

**DACUM:**  
**A contribution to competency-based spiritual care education**

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## **1. Competence for Ministry – Origins and Drivers of the Concept**

**What is competence?** According to Boon & van der Klink (2002: 6) competence is a somewhat “fuzzy concept” but is nonetheless a “useful term, bridging the gap between education and job requirements.”<sup>1</sup> It has its origins in the modern workplace productivity movement, particularly neo-Taylorist / Functionalist scientific management approaches and Personal Competence / Human Relations School approaches.<sup>2</sup> There are many definitions of competence. For our purposes, that provided by Graham Cheetham and Geoff Chivers (2005), in their recent excellent analysis of professional competence will suffice.<sup>2</sup>

Competence is, “*Overall, effective performance* within an occupation which may range from the basic level of proficiency through to the highest levels of excellence” (xi).

Professional competence in particular is “the possession of the *range of attributes* necessary for effective performance within a profession and the ability to marshal these consistently to produce the desired *overall* result.” (xiii) (emphasis ours)

Cheetham & Chivers (1998:268; 2005) believe that professional competence can be observed in four domains: Knowledge/cognitive competence, Functional competence, Personal/behavioral competence, and Values/ethical competence.<sup>3, 2</sup>

- **Cognitive competence** is understood as, demonstrated “*possession of appropriate work related knowledge and the ability to put this to effective use*” in a defined field of practice (Cheetham & Chivers, 2005: 87, italics theirs). Until very recently, however, it could be argued that spiritual care in healthcare settings lacked a defined field of practice and that a defined body of knowledge regarding spiritual care theory, methods and outcomes was also lacking (see Cooper, 2008: 68f).<sup>4</sup> Indeed, systematic descriptions of what it is that we know and do are still emerging. And, as we have all discovered, the connection between theory and practice is not invariably well established in classical theological education. In fact, many theologically well-trained persons entering clinical training programs appear to struggle to make the required connections between theory and practice that will allow them to artfully address what educator Donald Schön (1983: 42) has called the “messes” of real life.<sup>5</sup> This disjuncture between relevant theory and pastoral practice may arise from the observation that theology tends to follow largely a classical / deductive model of education (i.e. from theory to practice) as opposed to a workplace-based / inductive approach (i.e. from required practices to best methods and content of training). As we will see from what follows, efforts are underway to reverse that situation.

- **Functional competence** is understood as demonstrated “*ability to perform a range of work based tasks effectively to produce required outcomes*” within a defined a scope of practice and professional role (Cheetham & Chivers, 2005: 87, italics theirs). This requires development of a set of statements regarding major areas of responsibility and major related tasks (e.g. conduct a spiritual assessment and demonstrate efficiency in charting, or function effectively as a member of an interdisciplinary team). Again, this begs a degree of definition that, until recently, has not been available. It also requires a method of evaluating what degree of competence can be observed, demonstrated and measured, something that is quite challenging indeed. (Cheetham & Chivers, 2005:59-65).
- **Personal / Behavioral Competence** is understood as demonstrated “*ability to adopt appropriate, observable behaviours in work related situations,*” in other words, acquisition of requisite professional characteristics and behavioral skills (Cheetham & Chivers, 2005: 88, 65-69, italics theirs). For example, the ability to demonstrate ‘compassionate presence’ is fundamental to the ability to enter into therapeutic relationships with clients. Cheetham & Chivers (2005:277) further identify a range of important generic personal attributes: communication (oral/written), problem solving, analytical skills, team working skills, personal competence, mental/cerebral skills, inter-personal skills and reflection.
- **Values / Ethical Competence** is understood as demonstrated “*possession of appropriate personal and professional values and the ability to make sound*

*judgements based upon these in work related situations*” (Cheetham & Chivers, 2005: 88, italics theirs). The ability to navigate the ethical complexities of the role and to execute the related ethical tasks of supporting clients and team members is of increasing importance in professional practice today.

