

# DANBURY HOSPITAL

## Spiritual Care

### **What you always wanted to know but were afraid to ask about CPE: A Beginner's Guide to Clinical Pastoral Education**

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#### **1. What is Clinical Pastoral Education?**

Not the best name in the world. However, it is a good description of what it started out to be many years ago. That is, a clinical learning experience for those people interested in the “pastoral” or spiritual concerns of people in distress. One aspect that makes this type of education unique is that it is hands on. CPE entails learning spiritual care by doing spiritual at the bedside. It originally began in a state psychiatric hospital setting. Although today CPE programs are usually conducted in hospitals or medical centers, programs may also be found in other centers that serve special populations, such as psychiatric hospitals, nursing homes, prisons, community service agencies, and counseling centers, among other settings.

#### **2. Why CPE?**

Why not? Seriously, while the work of CPE is based on some very basic concepts – active listening and spiritual presence, learning to develop these skills is not so simple. Clergy in all religious traditions are called upon to listen to the concerns of members of their communities. In a crisis, during a hospitalization, in the office, or even on the run, people look to their religious leaders for counseling and consolation. And, while some clergy are quite good at being compassionate, the skills of listening with understanding and empathy are harder than one might think. Beginning students in CPE typically believe that they are good at listening; yet experience demonstrates that they usually are not quite as good as they imagine. That is why many denominations, seminaries and religious leaders expect all candidates for ministry to spend time doing, at least, one unit of CPE.

#### **3. What are ACPE, NACC, and CPSP?**

At present, there are essentially three different national groups that accredit programs of Clinical Pastoral Education. For someone who is seeking to do CPE, it is important to know about the differences. Before offering a brief description of these three groups, it should be noted that there are a few programs around the country that claim to offer CPE or a CPE-like experience using similar models of clinical learning that are not accredited with Supervisors who are not certified (regarding certified Supervisors, see below). One should be careful to ask which group accredits the educational program.

The three organizations that accredit CPE include the Association for Clinical Pastoral Education (ACPE), by far, the largest, and the first such organization in the United States. ACPE accredits around 300 educational sites and nearly 600 certified Supervisors. The Association for Clinical Pastoral Education, Inc. is a multicultural, multifaith organization devoted to providing education

and improving the quality of ministry and pastoral care offered by spiritual caregivers of all faiths through the clinical educational methods of Clinical Pastoral Education. In the interest of disclosure, this guide is written from the perspective of an ACPE-certified Supervisor.

The National Association of Catholic Chaplains is a second, much smaller, organization, part of the hierarchy of the Roman Catholic Church. The United States Conference of Catholic Bishops Commission on Certification and Accreditation (USCCB/CCA) serves as an accrediting agency of the United States Conference of Catholic Bishops, establishes accreditation standards, policies, and procedures, and accredits quality ministry formation programs (e.g., CPE) that prepare people for ministry.

The College of Pastoral Supervision & Psychotherapy, another smaller and more broadly focused organization, is, in its own terms, a theologically based covenant community, dedicated to "Recovery of Soul." CPSP offers CPE and pastoral counseling programs.

#### **4. Who are CPE Supervisors?**

This is what we call the certified, highly trained professional chaplain educator who directs the CPE program experience. This person is actually more accurately identified as a professor of spiritual care and counseling, someone who teaches the many dimensions of CPE including clinical theology, basic psychological understanding, small group process, counseling skills, and much more. The CPE Supervisor is responsible for all dimensions of a program and in order to best understand what any given CPE program is like, it is recommended that a potential student interview the Supervisor in order to learn the style of leadership and education.

#### **5. Who is eligible to enroll in CPE?**

The original impetus for CPE was to help clergy; in particular, seminarians better understand interpersonal and religious issues faced by patients and parishioners. Today, many of the students in CPE are seminarians, some are ordained clergy, and many are lay people, representing all faith traditions. These lay people are often already involved in their own religious communities as part of a congregational ministry to the sick or home bound. Some of these lay people are second career folks who are looking to refocus their life's work to something that is more meaningful. Others are retired and looking for new opportunities to serve others in a meaningful way. Lawyers, business people, healthcare professionals, former teachers, counselors and others have enrolled in CPE to learn skills, to discern a new theological path or simply to develop as persons of faith.

The primary point is that CPE is open to people from all walks of life and all religions that are seeking a path to live out their faith in a caring role. CPE inherently is helpful to people who are trying to discern next steps in life's journey of faith.

