

**A CURRICULUM**  
**for**  
**Basic Clinical Pastoral Education:**  
**An Introduction**

**AUTHORS:**

Rev. Dr. Peter Van Katwyk  
Member Emeritus

Rev. Dan Cooper  
Certified Specialist [Pastoral Care] and Teaching Supervisor [CPE]

Clinical Pastoral Education (CPE) is couched in Anton Boisen's gripping image of the *living human document*. Originally this document was both autobiographical, telling the story of how Boisen examined the madness of his psychotic delusions to find his life's meaning, and educational, how caregivers can learn pastoral care and theology in clinical, disciplined contact with their patients in the hospital. CPE has found its identity in these twin roots of self-awareness in concert with deep respect for the sacred texts encountered in the *living human document* of those cared for in the pastoral relationship.

With the present development of a curriculum for basic clinical pastoral education in a variety of clinical settings, critical questions may well arise whether a written curriculum takes away from the primacy of the *living human document* and the pastoral /

spiritual caregiving relationship. Is the curriculum reversing the order in the CPE tradition of learning from the patient rather than from authoritative textbooks, and caring through the pastoral relationship rather than following the dictates of professional practice and expertise? Is the curriculum designed to be a corrective to a supposedly anti-scientific bias and culture of neglect and suspicion for written texts and professional directives in CPE?<sup>1</sup>

The curriculum does reflect significant changes in the Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP) linked to recent trends in scientific and professional procedures in health care. Several forces that drive these current changes impacting CPE have been identified:

1. Canadian privacy and public safety legislation can put institutional chaplains and pastoral counsellors at risk of losing access to clients.
2. Chaplains and pastoral counsellors may face the prospect of having to affiliate with existing, legislatively endorsed, secular professional organizations to practice their primary or specialist counselling ministry.
3. Health care institutions increasingly expect their chaplains to demonstrate enhanced theoretical and practice competencies in keeping with a highly professionalized, evidence-based workplace.
4. Spiritual care, no longer reserved for chaplains alone, has been increasingly claimed by other health care professionals as their legitimate professional territory, both in terms of research and practice.<sup>2</sup>

The curriculum, however, intends to be more than a defensive and reactive response to these forces in health care reform. The focus and main intent of the curriculum is to facilitate students in the course of their clinical pastoral education, and to do so in the context of the realities of the present health care system. The curriculum will identify an essential knowledge base and skills for institutional ministry in conjunction with fostering the development of personal characteristics in helping relationships for the practice of spiritual care.

The research that shapes the curriculum comes from the relevant spiritual care, pastoral counseling and clinical education literature. It is further informed by two recent occupational analysis / workplace competency profiles (DACUM Charts) and by a recent process arising out of British Columbia and Ontario to identify entry level competencies for ministries of counseling. The competency lists thus generated were validated in 2008 by a national on-line survey of members conducted under the authority of the Education Standards Commission of CAPPE/ACPEP.<sup>3</sup> Lastly, these academic and competency findings are informed by the legacy of CAPPE/ACPEP's standards for training and certification.<sup>4</sup>

DACUM is an acronym for *Developing a Curriculum* and has been utilized in the development of curriculum for occupational training programs since the 1960's. 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 (2006:28) 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>5</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.<sup>6</sup> 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)*.<sup>7</sup> The two job profiles nicely complement CAPPE/ACPEP's own practice and certification standards in specifying and clarifying the ministry of spiritual care.<sup>8</sup> *More details about*

*the DACUM process, DACUM Charts and the process of curriculum design and development will be found in the Chapter on DACUM in this core curriculum.*

Both profiles delineate spiritual care under three distinct categories. Taking the Specialist (Pastoral Care) DACUM chart as example, a three-dimensional picture of spiritual care comes out in the following table:

