Self Regional Healthcare
Greenwood, SC

Clinical Pastoral Education
Student Handbook

Level I and level II CPE

Rev. Dr. John Carter Thomas, M.Div.,D.Min.
ACPE Certified Educator
Director of the Spiritual Care & Clinical Pastoral Education (CPE) Department

Association for Clinical Pastoral Education, Inc.
55 Ivan Allen Jr. Boulevard, Suite 835
Atlanta, GA 30308
(404) 320-1472
Fax: (404) 320-0849
www.acpe.edu

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Appendix A: Contracts

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Student Handbook Statement of Purpose

This student handbook is a tool designed to help orient you as a student to the Clinical Pastoral Education (CPE) process. The purpose of this handbook is to familiarize you with the major aspects of the program and the clinical setting(s), which will serve as a context for your learning. This handbook also serves as a document to partially fulfill the requirements of ACPE accreditation review.

Note: This document is not to be considered a contract.

Student Handbook/Annual Notice Acknowledgment Form

This is to acknowledge receipt of the Clinical Pastoral Education Student Handbook. I understand that it is my responsibility to read this handbook and abide by its policies.

The Student Handbook is provided to acquaint you with our policies, benefits and responsibilities. It does not constitute a contract for employment in whole or part and may be changed at any time. The Spiritual Care & Clinical Pastoral Education (CPE) Department will notify you of any such changes.

Students own information about them and must know what information is being collected and how it is being used. A student's information cannot be shared without their written permission. Every ACPE center must publicize an **Annual Notice (see pages 47-48)**. Student's signature below will also note that they acknowledge Self Regional Healthcare's CPE Annual Notice within the handbook.

_____

CPE Student Signature

_____

Date

Self Regional Healthcare CPE
Accreditation Statement

The CPE program of Self Regional Healthcare is accredited through the Association for Clinical Pastoral Education, Inc. (ACPE). Information concerning ACPE may be obtained at the following address, phone number or website:

Association for Clinical Pastoral Education, Inc.
55 Ivan Allen Jr. Boulevard, Suite 835
Atlanta, GA 30308
Phone: (404) 320-1472
Fax: (404) 320-0849
www.acpe.edu

Self Regional Healthcare
Mission and Vision Statements

Mission
Our hearts, hands and minds are leading our communities to better health.

Vision
The care, experience and value we provide will be superior for all the communities we are entrusted to serve.

Our Purpose
Always create the best experience.

Self Regional Healthcare

Spiritual Care Department
Vision Statement

To provide the highest quality of Pastoral Ministry to everyone we serve: individuals, families, churches and organizations.

Dear CPE Resident,

Welcome to this new experience as a chaplain resident or intern in the Clinical Pastoral Education Program at Self Regional HealthCare. You have embarked on a new journey of self- exploration and ministry supervision that focuses on increased pastoral competence and theological reflection. It is my hope that you will learn the art of spiritual care to persons in crisis through our Action-Reflection-Action model of education. I assume you applied to CPE because you are open to learning new things about yourself, ministry, and your relationship with others and with God. Therefore, you are invited to take risks and push beyond your comfort zone. Learning is never achieved by being complacent. Learning happens when you choose to try new things and new ways of understanding. Learning also takes place best in a community of other learners. CPE is process-education that unfolds in the context of a matrix of various relationships. Your peers, staff chaplains, patients and their families, medical personnel and hospital administration are all parts of the web of relating that will contribute to your learning experience. Endeavor to learn from these relationships.

As the Certified Educator (CE), I am responsible for ensuring you receive a quality CPE experience during your residency. This handbook explains the various aspects of the program and describes in detail your rights and responsibilities as a student. Please take the time to read the handbook carefully and feel free to ask questions for clarification. I am available to support your learning and growth as a skilled practitioner of spiritual care.

Again, welcome to the CPE experience at Self Regional. It is my prayer that you will become all that God has called you to be.

Faithfully,

John C. Thomas
Dr. John Carter Thomas, M.Div., D.Min.
ACPE Certified Educator

SELF REGIONAL
HEALTHCARE

Dear CPE Student:

As the administrator responsible for the Pastoral Services Department of Self Regional Healthcare, I welcome you to your Clinical Pastoral Education experience. I pledge continued support on behalf of Self Regional Healthcare to this most worthy of efforts. The impact of CPE is considerable for your education and ministry formation as well as to the emotional and spiritual health of our patients, families and staff. We believe that in order to treat the whole person, it is essential that we address the patient's spiritual needs as well. As a CPE student chaplain, you will be involved in the provision of a broad range of pastoral care from a ministry of presence and pastoral support to more formal or ritualistic care such as administering the sacraments, worship, support groups and memorial services. You will also be involved in educational sessions that will strengthen your competence and identity as a minister. I pray God's blessing on you as you minister and as you learn.

Very Respectfully,

M. Michael Dixon

M. Michael Dixon
Vice President, Human Resources

SELF REGIONAL
HEALTHCARE

Dear Clinical Pastoral Education (CPE) Students:

On behalf of our entire staff, I take this opportunity to welcome each of you as a Clinical Pastoral Education student to Self Regional Healthcare.

My hope is that this unit will allow you the opportunity to mature in your faith, to grow in your ability to form interpersonal relationships. In addition, may this unit allow you to grow in your ability to intervene in crisis, to facilitate ethical decision making, to lead in worship and to allow our patients to experience God and to mobilize their spiritual resources.

Again, we are pleased that you are here to join us in providing quality spiritual care to our patients, families and staff.

There are many resources here to assist you in you process that I hope you will make use of as you pursue your learning. Most of all please be reminded that it is our patients, their families and our staff that we are here to serve. May God bless you as you respond to their needs for spiritual support and care.

Congratulations upon your selection and I look forward to meeting and working with you.

Sincerely,

James A. Pfeiffer
President and Chief Executive Officer

1325 Spring Street • Greenwood, South Carolina 29646-3875 • 864-725-4111

SPIRITUAL CARE
and
CLINICAL PASTORAL EDUCATION STAFF

ACPE Standard 3 – uses persons authorized by ACPE to supervise students in group and individual formats

Reverend Dr. John Carter Thomas - *Certified Educator (CE), ACPE Director of the Spiritual Care & Clinical Pastoral Education (CPE) Department/ACPE Certified Educator*

Rev. Dr. John C. Thomas, Jr. received the Bachelor of Arts (BA) degree from Oral Roberts University in 1985. He received the Master of Divinity (MDiv) degree from Phillips Graduate Theological Seminary in 1991 and the Doctor of Ministry (DMin) degree from Phillips Theological Seminary in 2000. He was ordained in 1994 by National Baptist Convention, USA, Inc., and subsequently endorsed for ACPE Supervisory training. In 2000, he was certified as an ACPE supervisor with the Association for Clinical Pastoral Education, Inc. He served 18 years as Associate Dean for Contextual Education and Associate Professor of Practical Theology at Phillips Theological Seminary in Tulsa, Oklahoma. His wife Alexis, and son, John III, all live in Greenwood, SC. Hobbies include writing, watching movies, and having family outings.

Reverend Henry Anderson - *Staff Chaplain, Community Clergy Group Resource Person*

Rev. Henry Anderson was born in Albany GA number 9 of 12 children. He grew up in Miami Fla and came to South Carolina via the Air force and was stationed at Shaw AFB SC. It was there that he met his wife of 28 years Sheryl. They are members of Zion Hill Baptist Church where Henry is an associate minister. In 2007 Henry was licensed to preach and entered the ministry. Henry is a graduate of Grand Canyon University with a Bachelor's Degree in Christian Studies, Masters of Divinity with an emphasis on Christian Counseling from Liberty University. After completing 2 units of Clinical Pastoral Education as an intern in 2012 at Spartanburg Regional Hospital Henry entered into the resident program in 2014 at Self Regional. After completing the residency Henry joined the hospital as a staff chaplain. Henry and Sheryl reside in Clinton SC. Henry's free time is spent on his boat fishing with his wife and bow hunting.

Reverend Charles Stevens - *Staff Chaplain**,** Scheduling*

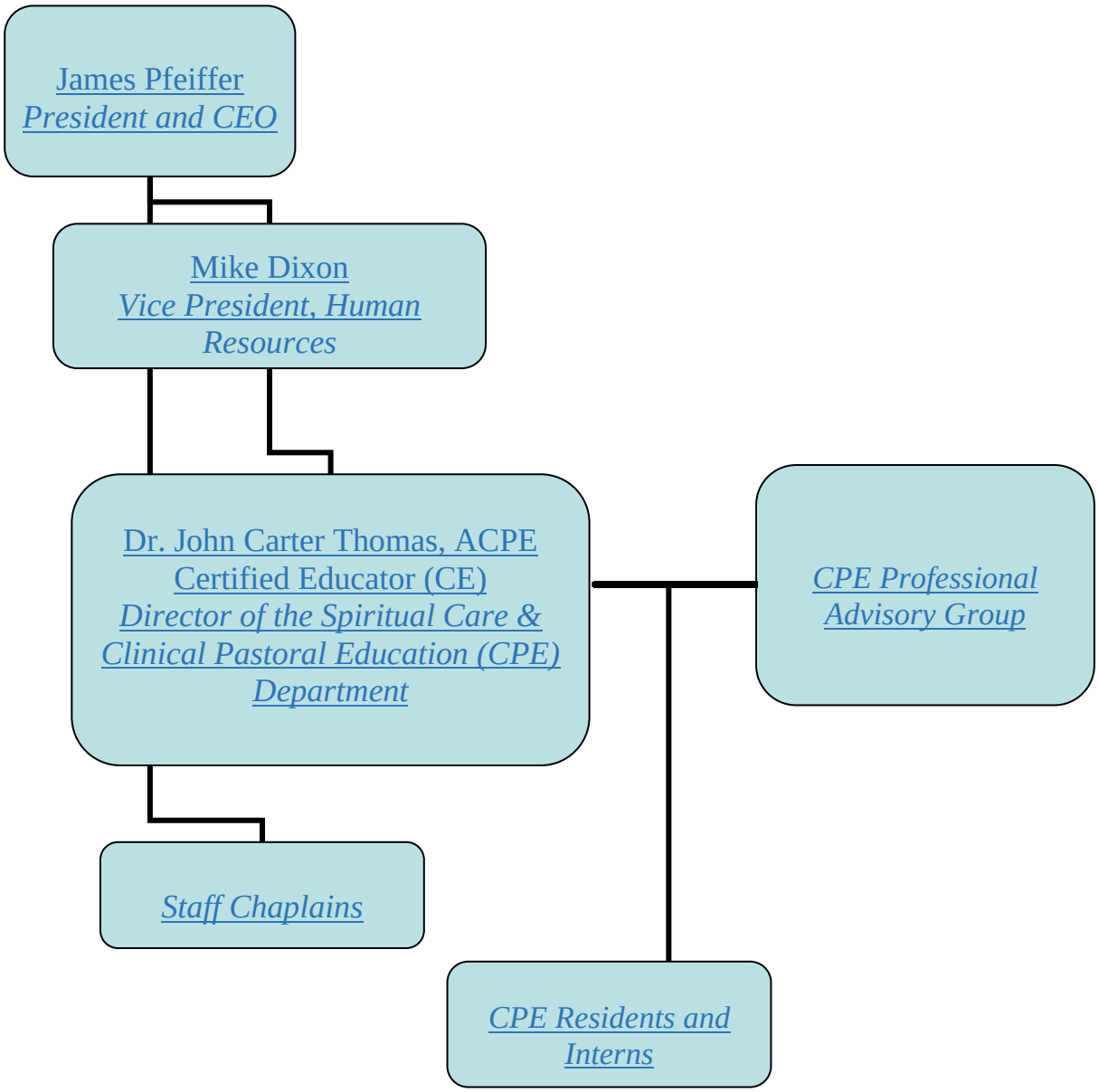
Rev. Craig Stevens has been with Self Regional Healthcare since 2012. He was a CPE intern in the summer of 2012, returned in 2013 to complete a CPE residency, and has been with the hospital as a staff chaplain ever since. Originally from Inman, SC, Craig met his wife, Susan, while they were members of the Clemson University Tiger Band. He earned a Bachelor of Science in Marketing at Clemson. Craig was in the building supply industry for several years before feeling called to ministry. He received his Master of Divinity with emphasis in Pastoral Care and Counseling from the M. Christopher White School of Divinity at Gardner-Webb University. At his 2013 graduation, Craig was awarded the Donald E. Cook Academic Award, the highest academic award given by the seminary. He was ordained to the gospel ministry by his home church of Inman First Baptist in Inman, SC and is endorsed as a chaplain by the Cooperative Baptist Fellowship. Craig currently resides in Saluda, SC with his wife and three children. They are currently members of Richland Springs Baptist Church in Ward, SC. When Craig is not attending his kids' ball games, dance recitals, school musicals, and color guard competitions, he and his family enjoy camping in their RV and returning to Clemson for ball games.

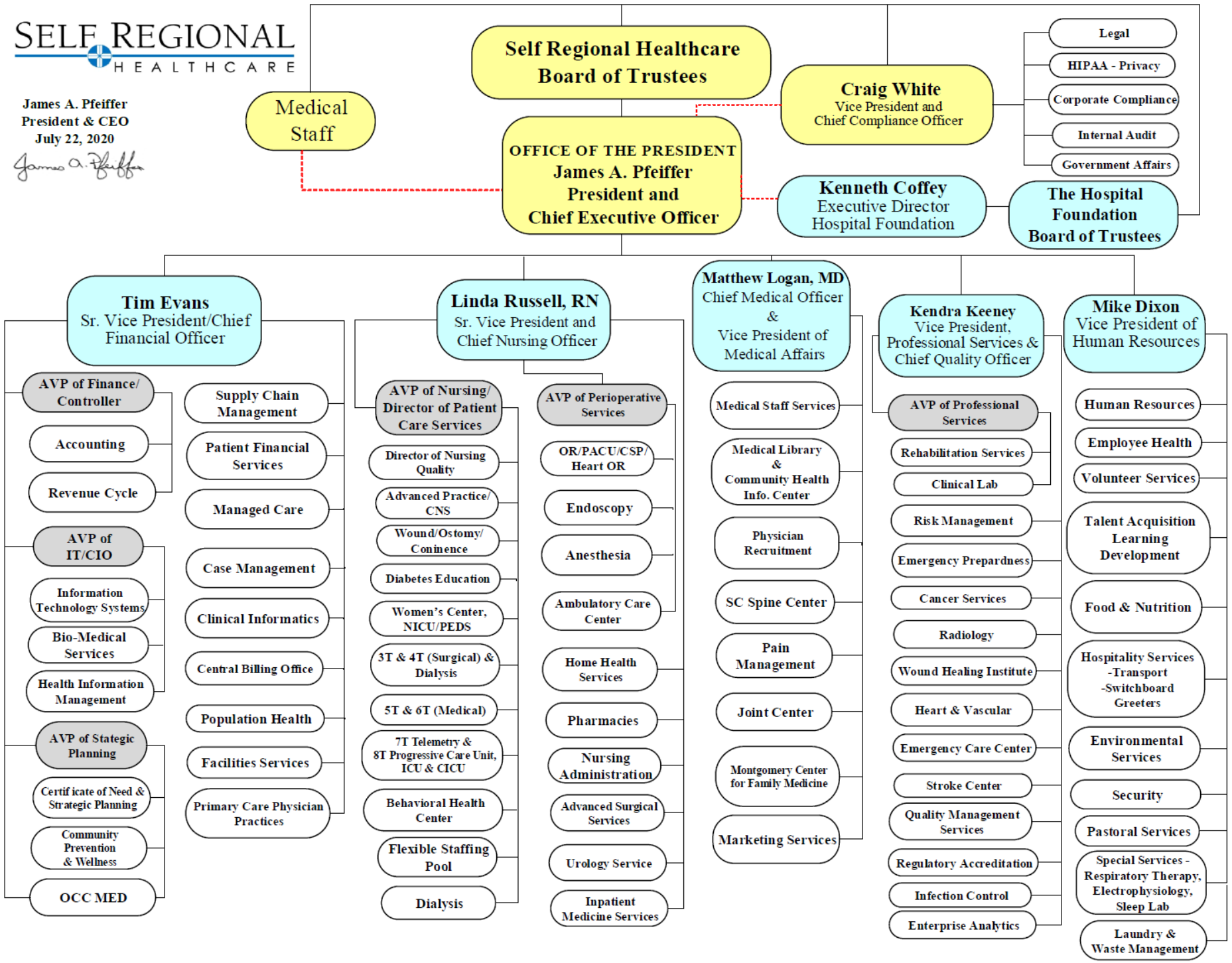
Jalesa Price - *Office Secretary, Phone: 864-725-4158*

Jalesa was born in Columbia, SC, but soon became a native of Greenwood, SC. She graduated from Emerald High School in 2014. By 2018, she had become a summa cum laude graduate of Allen University located in Columbia, SC where she received a BA in Music with a concentration in voice. While there, she received an award for having the highest GPA in the music department. Throughout her four years at Allen, Jalesa was a part of the Concert Choir and soon joined the Gospel Choir where she was vice president, and president. While living on campus, she also became a Residential Assistant from her sophomore year up until her senior year. She is married and attends worship with her husband where they both minister their gifts of music. Her favorite food is rice, but her favorite meal would be tilapia with rice. Ministering in song is not a hobby, but a gift she loves to render whenever she can.

CPE Residents:

Self Regional Organizational Chart




SELF REGIONAL HEALTHCARE
James A. Pfeiffer
President & CEO
July 22, 2020
Self Regional Healthcare Board of Trustees
Medical Staff
OFFICE OF THE PRESIDENT
James A. Pfeiffer
President and
Chief Executive Officer
Craig White
Vice President and
Chief Compliance Officer
Legal
HIPAA - Privacy
Corporate Compliance
Internal Audit
Government Affairs
Kenneth Coffey
Executive Director
Hospital Foundation
The Hospital Foundation Board of Trustees
Tim Evans
Sr. Vice President/Chief Financial Officer
AVP of Finance/ Controller
Accounting
Revenue Cycle
AVP of IT/CIO
Information Technology Systems
Bio-Medical Services
Health Information Management
AVP of Stategic Planning
Certif icate of Need & Strategic Planning
Community Prevention & Wellness
OCC MED
Supply Chain Management
Patient Financial Services
Managed Care
Case Management
Clinical Informatics
Central Billing Office
Population Health
Facilities Services
Primary Care Physician Practices
Linda Russell, RN
Sr. Vice President and Chief Nursing Officer
AVP of Nursing/ Director of Patient Care Services
Director of Nursing Quality
Advanced Practice/ CNS
Wound/Ostomy/ Coninence
Diabetes Education
Women's Center, NICU/PEDS
3T & 4T (Surgical) & Dialysis
5T & 6T (Medical)
7T Telemetry & 8T Progressive Care Unit, ICU & CICU
Behavioral Health Center
Flexible Staffing Pool
Dialysis
AVP of Perioperative Services
OR/PACU/CSP/ Heart OR
Endoscopy
Anesthesia
Ambulatory Care Center
Home Health Services
Pharmacies
Nursing Administration
Advanced Surgical Services
Urology Service
Inpatient Medicine Services
Matthew Logan, MD
Chief Medical Officer &
Vice President of Medical Affairs
Medical Staff Services
Medical Library & Community Health Info. Center
Physician Recruitment
SC Spine Center
Pain Management
Joint Center
Montgomery Center for Family Medicine
Marketing Services
Kendra Keeney
Vice President, Professional Services & Chief Quality Officer
AVP of Professional Services
Rehabilitation Services
Clinical Lab
Risk Management
Emergency Prepardness
Cancer Services
Radiology
Wound Healing Institute
Heart & Vascular
Emergency Care Center
Stroke Center
Quality Management Services
Regulatory Accreditation
Infection Control
Enterprise Analytics
Mike Dixon
Vice President of Human Resources
Human Resources
Employee Health
Volunteer Services
Talent Acquisition Learning Development
Food & Nutrition
Hospitality Services -Transport -Switchboard Greeters
Environmental Services
Security
Pastoral Services
Special Services - Respiratory Therapy, Electrophysiology, Sleep Lab
Laundry & Waste Management

SELF REGIONAL HEALTHCARE
and
CLINICAL PASTORAL EDUCATION

A BRIEF STORY

ACPE STANDARD 1 – a population that provides students with opportunities for ministry and clinical pastoral education

Self Regional Healthcare

The late James C. Self, founder of Greenwood Mills, envisioned a modern hospital for the community of Greenwood. To carry out that dream, he established The Self Foundation in 1942. Today, Self Regional Healthcare (opened in 1951) operates as one of the state's finest hospitals, an ongoing tribute to James C. Self's vision.

On his death in 1955, James C. Self was succeeded as Chairman of the Foundation by his only child Jim Self. Under Jim Self's leadership the hospital remained true to the principles established by his father. He also sought to meet the new challenges brought by rapid social and economic change in South Carolina, a desperately poor state. The hospital focused on building much-needed infrastructure in health care and education and improving the quality of life in Greenwood County. Realizing the huge potential in genetics research to cure birth defects and mental retardation in children, Jim Self was the driving force in establishing the Greenwood Genetics Center, now a world class research facility dedicated to the very same.

In 1996, Jim Self (1919-1998) passed control of the Foundation to his children with the election of his daughter, Virginia Preston Self, as chair. Under the leadership of the third generation, the Foundation focused its efforts on school readiness, community wellness, intellectual and social development of youth, and cultural opportunities.

Self Regional Healthcare is a licensed, fully accredited 358-bed hospital which serves as a medical referral center for seven counties. Almost half of the hospital's patients come from outside Greenwood County. The hospital is a not-for-profit facility governed by a Board of Trustees appointed by the Governor of South Carolina.

As a regional referral center, Self Regional offers a wide range of general and specialized diagnostic and treatment services. The hospital features specialty centers in a number of areas, including peripheral vascular surgery, neurosurgery, alcohol and drug treatment, cancer care, heart care, maternity care, and outpatient services.

Other services include a 24-hour level III emergency center, intensive and coronary care units, home health, a neonatal intensive care unit offering the highest level of infant intensive care, a cardiac rehabilitation program, inpatient pharmacy, respiratory therapy, physical therapy and occupational therapy. Self Regional offers the most modern imaging technology including MRI, CT scan, PET-CT scan, ultrasound, nuclear medicine and cardiac catheterization.

Of significant importance to the community is Self Regional's role as a teaching hospital. The Montgomery Center for Family Medicine offers a three-year post-graduate medical residency program in family medicine and a sports medicine fellowship through the Statewide Family Practice Program and the Medical University of South Carolina.

The hospital features a medical staff of about 200 physicians. Nearly every major medical and surgical specialty is represented on the staff. Self Regional is fully accredited by the DNV Accreditation and quality patient care is the institution's highest priority.

Self Regional Healthcare Spiritual Care Department

The key personalities who guided our programs development are:

- The late Reverend Dr. William "Bill" Eubanks was the first full-time chaplain of the hospital. Although Dr. Eubanks was not an ACPE Supervisor, upon his retirement he encouraged the Hospital Administration to hire an ACPE supervisor as his replacement and begin Clinical Pastoral Education in the Greenwood area.

- The Reverend Dr. Earl Troglin, an ACPE supervisor, became Self's second Spiritual Care Director in 1990. He served in this position until his retirement in 2005. During Dr. Troglin's tenure, he succeeded in Self Regional becoming a fully accredited ACPE center. He then began recruiting students for the CPE program. During his tenure, Rev. Troglin supervised hundreds of CPE students through the extended and summer programs that he established. He also put together a strong CPE Professional Advisory Group made up of Clergy and Laity from the Greenwood areas who meet regularly offering guidance for the CPE program.

- The Reverend Stephen A. Lemons became the third Director of the Spiritual Care Department in October, 2005. He pledged to continue the CPE program with the same passion that has been evident here at Self since its beginning. In June 2007, the first CPE residency program began with 5 full-time students.

After completing a residency here at Self, The Reverend Dr. Jay Collins was hired as Staff Chaplain in 2000. During his five-year tenure, Jay worked closely with the Clinical Pastoral Education Program. Jay and Earl were instrumental in establishing 13 part-time Associate Chaplain positions. The Associate Chaplains help us to provide continuous 24- hour, year-round Chaplaincy coverage of the hospital.

Self Regional Healthcare has moved forward with some gusto to define ways in which they will work together to help shape the future of healthcare in the Greenwood area. The hospital leadership has kept its promises to the community and continues to pursue its visions of superior patient care, spiritual health, community health, medical education and clinical research, and financial well-being.

The Reverend Leslie Young-Ward served as the ACPE Certified Educator until her retirement in 2018. Dr. John C. Thomas is the current ACPE Certified Educator (Supervisor). He started at Self Regional on January 7, 2019 after completing a career as a seminary professor in Oklahoma.

Educational Resources

SRH ensures that supervision and program management will always be conducted by a person authorized by ACPE (Standard 3).

The Rev. Dr. John C. Thomas, Jr. received the Bachelor of Arts (BA) degree from Oral Roberts University in 1985. He received the Master of Divinity (MDiv) degree from Phillips Graduate Theological Seminary in 1991 and the Doctor of Ministry (DMin) degree from Phillips Theological Seminary in 2000. He was ordained in 1994 by National Baptist Convention, USA, Inc., and subsequently endorsed for ACPE Supervisory training. In 2000, he was certified as an ACPE supervisor with the Association for Clinical Pastoral Education, Inc. He served 18 years as Associate Dean for Contextual Education and Associate Professor of Practical Theology at Phillips Theological Seminary in Tulsa, Oklahoma.

Contact Information: Rev. Dr. John C. Thomas, Jr., 864.725.4158 Email: john.thomas@selfregional.org

Professional Advisory Group

The Professional Advisory Group (PAG) is made up of interdisciplinary professional resource persons who are knowledgeable about CPE. The PAG meets at regular intervals to provide advice and consultation on Clinical Pastoral Education program planning, development, and program evaluation. The PAG functions in order to

- Support SRH CPE students as they develop a new awareness of themselves as person/pastor and of the needs of those they serve
- Support SRH faculty in adhering to ACPE standards
- Facilitate communication and cooperation between CPE students, faculty, and ministry settings
- Provide SRH students with opportunities for continuing education
- Provide CPE program evaluation through conducting application interviews, exit interviews for exiting students, and actively participating

Welcome Letter from the Professional Advisory Group

Welcome to CPE at Self Regional Healthcare from the Professional Advisory Group (PAG). We are a group of people enlisted by the CPE Certified Educator at this center to assist with the CPE program. We provide consultation, support, critique, and challenge to the CPE Certified Educator. Occasionally, we are called upon to teach didactics and various other training events. In addition, we serve as facilitators in the CPE Complaint Procedure which is described in this handbook. As outlined in the ACPE standards, the grievance procedure encourages persons to work out concerns or grievances informally, face to face, and in a spirit of collegiality and mutual respect. If informal discussion and pastoral communications do not resolve differences, you may register a complaint individually or as a group in accordance with the Professional Ethics Commission Manual, a copy of which is located in the Spiritual Care Department or can be downloaded from the ACPE website, www.acpe.edu. You may access additional local resources in your attempts to gain resolution to the issue or to get counsel to the ACPE Formal Resolution Process. Those resources are:

- Your Certified Educator (CE)
- CPE Professional Advisory Group members
- Vice President of Human Resources

As we seek further excellence in the program, the CE has arranged a facilitated group feedback session at the end of each unit as well as individual exit interviews in which the CE is not present or involved. The PAG members who conduct these meetings are eager to hear your perspectives and to engage in conversations regarding global trends, your CPE experience, and your perspectives regarding CPE. Like all conversations within the CPE program, the PAG honors confidentiality. Our goal as the PAG is to support CPE students as we all work in collaboration with Self Regional Healthcare.