**A critique of competency-based approaches.** A significant critique of Cheetham & Chivers’ 2005 text has been offered by continuing professional development specialist Michael Aherne.<sup>6</sup> Aherne (2006) observes that these authors place too much emphasis upon expert knowledge and technical-rational approaches vs. “reflective practice” and the “art” of a profession in handling modern challenges (cum Schön). Further, he feels that there is a failure to recognize the importance of understanding the cultural ethos of a profession. There may be unique ways of knowing and being as well as distinctive intellectual traditions. As Todd has noted, there is an important difference between “those who see professionals as ‘emotionally neutral technical experts [who] do something *to (or for)* a client’; and those who view professional practice as an arena for personal engagement between professional and client – in other words, the professional ‘works *with* a client’.”<sup>7</sup>

One instance of the uniqueness or special emphasis of spiritual care may be found in our understanding of the ‘person’ of the client and of the caregiver as being of central importance. Another would be the theological frameworks and embedded religious traditions within which spirituality has traditionally been nurtured and the practice of spiritual care has developed. Thus, it may be that that which is most unique to the ethos

of supervised pastoral education are the notions of spiritual formation and spiritual companionship, concepts that although ‘observable’ in many respects are inherently difficult to define or measure. One could ask, how one is to precisely quantify the degree of formation of professional character in a spiritual caregiver? How does one define the role and degree of personal faith and of religious identity and practice in professional formation? What does spiritual companionship look like? These are deeply culturally-bound and idiosyncratic notions, but they are very much at the heart of what it is that spiritual caregivers ‘are’ and ‘do’ and central to spiritual care education.

Indeed, the main focus in CPE since the modern emergence of adult-education theory (Mezirow, etc.) has very much been person-centred and learner-centred, a model that harmonizes well with the ‘original’ focus in CPE on Anton Boisen’s “living human document.” Whatever benefits the notion of competency may bring to clinical education it would be an unconscionable departure from our core values to attempt to produce ‘pastoral clones’. Somehow, while pursuing the obvious systemic advantages of the competency approach to training and practice, we must manage to retain our connection with the unique human story embodied in each client, learner and professional spiritual care provider. This is the ‘soul’ of clinical pastoral education. It is what defines the distinctive professional approach of the spiritual care provider.

Perhaps, what Cheetham & Chivers (1998: 268; 2005: 70, 109) would refer to as an important “meta-competency” for the spiritual care provider is the ability to hold what is known about the client’s religion, ethnic and familial culture, and individual ways of being and living in the world, together with the self of the care provider. Effective

interventions are then creatively evolved out of that nexus, utilizing but not being bound to the knowledge and interventional base of the field of practice. Another such meta-competency would be to reflect theologically/philosophically, within her/himself, with the client and with the team, about the meaning of what is experienced.

Amy Tan (2001:233) has a lovely description of competence in the creation of artistic beauty in her novel, *The Bonesetter's Daughter*.<sup>8</sup> Spiritual Care Providers will find something close to the 'soul' of what they do in this notion:

*“Competence...is the ability to draw the same thing over and over in the same strokes, with the same force, the same rhythm, the same trueness. This kind of beauty, however, is Ordinary...The second level...is Magnificent...This one goes beyond skill...its beauty is unique...The third level is Divine...A person seeing this would be wordless to describe how this is done. Try as he might, the same painter could never again capture the feeling of this painting, only a shadow of the shadow.”*

**Occupational Context & Competence:** Richard Boyatzis is one of the best known names in the field of professional competence.<sup>9</sup> He suggests that workplace environment bears significantly on the competencies required of professionals. (Boyatzis, 1982, cited in Cheetham & Chivers, 2005: 67, 107-109). In other words, while general or generic competency profiles will be of some use in guiding practice and curriculum development, the provision of spiritual care in distinctly different practice settings will likely involve acquisition of specialised knowledge, skills and attributes. For instance, spiritual care in Hospice Palliative Care settings may require different competencies than psychiatric

chaplaincy, corrections, or congregational ministry. More research is needed to understand the impact of workplace context upon practice in our field.