#### **6. What is the time frame for CPE?**

The time commitment for CPE is what are called units (at one time these were a known as quarters, similar to an academic quarter). A unit is a minimum of 400 hours in the program, three hundred of which are clinical time. That is to say, most of the time in a CPE unit is spent visiting

patients or residents, often referred to as clinical time. It is important to know that different CPE centers offer different options. All programs do not offer all time frames.

There are several common formats of scheduling CPE units. The most common is the fulltime summer unit that runs 10, 11, or 12 weeks for 40 hours a week. Full time units can be offered during the rest of the calendar year as well, by different centers. One type of program that uses the full time model is a CPE Residency. A CPE Residency is, typically, three or four consecutive units over 9 to 12 months. Again, not every center offers this program.

There are also part time units that run over a longer period of time. Most common is the Extended unit that entails approximately two days (16 hours) a week over the academic year (usually 30 weeks). Some programs offer a “semester unit” that involves a minimum of 20 hours a week over twenty weeks, often in fall and spring. A less common model of CPE is the “half” unit. This entails a total of, at least, 240 hours usually over an academic year. This type of program is substantially less intense in the learning because of the more limited time that students spend together in the program.

Other models also exist and it will be necessary to speak to the Supervisor about which forms are offered at any given center. For example, a few years ago, one Supervisor experimented with a full unit in one month. You do the math(Hint: 400 hours in 30 days).

## **7. What are the types of CPE?**

There are technically three types of CPE and there are a number of different ways in which they are offered. The Standards speak of Level I, Level II and Supervisory CPE. In essence, this means that there is a basic level (Level I) where the goals are centered on beginning pastoral identity, pastoral skills and pastoral reflection. The second level (Level II) also deals with these same three areas but in a higher, more complex fashion. There is no hard and fast rule, but a typical student does at least one unit of Level I before moving on to Level II. Some people need to complete several units of Level I before they are ready for Level II. It is ultimately up to the individual Supervisor to determine whether or not a student has completed Level I and is ready to move to Level II.

When someone feels drawn to teaching spiritual care and counseling and demonstrates competence to the CPE Supervisor, they may be encouraged to enter Supervisory CPE. The movement to this educational level is again at the discretion of the Supervisor and involves a significant commitment on the part of the potential student. First of all, the CPE center needs to be accredited for this level of CPE, which is not automatic. Second, the time commitment of the student is substantial, usually amounting to, at least, three years. And, most importantly, the individual seeking the goal of becoming a CPE Supervisor needs to have a very strong desire to accomplish this goal. It is “no picnic” and requires intelligence, determination and a high level of self-awareness.

## **8. How do I apply?**

In order to enter CPE, you must be accepted by a CPE center and, more specifically, by the Supervisor at that center. In order to prepare for an admissions interview, the Supervisor asks you to complete an application. Application forms are available from the ACPE website or from the particular CPE program. While some CPE centers have their own admissions process and expectations, generally, the least you need to do is fill out the face sheet (available on the ACPE, the CPSP and the NACC websites), and complete autobiographical statements about you, your life and your faith journey. This gives the Supervisor interviewing you some personal historical material with which to work. You should think a minimum of four typed pages and a maximum of ten. You are encouraged to tell your story, warts and all. For it is in that way CPE encourages you to be open and self-revealing, qualities that are valued in CPE.

Applications can be sent to as many CPE programs as you like, but it is suggested that you consider carefully where you can go to participate, considering time, distance and other factors. If you are not clear about something, call the center first and ask. For example, if you want to apply for a CPE Residency, make sure first that the center offers a Residency, before you apply. Generally it is suggested that you apply to not more than three centers at a time. Also, note that some programs have application fees.

## **9. What is an admissions interview?**

In order to be reviewed to see if you will fit into the particular program at a given center, you will need to schedule an admissions interview after submitting your application. Often, once you have submitted an application, the Center Supervisor will call you. Most frequently, the Supervisor of the program conducts the interview and it lasts 30 to 60 minutes. At some centers, especially when there is a CPE Residency, other staff and/or members of the center's CPE Advisory or Consultation Committee may participate in the interview. This allows staff and other professionals to review the makeup of the CPE group.

However many or few people are in the interview, the students should consider what he or she wants to know about the program. Just as the interviewers are looking for openness, professional presence, willingness to learn in the CPE process and so on, the student should get a sense of the Supervisor and his or her style of interaction with the student. This helps everyone involved in the program to be aware of respective strengths and weaknesses, of philosophies and communication patterns.

