

Report on the Pilot Phase of the Ideal Intervention Paper (IIP) Project: Introducing Pastoral Research into Clinical Pastoral Education

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INTRODUCTION

A pilot project to test one way of introducing pastoral research into clinical pastoral education programs was conducted in an extended CPE unit at St. Vincent Hospital, Indianapolis, during the first five months of 2006. The CPE students were assigned the task of developing a written detailed description of an ideal pastoral intervention for a patient visit which had occurred previously, and for which the student had written and presented a verbatim. The ideal intervention papers (IIPs) were exchanged by the students among themselves and reviewed before they were submitted to the supervisor. The level of detail required in the description of the ideal patient visit was that which would be sufficient to enable other chaplains to conduct a similar pastoral intervention under similar patient circumstances. The criterion for the adequacy of detail was replicability: the likelihood of another chaplain "reproducing" the visit according to the author's intent. The students found that this IIP exercise opened up for them another dimension of pastoral care, strengthened their perception of their pastoral identities, and suggested a practical way of introducing systematic pastoral research into their ministerial practice and careers. [For the "CPE Students's Manual for the Ideal Intervention Paper" and other materials, see §5 of the Spring 2006 *ACPE Research Network Newsletter*, vol. 4, no. 3 (Spring 2006): www.acperesearch.net/Spring06.html.]

THE INSTITUTIONAL ENVIRONMENT OF PASTORAL RESEARCH

The current hospital context in which pastoral care is provided to patients poses many challenges for chaplains that can discourage systematic research. The chaplain's workload usually does not provide time for systematic analytical work. There is no "publish or perish" incentive system in hospital chaplaincy, as there is for academic positions. There are few tangible rewards for systematic research, beyond the respect of colleagues and other professionals. Brief hospital stays by patients in acute care do not allow chaplains to get to know many patients well enough to develop information for thorough case studies. During short hospital stays, patients often are not clear-headed and free of the effects of anesthesia or pain control medication when a chaplain is available to visit, and patients also may be somewhat disoriented by the unfamiliar surroundings and the procedures of the hospital. It is in this context that the chaplain must identify the most appropriate pastoral intervention for each patient visited. The pastoral care needs of the patients are often, if not typically, inadequately known in advance of the chaplain's visit, and the chaplain usually must determine the most appropriate pastoral care plan rapidly and provide that care with little or no advance preparation.

The need for systematic pastoral research by chaplains in health care has been articulated by many in the profession for many years. The most recent overview of the history and methods of pastoral research has been provided by John J. Gleason.¹ Gleason has outlined a practical, straightforward approach that hospital chaplains can and should take in spite of these challenging circumstances and the disincentives to systematic research²:

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

¹ John J. Gleason, "Pastoral Research: Past, Present, and Future." *Journal of Pastoral Care and Counseling* 58, no. 4, (Winter 2004): 295-306.

² John J. Gleason, *ACPE Research Network Newsletter* 2, no. 2 (Winter 2004): §1 [www.acperesearch.net/Winter04.html].

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.³

A fuller description of the dimensions of pastoral research can be explored in the references cited in Gleason's articles.⁴ The essential pragmatic task that is involved in nearly all varieties and methods of pastoral research is the recording of detailed factual information about what actually happened in real pastoral encounters with patients. This basis of actual experience in pastoral care then can be examined to identify and evaluate what can be considered to be the most appropriate pastoral intervention that could have been provided in those specific circumstances with patients having that spiritual background and history, and that type of spiritual problem or need. Verbatim accounts, while more a testament to memory than to fact, have a great deal of potential for describing and refining pastoral practice.

STARTING SYSTEMATIC PASTORAL RESEARCH

The writing of an Ideal Intervention Paper (IIP) that describes how to conduct a pastoral visit for a patient with certain characteristics and specific needs is a first phase in a process of systematic pastoral research. This phase can most effectively be based on specific experiences with a patient that suggested some element of generalizability. Once this paper has been reworked to have a sufficient level of detail to enable other chaplains to understand and "replicate," in a sense, such a patient visit, then the second phase becomes the progressive refinement and elaboration of this IIP based on experience with other patients who have similar characteristics, problems, and needs.

After this paper has been refined through the progressive incorporation of experiences with other patients, the third phase of the process is the sharing of the refined IIP with other chaplains and pastoral caregivers who have a similar commitment to the professional improvement of their pastoral care services to patients through systematic pastoral research. The fourth phase looks to the analysis and comments of like-minded chaplains--their observations and insights from experience with similar patients would be recorded in annotations and comments on the IIPs. The sharing of these concrete pastoral care experiences with peer chaplains, in sufficient detail for in-depth understanding and evaluation, would ostensibly broaden the base of pastoral experience and insight for that particular characteristic type of pastoral need and lead to a refinement of pastoral care practices.

The fifth and final phase of this collaborative systematic pastoral research process would be the compilation of the annotated and elaborated descriptions of the ideal interventions into a databank, representing the consensus of a cadre of chaplains on possible best pastoral practices. The descriptions in the database would follow a consistent format, according to a template.⁵ The refined and annotated final versions of the initial IIPs would be recognized not as normative "best practices" but as *good* practices which are sound starting points for chaplains in their efforts to find intervention approaches to meet the needs of patients having the set of characteristics and spiritual needs outlined in one or more of the Detailed Structured Descriptions of fully elaborated IIPs.