Members of the PAG:

Dr. Robert Bell, Retired
Professor of Pastoral Care
Erskine Theological Seminary
PO Box 338
Due West, SC 29636
864-379-6571

Mike Dixon, Vice President
Human Resources
1325 Spring Street
Greenwood, SC 29646
864-725-4118

Larry Middleton, RN, Behavioral Health Unit
1325 Spring Street
Greenwood, SC 29646
864-725-4397

Belinda Nicholson, Director Case Management
1325 Spring Street
Greenwood, SC 29646
864-725-4121

Dr. Bobby Morris, Seminary Professor
And Pastor
651 Turner Road
Prosperity, SC 29127
803-271-2777

Dr. Kyle Hite, Pastor
First Presbyterian Church
108 East Cambridge Avenue
Greenwood, SC 29646
864-229-5814

Self Regional HealthCare
Clinical Pastoral Education Program
2020 Residency Unit Dates

First Unit: January 7, 2020 – March 10, 2020

Second Unit: March 31, 2020 – June 2, 2020

Third Unit: June 23, 2020 – August 25, 2020

Fourth Unit: September 15, 2020 – November 24, 2020

SELF REGIONAL HEALTHCARE	SECTION: **Spiritual Care & Clinical Pastoral Education (CPE) Department**	Page 1 of 1
	NUMBER: QSP-CPE-2001	Revision Level: 1
FORMULATED: 1/13/2006	TITLE: **Computer Use for CPE Chaplains**	
REVISED: 9/24/19	APPROVAL: Dr. John Thomas TITLE: Spiritual Care Director	
REVIEWED: 10/01/2019	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement: To give all students access to computers to complete their job responsibilities and student requirements.

Scope: This policy covers computer use for all CPE Chaplains

Responsibility: All CPE Chaplains

Process:

Computers are available to students for completing various written requirements for CPE. Students may also access the internet and patient information via these computers. This is for professional and educational use only. Chaplains are required to abide by the Self Regional IT Acceptable Use policy.

Each Resident Chaplain will be provided a user name, personal password, and SRH email address. Each resident will also be provided server space for saving his/her work (the H: Drive). All CPE students should save their work to the server; additionally, if a student has their own assigned computer, they are permitted to save files on the local computer to their "My Documents" folder.

For students who share a computer, if the demand for computer access is high, time may be negotiated with your peers in this matter.

References: QSP-ITS-0026 - IT Acceptable Use policy

Definitions: CPE - Clinical Pastoral Education

IT - Information Technology

SELF REGIONAL HEALTHCARE	SECTION: **Spiritual Care & Clinical Pastoral Education (CPE) Department**	Page 1 of 1
	NUMBER: QSP-CPE-2002	Revision Level: 1
FORMULATED: 6/11/07	TITLE: **Paid Time Off – PTO for CPE Chaplains**	
REVISED: 9/24/19	APPROVAL: Dr. John Thomas TITLE: Spiritual Care Director	
REVIEWED: 10/01/2019	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement: To educate the CPE Chaplain(s) in regards to our Paid Time Off Policy (PTO). In addition to the Self Regional Healthcare Policy (see comments in the process section), this policy will further explain how the Spiritual Care Department will implement our PTO policy concerning the CPE Chaplain(s).

Scope: The Spiritual Care Department will follow the Self Regional Healthcare PTO policy. A copy of this policy is available on the SRH intranet.

Responsibility: All Chaplains

Process:

1. As with all new hospital employees, CPE Chaplains will be allowed to take PTO days only after the first 90 days of employment with an exception of official hospital holidays.
2. You are encouraged to take your PTO days during the integration period between CPE units.
3. A Request for Time off form must be approved by your Supervisor before PTO is taken.
4. Special permission must be approved by the CPE Supervisor for any time requested during educational sessions.

PTO will be approved if:

1. You have arranged coverage for your clinical areas and any on-call responsibility from another chaplain on site (the chaplain covering will also have to sign the Request for time off form).
2. You have obtained prior approval from your supervisor by his signed signature on the Request for Time Off Form (QSF-CPE-3001). Important note: Failure to first obtain signed approval risks not being paid for PTO time.
3. There are a minimum of two Chaplain students on-site (unless exception is made by the Director).

References: QSP-HR-EMP BEN-002 – Self Regional Healthcare PTO Policy
QSF-CPE-3001 – Request for Time Off Form

Definitions: CPE – Clinical Pastoral Education
PTO – Paid Time Off

SELF REGIONAL HEALTHCARE	SECTION: **Spiritual Care & Clinical Pastoral Education (CPE) Department**	Page 1 of 2
	NUMBER: QSP-Chap-1002	Revision Level: 1
FORMULATED: 6/11/07	TITLE: **On Call acknowledgement (OCA)**	
REVISED: 9/24/19	APPROVAL: Dr. John Thomas TITLE: Spiritual Care Director	
REVIEWED: 10/01/2019	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement: To acknowledge the additional work load required by participation in the on-duty chaplain rotation: OCA is PROVIDED TO PROMOTE SELF CARE.

Scope: This policy covers the process and guidelines for OCA for all chaplains.

Responsibility: All Chaplains

Process:

For chaplains working as on-call chaplain after hours and/or weekends, OCA hours are allowed under the following conditions:

1. The time off is within the guidelines set below.
2. You have arranged coverage for your areas from another chaplain on site.
3. You have obtained prior approval from your supervisor by his signed signature on a request form (QSF-CPE-3001). Important note: Failure to first obtain signed approval risks not being paid for OCA time.
4. Special permission must be obtained by the CPE Supervisor if time is requested during educational sessions.
5. There are a minimum of two CPE Chaplains on-site (unless exception is made by the Supervisor and/or Director).

If the previous conditions have been met, OCA may be taken according to this guideline:

1. When working a weekend 24 hour shift or a hospital holiday, a chaplain receives 16 hours off for OCA.
2. When working an overnight weekday (Monday - Friday) on call, the chaplain will receive 8 hours OCA.

References: QSF-CPE-3001 – Request for Time Off Form

Definitions: CPE – Clinical Pastoral Education
OCA – On Call acknowledgement

SELF REGIONAL HEALTHCARE	SECTION: **Spiritual Care & Clinical Pastoral Education (CPE) Department**	Page 1 of 1
	NUMBER: QSP-Chap-1003	Revision Level: 1
FORMULATED: 1/13/06	TITLE: **Respect for Religious/Spiritual Diversity**	
REVISED: 9/24/19	APPROVAL: Dr. John Thomas TITLE: Spiritual Care Director	
REVIEWED: 10/01/2019	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement: Patients have the rights to express their religious or spiritual faith and to practice religious or spiritual rites and rituals, which will assist in their spiritual journey in the midst of illness, injury, dying, death and healing. Also, at the end of life many religious or spiritual faiths have rituals that need to be observed to provide for a death that is both dignified and faithful.

Scope: This policy covers patients' rights for Religious/Spiritual Diversity

Responsibility: It is the responsibility of all hospital chaplains and students to be aware of different religious or spiritual practices and rituals that help patients and families move toward healing or move toward a dignified death.

Process:

1. Assist patients in securing an appropriate representative of the patient's faith group when requested
2. Be familiar with resources within the department for addressing the polarity of multicultural and religious effects on medical treatments, grief, and other situations.
3. Respect and protect the rights of all faith groups by not proselytizing or allowing others to do so.
4. Provide requested literature when possible and prevent religious practitioners from random distribution of religious literature and advertising of religious services without the expressed permission of the Director of the Spiritual Care Department.
5. Report to the Director of the Spiritual Care Department the names of persons violating the religious rights of patients

Every Chaplain or CPE Students needs to have a general knowledge of different faith perspectives. They also need to possess a book such as "A Hospital Handbook on Multiculturalism and Religion" to use as a resource in providing care for the different faith traditions as patients move toward healing or death.

Definitions: **CPE – Clinical Pastoral Education**

SELF REGIONAL HEALTHCARE	SECTION: **Spiritual Care & Clinical Pastoral Education (CPE) Department**	Page 1 of 3
	NUMBER: QSP-Chap-1001	Revision Level: 3
FORMULATED: 1/13/06	TITLE: **Emergency Protocol**	
REVISED: 9/24/19	APPROVAL: Dr. John Thomas TITLE: Spiritual Care Director	
REVIEWED: 10/01/2019	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement: Chaplains will respond in a prompt manner to all code procedures (actual and drill).

Scope: This policy covers what to do in the case of a hospital emergency.

Responsibility: All Chaplains

Process:

A. EXTERNAL DISASTER (Facility Alert + Decontamination + Location + Directions)
DURING NORMAL WORK HOURS
(8:00 AM – 5:00 PM).

1. Chaplains will assemble in the Spiritual Care office immediately when an external disaster code is announced and remain there until directed to an area of service or until "All Clear" is announced.
2. The Spiritual Care Director will go to the Designated Command Center to make an assessment of disaster and an assessment of Chaplain personnel that will be needed to meet the pastoral care needs of the situation. If additional Chaplains are needed, the Spiritual Care Secretary will notify our Staff Chaplains asking for all that are available to assemble in the Spiritual Care office to help meet the pastoral care needs of the situation.
3. The Spiritual Care Director will notify the Emergency Debriefing Team made up of counselors and social workers and other helping professionals.
4. Chaplains may be directed to ECC or other areas to provide care to patients and team member(s). Chaplains may also be directed to ECC waiting area and/or Optimal Life Center to provide pastoral care to families of victims.
5. Chaplains will minister to patients, team member(s), and families as needed. This would include, but not limited to, such interventions as emotional support, sacraments, prayers, etc.
6. Chaplains will coordinate with medical personnel a roster of casualties who have expired so that the families of the deceased will receive appropriate care. **NOTE: THE CHAPLAINS WILL NOT ACT AS NOTIFICATION PERSON OR GIVE OUT MEDICAL INFORMATION TO FAMILIES OR PATIENTS**.
7. The Chaplains will coordinate their support efforts with other agencies such as the Red Cross.
8. In the event of a protracted, on-going crisis, two teams will be established for rotation/rest. Each team will be on a 12-hour shift rotation. The Spiritual Care Director will supervise one team and a Staff Chaplain will supervise the other team.
9. Follow-up care will be offered to ECC team member(s) and other team member(s) involved in the disaster by Chaplains and by the ECC Critical Incident Response Team (headed by the Spiritual Care Director).

B. EXTERNAL DISASTER (Facility Alert + External Disaster + Location + Directions) DURING WEEKEND OR AFTER WORK HOURS (5:00 PM - 8:00 AM):

1. The on-call Chaplain will act on behalf of the department by reporting to the designated Command Center and making assessment.
2. The on-call Chaplain will immediately call the Spiritual Care Director. The Director will make a decision about calling the remainder of the department.
3. Same procedures will be followed as above (steps 4-9).

C. In the event of a **Facility Alert + Fire Alarm + Location + Directions** the chaplain will follow Fire and Safety procedures Self Regional Healthcare procedures.
Facility Alert + Fire Alarm + Location + Activate Incident Command

D. **CODE BLUE + Location** signifies an adult life-threatening situation. **CODE 99 + Location** signifies a pediatric life-threatening situation. The on-call chaplain and the chaplain responsible for that unit will respond immediately to both of these pages.

E. **Facility Alert + Type of Hazardous Material Spill/Release + Location + Directions** signifies a **HAZARDOUS SPILL** requiring total evacuation of the facility. The on-call Chaplain will respond and offer counseling to visitors and team member(s) affected by the spill.

F. **Security Alert + Missing Person Description + Location + Directions** signifies an infant/child Abduction occurrence in the Labor & Delivery, Pediatrics, NICU or any area where a child may be receiving medical treatment.

1. The on-call chaplain will proceed to the area to provide comfort to the family, team member(s), and other patients and/or visitors as needed.
2. **NO HOSPITAL PERSONNEL ARE AUTHORIZED TO PROVIDE ANY INFORMATION REGARDING THE KIDNAPPING, FAMILY, ETC. ALL QUESTIONS ARE TO BE REFERED TO THE PUBLIC RELATIONS DEPARTMENT.**

G. **Facility Alert + Weather Event + Location + Directions** signifies SEVERE WEATHER WARNING. Several chaplains may be requested to be on-call during the night to provide support for patients/families.

H. **Security Alert + Immediate Threat + Location + Directions** signifies a BOMB THREAT.

I. **Facility Alert + Evacuation + Location + Directions** signifies EVACUATION.

J. **Security Alert + Security Assistance + Location + Directions** signifies a violent situation or person.

K. Security Alert + Active Shooter + Location + Directions signifies an Active Shooter
Refer to Active Shooter Situations Response Protocol (QSP-EM-EOP-0014)

L. Facility Alert + Utility/Technology Interruption + Location + Directions signifies an Electrical Problem

M. Trauma Alert + Level signifies a Trauma
Chaplains to respond per Trauma Alert System Protocol (QSP-ECC-Trauma-0010)

N. Rapid Response + Location signifies a Rapid Response
The on-call chaplain and the chaplain responsible for that unit will respond immediately to this page.

O. Fall Huddle + Location signifies a Fall Huddle

Definitions: **CPE – Clinical Pastoral Education**
ECC – Emergency Care Center
NICU – Neonatal Intensive Care Unit

SELF REGIONAL HEALTHCARE	SECTION: Infection Prevention Manual	Page 1 of 2
	NUMBER: QOP-IP-COVID-0021	Revision Level: 0
FORMULATED: 4/28/20	TITLE: **CODE BLUE for Confirmed or PUI COVID Patients – CODE BLUE 19**	
REVISED:	APPROVAL: Kendra Keeney TITLE: Chief Quality Officer	
REVIEWED:	SIGNATURE: Signature On File	

Purpose: To identify and notify SRH/SMG Team Members that are responding to In-House CODE Blue on positive COVID 19 Patients or those Persons Under Investigation (PUI); Proper protection of the resuscitation team including donning of PPE takes precedence before any resuscitative efforts are attempted.

Scope: SRH In-House Code Blue Patients that are Positive for COVID 19 or are currently a Person Under Investigation (PUI)

Responsibility: ALL SRH/SMG Team Members

Standard Work Procedure:

Step	Who	What	Tools/Supplies Needed
1.	Patient Care Team	Call (4000) to notify of Code Blue 19 in room ___	**Room number and Patient COVID status**
2.	SRH Team	Responds to the room and approaches with instructed Infection Prevention Precautions	**PPE to include N-95, gown, goggles, and gloves. Negative air flow is desired.**
3.		team member response: ○ Teams will consist of four personnel: Two nurses, one respiratory therapist and one physician (team leader). ○ No other personnel should enter the room. The nurse supervisor of the unit will be responsible to monitor the room entrance and not allow any other personnel in the room unless requested by the team leader. ○ The patient's attending physician should remain outside the room during the code. They may communicate from the door with the team as needed but should not enter the room unless requested by the team leader with full PPE. ○ The medication cart will remain **outside** the patient care area with a pharmacist available to hand medication through the doorway to the team members.	

		○ The Code Blue Team cannot enter the room until they have properly donned all PPE. This will include proper masks and eye protection. No exceptions should be allowed. ○ The physician responsible for the Code Blue will be the upper level resident physician on call for the medicine teaching service. ○ No extraneous personnel should congregate around the code or be in the room. ○ Airway intubations should be performed when possible under direct video assisted intubation under a protective hood for all COVID-19 positive and PUI patients. ○ Code status and goals of treatment should be discussed with the patient and their family at admission and clearly spelled out in the patient record. The Chaplain Service should be available for rapid consultation if needed. ○ Similar precautions should be taken with the Rapid Response Team.	

References: CDC – Centers for Disease Control; COVID 19 Command Center

Definitions: PUI – Persons under investigation; PPE – Personal Protective Equipment

SELF REGIONAL HEALTHCARE	SECTION: Infection Prevention	Page 1 of 2
	NUMBER: QSP-IP-COVID-0002	Revision Level: 2
FORMULATED: 3/19/20	TITLE: **Limited Visitation Policy During COVID-19**	
REVISED: 4/29/20, 8/19/20	APPROVAL: Kendra Keeney TITLE: Chief Quality Officer	
REVIEWED:	SIGNATURE: Signature On File	

This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.

Policy Statement:

The purpose of this policy is to provide specifics and guidance related to the implementation of a limited Patient Visitation program during the COVID-19 pandemic. Implementing restrictions is necessary to ensure the safety of both patients and staff while helping to decrease community spread of the virus. The organization recognizes allowing visitors can assist with meeting patients physical, emotional and educational needs.

Scope: All guests coming into the main hospital building to visit inpatients.

Responsibility: Visitors and all SRH Team Members

Process:

1. Limited Visitation will commence on Thursday, August 20, 2020 and remain in effect until further notice.
2. Days and hours of the Limited Visitation program will be 1 – 3 pm each day, 7 days a week.
3. Visitors must be age 16 or older.
4. Visitors will not be allowed in COVID-19 or PUI for COVID-19 rooms unless meeting the end of life criteria (see Exceptions section of this policy).
5. All Visitors must supply their own masks (which covers both mouth and nose) and wear it at all times while in the facility, including while in patient rooms.
6. Patients must wear a mask while visitors are in the room (exceptions for health conditions allowed).
7. Visitors will be subject to temperature screenings and may be asked questions related to COVID-19 symptoms, exposures, etc. before being permitted into the facility. Individuals with a temperature greater than 99.4 degrees will be denied entry into the hospital.
8. Upon successfully passing the temp screening, all visitors will receive a Visitation Sticker which will include the patient's room number and date of visitation. Visitation Stickers must be visible and worn above the waist at all times.
9. ALL visitors are to remain in the room of the patient being visited unless otherwise directed.
10. Visitors will be required to leave the hospital each day by 3 pm. An overhead announcement will be made at 2:45 pm to announce visitation will end in 15 minutes and at 3 pm announcing Visitation has ended and to please leave the facility.
11. No visitors will be allowed entry at 2:45 pm.

12. Maximum of 1 visitor per Day. Visitor Swapping (multiple individuals visiting the same patient within the designated two-hour window) will not be permitted.

13. Visitor's identification may be requested before entry is permitted.

14. Self Regional Healthcare at its sole discretion will determine which individuals are permitted into the facility during Limited Visitation hours.

15. EXCEPTIONS to Visitors Rules:
    - Pediatrics (<18) – One adult may switch with another adult outside the building to allow for rest for the initial adult)
    - LDRP – One designated Visitor Per Day for the length of stay
    - *Life threatening emergencies and end of life* – Limited to no more than two Visitors.
    - Visitation for Life threatening and emergencies and end of life COVID-19 patients by exception only (call nursing supervisor – Maximum of 1 visitor for no more than 15 minutes).
    - *Initial surgery*, *Cath lab*, *Angio Lab*, *Endoscopy* – One person until the patient leave the PACU. If admitted to the hospital as an inpatient, individual may remain during Limited Visitation hours 1 – 3 pm.

16. Critical Care Visitation for non COVID-19 patients will also be from 1 – 3 pm daily for one designated visitor only. Security is to call the critical care unit prior to sending a visitor to that area to see if visitation is permitted.

17. All hospital visitors must enter through Entrance A during Limited Visitation unless related to ECC or LDRP services.

References (if not noted elsewhere in policy):

N/A

Definitions:

LDRP – Labor Delivery Recovery and Post-Partum

ECC – Emergency Care Center

PUI – Patients Under Investigation

Self Regional Healthcare Clinical Areas

ACPE STANDARD 1 - A population that provides students with opportunities for ministry and clinical pastoral education

Chaplains may be needed in all areas throughout the hospital. Listed below are the majority of the areas served by the chaplains on a regular basis.

(Average Daily Census is abbreviated as ADC.)

WEST BUILDING

Surgical Waiting Area - First Floor at West Entrance
(Usually full of people in the AM)
In and Outpatient surgery. High stress level among the family members who await news from surgeons.

Outpatient Endoscopy (ADC - 6)- First Floor at West Entrance
Includes colonoscopy, endoscopy, and bronchoscopy procedures

Labor Delivery (LDRP) 2nd floor (ADC - 17)
LDRP - Patients admitted for vaginal births. (Pt. Stay: normally 2-3 days)

Nursing LDRP- Nursery (ADC - 7)
Healthy babies. Majority of pastoral ministry with patient/family in LDRP and Women's Center. (Pt. Stay: 2-3 days)

NICU 2nd Floor (ADC - 11)
Sick and premature babies requiring intensive nursing care. High stress area for team member(s) and families.

ICU Third Floor (ADC - 8)
Critically ill patients. Often ventilator dependent, requiring intensive nursing care. (Pt. Stay: days-weeks). ICU has a waiting area where family members gather when visiting hours are restricted.

CCU Third Floor (ADC - 7)
Critically ill cardiac patients, often ventilator dependent, requiring intensive nursing care. – Large waiting room where family members gather. High stress area. (Pt. Stay: days-weeks)

CICU 4th West (ADC - 8)
Cardiac patients usually recovering after heart surgery - often ventilator dependent, requiring intensive nursing care. – (includes waiting room for families and friends).

EAST BUILDING

ECC - First Floor
Self Regional Healthcare is a Level III trauma center. Equipped to deal with all emergencies. There is often high stress in the waiting area. Team member(s) support is required. (Pt. Stay-hrs.).

Cancer Center (ADC - 105)
Provides outpatient chemo and radiation treatments, blood transfusions, shots, fluids plus visits with Oncology physicians

Dialysis (ADC - 4) Located down hallway behind tower elevators
Provides dialysis for inpatients.

TOWER

2 Tower - Women's Center (ADC - 6)
Patients admitted for C-Sections. Also women for GYN Surgery and other issues. (Pt. Stay: 2-4 days)

3 Tower – Orthopedics and Vascular (ADC - 18)
Patients with bone-surgeries like Knee-replacement or Hip surgeries in the Ortho side. (Pt. Stay: 4 to 5 days)
Vascular has primarily circulatory related problems
(Pt. Stay: usually overnight for Carotids)

4 Tower – Surgery (ADC - 17)
General surgery patients (Pt. Stay: 3 days)

5 Tower – Medical (ADC - 21)
Variety medical conditions including patients receiving Chemotherapy. (Pt. Stay: 5 to 6 days)

6 Tower – Medical (ADC - 20)
High need medical conditions including Neurological patients (Pt. Stay: 5 to 6 days)

7 Tower – Telemetry (ADC - 25)
Step down unit for patients who still require vital monitoring. (Pt. Stay: 3 days)

8 Tower – PCU (Progressive Care Unit) (ADC - 25)
Staffed by Critical care nurses, seen as high level step down unit from ICU/CCU (Pt. Stay: 2-3 days)

EDUCATION STANDARDS AND GUIDELINES

All permanent full time ministry staff members are expected to maintain their ordination and denominational endorsement and remain in good standing within their denomination; meet the Code of Ethics as outlined in the Standards of ACPE and APC, and maintain their certification in both professional organizations. As an accredited training center from the Association of Clinical Pastoral Education, all policies, qualifications, continuing education requirements and clinical training is in compliance with their Standards. Our next Accreditation Site Review will be in 2025. All CPE related chaplain interns and externs are expected to practice their ministry within the Code of Ethics of ACPE and of their respective denominations. The department works in conjunction with the clinical areas within Self Regional Healthcare to meet the guidelines as outlined by DNV (our hospital's accreditation agency).

Access to ACPE Standards and Manuals

PURPOSE

To make all current ACPE standards, manuals, Policy for Complaints Alleging Violation of ACPE Education Standards and Policy for Complaints Against the Accreditation Commission available to all students.

STANDARD

Any current ACPE information, standards, manuals, etc. may be obtained on the ACPE website – www.acpe.edu. The certified educator will be available to assist any student in retrieving this information.

These include, but are not limited to:

1. ACPE Standards and Manuals
2. Policy for Complaints Alleging Violation of ACPE Education Standards
3. Policy for Complaints Against the Accreditation Commission

Admissions Standard

PURPOSE
To ensure a consistent process for appropriate admission of students into the Clinical Pastoral Education Program

STANDARD
The ACPE program of Self Regional Healthcare shall not discriminate against any individual for reasons of race, gender, age, faith group, national origin, sexual orientation, or disability. Equal access to educational opportunities is extended to all qualified persons. All members of the faculty and the CPE peers are expected to cooperate in compliance with this policy.

Qualification for Application
In accordance with ACPE requirements, students applying for entry into our full-time CPE Residency Program should demonstrate successful completion of High School/GED, College and some theological study or seminary education. Ordination by faith community or commission to function in ministry by an appropriate religious authority as determined by ACPE is preferred. Our admissions process includes review of a written application, reference checks, criminal background check, an interview, and the demonstrated ability to participate in CPE. This policy notwithstanding, all students accepted in the program shall be able, with or without reasonable accommodation, to physically perform the duties as contained in the job description for a Chaplain Resident, Chaplain Intern, and Chaplain Extern. At all levels, the CPE student needs to sustain physical and emotional health with or without accommodation to deliver pastoral care. The student must demonstrate the capacity to consistently establish and maintain relationships at significant levels and be open to learning, change and growth. The CPE student must demonstrate a capacity to endure at least moderate amounts of stress, which is a normal part of the hospital culture.

PROCEDURE

1. A student submits a completed ACPE application and the center's application fee.
2. Receipt of application is acknowledged and letters of reference are requested by the CPE Center.
3. An interview time is established that is convenient for both the ACPE center and the student.

   A. Residents:
   - ACPE Certified Educator, a member of the PAG and a current or former CPE resident.
   - The student will be voted on by the interviewing committee after the prospective student's interview has been conducted with final authority given to the ACPE Certified Educator.

   B. Interns and Externs:
   - Interviews will be conducted by an ACPE Certified Educator.
   - A student may submit a formal CPE interview conducted by a qualified person as outlined by the Standards of ACPE.
   - The ACPE Certified Educator decides if the student is accepted or not.

4. A decision is made on the basis of educational ability, readiness and personal and professional maturity (demonstrated in the interview, written materials and references). The student must possess ability to provide basic pastoral care to persons in crisis. The peer group learning needs are taken into consideration in making every effort to select a diverse group of individuals.

5. If accepted, a letter of acceptance is sent to the applicant requesting the applicant accept the invitation in writing within two weeks.
6. If the applicant is denied, a letter of denial is sent which states the applicant has 10 days to request that their written application materials be returned. Otherwise, all materials will be destroyed.
7. Acceptance to the CPE program is contingent on the Self Regional Healthcare employment policies, which includes but is not limited to a criminal background check, drug screen, Employee Health pre-employment physical screening and completion of New Employee Hospital Orientation.

Clinical Placement/Documentation

STANDARD

All CPE students within Self Regional Healthcare will be given clinical assignments that will provide the student with access to a population of sufficient size to provide opportunities for ministry and learning.

PROCEDURE

Residents and Interns Program:

1. Clinical assignments will be made during orientation. Students will have an opportunity to voice preferences and learning needs.
2. Residents and Interns are expected to participate as a member of the interdisciplinary team on all units assigned. Team meeting participation is included in the required clinical hours.
3. Residents and Interns will record clinical hours each week on the computer.

Extended Program:

1. All Extended students are expected to complete 20 hours per week of education and ministry at Self Regional Healthcare; and will be given a clinical placement assignment to facilitate meeting those hours.
2. All Extended students will be expected to participate in the on-call rotation at SRH.
3. Extended students involved in parish ministry may negotiate to count twelve hours per week of ministry towards the required 20 hours per week. A contract must be signed naming their church (or other pre-approved setting) as a clinical placement site.
4. Extended students without a parish assignment will be given clinical assignments within the hospital to facilitate the 12 hours of ministry per week.
5. Students have opportunity during orientation to offer preferences for clinical assignments.
6. Students will record clinical hours each week on the computer.

CPE Peer Group Size

STANDARD

CPE groups offered through Self Regional Healthcare will adhere to the ACPE standards regarding minimum group size of three.

PROCEDURE

1. All peer groups held within Self Regional Healthcare CPE program will begin with at least three students enrolled.
2. In the event a CPE class is cancelled due to lack of sufficient enrollment, students accepted into that program will be refunded any tuition monies paid, including deposit.
3. If an existing peer group drops below the three-student minimum after the unit is well underway, Self Regional Healthcare CPE program will creatively look for ways to ensure the remaining students are able to finish the unit.
4. Due to the dual role of being Director as well as CE, the maximum number of students for a single unit will be no more than six students.

CPE Unit Credit

STANDARD

Supervisors have responsibility to grant or deny credit for each student and each unit of CPE. If credit is denied, this policy ensures the rights of the student and the supervisor are honored with faculty support.

PROCEDURES

Clinical pastoral education is not only outer work i.e., learning styles of ministry and the conceptual framework for doing that ministry in a clinical setting, but also the inner work of reflecting on self and how one's history and personality impacts one's ministry. Thus, the granting of CPE credit is dependent upon the student being fully engaged in the inner and outer work of the before mentioned process. Ultimately the granting or denying of CPE credit is the decision of the student's primary CE supervisor.