## **10. Who gets accepted? Who gets rejected?**

Although we CPE Supervisors like to think we are objective about many things, the acceptance or rejection of a student is pretty much a subjective process. Of course, there are criteria that Supervisors are looking for – most commonly a balance among potential students in gender, religious tradition, personality types, and so on. So the decision, while subjective, must factor in many other program needs. The bottom line is that acceptance or rejection for a particular program is not a judgment about one's suitability for CPE, only for this specific unit.

### **11. What should I read before CPE starts?**

Nothing. Didn't anyone ever tell you that if you don't have any homework, you don't have to do it? Well, in fact, it may be helpful to do some basic reading about spiritual care and/or active listening. Pamela Cooper-White, Carrie Doehring, or Donald Capps come to mind for useful primary sources. Some Supervisors might also suggest theological books (Fr. Henry Nouwen's *The Wounded Healer*); others might recommend classic literature (*The Death of Ivan Illych*); still others might go with contemporary thought (*The Wounded Storyteller* by sociologist Arthur Frank). Check with the Supervisor in the program that accepts you.

What kind of orientation is there?

CPE involves learning by doing, but in order to do, there are certain things that you need to know. For instance, you need to know where to find patients in your setting. You need to know who the people with whom you will interact are. You need to know how to present a report of your work back to the Supervisor. Therefore, the Supervisor will plan and conduct an orientation. This usually lasts for several days and includes many things that are required either by the accrediting body of CPE, the hospital, the department or some other authority. These are the rules and regulations to guide and protect you, and the patients, within the program.

### **12. What is the peer group?**

Once the Supervisor has accepted all of the students that the program wants, they become the "group." From a traditional perspective, this is the small peer group that forms one key element of the learning in CPE. These people become important as they contribute significantly to your learning by actively listening to you and to one another. They can then ask questions of the members and provide feedback to one another during the program. One way to describe this process is to say that everyone holds up a mirror to one another. Sometimes these groups build a very special bond with one another. CPE peers then become a part of each person's circle of friends and colleagues beyond the program. In other groups for many reasons, this may not occur. This is not a reflection on the members of any one participant. It simply happens sometimes and may mean nothing.

### **13. How are clinical assignments made?**

Invariably the Supervisor makes the clinical assignments based upon the needs and opportunities within the institution. Sometimes, it is possible for a student to make a request for a specific clinical area and the Supervisor may be able to honor that. Other times, that is not the case. It is common for students to be assigned to several clinical areas in order to have some diversity in the patients whom they see. In Residencies and programs with overnight on-call, students may be asked to visit patients through the hospital. In the beginning of the program the Supervisor usually discusses that aspect of the program.

### **14. What do you need to know about the setting?**

As noted, CPE takes place in hospitals, nursing homes, counseling centers, and community agencies. Each setting is different and may have procedures and expectations that differ one from the other. As part of orientation the Supervisor will cover the clinical areas in which you may be assigned. You will want to know about the types of patients. For example, in a tertiary medical care facility, patients may be much sicker than in a community hospital because they have been

sent there for advanced treatment. Also, in a nursing home, most all of the patients are elders, whereas in a medical center patients could be anywhere from newborns to elders.

**15. What does it mean, “Trust the process”?**

CPE is, in many ways, a unique model of learning. It involves learning by doing, also known as the “action-reflection-action” model. You do, you reflect on what you did and why, and then you try to do it again with some perspective. This happens not only with patients, but also with your peers and Supervisor. Learning in this setting is not typically smooth and, yet, it usually results in growth and development. We say that it is necessary for everyone to “trust the process” of difficult and painful learning to result in something good and worthwhile for each person. When it gets especially challenging, we encourage you to continue. If you stay with it, the results will benefit you. Hence, “trust the process.”

**16. What is the notorious verbatim?**

That is a very good question, Grasshopper. This is the primary tool that we use in CPE. In effect, it is a written reconstruction of a conversation that you have with a patient, family member or staff person. You try to incorporate all that was happening including what was said, what you were feeling, noting the pauses in the dialogue, the interruptions and so on. This is then presented either to your Supervisor or to your peer group. In recalling the visit and the dynamics with the group, we look at what may have been factors that made the visit go well and those factors that interfered with the visit. This is a primary component of the reflection part of the action-reflection-action learning model.

**17. What is the small group process?**

IPR (Inter-Personal Relations Group) aka IPG – Covenant Group – Open Agenda Group. These are the various ways by which we identify the small group-learning environment. Whatever it is called, it is a setting in which you can do a great deal of learning and growing. It often is described as a place where there is no really clear focus. Instead, you and your peers are the focus. This means that you practice giving open and honest feedback with the intention of helping a peer see how he or she relates and communicates. This is a fairly intimate time that challenges CPE students to listen to one another and to respond with care to one another.