Table 1.1                      **KSAs of the Pastoral Care Specialist**

<b><u>Knowledge</u></b>	<b><u>Skills</u></b>	<b><u>Attitudes / Attributes</u></b>
<ul style="list-style-type: none"> <li>• Acquires mastery of a body of evidence and theory and related therapeutic methodologies suitable to the practice context</li> <li>• Multi-faith / inter-faith awareness</li> <li>• A suitable degree of understanding of the roles and functions of other disciplines</li> <li>• Currency in the literature of spiritual care</li> <li>• Institutional OH&amp;S policies and procedures</li> <li>• Principles of person-centered care</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Intervention</li> <li>• Consultation, documentation, follow-up</li> <li>• Advanced attending skills</li> <li>• Advocacy and strategic planning</li> <li>• Research and publication</li> <li>• Theological reflection on context and practice</li> <li>• Teaching</li> <li>• Self-knowledge</li> <li>• Relationship building</li> <li>• Cultivate a lively spiritual life</li> </ul>	<ul style="list-style-type: none"> <li>• Professional and contextual ethics</li> <li>• Maintains good relations with community religious leadership</li> <li>• Willingness to engage with other disciplines collaboratively and inter-professionally</li> <li>• Sensitivity to the distinction between client-focused care and provider-driven care</li> </ul>

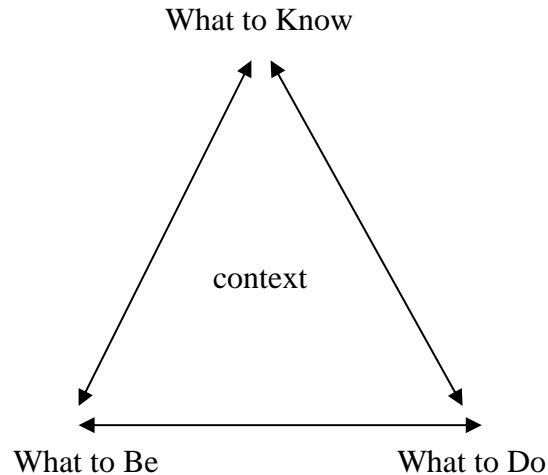
It is remarkable to note that CPE itself has evolved in a similar triadic fashion. Rather than a smooth, linear development CPE has played with, and fought about, its different dimensions. In its history, the CPE movement has performed on three main

stages that highlight its theology and practice of ministry.<sup>9</sup> The first stage centered on **what to do** with an emphasis on personal skills in supporting people in distress. Dr. Richard Cabot, a medical leader in the formation of CPE, and Russell L. Dicks, a chaplain / supervisor, who published several books on pastoral care and counseling and introduced the *verbatim* in CPE, were prominent voices who defined the chaplain's role as primarily one of sustaining and comforting the patient. Anton Boisen, having learned from the Freudian concepts of dynamic psychology, believed that the chaplain's role included a theological understanding of mental illness. Speaking from his own experience he advocated a more direct role for the chaplain in the interpretation of psychological forces and providing spiritual guidance for the patient.<sup>10</sup> He introduced the case method in theological education as the hermeneutical tool for the interpretation of the *living human document*. This led to the **what to know** stage in CPE, holding that spiritual care is not restricted to supportive action but includes a theological understanding that ministry could bring to human suffering. Late in the 1950's the focus changed to **what to be**, emphasizing the helping relationship as the key to healing. In this view spiritual care came of age when it disavowed both expert knowledge and clinical expertise as the primary tools in care. From this perspective, knowledge of self in relation to others rather than theoretical knowledge, and the use of the helping relationship rather than of practical helping skills, become the hallmarks of spiritual care and counselling.<sup>11</sup>

The three-dimensional job profile of the spiritual care provider in the Specialist (Pastoral Care) DACUM document and the HPC-SCP DACUM document reflect these three performance stages of CPE. By casting *doing*, *knowing*, and *being* in interaction of

three helping roles, the three are not ranked in a hierarchical order nor put in competition. Rather, the three constitute an animated composite, startling in its variety of variables and possibilities. This is *the caring triangle* pursued in the curriculum, the three way interaction of theory (knowing), practice (doing), and the helping relationship (being).