Basic Requirements for Student Receiving Credit for a Unit of CPE:

- Students must complete at least 300 hours of clinical ministry (180 hours for ½ unit credit) with the expectation of 20-25 hours of clinical ministry per week. In addition, they must have no less than 100 hours of structured group and individual education with supervised clinical practice in ministry.
- Students must document their clinical ministry through daily reports and/or by patient charting and engage in supervision of this ministry.
- CPE students have regularly scheduled supervision with the ACPE Certified Educator.
- There must be a collaboratively designed and written learning contract by student and certified educator that will guide the educational process of the unit. A format guide is located in Appendix B.
- In the case of a payment contract, the tuition must be paid in full by the end of the unit to receive credit.
- A tuition refund will not be given in the case of credit being denied.
- Every CPE student must pre-register for each unit through the acpe.edu student portal. Failure to pre-register will result in non-credit for the unit.

Disciplinary Action and Withdrawal

PURPOSE

To provide a mechanism for situations within the training programs when it is necessary for the certified educator to take disciplinary action in regards to a CPE student. The action may take the form of probation, dismissal, or provide for the withdrawal of a student from the CPE program.

POLICY

It is the policy of the department that probation and/or dismissal of a student may occur as a result of the behaviors listed below.

DEFINITIONS

Probation is for a specific period of time--not less than two weeks or more than six weeks within any unit of CPE. The status of probation indicates that continuation in the CPE program is in jeopardy. Probation may include the restriction of work in assigned clinical areas and/or participation in any or all of the structures of the CPE program.

Dismissal ends the student's participation in the CPE program and ministry within the institution at the initiation of the CPE Supervisor.

Withdrawal ends the student's participation in the CPE program and ministry within the institution at the initiation of the student.

PROCEDURES:

Probation in the CPE program

a. A student may be placed on/or removed from probation by a decision of the ACPE Certified Educator. Probation or dismissal may occur as the result of:
    - Failure to successfully complete a training unit
    - Failure to adequately participate in the educational program
    - Failure to act responsibly in pastoral obligations
    - Conduct unbecoming a CPE student

Dismissal from the CPE program

a. A student may be dismissed from the program without first receiving probation.
b. Tuition fees will be refunded according to the Financial Policy.

Withdrawal from the CPE program

a. A student may withdraw from the CPE program by submitting a letter of withdrawal to the CE Supervisor.
b. Students are encouraged to inform the CE Supervisor of the possibility of withdrawal in order to provide continuity in addressing the pastoral care needs of the hospital.
c. Tuition Fees will be refunded according to Financial Policy.
d. Withdrawal from the program terminates the student's services as a chaplain.

Ethical Conduct

PURPOSE
To describe expectation of professional and ethical conduct of students and program staff in an ACPE accredited program of CPE.

POLICY
All CPE program staff and students in programs of CPE at Self Regional Healthcare are expected to uphold and abide by the Code of Professional Ethics as detailed below.

Code of Professional Ethics for Members of ACPE

Maintenance of high standards of ethical conduct is a responsibility shared by all ACPE members and students. *The same ethical standards apply to both ACPE Members and Non-Members.*

ACPE members agree to adhere to a standard of conduct consistent with the code of ethics established in ACPE standards. Members are required to sign the *Accountability For Ethical Conduct Policy Report Form* and to promptly provide notice to the ACPE Executive Director of any complaint of unethical or felonious conduct made against them in a civil, criminal, ecclesiastical, employment, or another professional organization's forum.

Any ACPE member may invoke an ethics, accreditation or certification review process when a member's conduct, inside or outside their professional work involves an alleged abuse of power or authority, involves an alleged felony, or is the subject of civil action or discipline in another forum when any of these impinge upon the ability of a member to function effectively and credibly as an ACPE Certified Educator, chaplain or spiritual care provider.

1. In relationship to those served, ACPE members:

a. affirm and respect the human dignity and individual worth of each person.
b. do not discriminate against anyone because of race, gender, age, faith group, national origin, sexual orientation, or disability.
c. respect the integrity and welfare of those served or supervised, refraining from disparagement and avoiding emotional exploitation, sexual exploitation, or any other kind of exploitation.
d. approach the religious convictions of a person, group and/or CPE student with respect and sensitivity; avoid the imposition of their theology or cultural values on those served or supervised.
e. respect confidentiality to the extent permitted by law, regulations or other applicable rules.
f. follow nationally established guidelines in the design of research involving human subjects and gain approval from a recognized institutional review board before conducting such research.

2. In relation to other groups, ACPE members:

a. maintain good standing in their faith group.
b. abide by the professional practice and/or teaching standards of the state, the community and the institution in which they are employed. If for any reason they are not free to practice or teach according to conscience, they shall notify the employer and ACPE through the regional director.
c. maintain professional relationships with other persons in the ACPE center, institution in which employed and/or the community.
d. do not directly or by implication claim professional qualifications that exceed actual qualifications or misrepresent their affiliation with any institution, organization or individual; are responsible for correcting the misrepresentation or misunderstanding of their professional qualifications or affiliations.

3. In relation to ACPE, members:

a. continue professional education and growth, including participation in the meetings and affairs of ACPE.
b. avoid using knowledge, position or professional association to secure unfair personal advantage; do not knowingly permit their services to be used by others for purposes inconsistent with the ethical standards of ACPE; or use affiliation with ACPE for purposes that are not consistent with ACPE standards.
c. speak on behalf of ACPE or represent the official position of ACPE only as authorized by the ACPE governing body.
d. do not make intentionally false, misleading or incomplete statements about their work or ethical behavior.

4. In collegial relationships, ACPE members:

a. respect the integrity and welfare of colleagues; maintain professional relationships on a professional basis, refraining from disparagement and avoiding emotional, sexual or any other kind of exploitation.
b. take collegial and responsible action when concerns about incompetence, impairment or misconduct arise.

5. In conducting business matters, ACPE members:

a. carry out administrative responsibilities in a timely and professional manner.
b. implement sound fiscal practices, maintain accurate financial records and protect the integrity of funds entrusted to their care.
c. distinguish private opinions from those of ACPE, their faith group or profession in all publicity, public announcements or publications.
d. accurately describe the ACPE center, its pastoral services and educational programs. All statements in advertising, catalogs, publications, recruiting, and academic calendars shall be accurate at the time of publication. Publications advertising a center's programs shall include the type(s) and level(s) of education offered and the ACPE address, telephone number and website address.
e. accurately describe program expectations, including time requirements, in the admissions process for CPE programs.

Financial Standard

PURPOSE
To ensure that the CPE program addresses fees, payment schedule, refunds, stipends and benefits.

STANDARD
SRH Spiritual Care Department shall provide each potential CPE student with a copy of the tuition and fee schedule upon request. Tuition and fees may be reviewed and/or changed annually.

PROCEDURE

Application Fee – None At This Time

Unit Fee
ACPE Unit student fees are paid by SRH on behalf of each student.

RESIDENT TERMS OF EMPLOYMENT
- 4 units of ACPE credit
- 40-hour per week educational commitment
- One overnight On-call rotation per week
- One 24-hour weekend On-call per month
- Stipend: $41,000 (paid in bi-weekly increments)

The Residency Program Benefits include:
- Paid Time Off (PTO)
- Free parking
- Single/family health insurance is available

Maintenance of Student Records

PURPOSE

To assure that the Clinical Pastoral Education program maintains student records in a manner which addresses confidentiality, access, content, custody of student records, and custody of student records should the center be without a supervisor and/or accreditation. The center prominently publishes its ***Annual Notice*** before the beginning of each unit.

STANDARD

The SRH Spiritual Care Department shall maintain records in a manner consistent with the Guidelines for Student Records in accordance with ACPE standards. This includes the student records being secured in a locked file cabinet. Student records will not be released without the written consent of the student. The official record will consist of the application face sheet, the CPE supervisor's written evaluation report and the student's own written evaluation report. Material written by students such as verbatims and case histories that contain information about other persons will be destroyed unless used for pastoral research, with written permission from the student. Supervisory notes are not a part of the official record and are the property of the supervisor.

PROCEDURE

Student Records

1. The SRH Spiritual Care Department student files will be maintained for a period of at least ten years.
2. After ten years, the file may be thinned and only a face sheet will be held in the files.
3. The student has the responsibility to maintain his/her personal file for future use. The student will be informed that it is his/her responsibility to keep copies of evaluations for future use.
4. No evaluation reports will be released from the file without the written request of the student.
5. Student files are maintained in the SRH Spiritual Care Department.
6. Access to student records is restricted to the CE Supervisor and the Coordinator of CPE. Access to an individual's student record may be permitted for the purpose of research, accreditation review, or in the event that a complaint is filed.
7. In the event that the CPE program should cease to exist or in the absence of an ACPE Supervisor, student records will be sent to the national ACPE office in Decatur, Georgia and maintained for ten years.
8. Student records will be filed within 21 days of completion of a unit in accordance with ACPE Standards.
9. To receive a copy of a student record – application must be made in writing to the SRH Spiritual Care Department by the student. Response of a verification letter and/or copies will be made within two weeks of request.

Self Regional Healthcare

Annual Notice

ACPE requires that an Annual Notice be published annually prior to the start of any CPE program start and appear in the student and center handbooks in addition to other sources at the center's discretion.

Items must appear in the Annual Notice as stated here.

The Annual Notice contains:

A. The rights of students:
   i. **to inspect and review education records**
   ii. **to seek to amend them**
   iii. **to specified control over release of record information**

B. What constitutes directory information and how to opt out
C. The definition of student records
D. Details of the center's record's management protocols
   i. **the right to object to record content**
   ii. **if not negotiable, written objection will be kept with and released with record**

E. Definitions of persons having access to student records
   i. Education Official
   ii. Legitimate Education Interest

F. Report violations of these protocols to:

Chair of the Accreditation Commission
ACPE
55 Ivan Allen Jr. Boulevard, Suite 835
Atlanta, GA 30308
(404) 320-1472

SRH Directory information and how to opt out;
Directory information is student information not generally considered harmful or an invasion of privacy if released. SRH directory information includes: name, address, email, telephone, date of birth, religion, previous education, and photograph. This information is sometimes published in the hospital newsletter at the beginning of a CPE program. Students may opt out completely from having directory information disclosed. Students may also choose to review and select directory information that is acceptable to the student for release. All other information is released only with the student's written, signed, dated consent specifying which records are being disclosed, to whom, and for what limited purpose.

Before releasing information, students must have received this Annual Notice. Current students can restrict directory information and/or record access at any time during attendance. Restrictions must be honored even after the student's departure. Former students cannot initiate new restrictions after departure.

III. The definition of student records;
A student record is: (1) any record (paper, electronic, video, audio, biometric etc.) directly related to the student from which the student's identity can be recognized; and (2) maintained by the education program/institution or a person acting for the institution.

IV. SRH record's management protocols.
The following materials are included in the CPE student record as required by ACPE for 10 years following the student's CPE experience:

- The face sheet with directory information,
- The CE evaluation report and the student's own evaluation report, if submitted.
- Note: Application materials for students who are not accepted into the CPE program are not kept by the center. The applicant is given the choice of having the materials returned or destroyed.

A student has the right to object to record content. If not negotiable, the written objection will be kept with and released with the record. Grades are exempted from this right.

The CE will give each student the opportunity to write an addendum to the Supervisor's evaluation. This addendum is attached to the evaluation and is released with the evaluation when a proper release request has been received.

A copy of the ACPE Certified Educator's evaluation report will be given to the student within 21 days of completion of CPE unit. The student will be informed that the center will keep this evaluation for a minimum of ten years, and it will not be available to anyone else except with written permission from the student. If the student's own evaluation is included, it will be kept with the supervisor's subject to the same provisions.

V. Education Officials and Legitimate Education Interest.
Only Educational Officials (ACPE Certified Educators) will have access to student files for educational purposes without student consent. An example of a legitimate educational interest includes a certified educator accessing the application/biographical information of a student who is being supervised. In addition, the Coordinator of CPE, charged with assisting with the custodial care of the CPE student records will also have access to the student files without student consent. The Coordinator of CPE is not allowed to read the files.

VI. Violations of these protocols may be reported to the Chair of the Accreditation Commission at:

*ACPE***,** 55 Ivan Allen Jr. Boulevard, Suite 835
Atlanta, GA
(404) 320-1472

Research: If information in student records or in the ACPE Certified Educator's records is considered of research value, and a CPE center or ACPE desires to collect and use such material for research, a release form shall be made available for the person's signature. No personally identifiable material will be used for research without the person's written permission for its use.

Spiritual Care Department Library

PURPOSE

To provide all CPE students with access to a full array of educational resources.

LIBRARY RESOURCES

CPE Library

The Spiritual Care Department and Clinical Pastoral Education program have an extensive library that is available to all CPE students and department team member(s).

1. There is an electronic index located on the shared drive of each computer with a list of all books available.
2. All books and other materials are to be checked out through the department secretary.
3. All books will be returned by the due date.
4. Please be considerate of others who may be waiting for the same book(s).
5. Please do not swap books and other materials.
6. Check them OUT and IN by writing on paper the name of the book, the date, and your name. Be sure to record the return date to avoid being held responsible for books no longer in your possession.
7. There are no overdue fines, however, if a book is lost you could be asked to replace it or make a donation to cover the cost of the lost item.

Self Regional Healthcare Library Resources

The Self Regional Healthcare Medical Center library provides access to additional materials not available in the departmental library. Additional resources and information can be obtained via the Medical Library located in the Diabetes Education Center.

Procedure for Complaints

PURPOSE
To provide a mechanism for the handling of complaints or appeals by CPE students.

STANDARD
The CPE program at SRH encourages persons to work out concerns or grievances informally, face to face and in a spirit of collegiality and mutual respect. Procedures for complaints should be used only if informal discussion and pastoral communications do not resolve differences and when the complainant or group of complainants desires to register a complaint. It is recommended that the complaint be resolved at the closest possible relationship.

DEFINITIONS
A *complaint* is defined as a concern or grievance, presented in writing and involving an alleged violation of the ethical, professional, and /or educational criteria established by the *ACPE Standards*.

A *student* is defined as any person enrolled in any program of CPE for credit.

Mediation is a cooperative process which provides opportunity for both parties involved in a conflict to state their needs and interests. Through discussion with a mediator, the parties work to identify options and to find mutually acceptable solutions. If the parties agree to use mediation, they may contact the Regional Director or Executive Director of ACPE to discuss the possibilities for resolving the conflict in this manner.

PROCEDURE

I. Informal Proceeding within the CPE system

1. In the event of any grievance involving the CPE program, any function of the Department of Spiritual Care, or its supervisory staff, the student will inform directly the supervisor of the complaint in order to seek resolution.
2. It is the responsibility of the student to inform his/her CE supervisor that a complaint/potential grievance is involved.
3. The CE supervisor will schedule a meeting within twenty-four (24) hours or as soon thereafter as is possible.
4. If the grievance is lodged against the Director of the Spiritual Care Department and it remains unresolved, the complaint becomes a formal proceeding.

II. Formal Proceeding within the CPE System

1. If the complaint remains unresolved, the student will present the complaint or grievance in writing to the Director of the Spiritual Care Department within six (6) months of the occasion causing the complaint or within six (6) months of the conclusion of the educational experience in the system.
2. There shall be a time limitation of ten (10) years when the complaint involves sexual exploitation, and any complaint may be made within a longer period if the delay is explained by an occasion of fraud, intimidation, or other wrongful conduct that prevents the earlier surfacing of the complaint.
3. If the grievance is lodged against the Director of the Spiritual Care Department, and it remains unresolved, the complaint should be presented to the Chairperson of Self Regional's CPE Professional Advisory Group.
4. The written grievance must include:

a. A description of the occurrence/situation precipitating the grievance, specifically including the date(s) and time(s) of all events.
b. The name of all persons who, in the student's opinion, are involved in the concern.
c. A statement which provides the student's suggested resolution of the grievance including the student's reasons for the suggestion(s).
d. If the complaint involves the allegation of a breach of personal or professional conduct or ethics on the part of an ACPE CE Supervisor, the aggrieved must send a copy of the written complaint to the Regional Director of the Southeast ACPE Region:

ACPE Executive Director
55 Ivan Allen Jr. Boulevard, Suite 835
Atlanta, GA 30308
404-320-1472
confidential@acpe.edu

III. Right of Appeal

Each party to the complaint has the right of appeal within 30 days of the regional or national ACPE decision. Appeal criteria and guidelines are outlined in full on the ACPE website – www.acpe.edu.

Significant Institutional or Center Change

PURPOSE

To address Self Regional Healthcare's commitments to its students in the event of a substantial change within the Self Regional Healthcare Institution or CPE Center.

STANDARD

In the unlikely event of a significant institutional change that would result in the closing of our CPE Center, the hospital will make every effort to honor its commitments to its CPE students.

PROCEDURE

1. In the event that Self Regional Healthcare made the decision not to continue its Clinical Pastoral Education program:
   a. The hospital will fulfill its Agreement for Training contracts with its students.
   b. Each CPE Resident will be able to complete her/his one year commitment.
   c. Summer and extended students will be allowed to complete the current unit of CPE training.
   d. The Director of the Spiritual Care Department or Vice President of Human Resources will work closely with the ACPE to ensure an orderly transition for the CPE students and the SRH CPE Center.
2. In the event that for whatever reason, Self Regional Healthcare lost its ACPE accreditation as an ACPE Center or the hospital no longer existed, making it impossible for students to complete their CPE training:
   a. The Director of the Spiritual Care Department or Vice President of Human Resources will contact the ACPE for the purpose of formulating a plan of action to help students transition from the CPE program of Self Regional Healthcare. The plan of action will have the welfare and justice of its CPE students as its top priority.
   b. Any fees paid by students for units not completed will be refunded.

Staff Development Plan

STANDARD

Self Regional Healthcare promotes staff development and continuing education for professional growth and maintenance of current certification and ecclesiastical endorsement for ACPE Certified Educators and Board Certified Chaplains.

REQUIREMENTS

1. Certified Educators are to maintain current certification through ACPE, Inc. including current ecclesiastical endorsement.
2. Staff Chaplains are to maintain current certification through APC, including current ecclesiastical endorsement.
3. Each Certified Educator and/or Chaplain is responsible for participating in a minimum of fifty (50) contact hours of continuing education each calendar year for meeting ACPE and APC requirements.
4. Each Certified Educator and/or Chaplain will incorporate goals for meeting the educational requirements into his/her Performance Development plan.
5. The Certified Educator will document his/her involvement in a minimum of fifty (50) contact hours of continuing education per calendar year and will keep this file current.
6. The Department will include in its annual budget training/travel monies for regional and national conferences every year.

PROCEDURE

1. Staff members may use educational time to attend educational events pertinent to their professional development goals (as approved by one's supervisor).
2. Attendance for educational time off and any hospital paid travel expenses must be pre-approved by the Department Director.

Student Consultation

STANDARD

The CPE center will provide a mid-year consultation for all Residents regarding the student's learning process and/or learning goals as related to the goals and objectives of Level I or Level II CPE. This policy is to be discussed with all students during their CPE orientation.

PROCEDURES

A. The student shall be oriented to the goals and objectives of ACPE as spelled out in the most recent edition of *The Objectives and Outcomes for Level I/Level II CPE*.
B. At the end of each unit of CPE, the student's and the CE supervisor's evaluation of the student shall evaluate how the student has addressed the goals and objectives in his/her learning process.
C. Each Resident may have mid-year consultation.
D. In addition to the mid-year consultation, the CPE student may request a consultation at any time during their CPE experience. The student should make his/her request directly to his/her CE who will in turn select and schedule a consultation.
E. The consultation committee shall include the student's current CE, another CE, and at least one member of the Advisory Committee. Written Requirements for the consultation may include:
    - A copy of the student's learning covenant
    - Some documentation of the student's pastoral/supervisory work
    - A written statement by the student and/or CE outlining issues about which the consultation is requested.
    - The student's autobiography.
F. The CE supervisor will include the feedback from the consultation in the student's next final evaluation and/or in a separate report of the consultation.

Student Rights and Responsibilities

STANDARD

Students participating in the CPE program shall be informed of their Rights and Responsibilities.

PROCEDURES

A. Student Rights

1. A handbook (paper or electronic) is given to each CPE student containing:
   a. expectations
   b. curriculum
   c. student responsibilities
   d. policies
2 Orientation to CPE that includes a review of all ACPE policies and procedures is provided during the first week of CPE.
3. Protection of her/his professional privacy, through confidentiality of professional records as well as respect for confidentiality of training processes and inclusive of all written materials and conversations by supervisors, and peers.
4. Supervision by a Certified Clinical Educator, Associate, or CE Candidate. A written evaluation report by a certified CE or Associate within 21 days of completion of the unit.
5. Access to a population that provides significant opportunity for ministry and learning.
6. A peer group of at least three students that meets regularly.
7. A learning contract (covenant) with your primary supervisor and peer group and the presentation and use of literature and instruction appropriate to you learning goals.
9 Students may attach a written response to the supervisor's evaluation which then becomes a part of the student record.
10. Respect for individual religious and faith traditions.
11. Clearly written syllabus at the beginning of each unit.

B. Student Responsibilities

1. To attend and participate in the CPE and hospital orientation.
2. To deliver professional services to the assigned institutional populations.
3. To attend interdisciplinary rounds and meetings.
4. To honor peer and patient rights, to include confidentiality of medical and personal information.
5. To negotiate with peers and supervisors a learning contract and to actively and appropriately participate in one's clinical learning experience.
6. To meet minimum course requirements as outlined in the CPE curriculum.

Student Support Services

PURPOSE
To address Self Regional Healthcare's support of its CPE students through a variety of available services.

STANDARD
This policy is designed to serve as an informative resource to CPE students and a guide to the CPE staff regarding the support services available CPE students.

Available Support Services:

1. ***Orientation***
An orientation to Self Regional Healthcare and the CPE program is conducted for all persons entering CPE. See the curriculum section of the handbook for a more detailed description of the orientation process.

2. ***Educational Guidance***
The CPE program at Self Regional Healthcare is structured as an adult learning process that offers individual guidance to each student. Inherit in our program is regular individual supervision with the CPE Supervisor. The CPE program is designed to allow students to learn at their own pace. Intervention strategies vary for each person depending on the learning styles, openness to learning, and the individual learning contract.

3. ***Recommendations for Counseling Resources***
CPE students are encouraged to take advantage of counseling resources that are available through Cornerstone Counseling Service of Greenwood. The hospital financially supports those employees who want to experience personal growth by making therapeutic easily available. Ten sessions each fiscal year are provided free of charge to employees and immediate family members. Sessions after the ten free sessions are exhausted are available for a nominal fee.

4. ***Resume Preparation and Employment Search***
The Human Resource Department at SRH is a valuable asset to CPE students who are seeking employment after completion of their CPE training. The HR team member(s) offers guidance and tools for resume preparation. In addition the team member(s) offers guidance about how to market oneself for employment. The ACPE website offers additional help in resume preparation (http://www.acpe.org/Careers/Index.aspx).

Students seeking employment are encouraged to take advantage of many online resources for chaplaincy. These include but are not limited to (http://www.acpe.org/Careers/Index.aspx) and (http://www.professionalchaplains.org). In addition notices are posted on our department bulletin board.

Regular Collection of Data from Current and Former Students for Program Improvement

PURPOSE

To collect data from current and former students for the purpose of program evaluation and improvement.

STANDARD

Every group of CPE students who completes one or more units of training will be asked for feedback through an exit interview before they leave. The exit interview team will consist of the one member of the department staff, one or members of the Professional Advisory Group (PAG), and one former student. The departing student will meet with the exit interview team for one hour to give confidential feedback on their educational experience and suggestions for program improvement. The results of the exit interviews will be reported by the PAG to the Certified Educator and at the next PAG meeting. At that meeting there will be a discussion about how to implement student feedback for the improvement of the program. The department staff person will be responsible to schedule exit interviews. Feedback from students will include such questions as: What element of the program was most helpful to you? What element of the program was least helpful to you? What information/training would have been helpful to you as you move toward your future vocation? What surprised you about the program? What is one thing that happened that you will never forget? What suggestions do you have for improving the program? What was your favorite thing about the program?

In addition, each student will be sent an alumnae(i) questionnaire on the one-year anniversary date of their exit from the CPE program. The results of these questionnaires will be reported at the next meeting of the PAG with a discussion about how to implement suggestions from the feedback.

Self Regional Healthcare CPE Curriculum Cross Over

ACPE Level I & II Outcomes	ACPE Objectives	SRH CPE Curriculum Components	Common Qualifications and Competencies for Professional Chaplaincy
PASTORAL FORMATION			
L1.1: Articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry.	ACPE O1; O2; O3	**CPE Activities**: Orientation/Initial Group Formation, application materials, Mid-unit and End-unit evaluation, verbatim presentation, theological reflections, Level I & II consultation, IPR **Didactic:** Theological Reflection on the Practices of Ministry, Orientation to CPE and the Use of Self **Books**: *Models of Conceptual Theology,* Bevans. *When Bad Things Happen to Good People,* Kushner	**PIC2**: Articulate ways in which one's feelings, attitudes, values and assumptions affect professional practice. **PIC5**: Use one's professional authority as a spiritual care provider appropriately.
L1.2: Identify and discuss major life events, relationships, social locations, cultural contexts, and social realities that impact personal identity as expressed in pastoral functioning.	ACPE O1; O2; O3	Activities: Application materials, Mid-unit and End-unit self-evaluation, verbatim presentation, Level I & II consultation, IPR **Didactics:** Genograms in Pastoral Care, Family Systems Theory, **Books:** *Recalling Our Own Stories*-Edward Wimberly; *Generations to Generations*, Friedmann	**PIC1**: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care. **PIC3**: Attend to one's own physical, emotional, and spiritual well-being.
L1.3: Initiate peer group and supervisory consultation and receive critique about one's ministry practice.	ACPE O1; O2; O3	**CPE Activities**: Initial interview, verbatim presentation, Mid-unit and End-unit self-evaluations, shadow visits with peers and preceptors, Individual Supervision, IPR, Level I and II consultations **Didactics:** Orientation to CPE and the Use of Self, Care and Conflict in Pastoral Care **Books**: *Inside the Circle*-Joan Hemenway	**PPS1**: Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect. **MNT1**: Participate in a peer review process every fifth year. **PIC1**: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care

L2.1: Articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.	ACPE O1; O2; O3	**CPE Activities**: application materials, initial interview, verbatim presentation, theological reflections, Mid-unit and End-unit self-evaluations, Individual Supervision, IPR, Level I and II consultations, Pastoral Care Profile **Didactics:** Making Spiritual Assessments in a Post-Modern, Post-Church and Post-Christian World **Books**: *The Practice of Pastoral Care-* Carrie Doehring, *Toxic Mythologies*, Dolores T. Puterbaugh, *Images of Pastoral Care,* Dystra	**ITP1**: Articulate an approach to spiritual care, rooted in one's faith/spiritual tradition that is integrated with a theory of professional practice.

ACPE Level I & II Outcomes	ACPE Objectives	SRH CPE Curriculum Components	Common Qualifications and Competencies for Professional Chaplaincy
PASTORAL COMPETENCE			
L1.4: Risk offering appropriate and timely critique with peers and educators.	ACPE L1.4; O4; O5; O6; O7; O8 ACPE L2.4; O4; O5; O6; O7; O8	**CPE Activities**: Verbatim Consultations; IPR; Individual Supervision; Level I & II Consultations; Mid-unit & End Unit Evaluations; Exit Interviews; Program Evaluations; Alumni Surveys, role play, joint patient visits **Didactics:** Orientation to CPE and the Use of Self, Making Good Use of Pastoral Supervision **Books**: *Inside the Circle,* Hemenway,	**PIC6**: Advocate for the person's in one's care. **PIC8**: Communicate effectively orally and in writing. **PPS9**: Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups.