**What are the Drivers of competency:** As Cooper (2008, 64) has observed,

*Change in our Association has recently been driven by several forces. Canadian privacy and public safety legislation have impacted both our institutional chaplains and pastoral counselors. Chaplains, and particularly community religious leadership, appear to be at risk in some jurisdictions of losing access to clients on the basis of privacy requirements. Chaplains and Pastoral Counselors, in some jurisdictions, are fearful of being excluded by legislation from their primary or specialist counseling roles on public safety grounds unless they affiliate with existing, legislatively endorsed, non-spiritual care professional organizations. Health care chaplains appear under considerable pressure in their institutions to demonstrate enhanced theoretical and practice competencies in keeping with a highly professionalized, increasingly evidence-based workplace. Spiritual care has traditionally been assumed to be the chaplain's domain. It is, however, more frequently described in the health care literature by physicians, psychologists, nurses and others who have greater access to the resources needed to execute and publish research, and increasingly seem to claim spiritual care as their legitimate professional territory, both in terms of research and practice.*

Myatt suggests adding “working alongside other professions (who have a more developed definition of their competencies) in a regularized health care environment (which desires all allied health care professions to look alike, education included) as another pressure.”<sup>10</sup>

Clearly, spiritual care providers perceive pressures in the modern workplace that stimulate their educators to adapt traditional, person-centred models of clinical education to serve a competency-focused, workplace-driven agenda. This is not, however, an entirely reactionary development. A longstanding issue in the field of spiritual care has been the need to define for ourselves what it is that we actually do. This naturally leads to a search for a suitably rigorous methodology for determining the scope of practice and occupational responsibilities and tasks of the spiritual care provider. It is in the context of this discourse that the DACUM methodology was adopted as an established, transparent, rigorous and credible approach to occupational analysis, leading to curriculum design and development.

## **2. DACUM – Origins, process, product and uses**

DACUM is an acronym for *Developing a Curriculum*. First developed in Canada and in the United States in the 1960's, it rapidly proved its utility in describing the occupational responsibilities and tasks of a wide range of vocational and professional roles, and as a foundational datum for the design and development of curriculum for occupational training programs. It is both a *process*, a professionally facilitated DACUM workshop with specialists in a particular field of practice, and a *product*, a DACUM chart defining a specific role, describing scope of practice, and identifying major areas of responsibility and related major tasks. As Cooper, Temple-Jones and Associates (2006) note:

*The DACUM method is robust as assessed against its methodological rigor, process validity, descriptive reliability and ease of use. The strength of the DACUM method is its rigorous focus on major areas of responsibility and major tasks for defined roles, and on the expertise of the skilled worker in that role as the principal source of needs data.... In the field of spiritual care, with its profound diversity and inherently idiosyncratic nature, one might well anticipate grave difficulties in defining what it is that spiritual caregivers do. The key to success, from the DACUM perspective, is recognizing that any job can be defined by describing its component tasks.*<sup>11</sup>

Two DACUM workshops were conducted under the expert facilitation of Wilson Education Consultants and comprised of qualified CAPPE/ACPEP members from across Canada. The 2006 CAPPE/ACPEP sponsored DACUM workshop, held in Lumsden Saskatchewan, produced a chart for the *Certified Spiritual Care Provider (Specialist – Pastoral Care)* one of four CAPPE/ACPEP certifications. This workshop was preceded by the 2005 PALLIUM Project DACUM workshop in Calgary, Alberta that developed a profile of major areas of responsibility and related tasks for the *Professional Hospice Palliative Care Spiritual Care Provider (HPC-SCP)*. The two job profiles nicely complement CAPPE/ACPEP's own practice and certification standards in specifying and clarifying the ministry of spiritual care.<sup>12</sup>

A DACUM workshop for a specific role is an expertly facilitated round table event of at least several days. Expert practitioners gather to establish a name for the role, a scope of practice statement, and to identify, refine, collate and prioritize major areas of responsibility and their major related tasks. A list of relevant KSAs

(knowledge, skills and professional attitudes/attributes) for persons in the role is also devised. This material is subsequently sent to all participants for a sober second look and comments. The Chart, KSA list and comments are then fashioned into the end product for future wider validation and appropriate uses, such as in curriculum design, development of position description, workplace performance evaluation, and assessment of continuing professional development needs. DACUM charts are a 'snapshot in time'. While they cannot be subsequently changed, they can be reviewed and revisited over time. They are intended to be understood as *normative* documents and not as prescriptive statements.

For those interested in further information, an excellent introduction to DACUM theory and methodology may be found in Robert Norton's text: DACUM Handbook (2<sup>nd</sup> ed., 1997).<sup>13</sup> Readers are invited to view the two DACUM Charts mentioned above on the CAPPE/ACPEP web site as follows.