Figure 1.1 The Caring Triangle



The helping relationship has been developed in CPE in the humanistic tradition of person-centered caring with an emphasis on self-awareness in a disciplined, sensitive and compassionate ministry of presence with the other. This is the identity highlighted in the Specialist (Pastoral Care) DACUM document under the attitudes / attributes of the spiritual care provider: “sensitivity to the distinction between client-focused care and provider-driven care.” In the caring triangle the helping relationship retains its primacy as it coordinates and attunes theory (knowledge) and practice (skills) to a particular situation



<ul style="list-style-type: none"><li>• Principles of person-centered care</li></ul>	<ul style="list-style-type: none"><li>• Conflict management theory and practices</li><li>• Service and program development models and practices</li><li>• Organizational dynamics in large health care environments</li><li>• Constructs of “being,” “hope,” “suffering,” and “redemption.”</li><li>• Assessment / protocols appropriate to spiritual care</li></ul>
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The meaning of the contrast is not that one is superior or inferior but that there is a difference. While the Specialist (Pastoral Care) workshop participants represented a diversified group of spiritual care providers from a variety of health care settings, the Hospice Palliative Care group represented spiritual care providers in a hospice palliative care setting. It makes sense that the specificity in spiritual care setting is a main reason for the job profile also becoming more specific. As noted by Cheetham & Chivers (1998), workplace setting can make a significant difference in required competencies for any discipline.<sup>13</sup>

These factors have implications for this curriculum. The curriculum is not intended to be a comprehensive and definitive training manual covering all aspects and contexts of spiritual care. Both the Specialist (Pastoral Care) group and the HPC-SCP group described their respective workplace analysis profiles as a ‘living document’ that represented a ‘snap shot’, at a particular time, of a particular representative group of spiritual care providers in a diversified and reforming health care movement. As these DACUM workshop-generated documents come primarily from the life experience of active spiritual care providers rather than from the professional literature, they may

legitimately claim to be normative and descriptive in nature, but they are neither exhaustive nor prescriptive. They present as “living human documents.”

This is the purpose of the curriculum: to be a “living human document,” an in-process, working document welcoming the unique experiences of the various CPE centers and students. The curriculum will outline the knowledge, skill and personal / relational attributes areas as identified by their peers in spiritual care and invite students and supervisors to do their own research and rewrite the text in terms of their own specific workplace and personal challenges. In this way the curriculum will be constantly revised, refined, refitted, transformed to a “living human document.”

The curriculum covers a broad overview of what has been presently identified as essential learning areas in CPE for the professional practice of spiritual care. The resulting landscape is mapped or formatted in educational modules - concise units of study capable of integrating theoretical and practical content with the personal characteristics that shape the helping relationships in spiritual care. The curriculum reflects an integrated system of the practice of spiritual care and as such there is not a requisite or orderly sequence with a beginning and an end. CPE centers and students need to develop their own table of contents, organizing the materials along the specifics of their distinctive context of ministry and the particularities of their own questions and interests.

Since educational modules are about personal integration, educational content never stands by itself but participates in the process of experiential learning. Educational modules seek to connect the *what* and the *how* of learning. The curriculum will punctuate the presentation of contents with experiential interruptions for group discussions, role-play exercises, case studies and multimedia resources in recordings, literature and film – the common tools of CPE. These process interruptions intend to prompt and provoke the creative imagination of the student, the group interaction and the engagement of resources in the particular educational site.

The curriculum materials differentiate between *pastoral* care and *spiritual* care. There are good reasons in the current multi-faith world to go beyond the adjective *pastoral*, the traditional term rooted in the Jewish-Christian heritage of religious care. In a world that is ever more transformed into a pluralistic and global community, hospitals reflect this new reality in shifting the description of their chaplaincy services from providing *Pastoral Care* to *Spiritual and Religious Care* or simply to the all inclusive term *Spiritual Care*. Another reason for reconsidering the adequacy of the term *pastoral* is the phenomenal rise of the concept of *spirituality* in the health sciences. Similarly in the area of clinical psychology and therapy, the concept of spirituality has gained prominence. The words *soul* and *spirit* have re-entered the world of therapy, highlighting the spiritual dimension of the healing process. The term *pastoral* will be used in the curriculum when it has a specific reference such as to traditional / historical contexts or to the pastoral care and counselling literature.