An interfaith or multi-faith religious program: Is prayer together possible?

This is a dilemma that has challenged CPE since it has become more than just a Protestant model of theological education and will likely continue into the future. CPE is assumed to be a theological and, what some would call, a religious enterprise. Thus, many people expect CPE groups to pray together, when reality tells us that this obvious question is not so simple. Unfortunately, the honest answer is both yes and no. The dilemma stems in part from the definition of prayer. What one tradition needs to include in prayer can be a serious problem for someone of another religious tradition. Using particularistic religious language like “in the name of Jesus” in a multi-faith CPE group, for instance, can be exclusionary, at best, and offensive, at worst.

On the other hand, for people aware of the pitfalls, there are ways to come together in a prayerful spirit. It can be helpful to begin by not labeling the time as prayer or worship. This is not easy, but if everyone owns their religious orientation and expectations, then there are readings and reflections that offend no one and allow for everyone to take part.

### **18. So, what actually is spiritual care?**

Language is again important in answering this question. Historically, the ministry of caring for people's religious needs was termed "pastoral care." There is a long history of this ministry beginning in the Bible that evokes the image of the shepherd caring for his flock. The image has roots in the Christian concept of Jesus in the New Testament. Clinical Pastoral Education draws upon this idea in its original identity, as focusing on the religious care of those in crisis.

The second common term is chaplaincy. The military uses this term for the clergy serving in our Armed Forces. It is understood that each chaplain represents a particular religious tradition but addresses religious needs of all people in the service.

Spiritual care has become a more open and less particularistic label for this work. In particular, it allows for other non-Christian religions to practice and receive care focused on spiritual distress. The spiritual caregiver seeks to help a person access their own spiritual resources, which could be religious or not, in order to help the person cope with their current situation – crisis, illness, death, etc. This is how the Association of Professional Chaplains describes its mission, "Healing through Spiritual Care."

### **19. What is the main spiritual care task? Listening**

When we provide spiritual care to patient, it is often not what many seminarians imagine. They frequently see the task in terms of giving advice and answers. On the contrary, the major task in spiritual care is listening to the person without injecting one's own theology or answers. This can make providing spiritual care a challenge to some people. Active listening is a skill that incorporates hearing what the person is saying, as well as, how the person is feeling and then using oneself to better understand some of that person's experience. One helpful philosophic perspective is the work of Martin Buber. Buber suggests that authentic relationship involves a deep appreciation of the other person's reality, connecting with another person on the level of their struggles with life and meaning. It is that appreciation that we seek in active listening.

### **20. Can you do "Presence?"**

This is one of those skills that have a rather vague nature. It is more often described as "I know it when I see it." Presence is something that as clergy we seek to embody without at the same time inflating our sense of self importance. That is, of course, the challenge. In its simplest form, it means just being there for another person. The more complex manifestation involves conveying a sense of the sacred or holy in one's bearing. Another way to say this is in the notion of sitting in silence, without needing to do anything or say anything. It sometimes takes some time for people in CPE to understand and do this.

### **21. How does one pray with patients?**

The assumption made by many chaplain interns is that praying is the sine qua non of chaplaincy. It is not. Prayer is highly idiosyncratic and has multiple forms and uses. Typically, chaplains think to offer prayers at the end of visits. It can help to summarize a conversation, it can reflect the concerns named by the patient, or it can assist the chaplain in getting out of the room. Then, there is the question of what to pray, what words to use, and how does one pray when the patient's religious tradition is different from your own.

Most Jews would feel uncomfortable praying with a Christian chaplain. Jehovah's Witnesses do not believe that they can pray with anyone other than another Witness. Many Christians feel that they are not really praying unless it is in the name of Jesus. These factors, among others, make the process of praying with patients very complex. Prayer can be a vehicle for communicating with the Divine. It can be an expression of a person's deepest feelings in the midst of crisis. It can also be what connects a person to their source of religious authority. No one should underestimate the power and breadth of prayer.

### **22. "Every Patient Tells a Story"**

This is actually the name of a book by Dr. Lisa Sanders of Yale-New Haven Hospital. In part, Dr. Sanders addresses physicians and encourages them to listen to what their patients tell them. In a similar way, chaplains want and need to hear the stories that their patients tell them. Chaplains listen carefully, as noted above, to the important narrative which patients offer. We seek to integrate our own story and experience into the way in which patients experience crisis and illness. When we actively invite the patient to tell their story, we open up a line of communication and a link to the inner person. The bottom line is that stories can heal.