**3. *The Professional Hospice Palliative Care Spiritual Care Provider***  
(© 2005 The Pallium Project)

**LINK to chart:**

[http://www.cappe.org/dacum/download/Pallium\\_DACUM\\_HPCSpiritCarePro\\_March2005FINALA.pdf](http://www.cappe.org/dacum/download/Pallium_DACUM_HPCSpiritCarePro_March2005FINALA.pdf)

**4. *The Certified Spiritual Care Professional – Specialist (Pastoral Care)***  
(© 2006 CAPPE/ACPEP Education Standards Commission)

**LINK to chart:**

<http://www.cappe.org/dacum/download/DACUM%20Certified%20Spiritual%20Care.pdf>

## 5. From Competencies to Curriculum:

DACUM charts constitute one very useful foundation for curriculum design. In this methodology, designers do not work from theory to curriculum (which is a very common academic and theological approach) but from occupational role to curriculum, so that the resultant training program is grounded in real workplace expectations. This is of great quality assurance value to employers and learners alike, both of which want to 'get their money's worth'. The former have a need to identify suitably trained potential employees and relevant and effective continuing education programs. The latter, as adult learners on a career trajectory, want to determine their best options when it comes to the cost, time and effort of occupational training.

Major Areas of Responsibility and their component Major Tasks guide curriculum writers in the development of learning modules. Modules can be subsequently mapped against occupational analysis profiles, and other content-critical documents, to ensure that the important areas are covered in the curriculum. Further content validation occurs as draft modules are field tested in educational laboratories to obtain learner feedback and peer-reviewed by leading practitioners.<sup>14</sup> Expert sign-off on the final product is a last validation step prior to deployment of the curriculum.

This is exactly the process that was followed in the development of the occupational analysis-based core curricular package produced by the Spiritual Care Development Initiative of the Pallium Project: *The Professional Hospice Palliative Care Spiritual Care Provider* (© 2005 The Pallium Project). This curriculum was also

informed very intentionally by the then guiding document of the Canadian Hospice Palliative Care Association (Ferris, et al., 2002): *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice*.<sup>15</sup> The alignment of both documents with module contents is displayed prominently at the beginning of each module. The curricular resource was developed by principal writers the Reverends Dan Cooper (Pallium Project Consultant and CAPPE/ACPEP Certified Specialist [Pastoral Care] and Teaching Supervisor [CPE]) and Jan Temple-Jones (Pallium Project Resource Person), and 10 CAPPE/ACPEP co-designers/reviewers.<sup>14</sup> This core curricular package is available for purchase at the on-line *Marketplace* of the Canadian Hospice Palliative Care Association.<sup>†, 16</sup> A free outline of contents is available from the web site of the Pallium Project.<sup>17</sup>

A similar, if somewhat less structured process, has been followed in the developing the CAPPE/ACPEP core curriculum for CPE. A DACUM chart for the practice specialty was produced by CAPPE/ACPEP Certified Specialists, entitled: *The Certified Spiritual Care Professional – Specialist (Pastoral Care)* (© 2006 CAPPE/ACPEP Education Standards Commission).<sup>18</sup> Together with entry to practice competency lists developed in British Columbia and Ontario by means of a modified Delphi process (circulating and reviewing lists), these competencies were validated in a web-based National Validation of Competencies Survey in 2008. The result of this survey was that all competencies were validated by CAPPE/ACPEP members (each receiving >66% support), except the competency area of research. It would seem that CAPPE/ACPEP members are not yet certain that scientific research constitutes a core

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<sup>†</sup> The author and reviewers(s) of this chapter have no financial interest in this curricular resource.

competency for their roles. More about the BC and Ontario competencies will be found in a chapter written by those who had direct involvement with that process. Findings of the validation process may be found on the CAPPE/ACPEP web site.<sup>19</sup>

Following validation of competencies, the Board of CAPPE/ACPEP appointed the Reverend Doctor Peter VanKatwyk, a distinguished scholar, CAPPE/ACPEP Specialist (Pastoral Counseling) and recently retired Professor of Pastoral Care and Counselling at Waterloo Lutheran Seminary as principal architect and writer of this core curriculum for Clinical Pastoral Education. Peter shared aspects of this role with a number of colleagues, including the present author. Where applicable, each chapter demonstrates its alignment with the validated competencies. Each chapter was also reviewed by one or more certified CAPPE/ACPEP members. The curriculum, somewhat as an ‘in process’ or *living* document, was posted to the CAPPE/ACPEP web site.