The curriculum adheres to inclusive language throughout except in quotations from earlier professional literature where “man” language has been left unchanged. “God” language is used in the curriculum but placed in an inclusive and clinical context, i.e. how patients and clients experience and talk about God. Such God-talk is taken not as talk about God but as “theological self-talk.”<sup>14</sup> This is in line with the tradition of the care of souls where the troubles of the day are addressed in the “context of ultimate meanings and concerns.”<sup>15</sup> This is how the curriculum will use the term “theological” – as the spiritual depth dimension of human existence inclusive of but not confined to a theistic or particular religious context. A similar approach is present in academic institutions as they refer to “theological” studies and “theologians.” The curriculum will continue the term “theological reflection” when the word spiritual does not appear to be an adequate substitute for the manifold meanings this practice has acquired in the history of CPE.

In summary, this curriculum for basic CPE provides a map of the territory explored in the DACUM processed workshops of 2005 and 2006, and includes the clinical pastoral education objectives stated in CAPPE/ACPEP’s Handbook (202.14) on the Consultation for Admission to Advanced Education. The curriculum provides a general overview of essential dynamics in the professional practice of spiritual care. CPE programs with their students and supervisors will continue the work of the curriculum as they construct specific road maps of how best to navigate their way, searching out novel pathways in the ever changing, often uncharted landscape called *spiritual care*.

### **How this core curriculum can be utilized**

#### **Suggested lesson plans for didactic sessions**

It could be said, a la Donald Schön (1983)<sup>16</sup>, Graham Cheetham and Geoff Chivers (1998)<sup>13</sup>, that the ultimate goal of CPE is to facilitate the emergence of a *reflective (and competent) practitioner* who is an *artful doer*, able to integrate the various domains of competency in the delivery of care in a sensitive, sophisticated and effective way that will address the *messes* of real life practice. Each chapter of this core curriculum is intended, in addition to the exploration of theory, to suggest ways for learners to acquire and integrate the specific competencies deemed requisite by members of the Association for the practice of spiritual care.

The literature concerning competence in the professions generally recognizes three principal domains of competence: *Knowledge* (cognitive), *Skills* (functional) and *Attitudes / Attributes* (personal / behavioral). To these three classic KSAs, Cheetham and Chivers (1998: 268) also suggest the inclusion of a *values / ethical* domain,<sup>13</sup> an area that is both culturally timely and highly relevant to the practice of spiritual care. Suggested lesson plans, where relevant, accompany each chapter and are intended to support the development of professional competence through a variety of reflective, case based and interactive exercises suitable to the small group context of CPE. Lesson plans are intended for the guidance of Educators and not as rigid instructions or limitations of the way topics can be taught / learned.

There is no single standard for the design of lesson plans. Typically, lesson plans include:

- specific instructional notes (e.g. outline of topics and teaching methods)
- clearly defined learning goals and objectives
- suggested questions for discussion (e.g. key definitions and concepts)
- opportunities for theological / philosophical reflection in a manner appropriate to the discernment and expression of learner perspectives, the cultivation of understanding and tolerance of the views of peers, and the cultivation of an ecumenical / multi-faith perspective suitable for the clinical context
- illustrations or relevant case studies, verbatim reports, etc. to support the application of theory and methods to a clinical setting
- relevant personal and / or group exercises suitable for individual and interactive engagement with the content

By way of example, Cooper, Temple-Jones and Associates (2006), attach a 5-part lesson plan from Chapter 13 (Module 9) – *Ethics at the End-of-Life* -- from their core curricular package for Hospice Palliative Care spiritual care providers. <sup>\*, 5</sup>

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### **Facilitating Intentional Learning in the Four Domains of Competence:**

Perhaps, it goes without saying that different supervisors and programs will offer different learning opportunities. As Cooper, Temple-Jones and Associates (2006:37) note:

The literature of CPE tends to reveal that the particular training and interests of the supervisor do impact the educational experience. One analysis (O'Connor, 1998)<sup>17</sup> of 298 texts written on the subject of clinical supervision, demonstrated an emphasis upon a social science approach in a majority of texts (48%), followed by a hermeneutical (theological) approach (34%), a special interest (e.g. feminist, etc.) approach (12%) and a smaller variety of others (6%).<sup>5</sup>

Learners, as well, will come to CPE with different prior learning and learning needs. Individual learning assessment, and the mutual establishment of individual learning goals, leads to more engaged adult learning and is good practice in CPE.

Thus, CPE may offer a wide range of learning opportunities. In a core curriculum, however, a major focus is to ensure that subject matter generally thought critical for future professional development be well covered. While many learners will undertake CPE only as part of a First Basic unit requirement for theological education, this curriculum is intended to provide a framework for the formation of learners who may choose to go on to Advanced Training and possibly to certify as Specialists within our Association.

**(1) Knowledge Domain: Theological reflection and personality theory development:**

There is a necessary emphasis, therefore, on the acquisition of knowledge areas particularly important to the practice of spiritual care, specifically theology and psychology. In CPE, these two subjects are more specifically expressed as the *ability to reflect theologically upon experience* and the *ability to understand oneself and others through cultivation of a theory of personality* with which one is comfortable. CPE programs have not always provided a balanced emphasis on these two significant domains. CPE learners are typically not formally qualified theologians; however, some theological training is a common and desirable pre-requisite for CPE. A substantial challenge for university trained CPE learners is to understand and become comfortable with the ways in which theology is applied in the clinical context. The essential difference is that expressions of theological doctrine are generally found not to be helpful in the care of persons whereas insightful theological reflection on experience can be of great value. Indeed, theological / philosophical reflection is a core competency requisite for the skillful practice of spiritual care.

In CPE, learners are encouraged to identify and give appropriate expression to their own beliefs, and specific religious and cultural heritage as one of the foundations of self-aware and reflective practice. One aspect of this is discerning the ways in which such individual perspectives can either enhance or negatively influence the care that is offered to clients. Another is observing the challenge to individual beliefs that can arise within peer relationships. Growing theological competence is demonstrated by the ability

to articulate this reflective awareness in both group and clinical work. This is evidenced by the various written reports and evaluations typically utilized in CPE.

Because of their great utility in helping relationships, familiarity with a variety of psychological systems and their related methods can be of help in training for ministries of spiritual care. Again, CPE students are typically not qualified psychologists, but commonly have some prior education in the human sciences that can be helpful in their subsequent training. Learners are encouraged to identify at least one psychological system, with which they feel comfortable, and a set of related methods that prove useful to them in their own self-awareness and in the care of persons. Educators commonly provide an introduction to one or more such systems in the course of a unit of CPE as an aid to helping learners to understand the dynamics present in both caring relationships and peer interactions. Learners' acquisition of competency in this area will be demonstrated by their ability to make use of such knowledge and methods in both group and clinical work. This is evidenced by the various written reports and evaluations typically utilized in CPE.

The integration of these two areas into a coherent and clinically useful perspective is one of the requirements for certification as a Specialist. It is clearly a higher order or integrative competency that might be best described as a *meta-competency*.<sup>18</sup> This developing integration and its application to the care of persons is expected to mature as one progresses through Advanced training and be fully demonstrable by the time a candidate presents for certification as a Specialist. Some suggestions for program design:

- the usual instruments for evaluation in CPE (e.g. critical incident reports, peer case studies, verbatim reports / case work reviews) can all include a focus section on theological reflection and relevant psychological theory
- learners (at the Advanced level, in particular) can be encouraged to write and present to their peers, or clinical colleagues, a thoroughly reflective case study demonstrating such integration (*A suitable case study model may be found in the certification requirements for Specialist and has been posted by Cooper in the Supervisor's resource section of the CAPPE/ACPEP web site.*)