L1.5: Recognize relational dynamics within group contexts.	ACPE L15; O4; O5; O6; O7; O8	**CPE Activities**: IPR, verbatim presentations, Mid-unit and End-unit self-evaluations, shadowing visits with peers and preceptors, Individual Supervision, Level I and II consultations, inter-disciplinary teaming **Didactics:** Family Systems Theory, Emotional Intelligence in Ministry, Professional Boundaries **Books**: *Generations to Generations*, Friedmann, *Emotional Intelligence for Religious Leaders,* John Lee West and Roy M. Oswald	**ITP5:** Articulate a conceptual understanding of group dynamics and organizational behavior **PIC4**: Function in a manner that respects the physical, emotional, cultural, and spiritual boundaries of others **PPS9**: Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups
L1.6: Demonstrate the integration of conceptual understandings presented in the curriculum into pastoral practice.	ACPE L1.6; O4; O5; O6; O7; O8	**CPE Activities**: IPR, verbatim presentations, Mid-unit and End-unit self-evaluations, shadowing visits with peers and preceptors, didactics, webinars, Brown Bag Book Discussions **Didactics:** Orientation to CPE and the Use of Self, Chaplains as Team Member, Family Systems Theory, Ethics and Care **Books**: *Recalling Our Stories*, Wimberly. *Converging Horizons: Essays in Religion, Psychology and Caregiving*, Allan Cole, Jr.	**PPS2**: Provide effective spiritual support that contributes to well-being of the care recipients, their families, and staff. **PPS3**: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices. **OL3**: Understand and function within the institutional culture and systems, including utilizing business principles and practices appropriate to one's role in the organization.
L1.7: Initiate helping relationships within and across diverse populations.	ACPE O4; O5; O6; O7; O8	**CPE Activities**: Spiritual care to patients, families and staff across multiple units of the hospital; role plays; inter-discipline teaming and referral; joint visits and shadowing; didactics; **Didactics:** Making Spiritual Assessments in a Post-Modern, Post-Church and Post Christian World, Intersectionality of Race and Religion, Movie: White Savior: Racism In The American Church **Books:** *The Practice of Care,* Doehring. *In Living Color,* Lartey	**PPS1**: Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect. **PPS2**: Provide effective spiritual support that contributes to well-being of the care recipients, their families, and staff. **PPS3**: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.

L1.8: Use the clinical methods of learning to achieve one's educational goals.	ACPE O4; O5; O6; O7; O8	**CPE Activities**: Learning contract; initial group covenanting; verbatim presentations; Individual Supervision; Interpersonal Relationship Group; Mid-unit and End-unit evaluations; Level I & II consultations **Didactic:** Orientation to CPE and the Use of Self, **Books**: *How To Get the Most Put of CPE*-Gordon Hilsman; *Inside the Circle*-Joan Hemenway; *Pastoral Care in Context*, Patton.	**PIC1**: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care
L2.2: Provide pastoral ministry with diverse people, talking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspective.	ACPE O4; O5; O6; O7: O8	**Activities**: Spiritual care to patients, families and staff; critical incident debriefing; inter-disciplinary teaming; Interpersonal Relations Group; **Didactics:** Race and Religion, Ethics of Care, Boundaries and the Limits of Care. **Books**: *In Living Color,* Lartey. Taking Care*: Power Dynamics and Pastoral Care,* Doehring	**PPS3**: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices. **PPS11**: Document one's spiritual care effectively in the appropriate records.
L2.3: Demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.	ACPE O4; O5; O6; O7: O8	**Activities**: Spiritual care to patients, families and staff; critical incident debriefing; inter-disciplinary teaming; referral; Interpersonal Relations Group; memorial services/rituals; Spirituality Group **Didactics:** Empathetic Listening, Affects of Trauma on Chaplains-Webinar **Books**: *In Living Color*, Lartey, *Healthcare Ministry: Handbook for Chaplains,* Hayes and Poel, *Pastoral*	**PPS1**: Establish, deepen and conclude professional spiritual care relationships with sensitivity, openness, and respect. **PPS2**: Provide effective spiritual support that contributes to well-being of the care recipients, their families, and staff. **PPS3**: Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.

		Care and Counselin, Redefining Paradigms, Ramsey	**PPS4**: Triage and manage crises in the practice of spiritual care **PPS5**: Provide spiritual care to persons experiencing loss and grief. **PPS6**: Provide religious/spiritual resources appropriate to the care recipients, families, and staff. **PPS7**: Develop, coordinate, and facilitate public worship/spiritual practices appropriate to diverse settings and needs. **PPS8**: Facilitate theological/spiritual reflection for those in one's care practice **PPS9**: Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups. **PPS10**: Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care. **OL1**: Promote the integration of spiritual care into the life and service of the institution in which one functions.

L2.4: Assess the strengths and needs of those served; grounded in theology and using an understanding of the behavioral sciences.	ACPE O4; O5; O6; O7: O8	**CPE Activities**: Verbatim presentations, spiritual care to others, charting in EPIC, inter-disciplinary teaming, shadow visits with peers, educators or other care colleagues **Didactics:** Mental Impairments in Ministry. Making Spiritual Assessments, Mental Health Chaplaincy **Books**: *Understanding and Counseling Persons with Alcohol, Drug and Behavioral Addictions* by Howard Clinebell, *Behind the Masks,* Oates. *Coping with Genetic Disorders: A Guide for Clergy and Parents* by John C. Fletcher.	**ITP1**: Articulate an approach to spiritual care, rooted in one's faith/spiritual tradition that is integrated with a theory of professional practice. **ITP2**: Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of spiritual care. **ITP3**: Incorporate the spiritual and emotional dimensions of human development into one's practice of care **ITP4**: Incorporate a working knowledge of different ethical theories appropriate to one's professional context. **ITP5**: Articulate a conceptual understanding of group dynamics and organizational behavior. **ITP6**: Articulate how primary research and research literature inform the profession of chaplaincy and one's spiritual care practice.

L2.5: Manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.	ACPE O4; O5; O6; O7: O8	**CPE Activities**: Successfully navigating the various medical center systems and managing multiple schedules including the CPE, on-call, spirituality groups and charting, inter-disciplinary teaming **Didactics:** Time Management in Ministry, Professional Boundaries in Chaplaincy **Books**: *Health Care Ministry: A Handbook for Chaplains* by Helen Hayes and Cornelius J. Van Der Poel, .	**QUA1**: Provide documentation of current endorsement or of good standing in accordance with the requirements of his/her own faith/spiritual tradition. **QUA2**: Be current in the payment of the annual fees as designated by one's professional association. **QUA3**: Have completed an undergraduate degree from a college, university, or theological school accredited by a member of the Council for Higher Education Accreditation (CHEA) and a graduate-level theological degree from a college, university or theological school accredited by a member of the CHEA. Equivalencies for the undergraduate and/or graduate level theological degree will be granted by the individual professional organizations according to their own established guidelines. **QUA4**: Provide documentation of a minimum of four units (Levels I & II) of Clinical Pastoral Education (CPE) accredited or approved by the Association for Clinical Pastoral Education (ACPE), by programs that were accredited by the former United States Conference of Catholic Bishops Commission on Certification and Accreditation (USCCB/CCA), or the Canadian Association for Spiritual Care (CASC/ACSS). Equivalency for one unit of CPE (two units in CASC) may be considered. Section I: Integration of Theory and **PIC8**: Communicate effectively orally and in writing

L2.6: Demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.	ACPE O4; O5; O6; O7: O8	**CPE Activities**: Spiritual care to patients, families and staff; critical incident debriefing; inter-disciplinary teaming; referral; Interpersonal Relations Group; Spirituality Group **Didactics:** Orientation to CPE and the Use of Self in Ministry. Pastoral Care Profile **Books***: Shared Wisdom*-Pamela Cooper-White;	**PIC1**: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care. **PIC2**: Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice. **PIC3**: Attend to one's own physical, emotional, and spiritual well-being. **PIC4**: Function in a manner that respects the physical, emotional, cultural, and spiritual boundaries of others. **PIC5**: Use one's professional authority as a spiritual care provider appropriately. **PIC6**: Advocate for the persons in one's care **PIC7**: Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Clinical Pastoral Educators, and Students **PIC9**: Present oneself in a manner that reflects professional behavior, including appropriate attire, and grooming.

ACPE Level I & II Outcomes	ACPE Objectives	SRH CPE Curriculum Components	Common Qualifications and Competencies for Professional Chaplaincy
PASTORAL REFLECTION			
L1.9: Formulate clear and specific goals for continuing pastoral formation with reference to one's strengths and weaknesses as identified through self-reflection, supervision, and feedback.	ACPE O9; O10	**CPE Activities**: Application materials; admission interview; learning contract; weekly reflection; Mid-unit & End-unit evaluations; Level I & II consultations; Individual Supervision; verbatim consultations **Didactics:** Ministerial Assessment, HR Presentation, The Enneagram and You **Books**: *Faith Development and Pastoral Care*-James Fowler; *The Wounded Healer*-Henri Nowen; *The Skilled Pastor*-Charles W Taylor	**PIC1**: Be self-reflective, including identifying one's professional strengths and limitations in the provision of care.

L2.7: Establish collaboration and dialogue with peers, authorities and other professionals.	ACPE O9; O10	**CPE Activities**: Verbatim presentations, IPR, inter-disciplinary teaming, shadow visits with peers, educators or other care colleagues, webinars, conferences, didactics, making referrals to community colleagues **Didactics**: Nurse and the Chaplain, Case Management and the Chaplain, Spiritual Assessments, Chaplain as Professional **Books**: *Health Care Ministry: A Handbook for Chaplains* by Helen Hayes and Cornelius J. Van Der Poel.	**ITP6**: Articulate how primary research and research literature inform the profession of chaplaincy and one's spiritual care practice. **OL2**: Establish and maintain professional and interdisciplinary relationships. **OL4**: Promote, facilitate, and support ethical decision-making in one's workplace. **OL5**: Foster a collaborative relationship with community clergy and faith group leaders
L2.8: Demonstrate self-supervision through realistic self-evaluation of pastoral functioning.	ACPE L1.9; O9; O10	**CPE Activities**: application materials, initial interview, verbatim presentations, IPR, Individual Supervision, Mid-unit and End-unit self-evaluations, Level I and II consultations **Didactics:** Pastoral Care Profile, Ministerial Assessment, **Books**: *Basic Types of Pastoral Care and Counseling*, Clinebell, *Uncovering Spiritual Narratives,* Coyle	**PIC1:** Be self-reflective, including identifying one's professional strengths and limitations in the provision of care. **PIC3**: Attend to one's own physical, emotional, and spiritual well-being
L2.9: By the end of Level II, students will be able to demonstrate awareness of the Common Qualifications and Competencies for Professional Chaplains	ACPE O1, O2, O3, O4, O5, O6, O7, O8, O9; O10	**CPE Activities**: Learning contract, Mid-unit and/or End-unit self-evaluations, Individual Supervision, Level I and II consultations, resume writing, interviewing for jobs	**OL4**: Promote, facilitate, and support ethical decision-making in one's workplace. **MNT5**: Adhere to the Common Code of Ethics for Chaplains, Pastoral Counselors, Clinical Pastoral Educators, and Students

Basic Elements of the Self Regional Healthcare CPE Program

The following seminars and experiences detail the different learning experiences of our CPE program:

1. Verbatim Seminar

In this seminar, students will be presenting written accounts of their pastoral work in the form of verbatims, significant pastoral event reports, or case studies/stories for feedback, discussion, and evaluation with their peers. Students will be asked to take the lead in presenting their work and the questions or issues it raises for them. Both verbal and written feedback will be part of the process by CE and peers. One verbatim may be a case history that explores pastoral dynamics of a student's relationship with a particular person over the course of the unit.

2. Didactic Seminar

Didactics will be organized to provide a foundation for their work in the area of disabilities and their understanding of pastoral care. Some didactics will be led by the CE and Staff Chaplain while other didactics will be organized with student input and leadership.

3. Interpersonal Relationship Group (IPR)

The IPR group is an open time for the CPE group to work with each other on issues of pastoral support, clarification of personal and professional identity, and their capacity for mutual learning and growth in a learning community. A strong focus of the CPE curriculum is on issues of community building for everyone, particularly people with physical and mental illness and their families. Thus, the IPR Group is an opportunity for the group to work together on what it means to be a community with each other, to utilize a peer group for support, clarification, and confrontation, and to explore personal, practical, philosophical, and theological dimensions of community. That includes both the initial and ongoing process of contracting with each other about expectations, structure, hopes, and commitment.

4. Worship/Devotions

Each group learning day begins in community with a period for worship and devotions, with revolving leadership, including the supervisor, to serve as a time for spiritual support, and for integrating issues in learning into the practice of personal and communal faith. In addition, the regular chapel worship times will also be a way of learning about the diversity of religious traditions, gifts, and backgrounds within the group. All members will have responsibility for leading worship in ways that is inclusive of all participants.

5. Individual/Group Supervision

Over the course of one unit, each student will have the opportunity for approximately five to eight hours of individual/group supervision and consultation with the CE. Students are responsible for setting the agenda for these sessions with the supervisor, and can use them for a variety of functions that relate to their own learning goals, including reflection on written assignments, consultation on pastoral issues and strategies within their placement site and/or congregation, and personal support. The philosophy of the supervisors is that students will be encouraged to deal with significant therapeutic issues in more appropriate settings and those issues involving the learning group should be brought back to the learning community, i.e. IPR group. Individual/group supervision does provide an opportunity for more extended and specific interaction and consultation. One-on-one supervision is available upon request.

6. Evaluation

Throughout the unit students are giving opportunities to give and receive evaluative feedback from the CE and other peers. This usually occurs during mid-unit and at the end of each training unit. Final self

evaluations will be written and presented in group by each student on the last day of the training unit. NOTE: You must be present and participate in the final evaluation in order to receive credit for the unit. The CE Supervisor will also write a confidential final evaluation for each student after the end of the training unit. The CE's final evaluation will only be shared with the individual student and must will completed within 21 days of the completing of the unit. Refer to the 2020 ACPE Accreditation Manual for guidelines about the End of the Unit Evaluations: https://www.manula.com/manuals/acpe/acpe-manuals/2016/en/topic/final-evaluations.

Self Regional Healthcare
Clinical Pastoral Education Program
Adjunct Faculty

ACPE Standard 3 – uses adjunct faculty and/or guest lecturers who provide interdisciplinary consultation and teaching

A variety of educational options and resources are available to students in The Self Regional Healthcare Center CPE program, as outlined in the Student Handbook. In addition to the CE and Staff Chaplain(s), the following resources have been used for didactic components of the program:

- Interdisciplinary adjunct faculty are used to present educational workshops coordinated by our CPE Center.
- CPE Groups have attended workshops on mental illness, spirituality and health, and ethical issues sponsored by area seminaries or other organizations.
- Occasional use of training videos

Self Regional Healthcare
Clinical Pastoral Education Program
Orientation Process

The student orientation to The Self Regional Healthcare Clinical Pastoral Education Program is composed of three major components:

1. ***Orientation to Self Regional Healthcare***

   All CPE students must complete a two-day hospital orientation before beginning the CPE program at SRH. This orientation will cover such topics as HIPPA, safety, corporate compliance, and a general orientation to the culture of Self Regional Healthcare.

2. ***Orientation to the CPE Program***

   The first week of the program involves a structured process for introducing students to each other and a thorough review of the Student Manual. The Student Manual is given to students the first day of the program so they have a chance to review it. Students are also asked to sign a list of statements indicating their review of the responsibilities, policies and procedures for the program as outlined in the Manual. In the first month of the program, didactic sessions focus on such subjects as crisis ministry, on-call responsibilities, Emergency Room Ministry, spiritual assessment, theological reflection, introduction to grief and loss, age specific competencies, understandings of spirituality and pastoral identity, and discussions of strategies for integration into clinical sites.

3. ***Clinical Assignment Orientation***

   As outlined in the Student Handbook, the Staff Chaplain(s) have the responsibility of working out an orientation process with the CPE student orienting the student to the assigned areas. This orientation will include introduction of student to managers on the assigned area, observation, and understanding of interdisciplinary team meetings.

4. ***Development of the Learning Agreement***

   As part of the group sessions with the CE and Individual Supervisory Sessions, the first month of the program includes a focus on learning goals and the learning agreement, along with the use of a person centered educational process. The major goal of the first month of the program is the development of a learning agreement that draws upon the student goals, the resources of the program and the needs/options of the clinical assignments.

Written Requirements

These are the written requirements for the CPE Unit Program:

1. **A Learning Contract**
   A learning contract will be developed in the first month of program in consultation with the CPE Supervisor. The format and guidelines are in Appendix B - Guides.

2. **Verbatims or Significant Pastoral Event Reports**.
   These are reports of a learning experience in your pastoral work which raised questions for you, provided significant learning, and/or illustrates learning goals or issues for which you want group feedback and discussion. These are presented to the group for oral and written feedback on a rotational basis and submitted to the CE by the end of the workday each Friday. Names should be changed to protect confidentiality. Sample formats for a verbatim and critical incident report are located in Appendix B - Guides. We encourage one verbatim each unit to be a case study, with notes and reflections about a significant pastoral relationship over the course of the CPE Unit.

3. **Reflection Papers**
   Reflection reports are weekly reflections on your overall work and learning in the program, including reflections on progress toward your goals, the impact of your experiences on your pastoral identity, theology, etc. It can be a form of journaling, of putting issues and questions on paper that you want to talk about with the supervisor, and/or a way of commenting on the program. These are used in supervision with the program supervisor, who will also give you written comments and feedback. Refer to Appendix B - Guides.

4. **Mid-Unit Evaluation**
   A mid unit evaluation is conducted near the mid-unit mark of the Summer Intern, Extended and the first Resident CPE unit. See the guide in Appendix B - Evaluations.

5. **Final Evaluation**
   A Final evaluation is written by the student and the CE at the completion of each CPE unit. Refer to Appendix B - Evaluation

Expected Outcomes of Level I CPE

ACPE Standard 3 - Outcomes of CPE Level 1 Programs. At the conclusion of CPE Level I students are able to:

CPE provides theological and professional education using the clinical method of learning in diverse contexts of spiritual care. ACPE accredits two types of clinical pastoral education programs: CPE Level I/Level II and Certified Educator CPE. ACPE accredited programs provide a progressive learning experience through a two-level curriculum. Level I curriculum outcomes must be satisfactorily addressed prior to admission Level II. Completion of CPE Level I/Level II curriculum outcomes is a perquisite for admission to Certified Educator CPE. It is a goal to ensure that students are knowledgeable about the Common Qualifications for Professional Chaplains. Students in the CPE program are asked to use these Expected Outcomes of Level CPE, as outlined in ACPE Standards, as a resource for guiding the development of their learning goals. The Expected Outcomes will be utilized by the CE in mid-unit and final evaluations, and by the on-site mentor as a way of providing feedback to the student and supervisor.

Pastoral Formation
Level I Outcomes

L1.1. articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry.
L1.2. identify and discuss major life events, relationships, social location, cultural contexts and social realities that impact personal identity as expressed in pastoral functioning.
L.1.3. initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Pastoral Competence
Level I Outcomes

L1.4. risk offering appropriate and timely critique with peers and supervisors.
L1.5. recognize relational dynamics within group contexts.
L1.6. demonstrate integration of conceptual understandings presented in the curriculum into pastoral practice.
L1.7. initiate helping relationships within and across diverse populations.
L1.8. use the clinical methods of learning to achieve one's educational goals.

Pastoral Reflection
Level I Outcomes

L1.9. formulate clear and specific goals for continuing pastoral formation with reference to one's strengths and weaknesses as identified through self-reflection, supervision and feedback.

Expected Outcomes for Level II CPE

ACPE Standard 3 - Outcomes of CPE Level I1 Programs. At the conclusion of CPE Level II students are able to:

Students in the CPE program are asked to use these Expected Outcomes of Level CPE, as outlined in ACPE Standards, as a resource for guiding the development of their learning goals. The Expected Outcomes will be utilized by the CE in mid-unit and final evaluations, and by the on-site mentor as a way of providing feedback to the student and supervisor. Students who have applied for Level II CPE are expected to achieve the following outcomes upon completion. These will be used by the CE and On-Site Mentor in mid-unit and final evaluation processes.

From 2020 ACPE Standards:

> The curriculum for CPE Level II addresses the development and integration of pastoral formation, pastoral competence and pastoral reflection to a level of competence that permits students to attain professional certification and/or admission to Supervisory CPE. Level II curriculum involves at least two or more program units of CPE. The CE determines whether the student has completed Level II outcomes based on the student's competence. The CE must document completion of Level II outcomes in the student's final evaluation.

Pastoral Formation
Level II Outcomes

L2.1. articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.

Pastoral Competence
Level II Outcomes

L2.2. provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspectives.
L2.3. demonstrate a range of pastoral skills including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
L2.4. assess the strengths and needs of those served grounded in theology and using an understanding of the behavioral sciences
L2.5. manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.
L2.6. demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.

Pastoral Reflection
Level II Outcomes

L2.7. establish collaboration and dialogue with peers, authorities and other professionals.
L2.8. demonstrate self-supervision through realistic self-evaluation of pastoral functioning.
L2.9. by the end of Level II, students will be able to demonstrate awareness of the Common Qualifications and Competencies for Professional Chaplains.

Self Regional Healthcare
Clinical Pastoral Education
CPE Intern Unit Guidelines

Each unit, you are expected to participate in your learning through your ministry, assigned readings, individual reflection, your peer group, supervisions, and written work.

I. Clinical Practice

400 clinical and educational hours are required to receive one unit of CPE. The unit will require a forty-hour commitment each week plus one overnight every week. There are two options for each student to fulfill the necessary amount of hours required for CPE:

1. All hours completed here at Self Regional Healthcare. Student will need to be present at SRH M-F (8:30AM – 5:00 PM) plus one night on call each week.

2. For those students who serve as a congregational pastors or staff minister it is possible to complete 8 of the required hours in the performance of pastoral care functions within the congregation. Students who have an approved field site (pre-approved by the CE) may also complete a Clinical hours at the field site. In addition, each student will need to document the 16 additional hours of pastoral care. A contract will be made with a site reflector in the student's parish or other approved site who will be willing to meet with the CE and student and offer honest feedback concerning his/her observation of the student's pastoral care. Educational offerings will normally be held on Tuesday, Wednesday and Thursday each week. There will be exceptions to this during orientation, the final graduation week and during other educational opportunities.

3. Each student is required to provide a minimum of 22-25 hours of documented pastoral care weekly. A minimum of 50 patients visits are to be made. In addition, the Chaplain is expected to be a pastor to his/her staff. This includes:

- Participation in team meetings & other interdisciplinary meetings with staff.
- Weekly On Call: Only actual clinical hours may be counted (making rounds, visits)

II. Clinical (Verbatim) Seminars

The heart of CPE is ministering and learning from the experience. One primary method that will be used in accomplishing this is the verbatim. We will have weekly verbatim seminars. In the clinical seminar two students will each present a pastoral encounter to other students and the CE for discussion and feedback. These seminars will typically last 1 ½ hours.

III. Didactic Seminars

During the unit we will participate in weekly didactic seminars. The CE or other pastoral care specialist will lead these seminars. These seminars will emphasize basic pastoral care skills. Each seminar will include lecture and group participation.

IV. Community Ministry (optional)

Each Intern will be expected to perform community ministry this unit. Each student should give thought to how she/he will meet this requirement. Some suggestions from past projects include: The Free Medical Clinic/Greenwood United Ministries, prison ministry, PTSD Counseling at the Lutheran Residential facility, mentoring/tutoring school children. Each student is responsible for creating their place of community ministry. The community ministry must average at least one hour per week. A contact will be developed between the student and the Staff Chaplain/Clinical Supervisor.

V. Reading Seminar

The general format will be the students taking turns facilitating the discussion. In addition, each student will be expected to reflect on his/her reading in his/her weekly reflection papers.

VI. Individual Supervision

Each student will meet with his/her CE one hour every other week for supervision. The student is responsible for scheduling supervision sessions with the supervisors, bringing work for supervision, and asking for the consultation needed. A learning contract will be developed between the student and CE stating no more than three goals that the student would like to work on during the unit that will focus on pastoral reflection, pastoral formation, or pastoral competence.

Materials Required for Individual Supervision: Weekly written materials required (unless otherwise negotiated) include a weekly reflection paper, verbatim and weekly report forms that will be used for documenting the 22-25 hours of clinical work and initial visits. The weeks, in which you are presenting a verbatim to the group, a verbatim for individual supervision is optional. Also a verbatim is not required during the weeks of mid-unit and final evaluation.

VII. Interpersonal Relationship Group

Each week we will meet together for IPR - interpersonal relationship group sessions. These sessions will involve mutual support confrontation and clarification. The group will begin with an opportunity for each person to “check in” – stating “where each person is” interpersonally. Any group member can claim time to discuss an issue after the initial check-in. You will be expected to risk offering appropriate and timely critique to your peers and risk receiving the same from them.

VIII. Mid Unit and Final Evaluations

A mid unit and final evaluation are scheduled. A guide sheet will be provided to you to help you evaluate your progress on the learning contract, pastoral care skills, and your relationships with patients, peers and CE(s). Your final evaluation will become a permanent part of your CPE file.

Self Regional Healthcare
Clinical Pastoral Education
Resident Unit Guidelines

Each unit, you are expected to participate in your learning through your ministry, assigned readings, individual reflection, through utilizing your peer group, supervisions, and through your written work.

I. Clinical Practice

Each student is required to provide a minimum of 22-25 hours of documented pastoral care weekly. A minimum of 50 patient visits are to be made. In addition, the Chaplain is expected to be a pastor to his/her staff. This includes:

- Participation in team meetings & other interdisciplinary meetings with staff.
- Weekly On Call: Only actual clinical hours may be counted (making rounds, visits)

A minimum of 22 hours each week (or average of all weeks) must be achieved in order to successfully receive a unit of CPE credit (400 Clinical & Educational Hours).

II. Clinical (Verbatim) Seminars

The heart of CPE is ministering and learning from the experience. One primary method that will be used in accomplishing this is the verbatim. We will have 1 – 2 verbatim seminars per week. In the clinical seminar two students will each present a pastoral encounter to other students and the CE for discussion and feedback. These seminars will typically last 1 ½ hours.

III. Didactic Seminars

During the unit we will participate in weekly didactic seminars. The CE or other pastoral care specialist will lead these seminars. These seminars will emphasize basic pastoral care skills. Each seminar will include lecture and group participation.

IV. Community Ministry (optional)

Each Resident will be expected to perform community ministry this unit. Each student should give thought to how she/he will meet this requirement. Some suggestions from past projects include: The Free Medical Clinic/Greenwood United Ministries, prison ministry, PTSD Counseling at the Lutheran Residential facility, mentoring/tutoring school children. Each student is responsible for creating their place of community ministry. The community ministry must average at least one hour per week. A contact will be developed between the student and the Staff Chaplain/Clinical Supervisor.

V. Reading Seminar

The general format will be the students taking turns facilitating the discussion. In addition, each student will be expected to reflect on his/her reading in his/her weekly reflection papers.

VI. Individual/Group Supervision

Each student will meet with his/her CE one hour every other week for supervision. The student is responsible for scheduling supervision sessions, bringing work (explained below) for supervision, and asking for the consultation needed. A learning contract will be developed between the student and CE stating no more than three goals that the student would like to work on during the unit that will focus on pastoral reflection, pastoral formation, or pastoral competence.

Materials Required for Individual-Group Supervision: Weekly written materials required (unless otherwise negotiated) include a weekly reflection paper, verbatim and weekly report forms that will be used for documenting the 22-25 hours of clinical work and initial visits. The weeks, in which you are presenting a verbatim to the group, a verbatim for individual supervision is optional. Also a verbatim is not required during the weeks of mid-unit and final evaluation.

VII. Interpersonal Relationship Group

Each week we will meet together for IPR - interpersonal relationship group sessions. These sessions will involve mutual support confrontation and clarification. The group will begin with an opportunity for each person to "check in" – stating "where each person is" interpersonally. Any group member can claim time to discuss an issue after the initial check-in. You will be expected to risk offering appropriate and timely critique to your peers and risk receiving the same from them.

VIII. Mid Unit and Final Evaluations

A mid unit evaluation will be scheduled at the midpoint the first unit. A final evaluation day will be scheduled at the conclusion of every unit. A guide sheet will be provided to you to help you evaluate your progress on the learning contract, pastoral care skills, and your relationships with patients, peers and supervisor(s). Your final evaluation will become a permanent part of your CPE file.