### **23. When chaplains become the symbolic exemplar**

A rabbinic colleague of mine wrote up his doctoral thesis in a book that was called The Rabbi as Symbolic Exemplar: By the Power Vested in Me. In it he talks about levels of power and authority that come to clergy by virtue of the role they assume. When a chaplain (or clergy) walks into a patient's room, there are many levels of authority. What the patient sees and feels, what the staff perceives, and what the chaplain might understand or feel within the chaplain's self. Many beginning CPE students do not have much perspective on this. After all, they are "only" seminarians or "only" a lay person or they have "only" been ordained a short while. This hospital experience poses a challenge to chaplain interns to step back and understand how they might be perceived by others and what the meaning of that perception might be. Additionally, even when one just walks down the halls of the hospital, staff observes and assesses the symbolic power associated with the clerical role. In a very real sense, the chaplain can represent God (or the church/synagogue) to many people. It can be a difficult transition to fully comprehend how that dynamic works in the hospital. Frequently, it becomes the focus of a student's goals in CPE.

### **24. Do we not need to ask questions?**

The answer is yes and no. I am sure that helps you. The real issue is not whether or not we ask questions; the issue is what kind of questions we ask. Most people ask questions in order to get information. How old are you? Where do you live? And so on. In spiritual care, these are not necessarily the most helpful questions because collecting data is not what spiritual care is about.

It is often better to ask open-ended questions which allow the person to tell their story (see above). What happened to you? How are you feeling? Tell me about what is going on. In this way, we invite the person to share what is really on their mind and heart, instead of our guessing about what is bothering them. For instance, we might pose the reasonable question to an apparently lonely person, has your family been by to visit? We do not know whether the patient even has a family, whether they are on good terms with one another, or whether the family is in town or across the country. Thus, we want to be less specific, not simply asking a yes or no question. Instead, we might ask, what visitors have you had since coming into the hospital?

### **25. What is the meaning of patient questions?**

When a chaplain goes to visit a patient, they often are asked questions by the patient of a religious or theological nature. This is frequently a trap that chaplains fall into. What we need to understand is what prompts these questions. For instance, the question “why is God doing this to me?” does not require an answer from the chaplain. Most of the time, that questions, and similar ones, reveal the pain and suffering that a person feels. Therefore, in a gentle fashion, the chaplain might respond by saying, “it seems that you are really struggling in your faith right now.” This conveys that the chaplain is listening and invites the person to tell more of her story.

### **26. How do we deal with suffering? The case of Job and no answers**

Dealing with this issue of suffering is at once the greatest opportunity and the greatest pitfall in spiritual care. Giving people an opportunity to talk about their pain is, as noted previously, an opportunity to experience healing. Trying to provide theological answers to patient questions about God’s intention or the meaning of suffering can be a real quagmire. Chaplains do not know what kind of religious education or ideological posture any patient may have. Therefore, in attempting to answer such questions, we risk opening up issues that we cannot address or that might even offend the person. It is usually better to help clarify the significance of the current suffering by exploring what it means to the individual.

### **27. What about emotions/feelings? Your, mine, and theirs.**

To set up a very simplistic dichotomy, religion for most people is much more about feelings than it is about thoughts. If this leap of rationality holds true, then the chaplain needs to pay attention to the emotional content of interactions with patients. This includes the chaplain’s feelings, the patient’s feelings, the feelings generated in the encounter itself by and through the conversation. This is part of active listening and it is often not easy. The main reason is that we rely on reason and concrete data. Emotions are much less common as the focus in our interpersonal communication, of course, unless we are feeling strong reactions to something, such as anger or fear. In spiritual care, we begin with an assumption that patients are feeling a range of difficult emotions that most of the world is not interested in knowing. We, on the other hand, want to invite the patient to express their feelings. Of course, that is true as long as the negative feelings are not directed at us. If a patient is angry, most of us do not want to hear it. If the patient is fearful of dying, we do not want to hear that. But, at the same time, when we think about it, those are precisely the kinds of feelings we do want to hear. We want patients to be able to express their feelings as a means to work through their suffering. We, as chaplain, in turn, need to be aware of our own emotional life journey because we carry all the elements of that history with

us, whether we know it or not. Think counter-transference. Thus, one of the aspects of CPE that challenges all of us is becoming aware of our own emotional “stuff,” so that it does not interfere with our provision of spiritual care. This is a great deal easier to say than it is to do.

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