**(2) Skills / Behavioral Domain: Development through supervised practice exercises:**

CPE Educators routinely provide learners with opportunities to cultivate a wide range of skills relevant to the theories and methods of CPE. These occur within the context of small group and individual supervision of case work, and peer encounters. A skills-based approach considers such fairly basic activities, such as:

- providing instruction and cultivating attending / active listening skills through
  - reviewing verbatim dialogue with clients
  - facilitation of effective ad-hoc communications (in the moment) in peer interactions
- use of role play in group to unpack and demonstrate behaviors, and to develop intentionality and flexibility in inter-personal relationships

- use of observation rooms or video-taping technology to view “live” client work or group work (with appropriate consents) in order to facilitate post-hoc reflection and learning
- providing instruction on institutional charting standards, requiring learners to practice charting until standards are satisfactorily achieved, and follow-up with periodic chart audits to maintain best practice.

**(3) Attitudes / Attributes Domain: Cultivation of professional manner and team-based interactions**

One of the hallmarks of competent professionalism is seen in the manner and attitude of the caregiver towards the client and towards fellow team members. We all want to be caregivers who demonstrate compassion, an appreciation for holistic approaches, a client-focused approach to decision-making and a collaborative, team-based model of care. Learners can begin to acquire these characteristics through such means as:

- use of the case study method to critically articulate the professional values displayed and discussion of optimal values, with particular consideration of the nature of the client-caregiver relationship
- use of learner verbatim work with inter-disciplinary team members (e.g. consults, differences of opinion, role conflicts)
- small group discussion of important medical / interdisciplinary texts in understanding the nature of suffering and the development of holistic and compassionate approaches to spiritual companionship and the amelioration of suffering (e.g. Cassell, Eric [1994 ] The Nature of Suffering and the Goals of

Medicine; Kearney, Michael [1996] Mortally Wounded, and [2000] A Place of Healing; Yoder, Greg [2005] Companioning the Dying: A Soulful Guide for Caregivers.)

**(4) Values / Ethical Domain:**

A very significant challenge to the professionalism of persons in ministry in recent decades has been offered by the unethical and illegal behavior of a few. Educators of persons planning a career in institutional ministry are particularly mindful of the risks to vulnerable client populations and to institutions that may arise from inadequate ethical formation in training. Some suggestions for enhancing values / ethical competency might include:

- case-based seminars on professional ethics – particularly, the CAPPE/ACPEP Ethics Module taught by the Regional Admitting Chair or similar leaders in the Association
- case-based seminars on medical ethics, taught by suitable scholars and / or members of the inter-disciplinary team
- building ethical reflection into every written report of client work
- opportunities that may arise to expose learners to ethical review processes in institutions

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<sup>1</sup> The debate whether professional chaplaincy and clinical pastoral education should become more scientific is a contentious one:

• *NO! THEY WILL LOSE THEIR VOICE JUST WHEN THEY NEED IT MOST.* Clinical pastoral education and health care chaplaincy need to pray, “Lead us not into temptation!” That prayer may help them resist health care reform pressures sorely

tempting them to become scientific disciplines. If they give in to the temptation, they will become minor scientifically oriented professionals in the eyes of all concerned—and those in need of spiritual care don't need scientific professionals. Clinical pastoral education and chaplaincy, like all of ministry, is an art and not a science....

- **YES! THEY WILL FIND THEIR VOICE JUST WHEN THEY NEED IT MOST.**

Clinical pastoral education and health care chaplaincy need to pray, “Lead us not into temptation!” Health care reform offers a significant opportunity to improve ministry by using scientific tools...As technology becomes more dominant and business perspectives manage health care, clinical pastoral education and chaplaincy are called to support those experiencing illness, despair, and death by presenting the message of the great religious traditions. They cannot expect to do that by holding themselves aloof, outside the circle of other professionals who seek to help...

Taken from the preface in Larry VandeCreek, *Professional Chaplaincy and Clinical Pastoral Education – Should Become More Scientific: Yes and No*. 2002, New York: Haworth Pastoral Press.