Self Regional Hospital
Clinical Pastoral Education Program
Unit Training Schedule

Schedule

8:30a – 9:00a Morning Report
9:00a -9:15a Devotional Reading
9:30a – 11:00a Didactic
11:15a – Noon Verbatim
Noon – 1:00p Lunch
1:00p – 4:00p Individual-Group Supervision
4:15 – 5:00p IPR and Debriefing

Learning Covenant Guide

An individual learning covenant is developed by each participant in CPE early in the unit (within the first month of an extended unit; two weeks for a full time unit) (Due dates will vary). Each student must develop no more than three learning goals for each unit.

The purpose of the learning covenant is for the CPE student to identify the key learning goals and questions which he/she wants to address during the course of the unit.
It will be used in following ways:

1. As a focus for the first month of the CPE orientation, developed in collaboration with the CE.

2. It will be verbally shared with peers in the training group early in the unit as part of facilitating peer feedback and support.

3. It will be verbally discussed with Clinical Site Mentor and Consultation Committee in order to help the student in meeting his/her learning goals.

4. At mid-term evaluation, it will provide a framework for evaluation of progress, and feedback with peers, CE, and Consultation Committee. This is a good point to make revisions as appropriate.

5. It will be utilized by the student and CE, and Professional Consultation Committee, in the final evaluation of the student's learning within the unit.

In developing a learning covenant, a student needs to consider:
- The personal, professional and practical goals which they bring into the CPE unit.
- The objectives of CPE and our curriculum based on those objectives.
- The Expected Outcomes for Level I and Level II CPE.
- The learning resources available to them through the educational and training resources of Self Regional Healthcare, including pastoral work and assignments, the variety of educational experiences available, staff, peers, CE, readings, clergy, and others. In an extended unit, students have the first month of the program to use for orientation and consultation on their specific learning goals.
- An Outline and Worksheet for the written learning goals will be used with the consultation committee, CE, and peer group to outline and share those goals.
- In the early part of the program, we will utilize a group process to help students articulate and frame their learning goals.

Goals need to be:
- Realistic
- Specific
- Appropriate to the clinical setting
- Appropriate to the time limits of the CPE program
- Measurable or observable

Attention should be given to the CPE Objectives. A few guiding questions that me be used in formulating goals include:

1. What am I motivated to learn about now?
2. Where do I feel uncomfortable and want to grow?
3. What interest area excites my curiosity presently?
4. What am I willing to do to reach my goal?
5. What benefit will I gain by accomplishing this goal?
6. How will I know when I have reached it?
7. What would I gain be sabotaging myself concerning this goal?
8. What goals am I avoiding or postponing for now?
9. How do I want to change my relationships?

Each student is asked to identify no more than three learning goals. Learning goals should be based on specific attitudes, knowledge, behavior or skills necessary for you to become a competent practitioner of pastoral ministry. Students are asked to choose one goal for each of the following categories:

1. **Personal** goals are related to any changes in one's personality or behavior that are preventing effective pastoral care. E.g. Avoiding conflict, procrastination, issues with authority, personal insecurities, etc.

2. **Professional** goals seek to enhance one's knowledge of a subject area related to your clinical assignment. E.g. Proficient use of Medical Terminology, Understanding the role of a chaplain as a member of the multidisciplinary team, Learning more about spiritual assessments in pastoral care, etc.

3. **Practical** goals focuses on developing skills that will improve the quality of your pastoral care to patients in the hospital. E.g. Active Listening, Effective prayers, Appropriate responses to grief, Use of religious resources to address patient needs, etc.

Goals should be specific, clear, realistic and measureable. Goals can also be renegotiated as the unit progress and your understanding of your learning needs become more well-defined. The Learning Covenant should be discussed with your CE and peers, and should serve as a centering-point for all reflections during the unit. See the format for the Learning Covenant in the handbook.

Format for the Learning Covenant

Name _____ Date _____
Subject: Learning Contract for ____ unit.

(Repeat this guide for each of your goals.)

My Learning Goals for this unit are:

I. Goals (Personal, Professional, Practical) _____

II. My Action Plan for achieving this goal. (To meet this goal I will do……)

b. _E.g. Verbatims_____

c. _E.g. Readings_____

d. _E.g. Interviews_____

e. _____

III. Resources I will utilize to achieve this goal. Be sure to include written resources you will use, lectures, conferences etc., as well as, human resources such as the CE, staff chaplains, medical personnel, etc.

a) _____

b) _____

c) _____

d) _____

IV. Success in the Learning Process
What awareness do you have of how you learn? What three (3) ways do you learn best? What keeps you from being successful in your learning? List (3) ways you sabotage learning?

_____ _____
Student Certified Educator

Guidelines for Reflection Paper (RP)

Name:
Date:
Unit:
Certified Educator:

1. Describe your progress with your learning goals? What goals have received the most attention? Why? Are there any changes that need to be made on your Learning Covenant?

2. What peer relationships have had the greatest impact on you this unit? The least impact? (This may include parishioners, peers, CE, ministry staff, denominational leaders, seminary faculty, etc.)

3. What new things have you become aware of about **SELF** this week? What changes have you made? How have you practiced self-care? Give examples.

4. What have been the main theological themes this week? What scriptures come to mind that reflect your pastoral care?

5. What would you most like to focus on in individual supervision today?

NOTE: One-two pages single spaced typed. Make copies for each peer member and supervisor.

(Sample)

Verbatim

Person's Initials L,R	*Person's Age* *18 years old*
Date and Location of Visit June 22, 2000/ Hospital	*Person's Race* *Caucasian*
Length of Visit *20 minutes*	*Person's Marital Status* *Single*
Type of Visit *Request by the mother*	*Person's Gender* *Male*
Verbatim Number (e.g., 001, 002) *1*	*Describe Your Assessment of the Need for Pastoral Support Supportive care for the mother*
Name of CPE Student *Lois Lane, Youth Pastor Intern*	*Name of CPE Supervisor* *Dr. Thomas*

Title: The "bites" of life

Chaplain's Dilemma(s): How to connect?

Diagnosis/prognosis: An eighteen-year-old male who was being discharged this afternoon after being treated for a poisonous spider bite.

Peer group focus: I would like the group to focus on my ability to engage with the mother, **L**, in this pastoral visit. Moreover, I would like suggestions/insights to how I could have been more intentional in my pastoral role.

Introduction: I was at the church making preparations for another meeting when I received a page from the 6th floor about the mother of a teenage patient. She indicated her son was about to be discharged from the hospital within the next hour or so. The mother asked if I would be willing to visit with them. She explained, in a low tone of voice that was almost a whisper that they were returning to a local shelter today. Surprised by this information, I agreed and immediately headed to the hospital floor.

L is a Caucasian woman in her mid-forties. She has shoulder length blonde hair and was casually dressed in blue jeans and brightly colored blouse. Her eyes were swollen and red and her make-up was smeared. My sense was that she was distressed and anxious. The father, Native American, was also present. He was tall and very quiet.

C= Youth Pastor **L**= Mother **F**= Father

C1: Good morning, I am the chaplain. Who are you?

L1: I am his mother (Looking sad)
F2: (Remaining quiet and distant).

C2: How can I be helpful as your chaplain?

L2: Please pray for us (Tears coming down her left cheek).

F2: (Looks at me) Amen. We need the Lord's help.

C2: (Feeling anxious). Sure. What would you like me to specifically prayer for?

Self-Evaluation: I was aware during this visit of my feelings of helplessness. L was uncertain of how to best help her son. In a parallel way, I was uncertain of how best to help L. I felt empathy for L and my heart went out to her. I also experienced a sense of inadequacy when I could not directly relate to her journey as a parent. In an effort to connect with her, I thought back to my teenage years and how my parents felt about my leaving home to go to college. I tried to relate to L's pain through the eyes of a teenager. I offered her a personal family story that came to mind and hoped it would help.

Theological Reflection: As I reflected on this pastoral visit, I remembered the parable of the prodigal son and his older brother (Luke 15: 11-32). In this visit, however; it was a mother who told me how much both of her sons meant to her. She seemed to understand the older son but the youngest son is a mystery to her. In a way, T is L's prodigal son right now. She doesn't understand him but she longs for his safety and his well-being. She is experiencing guilt and lamenting the circumstances of the situation. My sense is that she also has hope that she will one day be able to welcome T home with open arms and that he will be a stronger, wiser and more independent young man.

Lessons in Ministry: I was reminded in this visit of the importance of gathering basic data on the situation. I learned that obtaining necessary information helps me feel more confident and relaxed in my ministry. I have a sense of being better connected to the people and dynamics of the event. (Include concepts for your readings that were most helpful to your understanding of this event.)

WELCOMING AND PRAYER FOR FIRST DAY OF CLINICAL PASTORAL EDUCATION

WORSHIP

OPENING PRAYER: (Prayer together)

I love you, O God, with all my heart,
And with the whole of my being.

Wide open am I to love and be loved
Because You have first loved me.

Daily I seek to share that love
As I touch the lives of others.

Daily I seek and receive love
As others reach out to me.

Teach me to serve You generously
As a sign of love extended.

HEBREW SCRIPTURE READING: I Samuel 3:1-10

RESPONSIVE READING:

Leader: God's kingdom come!
In the healing of pain and suffering.
Of poverty and oppression.

All: God's kingdom come!
In the bursting forth of our care
For your planet earth and for all peoples.

Leader: God's kingdom come!
In the harmony between nations
And people of every race, of every creed.

All: God's kingdom come!
In the cherished dignity for each person,
For family, for congregation.
God's kingdom come!

We praise You and thank You for Your faithfulness to us on our journey of life and Mission. Fashion us according to the designs of Your heart. Make us and all things Your gifts for this age. Amen.

COMMISSIONING FOR SERVICE AT SELF REGIONAL HEALTHCARE

PRAYER

O God of Wisdom, and God of love.
You have called each of us by name.
You have called us to participate in your mission.
You have called us in a special way to serve the sick and needy at this hospital.
Today, we recognize each of these new ministers who join us, for a time and we bless them as they begin
Their ministry to the patients, families and staff of Self Regional Healthcare.
You go before each of us preparing the way
Through difficulties…fury, fire and flood,
Crises, pain, days on call.
Be with each of us and especially these chaplains who join us today
As we live in and through You and Your love. Amen

LITANY

Leader: We beg You, O God!
See our mistakes: be our truth.
See our struggling: be our road.
See our death: be our life.

All: Be with us, O God, for You are our hope.

Leader: See our weakness: be our strength.
See our foolishness: be our wisdom.
See our failures: be our hope.

All: Be with us, O God, for You are our hope.

Leader: See our anguish: be our peace.
See our hunger: be our bread.
See our thirst: be our faith.

All: Be with us, O God, for You are our hope.

Leader: See our pride: be our humility.
See our darkness: be our light.
See our night: be our star.

All: Be with us, O God, for You are our hope.
In each of us may your presence be our strength,
And may You guide us in all we do, O God, we pray. Amen.

BLESSING:

May the God of strength be with you, holding you in strong-fingered hands; may you be the sacrament of God's strength to those whose hands you hold; may the blessing of strength be on you. Amen.

May the God of gentleness be with you, caressing you with sunlight and rain and wind; may God's tenderness shine through you to warm all who are hurt and lonely, may the blessing of gentleness be with you. Amen.

May the God of compassion be with you, holding you close when you are weary and hurt and alone…when there is rain in your heart; and may you be the warm hands and warm eyes of compassion for the patients and others who reach out to you in need; may the blessing of compassion be on you. Amen.

May the God of Love be with you, listening to you, telling you Her secrets, giving Himself to you, drawing you close as you tremble ant the edge of self-gift. May God's love light in you the fires of faith and hope, and may the fires grow, burst, and enflame the whole earth; and may God's love in you glow in your eyes and meet God's love glowing in the eyes of all who meet you; may the blessing of love, the blessing of service, be on you. Amen.

A SERVICE OF BAPTISM/BLESSING/NAMING/COMMENDATION AT THE DEATH OF A BABY

We are gathered in the name of Jesus the Savior, who died and was raised to new life by the grace of God. We come to seek the comfort of God as we mourn the death of a child. We commend this child to our merciful redeemer, even as we console one another in our grief.

Use as many of the following sentences as you want:

Lord, you are near to those who call upon you, to all who call upon you faithfully.

As a father has compassion for his children, so you have compassion for those who fear you, O Lord.

"As a mother comforts her child, so I will comfort you," says your God.

Jesus took the children up in his arms, laid his hands on them, and blessed them.

If the parents wish to name their child publicly the prayer below may be used. Naming the child is important at whatever stage of development because it makes the baby more of a person which makes the parents' loss more worthy of grief.

The word of the Lord came to Jeremiah, saying, "Before I formed you in the womb, I knew you." The name Jesus was given to the child of Mary, the Son of God, as a sign of salvation for all people. The naming of this child reminds us of God's care for her/him and helps us remember this child's coming among us.

Then the leader asks the parents: **What do you name your child?**
Parents respond: **Her/his name is_____**

If the parents wish to have the child baptized the following may be said: **Her/his name, child of the covenant, I baptize you (either sprinkle a few drops of sterile water on the baby's head or make the sign of the cross on the baby's forehead with sterile water) in the name of the Father, Son, and Holy Ghost.**

OR

If the parents only want the baby blessed, because they don't believe in infant baptism say: **His/her name, child of the covenant, I bless you in the name of the Father, Son, and Holy Ghost.**

PRAYERS

Out of the depths we cry to you, O loving God. Come near to those whose hearts are torn with grief and sorrow, for you know and share our tears. Help us to trust your care, so that even in the pain of losing child's name/this child, we may be assured that we do not walk alone in the valley of the shadow of death; through Jesus Christ, our Savior and Lord.

Merciful God, your Spirit intercedes for us even when we do not know how to pray. Be present among us now, that we might commend child's name/this child into your loving care and, by your presence, find comfort; through Jesus Christ, your Son, our Savior.
At the death of an infant

God our creator, you called into being this fragile life, which had seemed to us so full of promise. Give to child's name/this child, whom we commit to your care, abundant life in your presence, and to us who grieve, courage to bear our loss; through Jesus Christ, our Savior and Lord.

In the event of a miscarriage

O God, who gathered Rachel's tears over her lost children, hear now the sorrow and distress of names of parents for the death of their expected child. In the darkness of loss, stretch out to them the strength of your arm and renewed assurance of your love; through your own suffering and risen Son, Jesus our Savior.

A stillborn child, or a child who dies shortly after birth

Heavenly Father, your love for all children is strong and enduring. We were not able to know child's name/this child as we hoped. Yet you knew her/him growing in her/his mother's womb, and she/he/ is not lost to you. In the midst of our sadness, we thank you that child's name/this child is with you now, and with you forever.

Those who mourn

Merciful God, you grant to children an abundant entrance into your kingdom. In your compassion, comfort those who mourn for child's name/this child and all who mourn the death of children. Be gentle with them in their grief, and reveal to them the wideness of your mercy. Deliver them from all despair and guilt. Grant us grace so that one day, united with child's name/this child and with all your children, we may stand in your presence in the fullness of joy; for the sake of Jesus Christ, our Savior and Lord.

Commendation

Child's name, Child of God, we entrust you to the arms of God's mercy.
Almighty God, who formed us all out of the dust of the earth, receive you in peace.
Christ, the Good Shepherd, enfold you with his tender care.
God the Holy Spirit, our Comforter, bear you to life in God's new creation.
May you dwell forever in the paradise of God. Amen.

"A Structural View of the Dynamics of Pastoral Conversation"

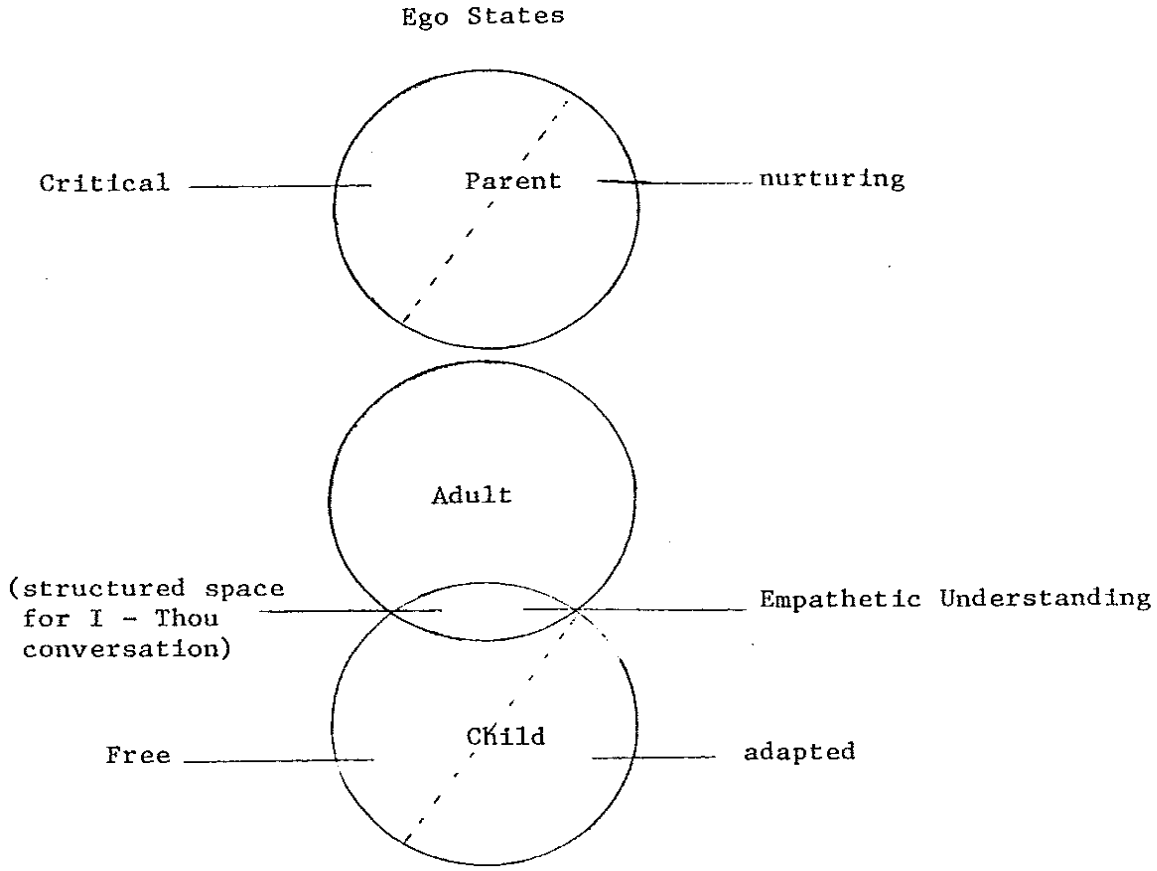
Proposition: that there is a structural and dynamic difference between relating empathetically on the one hand and relating with empathetic understanding on the other hand.

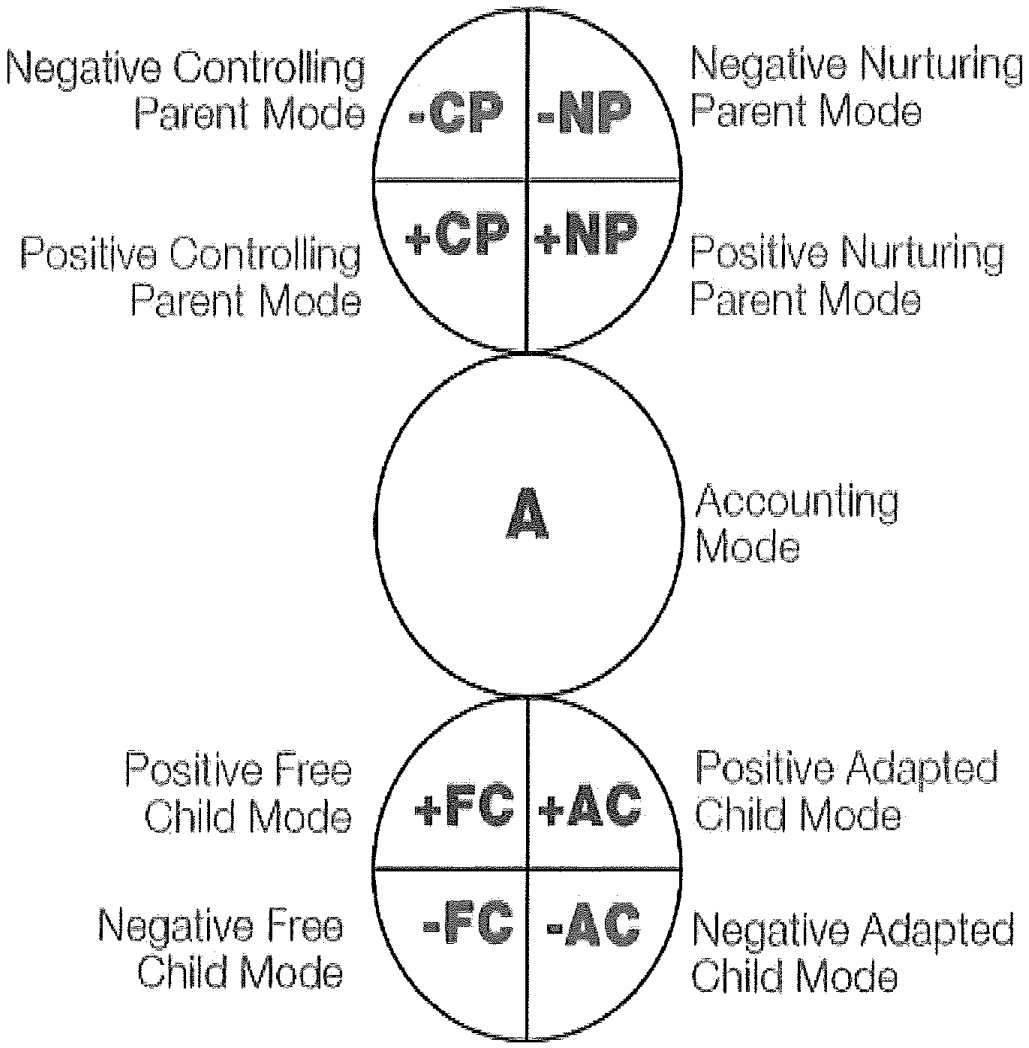
corollary: that this difference is experienced both intra and interpersonally.

Definitions:
Direct Empathy: (or "sympathetic resonance") 1) the imaginative projection (emphasis mine) of a subjective state into an object so that the object appears to be infused (emphasis mine) with it. 2) the capacity for participating in another's feelings or ideas (Webster's Seventh New Collegiate Dictionary, 1971).

Empathic Understanding: "implies a split in the observer's ego. With one part of his ego, he remains in sympathetic resonance with the person who is understood. The other part of his ego, remaining detached, "understands" by observing the part of his own ego that is in sympathetic resonance with the observed person." (Thomas M. French, Psychoanalyic Interprelations, 1970)

French is working off a psychoanalytic model of personality, ie., Super-ego, ego, id. Therefore, he speaks of a spliting of the ego which in some instances can indicate pathology from a psychoanalytic perspective. For that reason, and others, I propose the use of the transactional Analysis model of personality to explain the structural dynamics of direct empathy and empathetic understanding. I will keep French's definition, minus the aspect of "ego spliting". See diagram below:




Negative Controlling Parent Mode
-CP
-NP
Negative Nurturing Parent Mode
Positive Controlling Parent Mode
+CP
+NP
Positive Nurturing Parent Mode
A
Accounting Mode
Positive Free Child Mode
+FC
+AC
Positive Adapted Child Mode
Negative Free Child Mode
-FC
-AC
Negative Adapted Child Mode

SOCIAL AND PASTORAL CONVERSATION: COMPARISON

SOCIAL CONVERSATION concentrates on:	PASTORAL CONVERSATION concentrates on:
1. External subjects: weather, world events local events, sports	1. The person
2. Maintaining a congenial atmosphere	2. Accepting tension areas
3. Comfort through avoiding	3. Comfort through facing
4. Sharing stories: experiences, mutual trading	4. Helping the person share himself/herself
5. Being pleasant, positive	5. Being understanding, empathetic
6. What should be	6. What is - as a step to what should be
7. Generalizing, universalizing: what they say, what people do	7. Being specific: what you do, think, feel
8. Being helpful by entertaining	8. Being helpful by intimate sharing
9. Religion: differences between churches, services, ministers	9. God: and my and your relationship to God
10. People in general	10. Significant relationships of the person
11. What has happened	11. What is happening
12. Tends towards literal	12. Uses paraphrase
13. Moves toward empathy and fusion	13. Empathetic Understanding; Honors boundaries

PARAPHRASE

Inaccurate Paraphrase

A. Verbal
   1. "yes-but" – Patient usually gives up after 3 tries
   2. Change subject
   3. "Go out of room" with topic
   4. Dismissal- Thank you so much for coming by, Chaplain
   5. Words and feeling are not congruent
   6. Chaplain asks many questions
   7. Chaplain responses are longer than patient responses

B. Non-Verbal
   1. Starts watching TV etc.
   2. Patient turns away from Chaplain

Accurate Paraphrase

A. Verbal
   1. Patient responses are longer than Chaplain responses
   2. Conversation flows
   3. Chaplain makes statements more than asking questions

B. Non-Verbal
   1. Good eye contact
   2. Body language, words, and feelings are congruent

THE TWELVE RULES FOR HELPFUL DISCOURSE

As we begin the attempt to understand and talk about the lesson of the body it seems worthwhile to review what the culture has learned (slowly and painfully) about the guidelines for straight, open, helpful discourse and to try to guide ourselves by them. They are listed here to remind us.

1. The speaker is the world's sole expert on his/her own feelings.

2. Sharing our feelings about each other is more important and useful than sharing our ideas, opinions, or beliefs about each other.

3. Asking questions is a way of having the other reveal his/her feeling first. (There is always a feeling under the question; telling the other that feeling is more useful than asking the question.)

4. What is going on here and now is paramount.

5. Defensiveness* is not helpful. Someone else's feelings about you may or may not be "their problem." They are always useful data for you. To call them "your problem" is usually a defensive maneuver. (*Refusing to listen to and accept another's feelings about you.)

6. Feedback works best when it is non-evaluative, non-judgmental and is given in terms of one's own feelings.

7. Initiating direct confrontation is valuable, while indirect of bootlegged confrontation is self-protective and only serves to confuse.

8. Risk-taking and self-exposure are worthwhile both to the individual and the group.

9. Risk-taking and self-exposure in others need support. (Be careful not to use another's self-exposure as a chance to one-up on him/her.

10. Freedom and truth and openness do not have absolute value and can be senselessly destructive if they are not employed in a context of sensitive responsibility for the other.

11. Accepting responsibility for one's own remarks facilitates directness. Using 'I" instead of "you" and being explicit instead of using "that" are helpful.

12. "Help" imposed, forced or showered on another without request is seldom helpful and is frequently destructive.

BEST PRACTICE APPROVED CHARTING PHRASES

- Listened supportively
- Allowed patient to verbalize
- Helped patient to begin life review
- Encouraged patient to use religious faith as a resource
- Heard patient's confession
- Helped patient to solve problems
- Helped patient set short-term goals to avoid feeling overwhelmed by long-term treatment
- Helped patient set realistic goals
- Helped patient identify and express feelings
- Assisted in decision-making
- Provided religious reading matter
- Planned on-going pastoral care program for their hospitalization
- Helped patient set priorities
- Conducted ritual of blessing for……
- Clarified, confirmed or reviewed information
- Role-played communication techniques
- Explored issues of guilt and forgiveness
- Helped patient find religious words of encouragement
- Helped patient identify support systems – family, church, priest, etc.
- Helped patient identify coping strategies
- Reassured patient that responses are a normal reaction
- Gave information about…..
- Helped patient maintain hope
- De-escalated patient's anger by allowing him/her to verbalize
- Will make referral to patient's pastor
- Helped patient clarify questions of faith (guilt)……..

COMMON MEDICAL TERMS – HELPFUL THINGS TO KNOW

Alzheimer's Disease – a progressive degenerative disease of the brain of unknown etiology characterized by diffuse atrophy throughout the cerebral cortex. The first signs of the disease are slight memory disturbance or subtle changes in personality; there is a progressive deterioration resulting in profound dementia over a course of 5 to 10 years.

Aneurysm – a balloon–like sac on an artery or view caused by weakening of the vessel wall.

Angioplasty – an angiographic procedure for elimination of areas of narrowing in blood vessels.

Angina – spasmodic chocking or suffocative pain.

