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Perspectives from early-career healthcare chaplains on the strengths and weaknesses of their clinical pastoral education and graduate degrees

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ABSTRACT

This study investigated the educational experiences of early-career healthcare chaplains (ECHCs) to identify their perceptions of the strengths and weaknesses of their academic and clinical training. We conducted an online survey with fixed-choice and open-text questions, gathering data from 288 ECHCs. Their responses revealed substantial gaps between traditional academic programs, such as the Master of Divinity (M.Div.) degree, and the competencies needed for effective healthcare chaplaincy, with only 40% of respondents feeling adequately prepared. Although Clinical Pastoral Education (CPE) was recognized for fostering practical skills and self-awareness, areas for improvement were noted by 15%-50%. The study highlights the need for integrated curricula that combine academic knowledge with clinical practice, ensuring chaplains are equipped with the competencies needed to meet the demands of modern healthcare. The research suggests that chaplaincy education should be redesigned to better align with the evolving professional landscape of healthcare chaplaincy.

KEY WORDS

Chaplaincy education; clinical pastoral education; early career chaplains; healthcare chaplaincy; theological education

Introduction

The recognition of patients' overall well-being has become a key focus in healthcare, emphasizing the integration of emotional and spiritual dimensions into patient care (Mount, 1993; Puchalski, 2008; Sulmasy, 2002). Healthcare chaplains (HCCs) play a vital role in the whole-person care model, providing spiritual and emotional support to patients, families, and healthcare staff and contributing to the multidisciplinary medical team, particularly in complex care environments (Handzo et al., 2023). Although the importance of HCCs is well-established (Balboni et al., 2022), there is an acknowledged need to improve the educational pathways that form the foundation of HCC training

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(Cadge et al., 2020, 2022; Fitchett et al., 2015; Massey, 2014; Rambo & Giles, 2022; Tartaglia, 2015; Wintz & Hughes, 2018).

Conventionally, the path to becoming a HCC involves obtaining a Master of Divinity (M.Div.) degree initially structured for Christian ministry leadership (Cadge et al., 2021, 2022; Rambo & Giles, 2022). This is typically followed by Clinical Pastoral Education (CPE), a supervised, experiential learning program designed to develop spiritual care competencies through direct clinical practice. However, M.Div. curricula often lack a specific concentration on the unique demands of healthcare chaplaincy (Cadge et al., 2021). Although healthcare chaplaincy scholarship has advanced in areas like outcomes-oriented chaplaincy (Peery, 2020), spiritual struggle (Doehring, 2019), and promoting evidence-based practices (Fitchett et al., 2018), chaplaincy educational programs still struggle to consistently and adequately integrate these and related concepts (Cadge et al., 2022). As a result, leaders have called for a unified and comprehensive set of curriculum standards addressing the inefficiencies that result from the current siloed academic and clinical approach to training HCCs (Cadge et al., 2020; 2022). Leaders within the field have advocated for substantial reforms in chaplaincy education (Cadge et al., 2020, 2022; Fitchett et al., 2015; Massey, 2014; Tartaglia, 2015), with recommendations that include revising existing educational models (Ford & Tartaglia, 2006; Tartaglia, 2015), introducing master's programs designed explicitly for healthcare chaplaincy (Cadge, 2012; Fitchett et al., 2015), and embedding chaplaincy education within academic medical centers to integrate academic learning with clinical practice (Cadge, 2012). Significant engagement with various healthcare professionals is also emphasized to help develop critical skills needed by future chaplains (Cadge et al., 2020).

The project reported here is part of a broader research initiative to establish joint academic and clinical curriculum standards for training HCCs. A key first step in that effort is understanding how those most recently trained experience their preparation, what worked well, and where gaps remain. Early-career healthcare chaplains (ECHCs) are uniquely positioned to offer such insights. They are close enough to their educational experiences to recall them in detail, yet far enough into their practice to critically evaluate how well those experiences prepared them for real-world chaplaincy. Their reflections offer a valuable, underexamined window into the alignment (or misalignment) between current training models and the demands of the field. Thus, this study asked: How do early-career chaplains view the strengths and weaknesses of their academic and clinical pastoral education (CPE)? Unlike most previous work, which have primarily been opinion pieces, this study offers data-driven insights into this question.