³ John J. Gleason, *ACPE Research Network Newsletter* 2, no. 2 (Winter 2004): §1 [www.acperesearch.net/Winter04.html].

⁴ John J. Gleason, "Pastoral Research: Past, Present, and Future." *Journal of Pastoral Care and Counseling* 58, no. 4, (Winter 2004): 295-306; and John J. Gleason, "Guest Editorial: Evidence-based Standards of Care in Pastoral Practice" *Journal of Pastoral Care and Counseling* 60, no. 3 (Fall 2006): 195-199.

⁵ Henry G. Heffernan, *ACPE Research Network Newsletter* 4, no. 1 (Fall 2005): §3 [www.acperesearch.net/Fall05.html].

The IIP exercise introduced into the CPE extended unit described in this report was intended to be the first step in starting student chaplains off on a systematic pastoral research-based practice for their ministerial careers.

THE IDEAL INTERVENTION PAPER EXERCISE

In this pilot project, right after the mid-point of the CPE unit, students were given the assignment to write an Ideal Intervention Paper (IIP) for one of the pastoral visits that they had already described in a verbatim and discussed with their peer group and with the supervisor. The intent of the exercise was to deepen students' insight into what transpired during a particular visit and to encourage further creative thinking about how the visit might have been conducted more effectively and how it might inform future visits with patients who have similar personal characteristics, spiritual problems, and needs. The IIP was introduced as a model of systematic reflection and analysis commonly used by human services professionals to refine their interventions with clients--as with the example of physicians, who have historically sought to improve their competence and contribute to the development of the medical profession by reflecting on their experiences with patients, reviewing specific characteristics and manifestations of patients' health problems, considering the effectiveness of alternative interventions for specific issues, and sharing their thoughts with colleagues (through conferences and journal articles).

To determine whether and how CPE students found the IIP exercise helpful in deepening and broadening their own pastoral identities during the unit, they were interviewed three months after graduation, which allowed time for them to put the experience into some perspective and thereby to understand their experience better. The interviews had the practical intent not only to learn how students saw the exercise enriching their CPE unit or affecting their approach to continuing self-education and development in their ministerial and chaplaincy careers, but also to glean suggestions about how the exercise itself might be improved.

The first question asked the students was whether the IIP exercise was a positive experience for them in the course of the CPE Unit, and they uniformly responded that it was a positive experience, in retrospect. At the time the assignment was given to them, however, they all said that they felt some frustration, because they had not had an assignment like this in the past, and the instructions concerning what was expected in the IIP were limited. This issue of how the exercise could be presented better is discussed in more detail below.

The second question asked was whether the exercise contributed to achieving their specific goals for the CPE unit. The initial response of each of the students to this question was that they had not originally thought of the IIP exercise in terms of how it related to their personal goals for the CPE unit, and this was still not clear to them. In general, they stated that they had not thought about how the IIP exercise related to their very concrete learning goals, such as being sensitive to cultural differences or listening more to the patients instead of controlling the conversation, because the IIP exercise did not explicitly address these things. Nevertheless, the exercise was said to have opened the students up to a deeper awareness of patient characteristics and needs and to their perception of their own pastoral identities in relationship to patients. They indicated that writing the IIP was useful, apart from directly or exclusively contributing to their personal, concrete learning goals for the CPE unit.

They stated that, from their CPE experience, much of their pastoral activity tends to be reactive: namely, that in patient visits they do not have time to consciously think through alternative responses before responding to the situation confronting them in real-life and real-time. Rather, they have to respond to a continuing series of new experiences with patients and staff. The IIP development exercise, in contrast, gave students an opportunity and a challenge to think creatively about how one could do things better in a specific patient visit situation. Students said that it turned out to be the best opportunity during the CPE unit to describe and express their own creative approach to patient visitation.

From another perspective, the IIP exercise seemed to provide some closure to the students' thinking about patient visits that verbatim-writing exercises had stimulated. Verbatims are principally retrospective in nature. The discussion of a written verbatim with peers and the supervisor usually raises a number of stimulating questions and issues about the visit, yet afterward students need to move right on to the next verbatim, with relatively little opportunity to work further with the questions and issues raised. The IIP exercise provided a greater opportunity to think about a specific visit before moving on to the next case.

A general opinion of the students was that the IIP effort significantly helped their awareness of pastoral identity. The exercise motivated them to consider identity issues that otherwise would not have been as well thought through, such as the differences of approach in pastoral care of men and women and what one student described as a kind of "pastoral competition" in ministry. It also allowed them to explore how they handled acceptance or rejection by patients. The IIP exercise encouraged them to work through emotions and to identify attitudes and reactions to patients in the pastoral encounter. It was viewed as deepening students' learning about pastoral identity, but in ways that seemed difficult to articulate. There is no doubt that the effort to refine the IIP refocused attention on the patients in a unique way. The exercise clarified the pastoral role in dealing with a patient, and broadened the students' perspective on the visit to emphasize the actual outcome for the patient. The question that this exercise implicitly posed was: "What can I do in a similar situation to provide the best care and outcome for a patient like this one?"