CT Scan – computerized axial tomography; a diagnostic tool similar to an x-ray.

Cardiology – the study and treatment of the cardiovascular system.

Central Line – catheter entering a major artery or vein.

Chemotherapy – the treatment of disease by chemical agents; first applied to use of chemicals that affect the causative organism unfavorably but do not harm the patient.

Dementia – an organic mental disorder characterized by a general loss of intellectual abilities involving impairment of memory, judgment, and abstract thinking as well as changes in personality.

Do Not Resuscitate Order (DNR) – the written order by a physician to medical staff not to perform life saving measures (CPR) on a patient in order to prolong the process of dying.

Feeding tube – a nutritional port.

Foley Catheter – an indwelling catheter retained in the bladder by a balloon inflated with air or liquid.

Geriatrics – the branch of medicine that treats all problems peculiar to old age and the aging, including the clinical problems of senescence and senility.

Gynecology – the study and treatment of the female genital tract.

Heart Catheterization – passage of a small catheter through a vein in an arm or leg or the neck into heart, permitting the securing of blood samples, determination of intra-cardiac pressure, and detection of cardiac anomalies.

Intravenous – within a vein or veins.

Isolation – the separation of infected individuals from those uninfected for the period of communicability of a particular disease.

Hospice – a facility that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis.

Methicillin-Resistant Staphylococcus Aureus (MRSA) - common pathogen in a hospital setting; MRSA is resistant, hard-to-treat form of the pathogen. This is also known as "staff infection".

Magnetic Resonance Imaging (MRI) – a diagnostic tool similar to Cat-Scan.

Neurology - the study and treatment of the nervous system.

Nosocomial – hospital acquired.

Oncology – the study of tumors, both benign and cancerous.

Pulmonology – the study and treatment of diseases of the chest.

Radiation – the use of electromagnetic treatments, commonly used for the treatment of cancer.

Respirator – see ventilator.

Staff Infection – see Methicillin – Resistant Staphylococcus Aureus

Terminal – the end is eminent; condition is irreversible. Usually methods of treatment are comfort measures only to attempt quality remaining days. This does not always indicate a patient has "DNR" status.

Ventilator – an apparatus designed to control pulmonary ventilation either intermittently or continuously.

The Five Tasks of Successful Grieving (Grief Work)

Reverend Stephen A. Lemons, M.Div. BCC.
ACPE Associate Supervisor/Chaplain
Self Regional Healthcare

Introduction

What is grief?
How long should a person grieve a loss?

In the early 1940's there was a terrible fire at the Coconut Grove Night Club in Boston, Massachusetts. As horrible as this fire was, it resulted in an important study about grief. Eric Lindemann, a Harvard Psychiatrist was struck by the difference in recovery time of the survivors and the family members. Some recovered much slower than others and some did not seem to recover at all. This led Lindemann to uncover what he called,

"Grief Work.[1]**"** Things a person may go through to experience healing.

5 Tasks of Successful Grieving (Grief Work)

1) Accept the Painful Truth that Loss has Occurred.

This task involves experiencing shock, numbness, denial and gradually accepting the reality of the loss. When loss happens we are numb, and find it difficult to accept the reality that loss has occurred. Sometimes, after the death of a loved one, it is not unusual to think that your spouse, your parent will walk in the door anytime. Sometimes the experience seems more like a dream. So the first step of the griever is to accept reality.

2) Re-Experience and Talk About the Painful Feelings

Grief is more than a single feeling. It is a complex web of emotions that often include: anger, despair, guilt rationalization, idealization, remorse, resentment, shame, depression, loneliness, apathy, yearning, despair, apathy, anxiety, emptiness, loneliness, panic, disorientation, loss of clear identity,

A helpful Chinese Proverb: ***"Suppression leads to momentary relief and permanent pain. Feeling your experience leads to momentary pain and permanent relief."*** In another words, avoiding the pain prolongs mourning.

Often when the pain is suppressed, the pain manifests itself in other ways –

- Physical Pain

Suppressed grief can show up in such physical symptoms as tenseness, aching muscles, nervousness, fatigue, diminished appetite, digestive upsets, a sick feeling in the pit of the stomach, and sometimes a worsening of medical problems such as, ulcers, rashes, allergies and high blood pressure.

- Emotional Pain

Suppressed grief can show up in an emotional release such as, crying, anger, general irritability, pessimism about life in general and low self-esteem
What is needed during this period is what the Theologian Paul Tillich called "**Loving Listening."** A loving listener is one who will listen to our story without judging or giving advice. The loving listener listens with empathy, understanding and concern. A loving listener is one who will encourage us to pour out our feelings until they are released and healing occurs.

Eric Lindemann understood this task of grief as being most important. In fact, his work can be summarized by saying that ***the work of grief boils down to experiencing and expressing the pain in one's life.***

[1] Lindemann, "*Symptomology and management of acute grief*," American Journal of Psychiatry, Sept. 1944.

There is an old trite saying that says, ***"Time Heals All Wounds."*** While there may be some truth in this statement, if we continue to deal with unresolved grief, time will not bring healing.

Guilt as a major issue in grief work: Guilt is also a major virus to deal with during the grief process. We want to be forgiven for our sins/trespasses. We keep saying, ***"What if?" "What if I had not done this?" What if I had not done that?"***

Appropriate Guilt & Inappropriate Guilt. It is important that we distinguish between the two types of guilt in our grief work.

3) Begin Putting One's Life Back Together Minus Whatever One has Lost.

This task needs to begin long before task 2 is completed. Many decisions have to be made. New ways needs to be learned to satisfy needs previously taken care of by the one who is now gone. Losses plunge us into changes that we are almost never prepared for. We have to learn new skills. Grief work in this task may involve "saying goodbye" and reinvesting one's life energy in other relationships.

4) Examine Your Loss in the Context of Your Faith

This is especially hard to do when our faith has been shattered by loss. Grief often creates a crisis of faith for the person who has suffered loss. This can result in a struggle to rebuild faith. People often become angry with God. This creates difficulty since some of us have been taught that one should never question God.

Can a person of faith question God? (Read Psalm 10, 22, 39, 73, 74, 83, 137,143).

This task is about attending to your spiritual growth. Generally, people can't do much with this task until they have worked through some of their most devastating pain and begun to rearrange their lives (Tasks 1, 2 & 3).

Fear as an issue in grief work: Fear is also a big obstacle to healing. For many of us, our fears are connected to our present and past images of God. A time of death may put us in touch with a childhood image of God. What is your image of God?

How does your spirituality/faith help or hinder you in your grief work?

5) Task 5 – Reach out to Others Who Have Suffered Losses

The pain of loss often makes us want to hide, turn away from the world and avoid new relationships. As scary as it may seem to those who grieve, reaching out is critical. Those who know the suffering of painful loss and reach out to others in their grief are indeed ***"the wounded healers."***
"Bear one Another's Burdens" (The Apostle Paul)

"Holy Listening"

Stephen A. Lemons, Self Regional Healthcare

I. INTRODUCTION

For any person, going into the hospital is a pivotal event. For some people it is a time of personal transformation and growth. For others it is a frustrating experience that results in resentment.

What makes the difference? Can Chaplains make a difference? Listening is hard work.

1. PRINCIPLES OF LISTENING

Open Vs. Closed Approach to Listening

Open Approach—

"How are things going for you?"
"Can you tell me about some of your feelings?"
"How can I help?"

Closed Approach—

"What is your diagnosis?"
"Have you decided to stay home or go back to work?"

Helpful listening tips:

- Avoid closed ended (yes/no) questions.
- Consider using a minimal prompt such as "mmm mmm" or an encouraging nod.
- Be alert for your own negative feelings.
- Listen for more than facts.
- Listening is not about fixing their problems.
- Listening is about empathizing with their feelings.
- Listening is not about rescuing
- Listening is about walking with someone on their journey, entering into their pain.

More listening tips:

- Put yourself in the other person's shoes (as much as possible).
- Don't make judgments.
- Accept the person's feelings—and they may be different from your own.
- Trust that the person has the ability to work through his/her feelings and find the best way to move forward.
- Be patient. Allow plenty of time. Don't interrupt or be in a hurry to give answers. Be comfortable with silence.
- Understand that a person's feelings changes over time. Allow the person to experience feelings in their own way, and at their own pace.
- Listen closely. Pay close attention to what the person is describing. Do not prepare your answer while the other person is talking. Give him/her your attention.

Empathy Verses Sympathy

- Empathy is identification with another person's situation, feelings and motives.
- Unspoken message we convey when we empathize--- "Your feelings are important and you are not alone."
- Sympathy is a feeling or expression of pity or sorrow for the distress of another. Unspoken message—"you are alone."

Listening is a skill; it can be learned.

Barriers to Listening

- His/her view is different from yours.
- You have heard it all before.
- The thoughts or feelings being expressed shock you or cause you to feel anxious.
- Fatigue and Stress.
- Time Pressures.
- Anxiety

LISTENING TECHNIQUES

- Listening accounts for 42% of all communication
- Speaking – 32%
- Reading - 15%
- Writing - 11%

Good Advice for Active Listening:

- Stop Talking
- Concentrate on what is being said
- Show the talker that your desire is to listen--and making eye contact is an important way of doing that--Giving minimal prompts and making sure that you follow up by returning phone calls (and following up on whatever you tell the person you will do).
- Ask Open-ended Questions--as we have discussed earlier.
- Listen for More than Facts--How many times have you ever asked anyone "How are you doing?" and sometimes it doesn't matter if the house has burned down or a spouse has just died, the answer is--"I am FINE."

II. ATTITUDES WHICH BLOCK LISTENING

There are attitudes, which come into play, which block our ability to listen.

We find it easy to move out of our role of listener--into roles that are inappropriate including the roles of **evaluator, judge, therapist**.
What are the attitudes that interfere with listening and understanding?

1. THINKING ABOUT

As the other person talks with are speculating about the other persons' motivation. We wonder what the person's intentions are. And sometimes we judge—

2. THINKING FOR
   This is when we direct what the other person should be doing, thinking or feeling.
   We attempt to solve the problems for the other person, advise them, and guide them.

   "You shouldn't feel that way." You should make up your mind and act." The best thing for you to do under the circumstances is____" "If only you would stop reconsider and think positively, you would not have that trouble."

3. THINKING AHEAD
   This is when we complete the thought for the other person before the other person has a chance to finish what he/she is saying.

The only attitude that facilitates understanding this attitude is:

4. THINKING WITH
   When you are thinking with another person, you are simply trying to understand what the person means by what he/she is saying---
   It is in understanding how things look from the other person's point of view.

PASTORAL CARE AND RESPONSE TO DISASTER
The Oklahoma City Experience

Used by permission from the author 4/13/07

Presented at the Cox Medical Center North
October 15, 1998
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Portions of this paper were first presented at the Sixth Plenary Meeting,
The College of Pastoral Supervision and Psychotherapy and
then at the ACPE Annual Conference, Portland, OR. This is an updated version.

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CRISIS MINISTRY AND CLINICALLY TRAINED CLERGY

A View from Oklahoma City

The bombing of the Alfred P. Murrah Federal Building on April 19th, which killed 168 persons including 15 infants and children, was the most devastating act of terrorism on American soil. The fact that a United States citizen and decorated army veteran pulled off this event was even more shocking. This incident created a crisis for America in many ways; it disrupted the general notion of public safety, it opened many questions about protecting federal buildings, it destroyed the notion that federal workers were safe in America, it threw into turmoil the FBI/CIA strategy of targeting foreign enemies as the likely culprits who plan terrorist acts, etc.

On a personal scale, it also created a crisis for pastoral caregivers who responded to the blast. Those whom Clergy responded to included: a) the victims treated at the bomb site, b) those treated in local healthcare facilities, c) family members and friends who came in search of their loved ones, d) those who waited at the Notification Center to receive word of the fate of their loved ones, and e) the rescue and recovery workers at the bomb site. For me, the nature of this event and its demand on pastors and chaplains who responded highlighted the strengths and resources of Clinically Trained Clergy.

This paper will attempt to discuss the nature of a crisis event. I will then address the crisis clergy found themselves in along with the victims, families and recovery workers. Finally, I will lift up 12 distinctives (or advantages) we identified that characterized Clinically Trained Clergy.

The Early Development of Crisis Theory

The seeds of crisis theory were first noted in the religious writings by Anton Boison, the first practitioner of Clinical Pastoral Education. He noted that in the midst of inner conflicts, people would pass though stages as they tried to resolve their inner tension. Boison identified what he called an "intermediate" stage where in resolving inner conflicts, the person could discover new and creative ways of coping. This "intermediate" stage would lead to a higher level of functioning for the individual. However, there

is a danger here; if the inner tension was not resolved in the intermediate stage, the person could be stuck in unresolved tension. Or worse, regress back to an earlier and less effective way of dealing with inner conflict.

Boison noted that an inner conflict could be created in two ways. First, it could be developmental, which identified inevitable and necessary encounters as one grew through life. Second, they could be situational where events quickly came upon the person, often without warning.

Later Developments in Crisis Theory

Dr. Erich Lindemann, M.D. developed crisis theory in the early 1940's. A psychiatrist at Boston City Hospital, Lindemann treated the families who lost loved ones in the well-known Coconut Grove Nightclub fire where nearly 500 patrons lost their lives. He noticed several patterns of behavior in the family members and wrote his findings in a paper entitled "Symptomatology and Management of Acute Grief." He noted that following the typical intense grief in the loss of a loved one, family members would also experience self-blame, guilt, anxiety and a sense of personal failure.

Lindemann also noticed that families began to use both realistic and unrealistic methods of coping with their loss. If the person used unrealistic methods of coping, they began to regress and were unable to reenter their world as functional as before. When realistic methods were engaged, they reentered with new strength and vitality. Often, Lindemann would use interventions to help the grieving person to place aside the unrealistic methods and use realistic means for coping with their loss.

Later, **Dr. Gerald Caplan, M.D.** followed up on the nature of a crisis, noting the difference between a developmental and an accidental crisis. The developmental crisis stemmed from the typical crises we all pass through as part of growing up, i.e., separation from parent(s) when starting school or at the onset of puberty. (This would coincide with Erik Erikson's psychosocial stages of development). Those who were in an accidental crisis, such as the families who lost loved ones in the Coconut Grove fire, were in a sudden, unexpected and intense crisis that required a quick response. This accidental crisis demanded more from the family members and therefore, would lift up their patterns of coping more quickly. Just as a realistic response to an accidental crisis would produce quick growth to a higher level of functioning, so an unrealistic response could quickly lead to paralysis or regression for the person in the crisis. This "speeding up" of the emotional and intellectual processes was always part of an accidental crisis. Note the similarities of Caplan's work and the earlier insights of Boison, i.e., developmental and situational crises.

Caplan, who worked with Lindemann, outlines four phases in the resolution of a crisis. These phases are:

1. The original tension (disruption of homeostasis) which produces anxiety and calls forth the usual or habitual repertoire of responses.

2. A lack of success in resolving the crisis through traditional responses would leave the person with a sense of helplessness, failure, guilt, etc.

3. The phase where we "hitch up the belt" and explore other possible responses to the crisis. We really search deep down in this phase of responding. This can include such processes as trial and error, consultation with other people and a "redefinition of one's rules and roles." If resolved in this phase, the person grows in maturity and strength.

4. If they do not resolve the inner tension caused by the crisis, reality testing is reduced, unrealistic responses grow, distortions increase and the person will be stuck in a tension-filled situation. Even worse, they could adjust in ways that are not helpful to them or others. I call this fourth phase mal-adaption or regression to an earlier stage of development. Psychoanalytic theory would call this a form of "regression in service of the ego."

Rappaport noted that a crisis has three interrelated factors: a) a hazardous event that poses a perceived threat, b) a threat to an instinctual need that occurred earlier in childhood, which left the person feeling vulnerable (chaining back to earlier events), and c) the inability to respond adequately to the perceived threat. These threats can be found in the psychological need for safety and the sociological need for common values and social order. I add the theological need for a God of Providence who is somehow involved in the midst of the event. When an accidental crisis occurs, we are disrupted. As a result, we try to respond, alleviate our anxiety and come to a new resolution within ourselves.

Current Development of Crises Theory

Rev. Charles Gerkin proposes a more existential view of crisis. He believes a crisis is connected to the existential condition of Modern Man (I use Man here to refer to women and men). In this current culture, there is a tension between our hope for infinite possibilities and finitude. Modem Man has thrown out the paradigm of a three-storied universe and replaced it with the myth of infinite possibilities through technology and human efforts (Technological Rationality). To continue infinite progress, all we have to do is increase our technology and stretch our boundaries.

While some of this myth occurred in past centuries, people at least had the sense of God's Providence that would be the framework to continue achieving. We have always known of death but knew this to be part of God's Providence. With God out of the picture for Modern Man, the only limit to our possibilities is the "unpleasant experience of death." We can master our lives only to an extent when the reality of death disrupts this. Caught in this paradox, we turn to defend ourselves through being the "hero" who faces the challenge of death alone. Our response to our vulnerability is to press ahead or "carry on."

For Gerkin, a crisis is the experience of finitude, contradiction and vulnerability whose only effective response is faith. A loss of trust in the “way things are” or “the way things are supposed to be” is built into a crisis experience. Therefore, even the most basic of human needs is disrupted. Faith gives us the larger picture in which to see our progress, which includes death as a natural part of living.

The Disaster in Oklahoma City

The people who survived the explosion of April 19th, including the families who lost loved ones, the recovery workers, ancillary support personnel and those who were shocked that an American citizen could do such a thing, were all forced into a crisis of huge proportions. If a natural disaster had occurred, our response would be different. After all, we expect this to happen to us upon occasion. However, a terrorist bombing is another matter. It was more disruptive and unsettling, which is exactly what a terrorist wants to create.

Besides the nature of the disaster, the recovery workers at the Murrah Building spent 16 days working in 12-hour shifts in search of bodies. The scene was gruesome. There were about 22 bodies recovered

after the first day and then the progress went very slowly. Not only were the workers finding pieces of bodies but as the search dragged on, decay and insect infestation set in. The bombing site eventually became a biohazard to the workers. Many saw what they hope never to see again.

The search was not only tedious but the constant discovery of body parts and dead people wore on the workers. Even the dogs trained to search for trapped victims became depressed and needed time to recover. Everyone involved in responding to the bombing was thrown into some form of crisis.

This crisis came as well to the Clergy and Chaplains who responded to the disaster. In the hospitals, the people brought in through the Emergency Room were very bloody, in shock, and some very badly injured and maimed. The intensity was considerable when you realize Presbyterian Hospital took in 80 patients in 90 minutes. The visual sights were enough to disrupt you. Add to that the children killed or injured and you can imagine how very upsetting it was. When we learned it was an intentional bombing, we lost our defense of reason that tried to explain why this event happened in the first place. It was just so senseless!

We noticed a general trend in our hospital and at the bomb site. The Clinically Trained Clergy were more prepared to face the impending crisis than were the local untrained clergy. I believe one aspect of this preparedness was that Clergy in Clinical Pastoral Education had been through a supervised training process that included situational and accidental crises. Clergy involved in CPE are usually disrupted by ministry events and face the intermediate stage crisis resolution. Attempts at finding resolutions to their own inner conflicts raised by the external circumstances were good training experiences for clergy. They found their way through the crisis by reaching deeply within themselves for solutions. Often, this demonstrated itself in specific behaviors, i.e., sharing their burden with others, reality testing with peers and supervisors, and growing to new levels of functioning. This experience equipped the clinically trained clergy to face the Oklahoma City disaster with a degree of confidence and strength.

Hospitalization: A Rite of Passage

JOHN KATONAH

Without question, temporary confinement in a hospital is a pivotal point in one's life. What emerges from that experience will vary: for some it is a time of personal transformation and growth, for others it is a stultifying period marked by rhetorical questioning and bitter resentment.

What makes the difference? Where, if at all, is the sense of sacred found within the walls of suffering and pain? How can pastoral care facilitate growth and transformation in the process? Is there a way of conceptualizing the hospital experience that might be helpful both to the patient and the pastor?

In many ways traditional pastoral care, with its major emphasis upon a sacramental ministry, has unintentionally missed its mark in enabling and facilitating spiritual growth through this period of upheaval. Part of its failure has been its inadvertent tendency to limit or narrow the spiritual to the sacramental. However, the sense of the sacred is much broader, more profound, and more expansive.

What is being proposed in this chapter is a concept to help us better understand the process of hospitalization and in so doing facilitate more effective pastoral care. That concept is "rite of passage," with a primary emphasis upon "initiation." Initiation is the traditional way cultures have sought to define and describe personal crises of meaning. It embodies our whole being: mind, emotion, body, spirit, relationships. It is a sacred process, a journey from the familiar and the secure into the unfamiliar and unknown, resulting in personal change and new visions and directions for the future.

It is my contention that the concept of initiation may be a helpful means of understanding the crisis of hospitalization. It may also be a means of bringing suffering and salvation into creative dialogue and of enabling the hospitalized patient to assume a more self-conscious, participatory role in the healing process.

This chapter will attempt to refine and further develop the concept of initiation by (1) defining its three major phases; (2) relating it to hospitalization; (3) identifying its implications for hospital chaplaincy.

Three Stages of Initiation

Initiations, or rites of passage, have been studied with great curiosity by anthropologists who have traveled to numerous cultures to observe, photograph, tape record, and otherwise document these ceremonies. The reason for all of the travel, anthropologists explain, is to identify cultures uncomplicated by technological and bureaucratic smoke screens. They claim that studying initiation rites in a primitive society presents a simplified manifestation of what is entailed in this transformation process. And, as the argument continues, once "a purer form of initiation" can be pieced together from comparative studies of many primitive cultures, we can then begin to look at this process of initiation from within our own Western culture.[1]

After years of such study and documentation, there has emerged a predominant process which occurs throughout these rites of passage, even though they may take different forms and shapes and follow divergent story lines (myths).

The process of initiation breaks down into three phases: *separation, betwixt and between,* and *transformation.*

Separation

The first phase can be identified as separation.[2] The individual at puberty leaves home, family, friends, and those persons and belongings which are familiar. In male initiations, the individual leaves his village and is taken, often away from his mother, to a place outside of his usual stamping grounds. In the female's initiation, the individual is usually not taken so far away but is left to remain separated for a designated period of time. In both cases, a separation begins this ceremony. It is a time when the initiate, through societal norms and customs, consents to prepare oneself for a very real and significant transformation, while submitting to an assortment of events and happenings, according to the culture's customs. In consenting in this manner, the individual enters a foreign world. The shift from the familiar to this foreign situation is always remarkable—frequently associated with unusual costume, purification rites, music, and a change in environment. A quickened sense of life's fragility is experienced as the initiate enters this first phase of the initiation. It is a time of submission and complete trust as one turns one's life over to the customs of the village *and* to the forces within the universe.

Betwixt and Between

The second phase of initiation is one of being betwixt and between.[3] The individual is neither defined by one's old identity/roles/status nor by any newly forged identity. Nonentity would be the most accurate word for defining the person's status during this phase. Hence, all responsibilities and tasks are relinquished and the person is freed up to become totally absorbed in the initiation.

The individual's birth name is often removed to await a new name which will emerge at the conclusion of the initiation.[4] This betwixt-and-between phase describes that sense of being lost, with no familiar landmarks to help determine one's way. The initiate encounters tests of strength, endurance, wisdom, courage, and faith. These tests require responses which summon all of one's inner resources.

This phase of transition marks the time when a personal encounter with a deity may occur. Through this encounter one recognizes that one is not in total control of life but is submissive to a larger force at work. The initiate engages this deity through a ritualistic acting out of "the culture's mythic story."[5] This mythic story becomes the crucial dimension to the second phase of initiation.

The mythic story is found in all initiations. The story varies from one culture to another, but the significance always lies in the belief that it is inherently sacred and holy. The story reflects the deity's values and purposes, which in turn reflects the community's values. The reenactment of the story (which requires community participation) lifts the participants outside of time so that the story is miraculously experienced as if it is occurring for the first time.

So this mythic story then embodies a twofold purpose for the community as well as the initiate: it is an embodiment of the origin, meaning, and purpose of the culture as established by the deity; and it is also the mutually supportive avenue by which secular and sacred leave the realm of time and become reunited in the present.

The mythic story is based on a historical event that, through legend and folklore, has been passed down through the ages to the present time. It explains the role of each participant within the initiation and also provides meaning and substance to the rituals. But inevitably the story gives a transforming sense of courage and power to the participant, for it is the initiate who is enacting a sacred journey previously traveled by many initiates. These characters in the mythic story are not just acting —they *become* the lion, the demons, the arrow, the wind, the goddess, the sun.[6]

As the second phase of initiation completes its course, the initiate is brought together with the elders, or guides, of the community to begin a new identity which will have bonding with them.

If this is a male initiation rite, the boy will begin to associate (i.e., sit with, smoke with, eat with) with the older men in the community. If this is a female initiation rite, the girl becomes surrounded by adult women who clothe her in adult costumes which clearly symbolize the emergence of a new, more mature person. A clearer sense of the initiate's identity and future begins to take shape.

Transformation

The final phase is one of transformation.[7] What was emerging in the betwixt-and-between phase continues with mounting *clarity* and new *vision.* Clarity is experienced through identification with the elders of the community and through new roles and responsibilities that coincide with a new sense of accomplishment, maturation, and inner achievement. It is the new vision, with its purpose and mission, that brings the individual to a communally recognized status and role within the community. The initiate has come face to face with personal death as well as the death of an old identity, Also the initiate has experienced the deity and has thereby been touched by the sacred. It is through such experiences that the individual is considered changed and transformed. The community acknowledges that transformation by conferring upon the individual new responsibilities and a new set of costumes. These acknowledge that new strength and maturity have emerged from this initiation. The initiate is given a new name to confirm that new identity.

Various media are used to characterize this transformation: the music may drastically change in tempo and/or pathos; the initiate is clothed in celebrative, bright garments; in some societies, a new home is constructed by the community and presented as a gift. New roles are immediately ascribed thereby providing an immediate access to status and acceptance.

Anthropologists have spoken to the participants of these initiations and heard described a sense of the sacred. The initiate is encouraged to review the past events of the initiation and to reflect upon their personal meaning. This reflection is usually done with one’s “new” peers, who aid in the interpretive process. Given that initiation rites are viewed as sacred, it is understandable that participants experience a sense of awe and wonder. The transformation is both *outward* (via already described physical alterations) and *inward* (through a maturation process that includes increased societal roles and a heightened sense of one's calling and mission).

Hospitalization as a Rite of Initiation

In American society hospitalization may provide a structure for initiation. Or, more to the point, I think we have already created a possibility for an initiation process. Consider this process through the example of an individual I shall call George.

George begins to be aware of physical or mental discomfort and, after attempting to use the old remedies and suggestions that others have recommended, he finally decides to make an appointment with his physician. Upon careful examination, George is admitted to the hospital. This decision to enter the hospital is not an easy one for George because it means temporarily relinquishing control over his life. He will be placing himself in the hands of others: separating himself from his neighborhood, vocation, faith community, family, and many other aspects of his life that are familiar and routine. Upon admission, he must answer many personal questions about his finances, job, habits, and relationships. Once in his room, George sheds his clothes and is given a hospital gown to wear. He is encouraged to send all jewelry and other valuables home with relatives. A name tag, with an identification number and doctor's name, is securely taped to his wrist. And the waiting begins.

Family members and friends are restricted on the time and number of visits. Hospital schedules and routines are imposed, freedom is restricted. Institutional living replaces a personal life-style. Roommate selection, noise level, accessibility to fresh air, food choices, physician and nurse visits, mobility in and out of bed, are not within George's control. Separation from the norm is dramatically experienced. This first phase, *separation,* begins the initiation process. George has left his familiar and established world for one which appears, upon first impressions, like an alien planet.

If George is able to accept the need for such a separation, he can then prepare himself for what is the *betwixt-and-between* phase of initiation: the lab tests, examinations, diagnostic work-ups, scans, cultures, X-rays, and consultations. George is a courageous man and tries to portray an air of confidence and calmness with all that is happening to him. However, underneath this exterior, he feels a growing turmoil and anxiety. With each procedure, George becomes nervous over the level of intrusiveness which each test may induce and he worries over his ability to endure the procedure. Given the uncertainty of his future, which hangs in the balance with each test examination, the ultimate questions he is raising (spoken or unspoken) concern the longevity and goodness of his life and threatening death. Many questions get asked with little feeling of relief.

