workshop in Hawaii, as one way to incorporate pastoral care research into the curricula of CPE programs. Incorporating research efforts into a CPE program must be done in a way that does not absorb a significant amount of the student's time, and must not diminishing the value of the CPE experience for the student. The proposed experience is designed to leverage the CPE student's work and stay within the overall process of a Unit.

For applied chaplaincy practice research, the development of a shared database of structured descriptions of many diverse chaplain interventions with patients will be an important resource for professional chaplains. Research on these papers may lead to the identification and refinement of "best practices" in pastoral care. This experimental approach, with the cooperation and joint effort of many CPE supervisors, is designed to provide the foundation information for applied chaplaincy research, in order to achieve this objective of identifying best practices.