The students were also interviewed about how the explanation of the IIP assignment affected the exercise itself. All said they found it frustrating to get started, because the instructions were quite general and short, with no great detail about what the supervisor wanted--just an outline and a template of the types of information needed in the structure of the paper. There was no stipulation of how long or short the IIPs were to be. (The supervisor in this case purposely chose to not give more information on what was expected.) Frustration over this seems, however, to have led to an interesting coalescence of the peer group and a personal opening up to one another to an extent that had not been experienced up to that point in the CPE unit. The mutual puzzlement about what was required, felt by each of the CPE students, resulted in the students cooperating in developing their own common approach to the assignment. This interaction of the students to figure out, as a close-knit group, how they would choose to undertake the assignment, was significant to the life of the group. The students may not have liked the frustration involved in figuring out how to get started, but they found their resultant interactions with each other to be stimulating and even fun, especially when they exchanged and compared their first drafts of the IIPs. They said they liked what happened as a result of having to rely on one another in developing their own consensus approach to the writing exercise.

The approach these students chose was for each to develop a draft of her or his IIP and then share the draft with the others for comparison and comment. Their discussions of each other's papers then determined how each would rewrite her or his own paper, and they found these discussions quite interesting, since they opened up the thinking processes and touched on the theological perspectives of the different students in ways that previous group discussions in the CPE unit had not. The students did not share their drafts with the supervisor at this stage and did not seek his input before submitting their final IIPs.

One discovery of the students when they compared their initial drafts was how the differences in their respective assignments to nursing units affected the content of their IIPs. Up to that mid-point in the CPE program, the students had not rotated through different types of nursing units, so they had developed experience only with the patients on a particular nursing unit: diabetic patients, emergency room patients, surgery patients, etc. Also, some nursing units typically had patients with fairly long stays, while others had patients with shorter stays, and this affected pastoral visitation, especially in terms of how many visits chaplains made to certain patients. These differences, not only in the make-up of patient populations but in how that make-up influenced chaplains' work patterns, came out during the IIP exercise. Whether students had the chance (or were expected) to visit patients frequently, or whether visitation schedules and patient

characteristics led to relatively infrequent visitation, became important to considering the "ideal interventions."

OBSERVATIONS ON IMPROVING THE IIP EXERCISE

The issue of clarification of instructions has already been mentioned. Students wished that they had more explanation and guidance at the outset. Another comment was that they would have liked an opportunity to see the same patient *after* the IIP was completed. Patients' short lengths of stay did not allow for this. However, there might be greater opportunity in this regard for residents, who sometimes have the chance to visit with the same patient over multiple admissions during a 9-month residency.

A further observation was that the IIP exercise might be too challenging for students in a first unit of CPE. The students who were in their second or third units found that they used their previous CPE experience and counseling experience to achieve "balance" and "confidence" in the development of their IIPs. Finally, students suggested that the IIP exercise might not be fully appreciated *during* the CPE unit, but that the value of the exercise may be more apparent when IIPs are reread and reviewed months later.

SPECIFIC SUGGESTIONS OF THE STUDENTS

First, students affirmed the value of scheduling the IIP exercise shortly after the mid-point of the CPE unit. By then, the students had gotten used to each other and were more open to sharing their views and perceptions of ideas and approaches. Also, by the mid-point, they had written several verbatims, so they could better choose the patient encounter for which they might best develop an ideal intervention description in a creative way. Moreover, the mid-point in the schedule left time for rewriting and editing the IIP before the end of the unit, and some students found it useful to revisit their completed IIPs and revise them yet again.

Second, regarding the template for the IIP, students indicated a need for more guidance in determining the level of *detail* required in their write-up. The general principle has been that the IIP should have a level of detail that would be sufficient to enable other chaplains to conduct a similar pastoral intervention under similar circumstances. More particular criteria for the level of detail in the IIP could be generally developed, but criteria might well also emerge during the exercise through the process of discussing the IIPs with peers and the supervisor. Fellow students should be able to give feedback as to whether an IIP seems to offer sufficient guidance to be useful in their own practice.

Third, students said that it would be helpful to have several "example" IIPs available. These examples would be understood to not be "normative," but merely illustrative.

Fourth, students found it useful to review and comment on each other's IIP *before* eliciting the comments of the supervisor. That practice might become a standard procedure. For this group of students, their own sharing and comparing of IIPs also played into the group dynamic by which frustration over the IIP assignment led to greater group cohesion.

Although the goal of developing Detailed Structured Descriptions⁶ of patient visits for research purposes--to be maintained in a databank--was discussed, that goal was beyond the scope of the pilot with the students in question. Nevertheless, refining an IIP to the point of databank submission might be a good task for a residency year.

⁶ Henry G. Heffernan, *ACPE Research Network Newsletter* 4, no. 1 (Fall 2005): §3 [www.acperesearch.net/Fall05.html].