The CAT scan is planned for George. While he is maneuvered into the scanner, he feels so helpless and alone. Just being confronted by the massiveness of computerized machinery conjures up for George images of smallness. He experiences a greater sense of the interconnectedness of life but without his usual thoughts of omnipotence and control. Instead, he grasps a glimpse of participating in the ebb and flow of life. "I guess there are many others in this place who also are going through these procedures as well as I. I am no different than anyone else."

He finds himself reflecting on his life, recalling memories both warm and reassuring, as well as painful and guilt-ridden. What George has taken so much for granted, he now craves for and promises himself that once out of the hospital he will appreciate the simpler experiences of life. Rehearsing life and its lessons is what occupies George as he waits.

Supportive persons in George's life play an important role in this phase. Their very presence serves as a strong bond with life that exists outside of the hospital. Their supportive presence also communicates to George the value that is being connected to his personal world.

A host of varying professionals approaches him to discuss various facets in his life-style that need to be reviewed, modified, eliminated, strengthened. Nutritionist, social worker, financial counselor, occupational therapist, physical therapist, specialty instructors—each providing information and counsel to help prepare George for his eventual discharge from the hospital. However, with all the input being presented, George may only retain a portion of it, but he gains a clearer awareness of several values: life is precious and finite; each of us ultimately is responsible for the care of our bodies, minds, emotions, and souls; there are resources available to us when/if we need help.

George had a good upbringing in a church which his parents still attend. However, he has not found church-going a priority in recent years. His nonattendance does not preclude a developing faith, and it is during this betwixt-and-between time that George raises some basic faith issues. He searches for God's presence during this time when no one seems to fully understand what he is experiencing. Sometimes he even considers God as acting punitively, causing the pain and misery. Searching for meaning becomes a preoccupation. As his hospital stay extends beyond his expectation, his quest for meaning heightens.

During the treatment process, George begins making plans to return to his family, his community, his job. Anticipation mounts. But he also finds himself worrying about whether his symptoms will recur once discharged from the

hospital. "Will I be able to function as usual? Have I lost something here which I will not be able to regain? Am I different in some way from when I first came in?"

In some way, George is groping for understanding. Somehow, the recent experience has aroused his curiosity and his anxiety. To simply minimize this anxious anticipation in George is to do him a disservice. It is to fail to recognize a transforming quality that has taken place during his hospitalization. George has been separated from his secure and familiar world. He has been through the wilderness of tests and procedures; he has felt the unknown in the betwixt-and-between moments. Now he is being prepared to return to the old world. But George will be entering it with new insights into his life. That changes everything.

George removes his hospital gown and shoes and replaces them with his own street clothes. His wrist band is removed, and his valuables returned to him. Suddenly he is not a patient anymore. The transforming phase is yet to be actualized. It cannot take place in the hospital; it must occur out in George's old world. However, a transformation has already been brewing within George, part of which may be outside his awareness. He has endured the separation and the betwixt-and-between times. He has weathered the storm and is wiser; in many ways, stronger for it. We say farewell to George as he leaves the hospital with his wife and daughter. Whatever happens in George's life, he can feel confident that he has been through an important initiation.

Implications for Pastoral Care

What implications does this perspective on hospitalization as a rite of initiation bring to pastoral care? One central and descriptive image for me is the image of a maieutic helper. The term *maieutic* refers to the art of midwifery: that person who, during pregnancy and labor, guides and encourages the woman through the transition period to birth.

The term *maieutic* is defined by *Webster's New Twentieth Century Dictionary* as "designating the Socratic method of helping a person to bring forth and become aware of his latent ideas or memories." In *Thaetetus* Plato depicts Socrates as one who encounters people in philosophical dialogue. Socrates describes himself as inheriting his mother's skill in midwifery by bringing to birth the mental concepts of those whose souls are pregnant with ideas. "And the greatest thing in my art is this: to be able to test, by every means, whether it’s an imitation and a falsehood that the man's intellect is giving birth to, or something genuine and true."[9]

This is akin to the chaplain's role within the context of initiation. Unless one is encouraged and guided, there is the danger that the initiate will become engulfed by the chaos of hospitalization.

As the midwife needs to be present during the journey of labor, delivery, and initial care of the infant, so the chaplain is needed to affirm the patient's "journeying." This is particularly crucial during the betwixt-and-between phase of initiation. For it is in this phase that the patient perceives the experience as inactivity, not as progress or journeying.

To be in the betwixt and between phase is to travel like a nomad. It is common to feel stuck because the journey seems aimless and endless. However, if the maieutic helper affirms and redefines the feeling of inactivity as part of a sacred journey experience, then an openness to the sacred and the possibility for an initiation process may begin. This can be done as the patient is helped to elucidate personal experiences during this phase, whether through the use of traditional and religious words or images (e.g., "wandering through the wilderness like the Hebrews in the desert") or through personal associations with past memories (e.g., "that CAT scan reminded me of the time I delivered my first child"). By identifying unique, idiosyncratic symbols and images that are expressed, the maieutic helper can affirm the journey. By encouraging a significant story or myth that grows out of the individual's hospitalization experience, the chaplain can help the patient to redefine the significance of his or her hospitalization.

One patient I encountered was a vibrant, active woman of twenty-five who had been stricken with multiple sclerosis since the age of seventeen. She had been in and out of hospitals since that time for one treatment or surgery after another. When I met her she was having difficulty with urinary retention. After contracting multiple sclerosis, this young woman had gone on to finish high school, attended and completed paramedic training, and was in the process of applying to medical school in hopes of becoming a physician. Although she never graphically described the “story” of her experience through her illness, she periodically did share some of her beliefs which aided her journey. She spoke of her body as if it were separate from the rest of her, yet conversed about it (her body) as if talking about an old, dear friend. At times she could laugh at her uncooperative arms or legs. I once walked into her room and found her scolding her arm for not contributing its part in making her lunch time pleasurable. In her ability to separate from, yet remain connected to, her ailing body, this woman then was able to embrace life and make plans to accomplish certain goals and dreams which she set before herself. And when a setback occurred (like returning to the hospital), she naturally felt some sadness and regret

but eventually revamped her plans and soon was involved in new ways of remaining creative: reading, pen sketching, attempting to remain independent and self-sufficient.

From such stories, which each of us creates or draws upon in life's transitional crossroads, can emerge personal meaning in our experiences of pain and loss. Through such a story, the patient finds a way of participating in the event of hospitalization, rather than being a helpless, passive victim.

In the separation phase, patients frequently experience an inability to accept their own finiteness. This is accompanied by a lack of trust of others. If one does not appreciate one's own limitations and weaknesses, then surely one will have little understanding or acceptance of one's dependency. Therefore, one cannot trust the helpful efforts of others. As a maieutic helper, the chaplain can attempt to bring a trusting presence to the relationship, which in turn might facilitate the patient's confrontation with fear and helplessness. By supporting the patient's very decision to enter the hospital, the chaplain can help to foster the recognition that there are times in life when we need and must call upon others for help.

Speaking to an elderly man hospitalized for a bruised rib cage and pneumonia, I discovered that his wife suddenly had taken ill a year prior, and shortly thereafter died. This man still could not understand how she could die before him since he was so much older and sicker than she. He described how much he savored reading historical and political writings except during the very late evening hours when, because of his inability to sleep, he found himself drawn to reading mystery novels, sometimes not putting them down until he completed the whole novel. I interpret this repeated occurrence as symbolizing this man's repetitious search for resolution of the mystery, and the mystery continues to be: "Why did my wife die?" This individual was stuck in the separation phase and struggling to find his way through the "mystery."

In this twixt-and-between phase, one can clearly appreciate issues of faith and justice during those moments when the usual familiar landmarks for assessing the value of life are missing. During such times one often sinks into self-debasement and self-recrimination. Confession may be an important part of this phase. But unless it is balanced by the assurance of God's forgiveness, the betwixt-and-between phase can feel like an eternal hell.

Also manifest within this phase of initiation is the sense of the holy. As a maieutic helper, the chaplain can be a strong, positive force in affirming the patient's own belief in that sense of the holy. This can often be done by relating the biblical image of journeying as it relates to the patient's own current experience. Or the chaplain may also refer to personal, nontraditional experiences to nourish the idea of journeying. The chaplain must endure and accept the tremendous anxiety felt and acted out by patients during this difficult betwixt-and-between phase.

Diagnosed with breast cancer two years earlier, a woman entered the hospital because of lower-back pain. Her physicians quickly ascertained that she had bone cancer and were concerned that she evaded any discussions about her disease. Pastoral care was called. In our short visit she hesitatingly shared an image which was both confusing and frightening. She described seeing herself seated in a rocking chair, calmly rocking. At a distance she began noticing something approaching. As it got closer, she could not make out the form or content. Once within close range, she began to push the "thing" away with her hands. Her efforts to do so were in vain. She continued to be confused about what this object was and why it was encroaching upon her. This scenario was repeated over and over. She perceived the "thing" as destructive and judgmental of her past. She also spoke of feeling alienated from others because she could not determine how or with whom to share this. More importantly, however, the patient described much relief in now sharing it and being assured that her vision might contain a helpful message. Being able to accept this experience as potentially healing rather than destroying became a redeeming insight for her.

The third phase of initiation (transformation) is one not usually experienced in the hospital. However, for those who do express a sense of transformation, spiritual issues which emerge focus around gratefulness (grace) that one is now able to experience. The patient often confronts some important questions. Can one identify signs of transformation and change? Can one resolve grief over the loss of the old and begin to affirm the new?

Another spiritual issue in this phase is the sense of vocation and communion with life. This refers to "a person's willingness to be a cheerful participant in the scheme of creation and providence, so that a sense of purpose is attached to one's doings which validates his existence under his Creator."[10] This sense of purpose then can be viewed as having emerged from one's encounter with the sacred through the experience. Frequently these transforming signs and purposes are not clearly evident. Indeed, contemplation and reflection are needed in order to assimilate the intensity of the initiation and to get in touch with physical, social, emotional, spiritual changes that have occurred.

As a maieutic helper, the chaplain blesses the initiation and reaffirms it as a sacred journey. Ritual may be appropriate during this transforming time, since ritual can provide structure for reflecting on these recent events. Inclusion of family and friends in this rite will also affirm the individual as a member of the community and welcome that person back into society.

An example of someone whose spiritual issue centered around a sense of purpose comes to mind. A woman many years earlier had one of her kidneys removed. Over the past three years she had been battling cancer cells which had

invaded her colon. With each stage of cancer, her doctors made recommendations and she would consent. But she never experienced any freedom. "Either I do what they say or I die. That's not much of a choice." During her last hospitalization her remaining kidney became dysfunctional. After several weeks of being on dialysis (kidney machine), her doctors again came to her with their recommendations and her "options." Her decision was to discontinue dialysis and return home to her husband. When I visited her in her home, she stated that her decision to stop medical treatment was a profound relief. She admitted that it was the first time in the past three years that she had made a decision that was totally her own. She was thereby able to exert her control over her situation. Remarkably, as we talked further, she recounted how many friends, as well as hospital staff, had supported her in this decision and openly admired her courage. Although she was not able to appreciate what others appeared to appreciate in her, she felt at peace with the idea that she had "left my mark on the world" through this decision. This feeling of accomplishment left her awaiting death with a sense of peace and fulfillment.

Conclusion

As the maieutic helper, the chaplain provides direction and structure to a process through the initiation model of hospitalization. Both the midwife and the chaplain utilize those resources which the "patient" brings to the transforming experience. This model of hospitalization and pastoral care has only been touched in these pages. The possibilities for aiding this transforming experience are vast, awaiting only the chaplain's imagination and creativity.

If one were to transpose these rite-of-passage concepts to practical use within a medical setting, one might find the hospital itself may be transformed. Architecturally and functionally I would envision a hospital that includes windows that open and allow influx of fresh air when desired. Terraces on each floor would be accessible to patients and family members for the healing rays of the sun. Space on each unit would be provided for patients to congregate and to share their experiences with other "initiates." There also would be a policy, respected by all hospital staff, which granted patients thirty minutes of uninterrupted quiet each day in which to read, contemplate, pray, meditate, or to do anything else that appealed to their interest. An abundance of plant life would be growing throughout the hospital. All commercial TV would be eliminated and FM radios with headphones would be installed by each patient's bed to provide a variety of listening music.

Also placed by the patient's bed, along with the traditional Bible, would be books on artwork (i.e., painting, sculpting, carving, molding, soldering) as well as works of poetry, short stories, fairy tales, folklore. Plays, concerts, and dramatic readings would be regularly offered in the hospital auditorium for patients, families, and staff. A greater variety of artwork would be displayed throughout the hospital as well as within patients' rooms. These paintings would reflect scenes and settings which span human emotions. There would even be innovative crafts available to patients to facilitate various media for them to express their journey of hospitalization. Needless to say, all of these innovations would be enacted as ways of stimulating one's total senses, as well as calling forth one's creative energy, toward identifying a personal "mythic story."

Hospitalization is a time of separation and turmoil and mystery. It can, however, be a time of sacred journeying—leaving us, upon discharge, prepared to embrace life anew, with new skills and strengths that we have come to discover. Pastoral care needs to play a role in this journey so that more individuals may experience the creative possibility of new life through this rite of initiation known as hospitalization.

NOTES

1. Victor Turner, *Ritual Process: Structure and Anti-Structure* (New York: Cornell Paperbacks: Cornell University Press, 1969), p. v.
2. Arnold Van Gennep, *Rites of Passage,* trans. M. Vizedom and G. Caffee (London: Routledge and Kegan Paul, 1909), p. l0ff.
3. Ibid.
4. Bruce Lincoln, *Emerging From the Chrysalis* (Cambridge: Harvard University Press, 1981), p. 79.
5. Ibid., p. 95.
6. Steven Foster and Meredith Little, *Book of the Vision Quest* (California: Island Press, 1980), p. 91.
7. Van Gennep, *Rites of Passage,* p. l0ff.
8. Lecture by Janet Stein, Ph.D, at the C.C. Jung Center, Evanston, Illinois, on "Initiation and Archetypes" (October 1982).

9. Plato, *Thaetetus,* trans. with notes by John McDowell (London: Clarendon Press Oxford, 1973), p. 13.
10. Paul Pruyser, *Minister as Diagnostician* (Philadelphia: Westminster Press, 1976), p. 76.

The Random Initial Visit

LAWRENCE E. HOLST

A unique characteristic of hospital chaplaincy is "the right" of initiative. By that is meant the chaplain's license to intervene without the special sanctions of a referral or a patient's request. As someone once described it: "The chaplain needs no passport to enter any patient's room." Such geographic initiative provides the hospital chaplain broad access to all patients.

Granted, the chaplain is not the only member of the hospital community who makes unannounced, unscheduled visits. A nurse will stop in to take temperatures, a lab technician to draw blood, a medical resident to take a history, a nutritionist to discuss diets. These people, too, will be strangers to the patient. Unlike the chaplain, however, they come under the broad spectrum of medical authority to execute medical orders. They are part of "the hospital routine." Their presence and services are expected.

What distinguishes the chaplain's random initial visits is not anonymity (other hospital personnel are equally unknown) or their unexpectedness (other hospital personnel stop in unexpectedly). Rather, it is the unknown relationship of the chaplain's visits to medical care and the unforeseen images that such a presence stimulates.

The right of geographic initiative is a valuable vestige of pastoral care's rich heritage. It is "a custom of the discipline." It is essentially the *chaplain's freedom to create and control the time, place, setting in which, and persons to whom, pastoral care is to be offered.*

The right of initiative brings together many unique dimensions of pastoral care, namely, mobility, freedom of access, and control over the expenditure of time and skills. Obviously, such rights of initiative do not preclude pastoral responsiveness to others' initiatives. They simply open up another pastoral option.

The warrants for such initiative are varied. In the parish, such warrants are bequeathed through the covenant struck between pastor and congregation in the rite of installation. In the hospital, such warrants generally come through administrative or board decree. However, the sanctions are deeper even than those. *They are inherent in the office of ministry.* Clergy are expected to intersect people in crisis. Indeed, more likely it is not their presence, but their absence that draws criticism. Clergy are part of a vast supportive network available to those in need. That supportive role does not have to be earned; it is conferred by both the church and society.

The random initial hospital visit is but one expression of that conferred right. Yet despite its broad endorsement, it is a difficult type of ministry. It demands diligence, persistence, flexibility, spontaneity, and patience. At times, the initiating hospital chaplain feels like a traveling salesman. Like salesmanship, initial visits require aggressiveness. They risk rejection. At best, the initiating chaplain is uninvited; at worst, the chaplain is unwelcomed.

Consider the differences when the chaplain is requested to make a visit by a patient. Then the chaplain is a *responder*, rather than an *initiator* and can assume that this patient:

- has a recognized need for which one is now seeking pastoral help;
- has a sense of personal responsibility for that need, or at least owns the responsibility to do something about it;
- has a motivation to act upon that need now;
- has a willingness to entrust that need to an as yet unknown, unseen hospital chaplain.

Of course, these factors do not assure a favorable therapeutic outcome. But they do clarify the respective roles of initiator and responder. The responding chaplain has every right to assume that the initiating patient will define a reason for the requested visit.

However, when the chaplain initiates a visit the roles are reversed. The chaplain cannot presume needs, motivation, trust, or readiness in the patient. Nor can the chaplain presume that the patient will bear any responsibility for the visit, or even elect to utilize the services that are being offered. In a random initial visit the chaplain has chosen the patient for ministry; the patient has not yet chosen the chaplain to minister. In fact, that choice may never be made.

Though these factors seem less favorable, this is not to suggest that a very strong, productive relationship cannot be established under such conditions. The point is that the initiator of the relationship bears initial responsibility for its definition and direction. If such a relationship continues, then that responsibility will become mutual.

In a random initial visit the controls are evenly distributed. The initiating chaplain controls the time and place of the visit. The chaplain also enters the relationship with some vital information about the patient: name, age, address, religion, next of kin, physician's name, admitting diagnosis, estimated length of stay. Indeed, the chaplain may know some factors about the patient that the patient doesn't know. And, of course, the patient knows nothing about the chaplain at this point in the relationship. Neither patient nor chaplain "controls" the environment. Interruptions, phone calls, visitors, examinations, monitorings may occur without notice.

However, as responder, the patient retains considerable control and can accept or reject the chaplain's initiative. Rejections can be direct ("chaplain, I'm really not interested") or indirect (by indifference and avoidance). The chaplain cannot compel the patient to participate; without such participation it is difficult to foresee a meaningful interaction.

The initiating chaplain cannot presume the right to focus upon the patient's needs, even if discerned. While a broad license has been accorded a chaplain's physical initiative, no such license has been given for "psychological intrusion." Such license can only be given by the patient. So, in a deeper sense, a chaplain's initiative does not violate a patient's autonomy.

In fact, strange though it may seem, the relationship between the initiating chaplain and the responding patient is quite symmetrical, characterized by considerable mutuality and equality. Neither is in a superior position. Both can remain disengaged. Either can drop or pursue the relationship.

If the two of them do pursue further visits, the relationship may become structured and focused. On the other hand, future visits may remain unstructured, diffused, and scattered. The potential outcomes resulting from a random hospital initial visit are diverse. This is true, in part, because of the hospital setting, but also because the symmetrical relationship tends to evenly divide controls and options.

Advantages and Disadvantages of Random Initial Visits

As one has already surmised, the right of pastoral initiative is a mixed blessing. There are advantages:

Initiative allows the pastor to reach people in their earliest stages of need. Crises often immobilize even the quest for help. The physical presence of the pastor may be all that is necessary to facilitate that quest. Studies in crisis intervention stress the factor of *immediacy;* to achieve close timing between precipitating crisis events and the entry of help. If intervention is early, disequilibrium can be more healthily resolved before maladaptive coping resources become crystallized. The early entry of help also takes advantage of heightened energy stimulated in the early phases of a crisis.

Some people have needs they cannot readily articulate; some have needs that are too threatening to articulate. To seek help for such needs may be difficult and embarrassing. However, to respond to help that suddenly presents itself at their bedsides may be much easier. Initiative provides the visibility of help which often leads to its utilization.

Initiative reduces the need for a cumbersome referral process. Since pastoral care is not a required medical service, it is easy for hospital personnel to neglect its usefulness. In fact, part of pastoral care's value is its detachment from medical delivery. Many patient interactions have to do with medical concerns. When a chaplain drops by, the patient has the unusual opportunity to share matters that are not exclusively medical, yet are deeply important.

Pastoral initiative makes available services that might be missed if they were limited to staff referral or patient request. Staff may not know how to integrate such services into the medical spectrum; patients may not know such resources are available.

Since pastoral care falls outside the parameters of medical treatment, the chaplain's initiative is not perceived by staff to be intrusive or competitive with their services and, in most instances, is welcomed.

Initiative is the patient's due. The costs of pastoral care are "hidden" in most hospital budgets. Chaplains do not charge patients for visits made. Such costs are part of the patient's room rate. This makes it possible for the chaplain to take initiative and to expend lavish amounts of time on patients whose needs seem to warrant it.

Of course, if pastoral care was a fee for service, random initial visits would be presumptuous. One can imagine the consternation of patients who would be billed for pastoral visits they didn't request.

Consequently, one might maintain that every patient is entitled to an initial visit since pastoral care is part of every patient's medical costs.

As well, there are disadvantages to pastoral initiatives:

A psychological burden is always upon the initiator. Initiation carries with it the burden of defining the nature and purpose of the encounter. One cannot expect hospitalized patients to understand the ground rules and parameters of a visit they did not request. Nor can one expect them to bear responsibility for defining and developing the relationship.

Taking initiative with strangers (which is the case in random hospital initial visits) can be very difficult, especially for chaplains who are shy and reserved. Such chaplains would much prefer responding to patients' initiative.

Initiative may get ahead of a patient's readiness and motivation. Clearly, such unscheduled visits may be upon the wrong persons, in the wrong place, at the wrong time. The patient may be drowsy, talked out, uncomfortable, in pain, or just plain grouchy. Some patients may say too little; others may say too much (in their unguarded vulnerability they may blurt out things they mean, but did not mean to say). For most, it takes time to feel secure in a new relationship. A brief unannounced, unscheduled visit by a stranger usually does not provide the security required for openness.

Initiative may result in many vague, undefined, diffused relationships. It is indeed difficult to have the freedom of initiative without compromising some of the "neatness" of a clearly structured, formally contracted relationship. Since the ground rules and boundaries for such surprise visits are undefined, the surprised patient may be at a loss as to how to respond. And, since the customary response to strangers is to engage in safe social chitchat, that is what random initial visits often produce. One of the hazards of pastoral initiative is that the dialogue remains at that level.

Since initiative rested with the chaplain, the patient may expect the chaplain to control the entire visit, if not the relationship. When that does not occur, and the chaplain tries to switch gears, the patient may feel confused. The resultant dialogue between them may be unfocused and rambling. As the relationship terminates, with the patient's discharge, it might be difficult for either of them to see any purpose or value to their interaction.

Initiative may foster dependence in both patients and staff. Closely related to the above is the dependency that initiative often engenders. It may be a patient's underlying assumption that the initiator begin, carry out, and terminate the visit. Passivity, acquiescence, and dependency may characterize the relationship.

Staff, too, may grow so accustomed to pastoral initiative that they fail to make referrals, assuming the chaplain will find the troubling situations, anyway. Without question, the right of initiative can easily occupy a chaplain's day, thereby reducing the need for referrals. As this continues, it may cause the chaplain to become more and more independent of the staff.

Guidelines for Initiative

It is not a matter of whether random initial hospital visits are more or less difficult, more or less important, than formally scheduled pastoral counseling interviews. They are different. They have their own nature and style and demand different skills.

Given that random initial visiting is a crucial, if not indispensable, ministry for the hospital chaplain, the challenge is how to maximize its potential.

The following are suggested guidelines for the random initial visit:

Define one's identity and role as clearly as possible. For starters, this means name, profession, hospital assignment, and the purpose of this introductory visit (to get acquainted). If the patients are listening and absorbing, this will at least disabuse them of two common fears about a chaplain's surprise visit: that the chaplain is from a nearby parish recruiting members; that they have been selected for this visit because of the gravity of their illness. We must never underestimate "the image of death" that chaplains bear for many.

If it seems warranted, the chaplain might provide a broad overview of one's hospital functions without giving a detailed job description.

Such an overview is important because though many patients are active members of a congregation, this may be their first, personal, one-on-one visit with a member of the clergy. The unexpected visit may be disarming. A broad description of how a chaplain spends a day in the hospital might be reassuring and also provide some clues on how the patient might utilize such services.

Ten years ago Bruce Hartung put the issue succinctly:

> The initial call will be even more difficult if the question of role expectation is allowed to remain under the table, implicit rather than explicit in the relationship. What is needed is either chaplains who are comfortable with what seem to be the overwhelming cultural expectations of what a chaplain does in the hospital (bringing Sacraments and comforting the dying) or chaplains who, in the first few minutes of an initial call, provide some kind of experience that makes explicit why the chaplain is in the room, if that "what" is different from the patient-defined role of the chaplain.[1]

Other means can be used to describe broadly a chaplain's role, such as an attractive printed brochure (distributed as part of "the admission packet," or by the chaplain in the initial visit) or a "meet the chaplain" telecast in the hospital's daily multimedia schedule.

While it is assumed that a professionally certified chaplain will have forged out a clear role definition, each chaplain is encouraged to check out that definition against the expectations of patients, staff, and hospital administration.

Without doubt, a major source of chaplain frustration is the disparity between *self's* and *others'* expectations. What is needed is a means of identifying that disparity and a willingness to seek to narrow it. As was indicated in chapter 4 above, pastoral role is determined by external and internal forces. What is needed, ultimately, is a creative blend of the two. A chaplain who submits totally to external expectations will "burn out." If a chaplain pursues only his or her internal expectations, the job may "burn out."

Be attentive to patients' reactions to your pastoral presence. It has been said that first impressions are important and lasting. That may be. However, in this regard first impressions are important clues to what the chaplain symbolizes to the patient. Initially, patients will more likely respond out of their internal images and references (provoked by the chaplain) than to external realities of the chaplain's appearance, personality, and style.

Of all the helping professions, clergy has the longest history. It is a profession that is many centuries old. Consequently, time has allowed many images, concepts, and role expectations to emerge. These have been passed on from generation to generation. Carl Jung referred to these as "archetypes."

When a pastoral relationship is initiated, many of these historic, and often unconscious, images are stimulated. Psychoanalysis has provided a concept that is helpful in describing this phenomenon. It is called *transference.* Transference is an "as if" reaction. "As if" the therapist, or counselor, or authority (in this case, chaplain) were an emotionally important person from early in one's life. Many of these internal images are highly charged by early developmental stages (e.g., the priestly designation "father" is highly suggestive of a parental-authority figure).

In this sense, transference is a response determined principally by the inner needs and conflicts of the patient rather than by the behavior of the chaplain.

Transference usually includes three psychological phenomena:

Introjection. Qualities or characteristics learned from one's parents and/or other early authorities which are then incorporated into one's own personality.

Projection. Attributing those qualities and characteristics learned from early authorities onto current authorities, whether or not they accurately "fit" those authorities.

Displacement. Expressing those feelings onto current authorities that are intended for earlier authorities; that is, responding to the past through the present.

These transference reactions are unconscious; they may be positive or negative or, most commonly, both. Thus, a chaplain's presence at a patient's bedside may provoke a combination of trust, confidence, security, anger, guilt, fear, and dependency. As stated, these emotional reactions may have little to do with the chaplain's behavior or self-image.

All human interactions have some transference. It is part of the economy of relating to "transfer" past experiences onto the present. That way we're not always starting from scratch in every relationship. Of course, current experiences can, and do, modify those images, that's why transference lessens as the relationship continues.

In an initial pastoral visit it is important to observe these "pastoral images," and "internal references." For out of them emerge reactions and expectations. From the chaplain some patients will want reprimand or chastisement, rescue or restraint; others will want sanction and encouragement, hope and optimism. Still others will want the chaplain to change their situations or the behavior of their loved ones. To be sure, some of these expectations will derive from their immediate needs, others from their unconsciously held images. Some expectations will be appropriate and realistic; others will be magical and illusory. Some requests will be communicated as demands, others as pleas. Some of these will be congruent with the chaplain's own role concept, others will be incongruent. Failure to meet such requests may be perceived by patients as pastoral unwillingness, not as inability.