## **6. Assessment of Competency Acquisition – an early model**

Good evaluation is holistic and derived from multiple perspectives on the learner, sometimes known as ‘360<sup>0</sup> evaluation’. Thus, there are many possible frameworks for evaluation. For example, an interesting and well-known *post-hoc* approach to program evaluation is the *Four Levels* model of Kirkpatrick (1959; 1994; 1998: chapter 3), which acknowledges both cognitive and connotative aspects of learning, a behavioral dimension and a workplace impact dimension:<sup>20</sup>

- **Kirkpatrick's 4 levels of evaluation:**
  - **reaction** of student - what they thought and felt about the training
  - **learning** - the resulting increase in knowledge or capability
  - **behaviour** - extent of behaviour and capability improvement and implementation/application
  - **results** - the effects on the business or environment resulting from the trainee's performance

As we have seen above, a competency-based approach suggested by Cheetham and Chivers (1998: 268; 2005: 87-88) recommends that learners must be evaluated in at least 4 domains of competency:<sup>3,2</sup>

- **Cognitive** -- demonstrated “*possession of appropriate work related knowledge and the ability to put this to effective use.*”
- **Functional** -- demonstrated “*ability to perform a range of work based tasks effectively to produce required outcomes.*”
- **Personal / Behavioural** -- demonstrated “*ability to adopt appropriate, observable behaviours in work related situations.*”
- **Values / Ethical** -- demonstrated “*possession of appropriate personal and professional values and the ability to make sound judgments based upon these in work related situations.*”

While there is a rich literature on competency and on evaluation, unfortunately, there appears to be no published work discussing tools to evaluate the effectiveness of training

programs that utilize formally constructed, occupationally-relevant competencies of the kind we have been discussing. No doubt, this presents a moment of opportunity for educators and researchers.

In his accredited CPE program in Regina, Saskatchewan, focused in Hospice Palliative Care and Oncology, Dan Cooper has trialed an evaluation tool specific to the occupational analysis profile for the *Professional Hospice Palliative Care Spiritual Care Provider*.<sup>‡</sup> This profile was one of the central pillars of the core curricular resource utilized in his program: *Developing spiritual care capacity for hospice palliative care: A Canadian curricular resource* (ver. 1.0). The tool cross references the 14 Major Areas of Responsibility identified in the profile, against a 0 – 5 point Likert-type scale linked to CAPPE/ACPEP levels of training (from no demonstrated competence, to the individual's intuitive perception of what might constitute a Basic I level of competence, Basic II, Advanced I, Advanced II and ready to certify as Specialist).

This scale is thought by Cooper to have much in common conceptually with the Dreyfus & Dreyfus (1986) *Model of Skill Acquisition*, by which learners are thought to progress (not always without reversals / re-learning) through a progressive sequence of competency acquisition from novice to expert.<sup>21, 22</sup> \*

1. *Novice* – i.e. CPE Basic 1 (ACPE Level 1)
2. *Advanced Beginner* – i.e. CPE Basic 2 (ACPE Level 1)