Methods

Study aim and inclusion criteria

Our research aimed to identify strengths and weaknesses in chaplaincy education as perceived by ECHCs. Inclusion criteria for the study were chaplains who had earned a graduate degree, completed 1600 hours (approximately four units) of CPE and had been employed as HCCs for two to five years for at least 20 hours per week. We selected this time frame to capture chaplains who were far enough into their practice to reflect critically on their preparation, but still early enough in their careers to recall their

educational experiences in detail. The 20-hour-per-week threshold ensured that participants had sustained clinical exposure and experience as healthcare chaplains. Certified Educator Candidates were excluded because their participation in ACPE certified educator training typically involves additional education and supervisory responsibilities that fall outside the scope of standard early-career chaplaincy practice. This research was reviewed by the Rush University Medical Center Institutional Review Board and determined to be exempt.

Survey content

The survey was designed by the first author (DF) with feedback from the last author (GF) and was hosted on Research Electronic Data Capture (REDCap) at the Rush University Medical Center. It consisted of multiple-choice questions, Likert scale ratings, and open-ended responses covering various aspects of chaplaincy education and practice (see Appendix A). In addition to overall ratings of the perceived helpfulness of their graduate degrees and CPE experiences, questions included the adequacy of education in developing theologies/philosophies of spiritual care, knowledge in behavioral sciences, understanding of group and organizational dynamics, research literacy, self-awareness, ethics, spiritual care practices, and preparedness to lead public ceremonies/services, all synthesized from the 2017 Common Qualifications and Competencies for Professional Chaplains (Association of Professional Chaplains [APC], 2017). Additionally, we explored respondents' opinions on integrating CPE units into graduate degrees, the necessity of CPE residencies, and the value of CPE in healthcare settings over other settings. The survey also collected demographic information, including religious or spiritual identity, race and ethnicity, location, gender identity, and age.

Survey design process

To strengthen content validity, two focus groups were convened to review the draft survey prior to distribution. These focus group participants were not included in the study sample, and no data from the sessions were analyzed. Participants were recruited through chaplaincy-related social media platforms and received a $25 Amazon gift card as an incentive. The sessions were held virtually via Zoom and involved structured feedback on the clarity, relevance, and overall length of survey items. Participants were CPE residency graduates who had completed a graduate degree and were either unemployed or had been employed as healthcare chaplains for fewer than two years. Feedback from these groups informed revisions to the survey instrument, enhancing its usability and relevance for ECHCs.

Sampling strategy and recruitment

We used a convenience sampling strategy to recruit participants from February 14, 2023, to March 30, 2023, via invitations to participate posted on Facebook and LinkedIn groups focused on professional chaplaincy. The invitation to participate included a direct link to the REDCap survey to facilitate easy access and encourage high response rates.

Additional recruitment occurred through collaborative efforts with established chaplaincy organizations. Transforming Chaplaincy contributed by dispatching an invitation to its email list on February 14, followed by a reminder on February 22. Furthermore, we partnered with the Association of Professional Chaplains (APC), which issued an invitation email to its members on March 1, 2023, and a reminder one week later. To encourage participation, we offered respondents the opportunity to enter a raffle for a $25 Amazon gift card.

Response and data integrity

Our initial goal was to receive 200 responses. On the first day of posting the survey, we received 173 responses. The survey remained open for 45 days, concluding on March 29 with 824 responses. Upon closing the survey, the unexpectedly high response rate prompted a thorough investigation into the data's integrity. We identified significant infiltration by survey bots—automated programs designed to complete online surveys with fictitious responses to claim incentives (Pozzar et al., 2020). An emerging body of literature on protecting online surveys from such manipulations corroborated this discovery (Goodrich et al., 2023; Griffin et al., 2022; Leibbrand, 2021; Research Bow, 2023; Simone, 2019; Tang, 2023; Wang et al., 2023). We identified our critical errors as providing an open survey link on public social media platforms without using the "Completely Automated Public Turing test to tell Computers and Humans Apart" (CAPTCHA) combined with the economic incentive of an Amazon gift card, which likely attracted fraudulent bot activity (Griffin et al., 2022; Wang et al., 2023).