<sup>2</sup> Cooper, D., (2006). “Where is CAPPE/ACPEP Heading? Documenting the Journey and Debating the Issues in the Development of a Profession of Spiritual Care,” in *The Spiritual Care Giver’s Guide*, 62-77. (CAPPESWONT, 2008)

<sup>3</sup> See CAPPE/ACPEP website at [www.cappe.org](http://www.cappe.org)

<sup>4</sup> See CAPPE/ACPEP Handbook at <http://www.cappe.org/handbook/index.html>

<sup>5</sup> Cooper, D, Temple-Jones, J. & Associates. (2006). Developing spiritual care capacity for hospice palliative care: A Canadian curricular resource (ver. 1.0). Edmonton: The Pallium Project.

<sup>6</sup> The DACUM approach for educational program development has been in use for the last 35 years in North America. It brings together people who actually are front-line staff and supervisors for a systematic, analytic and descriptive process of gathering and analyzing tasks required in specific role functions. As such the resulting profile becomes useful if not essential in designing educational programs and professional development. See this DACUM Chart on the Curriculum Project page at

<http://www.cappe.org/dacum/index.html>

<sup>7</sup> See this DACUM Chart on the Curriculum Project page at

<http://www.cappe.org/dacum/index.html>

<sup>8</sup> The DACUM Workshop, 2006, (see specifically the *DACUM JOB PROFILE*, p.23) and THE PALLIUM PROJECT, 2005, (see specifically Appendix A, *CHARACTERISTICS*, p.10, & *KNOWLEDGE*, p.11) are available on the CAPPE/ACPEP website through the Education Standards Commission.

<sup>9</sup> Powell, R. (1975). *Fifty Years of Learning – Through Supervised Encounter with Living Human Documents*. New York: The American Association for Clinical Pastoral Education.

<sup>10</sup> For Boisen’s autobiography see *Out of the depths – An autobiographical study of mental disorder and religious experience*. 1960. New York: Harper & Brothers. The Cabot-Boisen split was reflected in the formation of two groups in 1932 over the meaning of mental illness and the role of the chaplain. The Boston group followed the line of Cabot, while the New York group sided with Boisen. The conflict is described in greater

depth in Allison Stokes book *Ministry after Freud*. (1985). New York: The Pilgrims Press.

<sup>11</sup> There are strong arguments for such an assessment:

- The first two focus areas relate to contents: what to do, and what to know. The last focus, *what to be*, signals a change from contents to process, and from the person as a separate entity to the person in relationship. This relational context brings a new perspective of the interpersonal process of spiritual care and healing.
- The *what to do* and *what to know* emphasis easily becomes problem and sickness oriented. The *what to be* philosophy concentrates on well-being rather than pathology.

<sup>12</sup> The same could be illustrated by comparing the areas of skills or personal characteristics/attributes in the two respective documents.

<sup>13</sup> Cheetham, G. & Chivers, G. (1998). The reflective (and competent) practitioner: a model of professional competence that seeks to harmonize the reflective practitioner and competence-based approaches. *Journal of European industrial training*, 22 (7), 267-276, 273.

<sup>14</sup> Peter L. VanKatwyk. "God Talk in Therapeutic Conversations." *The Journal of Pastoral Care and Counseling*. 2008. Vol.62, Nos.1-2.

<sup>15</sup> Clebsch & Jaekle. 1975. *Pastoral Care in Historical Perspective*. NJ: Prentice Hall, p.4.

<sup>16</sup> Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. London: Maurice Temple Smith.

<sup>17</sup> O'Connor, T. St. J. (1998). *Clinical pastoral supervision and the theology of Charles Gerkin*. Waterloo, Ontario: Wilfred Laurier University Press, 23ff.

<sup>18</sup> Cheetham & Chivers (1998: 268); and Cheetham, G., & Chivers, G. E. (2005). *Professions, competence and informal learning*. Cheltenham, UK: Edward Elgar. ISBN 1-84376-408-3 (pp. 70, 109).