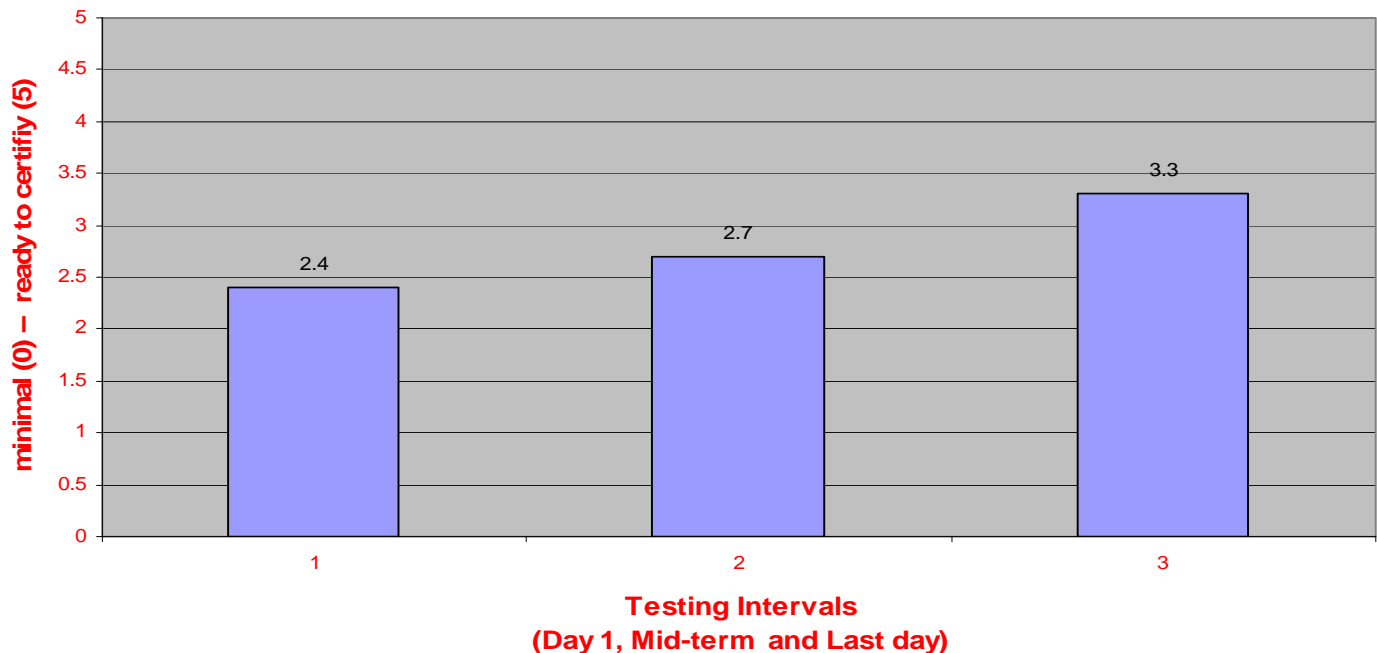
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\* An early version of this tool was trialed in the development of the related curriculum. It is further developed and shared here for interested comment.

3. *Competent* – i.e. CPE Advanced 1 (ACPE Level 2)
4. *Proficient* – i.e. CPE Advanced 2 (ACPE Level 2)
5. *Expert* – i.e. Ready to be certified Specialist (APC Board Certified Chaplain)

Cooper’s experimental practice thus far has been to ask learners to self-evaluate using this scale, although proxy evaluation by supervisor and possibly by other clinicians familiar with the scale is possible. A summary chart of learner self-assessed competency scores from 3 recent CPE intakes, with a blend of Basic and Advanced learners, follows:

**Self-Assessed Participant Acquisition of Core Competencies  
(Grand Means: CPE 2005, 2006, 2008)**



While there are methodological limitations and a small sample size in this evidence, it seems reasonable to conclude that learners perceived that their competency level improved over the day-one baseline, through mid-point to the last day of training. It is Cooper's view, however, that their assessments may be somewhat optimistic in terms of where learners saw themselves in the overall spectrum of what needs to be learned. As Ross (2006) has noted, it is a general axiom in the literature that it takes 10 years of practice to develop expertise, and no doubt this is particularly the case in professions that are complex and somewhat ill-defined as, it may be argued, is spiritual care.<sup>23</sup> In CAPPE/ACPEP Education Standards, a minimum of 1600 hours (4 CPE Units, 2 of which must be at the Advanced level of training) are the clinical requirement for certification as a Specialist. A cognate graduate degree and a term of post-training practice in the specialty is also required. So, as we all know, a unit of CPE does not an expert make!

More work is needed to validate and refine the use of this too. At the moment it is not used by Cooper, nor recommended by him for use, as part of a formal CPE written evaluation. It represents a tentative start down the path of competency-based evaluation in a specific spiritual care setting (in this case programs utilizing the Hospice Palliative Care core curricular package). Similar evaluation formats might be conceived utilizing the Specialist (Pastoral Care) occupational profile and related curricular packages.

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