We meticulously cleaned the data, applying pre-determined criteria to distinguish between legitimate and illegitimate responses (Supplemental Table 1). Surveys were categorized as ineligible, suspected of bot-infiltration, fraudulent due to bot-infiltration, incomplete, or legitimate. Two team members independently reviewed each entry, with disagreements resolved by the principal investigator (PI) based on the established criteria. Ultimately, 288 responses (35% of the total) were deemed legitimate and were used for analysis. The remaining 536 responses (65%) were discarded as suspected or fraudulent due to bot-infiltration, ineligible to participate, or illegitimate.

Data analysis

We used descriptive statistics to describe participant characteristics and their responses to fixed-response items about their chaplaincy education. To analyze how well participants felt their CPE and academic degrees prepared them as HCCs, we categorized responses into three subgroups: Strongly Agree/Agree (strong endorsement), Somewhat Agree (weak endorsement), and Disagree (no endorsement). This categorization was based on the distribution of responses across the initial five categories and their levels of agreement. Due to the low number of responses in the "Disagree" categories, we combined them into a single group. We also conducted a subgroup analysis to compare the perceived adequacy of degree preparation between those with and without a chaplaincy concentration in their degree. We used a Chi-Square test to assess differences in levels of agreement between these groups.

The survey included open-ended questions about the aspects of CPE and graduate education that HCCs found most and least helpful in their current practice and areas of study they wish they had pursued to better prepare for their roles. For these questions, we used reflexive thematic analysis to guide our coding of the data and theme development (Braun & Clarke, 2022). For each question, two team members independently immersed themselves in the data through repeated readings to identify preliminary patterns. Subsequently, we systematically applied codes to salient features across the entire dataset, ensuring comprehensive coverage. We addressed any differences in coding through discussions, where we collaboratively reviewed our interpretations and reached consensus to ensure consistency and accuracy in the thematic analysis. These codes were then aggregated into preliminary themes, which were further refined by assessing their coherence and consistency against the dataset. We proceeded to define and label each theme, ensuring that the labels accurately encapsulated the core essence of the data. Finally, we compiled a detailed report incorporating illustrative quotes for each theme. Throughout the process, we maintained a reflexive approach, continually scrutinizing our assumptions and interpretations to uphold the rigor of our analysis.

Results

Demographic and educational profile of participants

This section presents the findings from a survey developed using the 2017 Common Qualifications and Competencies for Professional Chaplains (APC, 2017) as its framework. The results reflect ECHCs' perceptions of the adequacy and relevance of their academic and clinical training. Among the 288 study participants, the average age was 45.5 years ($SD = 12.68$; See Table 1). Over a quarter of the participants (29%) were older than 55, including the oldest participant at 80. Slightly more than a third (39%) were between 36 and 55 years old, and one-third were 35 or younger. Gender identity distribution included 50% men, 46% women, and 4% identifying as other. Most respondents identified as White (68%), followed by Black or African American (15%), and Asian (6%), with smaller percentages representing other racial and ethnic backgrounds. Religiously, the composition was overwhelmingly Christian, with 63% identifying as Protestant Christian, 12% as Other Christians, and 9% as Catholics. Participants were geographically distributed across the Northeast, South, Midwest, and West regions of the United States.

As Table 2 shows, most participants (82%) had earned one graduate degree, predominantly an M.Div. (71%). Additionally, one-third earned a graduate degree with a concentration in chaplaincy, pastoral care, or spiritual care. Forty-two percent of the ECHCs reported earning their degree within five years; another 28% reported earning it within 6–10 years. Almost a third of the sample (30%) reported earning their degrees more than 10 years ago, including 19% who reported it was 11–20 years ago and 11% who reported it was more than 20 years ago. One participant reported earning their degree in 1967. A significant number had completed multiple units of CPE accredited by the Association for Clinical Pastoral Education (ACPE), with most earning four.

Table 1. Demographic profile of participants.