This is not an appeal for hospital chaplains to become trained in the extremely complex process of transference, but rather to be aware of its presence in all relationships, particularly in an initial visit. Since most random initial hospital visits bring together two strangers, it is natural that patients will draw upon past images to gear them up for this newly created relationship.

Nor is this an appeal for chaplains to modify their role in order to meet any and all patient demands. Rather, it is an appeal to recognize the vast array of role images and expectations a chaplain encounters, many of which are engendered by transference.

Be *patient with the patient.* By entering a patient's room unannounced, the chaplain has the advantage of being forewarned and forearmed. It is best not to press the advantage. A discerning chaplain may uncover many patient needs in those initial minutes. It is best not to exploit them in the early phases of the relationship, lest the patient later become defensive and resistant. Sensitive restraint should characterize the chaplain's behavior during a random initial visit. Trust and confidence can only come as time allows them to be engendered.

Attempt to facilitate a role reversal. In the random initial visit the chaplain is the initiator and the patient is the responder. Many years ago, in describing "The Pre-Counseling Possibility," Seward Hiltner spoke of attempting to convert the pastor's "geographic initiative" into the counselee's (or, in this case, patient's) "psychological initiative."[2] By "psychological initiative" is meant the active utilization of the relationship to meet one's needs. For this to occur, a role reversal must be effected.

Such role reversal is a goal of the random initial visit. This means a dynamic shift for both: the chaplain shifts from "physical initiator" to "psychological responder"; the patient shifts from physical responder to psychological initiator. When this occurs, each bears responsibility for the nature and character of the relationship. Such a reversal cannot be forced. All that the initiating chaplain can do really is to provide the time and space for it to occur. Sometimes it does, sometimes it doesn't. Sometimes it occurs partially. There are many shades of gray in the process.

Some patients can't assert a claim upon the relationship; some chaplains can't let go of their initial control. Some patients don't feel a need for a role reversal; some chaplains can't hear the needs expressed.

To effect such a role reversal, to help patients assume psychological initiative in response to the chaplain's physical initiative, requires pastoral sensitivity, patience, and skill. When it occurs, the relationship has a better potential for being mutually rewarding. When it doesn't occur, the relationship must be accepted on other terms.

Determine a follow-up. Every random initial visit should conclude with a follow-up plan. Three factors will determine that follow-up:

Needs. Expressed and perceived needs become a major criterion for follow-up. In addition to the chaplain's observations, it is advisable to check out the staff's perception of needs.

Motivation. Patient needs, however, may not always be paralleled by patient motivation. Patients may choose not to deal with recognized needs during their hospitalization, or at least not with the chaplain. Patient motivation may also vary with regard to *level* (intense or slight) and to *direction* (broad or narrow). Follow-up ministry must weigh and consider both level and direction.

Where needs and motivation are at variance, it does not mean that pastoral care should cease. It simply means that style and approach will be different. Continued visits may build trust; and motivation to deal with those needs may follow that trust.

Availability. Patients' physical and emotional availability will vary. So will chaplains'.

Some patients are available for ministry but do not want it (lack of motivation); some patients want an active ministry but aren't available for it (because of drowsiness, unconsciousness, long absences from the room, anesthesia, pain, the constant presence of visitors);

A chaplain's availability will also vary. No chaplain can possibly be to all patients what they need and want. Realistic limits must be set.

Again, it is advisable to collaborate with staff so that the hospital's collective resources (including the chaplain) can be responsibly deployed according to patient need, motivation and availability.

In considering all factors, the chaplain should determine a course of action, based on the following questions:

What information should I share with staff? What do I need to learn from them?

Do I plan to initiate a revisit? Does the patient know this? Was it agreed upon?

Do I plan to revisit only at the patient's request? Does the patient know this? Does the patient know how to contact me in the hospital?

What issues need focusing in subsequent visits?

Should you and the patient agree on those issues?

Should I contact the family?

What are the realistic possibilities and limits in this relationship?

It is advisable to encourage the patient to participate in such follow-up decisions:

Would the patient like a follow-up visit?

If so, what are the preferred times?

What issues would the patient want to pursue?

Would the patient prefer initiating a follow-up visit?

Does the patient know how to do this?

By "encouraging" the patient to participate in such questions, the chaplain is helping the patient to assert "the psychological initiative," and is thereby helping to foster "a role reversal."

It is ironic that chaplains who often protest the lack of patient autonomy in hospital routines are frequently unwilling themselves to submit their services and availability to patient determination. Control can be a vital possession for a hospital chaplain.

When a chaplain and patient begin to work out together the nature of their relationship, they will inevitably have to confront issues of control and surrender, assertiveness and dependency, freedom and mutuality. When they do this, they are drawing very close to some of the key struggles of life. When properly negotiated, the chaplain's random initial visit provides the opportunity for patients to engage those major struggles in a small but significant way. And, it may provide the opportunity for the patient to see the broader implications of such vital human struggles.

NOTES

1. Bruce Hartung, "The Initial Call," in *Toward a Creative Chaplaincy*, ed. Lawrence E. Holst and Harold P. Kurtz; (Springfield, Ill.: Charles C. Thomas, 1973) p. 20.
2. Seward Hiltner, *Pastoral Counseling* (New York: Abington

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1 This Bibliography is cited from the Society for Pastoral Theology Website – May, 2012 http://www.societyforpastoraltheology.com/B_pastcare_biblio.html

USE OF CLINICAL MATERIALS CONSENT FORM

This form must be reviewed and signed by the CPE student prior to formal admission to an ACPE accredited CPE program and at the start of each subsequent unit in which the student enrolls.

CPE students shall be informed prior to acceptance into the program, as well as at the start of each subsequent unit, that their clinical materials and recorded and/or live observation media that are pertinent to the certification processes for Certified Educator Candidates or Associate ACPE Certified Educators, that are pertinent to the peer review process for ACPE Certified Educators, that are pertinent to a center's accreditation process, or that are pertinent to ACPE approved research studies, may be used from the unit. ***All Identifying Information shall be redacted from written documents. A copy of this signed agreement shall* remain *a part of the center's files indefinitely. Materials that are not supported with this signed Consent Form MAY NOT BE USED.***

I,_____understand that_____
Students' Refuted Name *Certified Educator Candidate /Associate ACPE Certified Educator/ACPE Certified Educator*
will use my written evaluation, the above-named educator's written evaluation of me, and other clinical materials pertinent to the above-named educator's process toward certification as an ACPE Certified Educator or as part of the above-named educator's peer review process, and I understand that such materials will have personal information redacted. I understand that the above-named educator will use recorded and/or live observation media that are pertinent to the above-named educator's process toward certification as an ACPE Certified Educator or as part of the above-named educator's peer review process, and I understand that such media may identify me. I understand that this use is for the purpose of the above-named educator's professional development, certification, and/or peer review. I understand that my written materials and live/recorded observation media that may identify me may be read, heard, viewed, and discussed by the above-named educator's professional colleagues as they assess the above-named educator's professional development and competence as an ACPE Certified Educator.

I understand that my clinical materials may be utilized by my center as data for demonstrating compliance with ACPE Standards for accreditation and/or for ACPE approved research studies without further notification to me.

My signature grants consent to all of the above.

I understand that I may revoke this authorization, in writing, to the above-named individual and that if I choose to do this, I will no longer be able to participate in the unit of CPE and will not receive credit for the unit. Any clinical materials and/or live/recorded observation media obtained prior to the revocation of this authorization may still be used by the above-named educator.

_____ _____

Student's Signature Date

_____

Start and End Dates of the Unit

CPE Full-Time Intern Agreement

Site: Self Regional Healthcare

I, _____, hereby agree to the following considerations for being accepted as a Summer Intern in the Clinical Pastoral Education Program of Self Regional Healthcare.

1. I will participate in one unit of CPE from **_____ through _____**. I understand my continuation in the program is subject to re-evaluation at any time my process does not meet the standards of ACPE.

2. I understand that I will receive a stipend for my training in exchange for my full participation in the CPE program.

3. I understand that I will be required to complete occasional on-call after the second week of training as agreed upon by the CPE and Director of Pastoral Services.

4. I understand that I must participate in at least 400 hours of clinical and educational training in order to successfully complete one unit of Clinical Pastoral Education. For our extended CPE program this involves a minimum of 40 hours per week. The clinical hours must be documented and any agreement to complete any of the clinical hours outside the hospital must be approved by the CPE Supervisor.

5. I understand that my participating in the CPE program at Self Regional authorizes me to visit patients (while under the supervision of the CE Supervisor) and have access, when warranted, to appropriate clinical records. I further understand that I must abide by the CPE Center's policies as outlined in the student handbook including those pertaining to protecting confidentiality and the rights of clients, staff, patients and families.

6. I understand that even though I am not an employee, I will be subject to the same policies and procedures as an employee except where these are amended by the Director of Pastoral Services & CPE. I further understand that I am to be present at all scheduled CPE meetings and that any absence needs to be approved by my CE Supervisor.

7. I understand that as a student in the Clinical Pastoral Education program, I will be presenting clinical materials drawn from my pastoral ministry in the hospital. I will protect the identity of the patients by not disclosing their name or any other information which may identify the patient to others. I will treat any written notes, verbatims, and reflections dealing with my ministry with others as sacred and confidential.

8. I understand that my CE supervisor may seek consultation on his/her work with me as a student. I understand that he/she will protect my identity in the same way that I am asked to protect patient confidentiality.

9. I understand I am not an employee of Self Regional Healthcare; therefore, I am not eligible for unemployment compensation after this course of study nor will I be paid for my services. I do understand, however, that I will be covered under the Worker's Compensation program if injured while in the performance of chaplaincy services at Self Regional Healthcare.

_____ _____

CPE Intern Date

_____ _____

John Carter Thomas Date

ACPE Certified Educator – Director, Spiritual Care Department

_____ _____

Mike Dixon Date

Vice President, Human Resources

Extended CPE Agreement

Site: Self Regional Healthcare

I, _____, hereby agree to the following considerations for being accepted as an Extern in the Clinical Pastoral Education Program of Self Regional Healthcare.

1. I will participate in one unit of CPE from **_____ through _____**. I understand my continuation in the program is subject to re-evaluation at any time my process does not meet the standards of ACPE.

2. I understand that I will receive a stipend for my training in exchange for my full participation in the CPE program.

3. I understand that I will be required to complete occasional on-call after the second week of training as agreed upon by the CPE and Director of Pastoral Services.

4. I understand that I must participate in at least 400 hours of clinical and educational training in order to successfully complete one unit of Clinical Pastoral Education. For our extended CPE program this involves a minimum of 20 hours per week (5 hours within classroom). The clinical hours must be documented and any agreement to complete any of the clinical hours outside the hospital must be approved by the CPE Supervisor.

5. I understand that my participating in the CPE program at Self Regional authorizes me to visit patients (while under the supervision of the CE Supervisor) and have access, when warranted, to appropriate clinical records. I further understand that I must abide by the CPE Center's policies as outlined in the student handbook including those pertaining to protecting confidentiality and the rights of clients, staff, patients and families.

6. I understand that even though I am not an employee, I will be subject to the same policies and procedures as an employee except where these are amended by the Director of Pastoral Services & CPE. I further understand that I am to be present at all scheduled CPE meetings and that any absence needs to be approved by my CE Supervisor.

7. I understand that as a student in the Clinical Pastoral Education program, I will be presenting clinical materials drawn from my pastoral ministry in the hospital. I will protect the identity of the patients by not disclosing their name or any other information which may identify the patient to others. I will treat any written notes, verbatims, and reflections dealing with my ministry with others as sacred and confidential.

8. I understand that my CE supervisor may seek consultation on his/her work with me as a student. I understand that he/she will protect my identity in the same way that I am asked to protect patient confidentiality.

9. I understand I am not an employee of Self Regional Healthcare; therefore, I am not eligible for unemployment compensation after this course of study nor will I be paid for my services. I do understand, however, that I will be covered under the Worker's Compensation program if injured while in the performance of chaplaincy services at Self Regional Healthcare.

_____ _____

CPE Extern Date

_____ _____

John Carter Thomas Date

ACPE Certified Educator – Director, Spiritual Care Department

_____ _____

Mike Dixon Date

Vice President, Human Resources

CPE Resident Agreement

Site: Self Regional Healthcare

I, _____, hereby agree to the following considerations for being accepted as a Resident in the Clinical Pastoral Education Program of Self Regional Healthcare.

1. I will participate in four units of CPE from **_____ through _____**. I understand my continuation in the program is subject to re-evaluation at any time my process does not meet the standards of ACPE.

2. I understand that I will be required to complete one overnight on-call each week beginning in the second week of training.

3. I understand that I must participate in at least 400 hours of clinical and educational training in order to successfully complete one unit of Clinical Pastoral Education. For our full-time program this involves a minimum of 40 hours per week. The clinical hours must be documented and any agreement to complete any of the clinical hours outside the hospital must be approved by the Certified Educator Supervisor (CE).

4. I understand that my participating in the CPE program at Self Regional authorizes me to visit patients (while under the supervision of the CE Supervisor) and have access, when warranted, to appropriate clinical records. I further understand that I must abide by the CPE Center's policies as outlined in the student handbook including those pertaining to protecting confidentiality and the rights of clients, staff, patients and families.

5. I understand that as an employee I will be subject to all policies and procedures of SRH.

6. I understand that as a student in the Clinical Pastoral Education program, I will be presenting clinical materials drawn from my pastoral ministry in the hospital. I will protect the identity of the patients by not disclosing their name or any other information which may identify the patient to others. I will treat any written notes, verbatims, and reflections dealing with my ministry with others as sacred and confidential.

7. For purposes of quality control, I understand my written work may be shared by my supervisor for his/her consultation needs in a group outside of my own. I understand I have the right to request my identity be protected if the written work is to be used outside of the immediate faculty.

_____ _____

CPE Resident Date

_____ _____

John Carter Thomas Date
ACPE Certified Educator
Department, Spiritual Care Department

_____ _____

Mike Dixon Date
Vice President, Human Resources

CPE PROGRAM EVALUATION

This evaluation provides your supervisor, the CPE Center and ACPE a way to know about your experience in CPE and it assists them in their on-going quality assurance and improvement processes. Please complete and give this form to your supervisor or designated individual *after you have received your supervisor's evaluation.* Thank you for responding.

Dates of CPE Unit_____

Primary supervisor's name _____

If you were supervised by a person in supervisory education, please give that person's name:
_____

Number of units of ACPE accredited CPE now completed ___1 ___2 ___3 ___4 ___5 or more

Did you take this unit for academic credit? _____Yes _____ No

Did you take this unit as required for ordination? _____Yes _____ No

1 - very negative; 2 - somewhat negative; 3 - positive; 4 - very positive; N/A - not applicable

PERSONAL LEARNING/MINISTRY DEVELOPMENT

This unit of CPE provided me opportunity to:

1. Further develop my personal and pastoral identity. 1 2 3 4 N/A
2. Develop self-knowledge that improved my pastoral function. 1 2 3 4 N/A
3. Increase my awareness of how my ministry impacts persons. 1 2 3 4 N/A
4. Develop my ability to use my theology in pastoral ministry. 1 2 3 4 N/A
5. Develop the ability to think theologically about my experience. 1 2 3 4 N/A
6. Develop pastoral skills in crisis intervention. 1 2 3 4 N/A
7. Develop pastoral skills in initial pastoral visitation. 1 2 3 4 N/A
8. Develop pastoral skills with diverse faith groups. 1 2 3 4 N/A
9. Develop my capacity to minister professionally in a variety of functions, e.g., preaching, teaching, administration, and brief counseling. 1 2 3 4 N/A
9. Learn to use the clinical method of learning. 1 2 3 4 N/A
10. Foster my ability to evaluate my own ministry. 1 2 3 4 N/A
11. Make pastoral use of my religious heritage. 1 2 3 4 N/A
12. Make use of the behavioral sciences in my ministry. 1 2 3 4 N/A
13. Become more aware of how organizational structure and social conditions affect the lives of others and myself. 1 2 3 4 N/A

THE CPE PROGRAM:

14. Orientation to CPE was helpful.	1 2 3 4 N/A
15. Orientation to my pastoral care responsibilities was sufficient.	1 2 3 4 N/A
16. Student handbook was an effective guide to the CPE program.	1 2 3 4 N/A
17. Provided sufficient access to library resources.	1 2 3 4 N/A
18. Dealt with sufficient didactic material to contribute to my conceptual framework for the practice of ministry.	1 2 3 4 N/A
19. Was open to diversity.	1 2 3 4 N/A
20. Was accepted within the institution and integrated with services.	1 2 3 4 N/A
21. Provided opportunities for interdisciplinary team functioning.	1 2 3 4 N/A
22. Used interdisciplinary instructional resources.	1 2 3 4 N/A
23. Adequately mixed the practice of ministry with didactic/other learning opportunities.	1 2 3 4 N/A
24. Provided peer group experiences that helped me learn about myself in ministry.	1 2 3 4 N/A
25. Influenced the direction of my ministry.	1 2 3 4 N/A
26. Offered opportunities to pursue theory and practice of a pastoral specialty.	1 2 3 4 N/A

QUALITY OF SUPERVISION

27. Individual supervision was effective for me in this unit of CPE.	1 2 3 4 N/A
28. Group supervision was effective for me in this unit of CPE.	1 2 3 4 N/A
29. My supervisor assisted my pastoral function and reflection.	1 2 3 4 N/A
30. My supervisor helped me use the teaching/learning contract effectively.	1 2 3 4 N/A
31. My supervisor's behavior was professional at all times.	1 2 3 4 N/A

Using a separate sheet, comment about your supervisor's strengths and weaknesses as a pastoral educator, based on your experience in this program. Add any additional comments about your supervisor, the program unit and/or your experience in the program

Name (optional) _____Date_____

Guidelines for Mid-Unit Evaluation

I. General Information

The Mid-Unit Evaluation, when required, is your evaluation of your work from the beginning until the mid-point of the unit, along with feedback from peers and the CE. Using the outline below, write a clear, concise, complete essay. Report on your learning progress. Be specific and concrete. Use clinical illustrations from case material, significant incidents, and/or parishioners/peers/supervisor/ministry staff/denominational leaders/seminary staff.

Expectations for evaluation is as follows

A. Single-space typed essay limited it five pages
B. Prepare to complete your evaluation and all discussion in 45 minutes
C. Provide a copy to each person in the group; give the original to your CE.
D. The CE does not write a mid-unit evaluation

II. The Evaluation Outline

A. *Cover sheet*, please include your name, the name of the CPE Center, the date of your mid-unit evaluation, your CPE level and number of units, your denomination, and your CE's name.

B. *Self-Awareness*
Briefly describe at least three new things you have learned about yourself so far in the Unit. Explain how these new awareness's have changed the way you provide ministry to others.

C. *Learning Covenant* (*ACPE Standard 3*)
Include a copy of your Learning Covenant as agreed upon by you, your peers, and supervisor. Evaluate your growth in regard to the Learning Covenant.

D. *Clinical Setting* (ACPE Standard 3)
Describe your clinical assignment and a description of the persons to whom you provide ministry, and any other details that can help your peers and supervisor understand the ministry you provide. What learning issues unique to this assignment have arisen for you? How have the needs of the patients impacted/changed the way you normally practice ministry? Describe your ministry with/to the staff?

E. *The Peer Group*
Somewhere within your evaluation, discuss your relationship with each peer individually, and discuss the functioning of your peer group. What do you like most about your peers? What would you like to see change?

F. *Program Feedback*
Provide feedback about the CPE program and the CE.

III. Evaluation Session Process

The Mid-Unit Evaluation is a time for you to receive feedback from your peers and Supervisor about your learning. You are expected to structure the time for your learning needs.

Self Regional Healthcare
Final Evaluation Guide
Residents - Level I/II

Your final evaluation will become part of your permanent CPE record. Address the areas listed below. You are invited to add other areas if some important part of your learning calls outside the questions given here. Please limit your evaluation to no more than five single-spaced pages. Always illustrate your observations and reflections with examples. Always use initials (or first name) only for your peers. Use pseudonyms for your patient/parishioner examples. Please bring copies for your peers and supervisors.

1. Your Leaning Goals. List your learning goals. Evaluate how you addressed your learning goals for this unit. Evaluate their effectiveness for your learning. Describe the finished and unfinished pieces of your work. What new goal might you add? Evaluate your progress toward completing learning outcomes. (ACPE Standard 3 Outcomes)

2. Your Learning as a Pastor/Person. How do you describe your pastoral identity and style? In what ways does your life story have an impact on your way of doing pastoral care? What did you learn this unit about your relationship with God? Include a brief description of one significant learning this unit from your relationship with Self Regional Healthcare patients or staff.

3. Strengths and Weaknesses. List your strengths and limits as a pastor. How has this unit helped in your understanding and use of your personal strengths and weaknesses in your pastoral functioning? Give examples.

4. Clinical Method of Learning. How has your theology been strengthened this unit? How has it been stretched? How have you been open and/or closed to God's revelation in your ministry and educational process? Comment on any relevant learning from our texts for the unit and other personal reading that informs your pastoral care and personal awareness. Discuss any additional theoretical frameworks that were helpful for your learning this unit. (Include progress toward meeting Level I/II Outcomes)

5. Peer Learning. Comment on your relationship with each of your peers. How do you see the strengths and limits of each peer? How has each peer helped you in your learning? How could they have been more helpful? Describe your way of relating in the peer group. Assess your strengths and limits as a peer group participant.

6. Your relationship with your supervisor(s). Describe your relationship with your CPE Supervisor and your Clinical Supervisor. Evaluate your capacity to utilize supervision. What was the most and least helpful aspect of your supervisory relationship? Evaluate your supervisor(s) strengths and limits.

Certified Educator's Confidential Evaluation Cover Sheet

Student's Name:	
Student's Faith Affiliation:	
CPE Program *(check all that apply)*: ☐ Residency ☐ Extended ☐ Summer ☐ Single unit	
Year: ☐ Fall ☐Winter ☐ Spring ☐ Summer ☐ Other:	
Program Type: ☐ CPE Level I/II ☐ Supervisory CPE	
Completion Rate: received credit for ☐ 1 unit ☐ ½ unit ☐ No credit	
Number of previous units completed in this center: #	ACPE units completed in other centers: #
CPE Center:	
Accreditation Area:	
Address:	
Certified Educator(s) Name(s):	
Certified Educator Candidate (if applicable):	
Date of Unit Evaluation:	
Start and End Dates of CPE Unit:	
Date *evaluation* was sent to student:	Within 21 calendar days: ☐ Yes ☐ No
Date *Student Unit Report* was submitted to ACPE:	Within 21 calendar days from the end of the unit: ☐ Yes ☐ No

Student's Rights and Responsibilities:

- This CPE unit was comprised of at least 400 hours combining no less than 100 hours of structured group and individual education with supervised clinical practice in ministry. Half units: at least 240 hours/no less of 60 hours.
- This report has been made available to me within 21 calendar days of the completion of the unit. If not, the evaluation documents the extension arrangements discussed with the regional accreditation chair and the student according with Standard 308.8.1 "*Supervisor's evaluation will be available to the student within 45 calendar days of the completion of the unit. To extend this deadline in rare unusual circumstances, the supervisor may negotiate with the student and receive approval from the regional accreditation chair to extend this deadline. The supervisor's evaluation will document this process, and such extensions must be reported on the next annual report.*"
- I can respond formally by writing an addendum, if I choose, only after discussing this report with my supervisor. This addendum (written response) then becomes part of my student's record (Standard 308.8.4).
- If I have chosen to respond formally by writing an addendum, my response is attached to this report. If I have attached an addendum, I will indicate this (at the place of signature in this document), sign the document, attach my addendum, and return all items to the CPE Center. I will return the signed evaluation to the center according to center policies.
- The timeline and deadline for student response and return of the supervisor's evaluation are established by the center's policies.
- I understand it is my responsibility to retain copies of this report and all evaluations written by my supervisor and me.
- The CPE Center will retain copies of both documents for 10-years from the date the evaluation was sent to the student (10-year suspense date). After 10 years, the center's record retention policy will determine what will happen with the documents.

CONFIDENTIAL

- These evaluations will not be available to anyone else except with written permission from the student. Exceptions: see ACPE Accreditation Manual, Appendix 7B.
- I have received this report, read it, and have been given an opportunity to respond to it informally and/or formally. My signature confirms acknowledgement of these rights and responsibilities and receipt of the educator's unit evaluation.

Signature:

CPE Student *Signature:*	Date Received Date Signed & Returned Addendum: ☐ Yes ☐ No
Certified Educator Candidate ***(if applicable)*** *Signature:*	Date Signed
ACPE Certified Educator	Date Signed & Sent to Student

Sample
Self Regional Healthcare
Clinical Pastoral Education

Certified Educator's Confidential Final Evaluation

Student:	**Supervisor: Dr. John C. Thomas, Jr.**
Training Level:	**Unit Dates:**

Background Information:

Description of CPE Center. Self Regional Healthcare began as Self Memorial Hospital in 1951 and was built to be one of the most advanced hospitals in the country. Local business leader and philanthropist James C. Self personally oversaw the construction and recruited top physicians from across the country.

By Act 1554 of 1968, the State Legislature established Greenwood County Hospital Board (the "Board"). In 1969 the Trustees of Self Memorial Hospital conveyed the hospital facilities to Greenwood County which leased them to the Board by long term lease. The Board (appointed by the governor) operates Self Regional Healthcare as a governmental hospital.

Mr. Self's commitment to advanced care with leading-edge technology continues today. The difference is that we've grown into a major referral and medical center that provides advanced healthcare services to a population of more than a quarter of a million people.

At one time or another, everyone in the surrounding seven counties has been touched by Self. From a broken arm, to the birth of a child or chemotherapy, Self was always there. And we're still close to home with the latest technology and finest doctors. To separate Self from the community would be impossible. Community is a huge part of what we are, which explains the great sense of pride we feel when people say "I am Self."

Curriculum Description

Composition of student's peer group during training unit.
Biographical sketch of the student receiving evaluation below.

Student's clinical setting during the training unit:
Learning Covenant.

The Learning Contract and Level I/II Outcomes

Pastoral Formation

Level I Outcomes

L1.1. articulate the central themes and core values of one's religious/spiritual heritage and the theological understanding that informs one's ministry.
L1.2. identify and discuss major life events, relationships, social location, cultural contexts and social realities that impact personal identity as expressed in pastoral functioning.
L.1.3. initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Level II Outcomes

L2.1. articulate an understanding of the pastoral role that is congruent with one's personal and cultural values, basic assumptions and personhood.

Pastoral Competence

Level I Outcomes

L1.4. risk offering appropriate and timely critique with peers and supervisors.
L1.5. recognize relational dynamics within group contexts.
L1.6. demonstrate integration of conceptual understandings presented in the curriculum into pastoral practice.
L1.7. initiate helping relationships within and across diverse populations.
L1.8. use the clinical methods of learning to achieve one's educational goals.

Level II Outcomes

L2.2. provide pastoral ministry with diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, justice and applied clinical ethics issues without imposing one's own perspectives.
L2.3. demonstrate a range of pastoral skills including listening/attending, empathic reflection, conflict resolution/transformation, confrontation, crisis management, and appropriate use of religious/spiritual resources.
L2.4. assess the strengths and needs of those served grounded in theology and using an understanding of the behavioral sciences
L2.5. manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.
L2.6. demonstrate competent use of self in ministry and administrative function which includes: emotional availability, cultural humility, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.

Pastoral Reflection

Level I Outcomes

L1.9. formulate clear and specific goals for continuing pastoral formation with reference to one's strengths and weaknesses as identified through self-reflection, supervision and feedback.

Level II Outcomes

L2.7. establish collaboration and dialogue with peers, authorities and other professionals.
L2.8. demonstrate self-supervision through realistic self-evaluation of pastoral functioning.
L2.9. by the end of Level II, students will be able to demonstrate awareness of the Common Qualifications and Competencies for Professional Chaplains.

Conclusion:

I certify that _____ has completed the _____ Unit of CPE (Level I/II). This evaluation should always be read conjointly with the student's self-evaluation.

John C. Thomas, Jr., ACPE Certified Educator ________
Date

I have read this evaluation and have had the opportunity to discuss it with my supervisor.

_____ _____
Student Date