	Min	Max	Mean	SD
Age ($n = 273$)	28	80	45.54	12.68
How do you currently describe your gender identity? ($n = 273$)				*n* (%)
Man				137 (50%)
Woman				125 (46%)
Other				11 (4%)
Which categories describe you? ($n = 285$)[a]				*n* (%)
White				195 (68%)
Black or African American				44 (15%)
Asian				18 (6%)
Other[b]				40 (14%)
How do you describe your religious or spiritual identity? ($n = 283$)[1]				*n* (%)
Protestant Christian				177 (63%)
Other Christian				34 (12%)
Catholic				26 (9%)
Spiritual, not religious				14 (5%)
Buddhist				13 (5%)
Other[c]				56 (20%)
Where do you live? ($n = 283$)				*n* (%)
Northeast				51 (18%)
South				97 (34%)
Midwest				65 (23%)
West				69 (24%)
Puerto Rico or other U.S. Territories				1 (< 1%)

[a]Participants could select multiple categories therefore the total percent may not equal 100.
[b]Other included groups with less than 5% representation including American Indian or Alaska Native, Hispanic, Bi-racial, Latino or Spanish Origin, Middle Eastern or North African, Native Hawaiian or Other Pacific Islander, I Prefer Not to Answer, Jewish.
[c]Other included groups with less than 5% representation including Hindu, Humanist, Jewish, Muslim, Native American, Unitarian Universalists, and Interspiritual.

Notably, 73% had completed at least one CPE residency, and 53% were board-certified chaplains, primarily through the APC.

ECHCs' ratings graduate degree and CPE

Our survey results provided insights into how well respondents perceived their graduate degree, and their CPE prepared them for healthcare chaplaincy (see Table 3). Fewer than half of the respondents (40%) strongly agreed or agreed that their graduate degree prepared them well for healthcare chaplaincy, while another third (34%) provided weak endorsement ("somewhat agree"). However, 26% disagreed that their degree had adequately prepared them. To further explore these perceptions, we conducted a subgroup analysis to assess the influence of having a chaplaincy concentration within their degree. The results showed that the proportion with high agreement about how well their degree prepared them to function as a chaplain was similar for those who had a chaplaincy concentration in their degree and those who did not (41% vs. 39%). There was somewhat higher weak agreement about preparation among those with a chaplaincy concentration (41% vs. 31%), and notably lower disagreement (18% vs. 30%) compared to those who did not have a chaplaincy concentration. However, these differences were not statistically significant ($p = 0.08$).

Regarding CPE preparation, most respondents (85%) strongly agreed or agreed that their CPE experiences prepared them well for their roles as healthcare chaplains. Despite this

Table 2. Educational and professional characteristics of participants.

How many graduate degrees have you earned? ($n = 287$)	*n*	(%)
One	235	(82%)
Two	45	(16%)
Three	5	(2%)
Four	2	(1%)
Please indicate the graduate degree(s) you have earned. ($n = 287$)[a]	n	(%)
Master of Divinity	205	(71%)
Other degrees[b]	65	(23%)
MA Theology	17	(6%)
MA Religion	14	(5%)
MA Chaplaincy	10	(3%)
MS Chaplaincy	7	(2%)
MA Ministry	6	(2%)
MA Pastoral Care	6	(2%)
Doctor of Ministry	18	(6%)
Did your degree include a concentration in chaplaincy, pastoral care, or spiritual care? ($n = 285$)	*n*	(%)
No	190	(67%)
Yes	95	(33%)
How many total units of Level I/II CPE have you completed? ($n = 287$)	n	(%)
4	170	(59%)
5	73	(25%)
6-8	29	(10%)
9-15	15	(5%)
Through which CPE accrediting organization did you complete the majority of your Level I/II CPE units? ($n = 285$)		
ACPE (Association for Clinical Pastoral Education)	259	(91%)
Other[c]	26	(9%)
Did you complete one or more Level I/II CPE residencies? ($n = 285$)		
Yes, I completed one CPE residency.	208	(73%)
Yes, I completed more than one CPE residency.	42	(15%)
No, I did not complete a CPE residency.	35	(12%)
Are you a board-certified chaplain (BCC)? ($n = 287$)		
Yes	153	(53%)
No	134	(47%)
If yes, through which certifying organization did you receive your board certification? (n = 152)	*n*	(%)
APC/BCCi (Association of Professional Chaplains/Board of Chaplaincy Certification, Inc.)	122	(80%)
NACC (National Association of Catholic Chaplains)	12	(8%)
Other[d]	17	(11%)

[a]Participants were asked to indicate all their earned graduate degrees which resulted in more degrees ($n = 348$) than research participants ($n = 287$) and total percent greater than 100.
[b]Other degrees included those that were written in such as M.A. Christian Ministry, M.A. Theological Studies, M.A. Pastoral Counseling, M.A. Spiritual Care, Master of Jewish Studies, Master of Hebrew Letters, Master of Sacred Theology, etc.
[c]Other CPE accrediting organizations included Healthcare Chaplains Ministry Association, Clinical Pastoral Education International, Institute for Clinical Pastoral Training, Canadian Association for Spiritual Care, College of Pastoral Supervision and Psychotherapy, CAREForce, and Center for Spiritual Care & Pastoral Formation.
[d]Other certifying organizations included Association of Certified Christian Chaplains, College of Pastoral Supervision and Psychotherapy, Neshama: Association of Jewish Chaplains, Spiritual Care Association, Canadian Association for Spiritual Care, Healthcare Chaplains Ministry Association, National Association of Veterans Affairs Chaplains.

Table 3. Preparation to function as a healthcare chaplain.

	All Participants				Sub-analysis for any Chaplaincy Concentration in Degree[a]			
	CPE		Degree		Yes		No	
My CPE/Degree prepared me well to function as a healthcare chaplain.	*n*	%	n	%	n	%	n	%
Strongly agree, Agree	242	85%	112	40%	38	41%	74	39%
Somewhat agree	29	10%	96	34%	38	41%	58	31%
Disagree (somewhat disagree, disagree, strongly disagree)	15	5%	73	26%	17	18%	56	30%
Total	286	100%	281	100%	93	100%	188	100%

[a]Test for difference between chaplains with and without a chaplaincy concentration in their degree, Chi-square $= -3.2567$, $df = 2$, $p = 0.081$.

Table 4. CPE And graduate degree preparation for healthcare chaplaincy competencies.

	CPE		Degree	
	n[a]	%[b]	n	%
To what extent did your graduate degree and CPE …				
Increase your self-awareness?	287	(93%)	286	(52%)
Prepare you to practice spiritual care?	285	(93%)	284	(47%)
Help you develop your theologies/philosophies of spiritual care?	287	(85%)	286	(49%)
Prepare you to use spiritual assessments, interventions, outcomes, care plans, and document your spiritual care?	285	(83%)	285	(16%)
Teach you about various behavioral sciences related to spiritual care?	286	(74%)	286	(38%)
Teach you about groups and organizations?	287	(74%)	285	(37%)
Teach you knowledge and skills related to ethics?	286	(71%)	285	(54%)
Teach you research literacy?	285	(49%)	287	(51%)
Prepare you to perform public ceremonies/services in diverse settings?	283	(49%)	282	(52%)

[a]Numbers represent the number of people who answered the question on the survey.
[b]Percentages represent the proportion of people who responded with 4 (moderately) or 5 (a great deal) on a scale ranging from 1 (not at all) to 5 (a great deal).

strong endorsement, 10% of respondents gave a weak endorsement ("somewhat agreed"), and 5% explicitly disagreed that CPE had adequately prepared them.

To gain more specific insights, we asked participants to evaluate how well their graduate degrees and CPE prepared them across nine key areas of knowledge and skills essential for their roles (see Table 4).

CPE was perceived as especially effective in developing chaplains' self-awareness (93%) and preparing them to deliver spiritual care (93%). It also received strong ratings for fostering a theology or philosophy of spiritual care (85%) and for equipping chaplains in spiritual assessment, intervention, and documentation (83%). These findings affirm the central role that CPE plays in skill development and formation. Although graduate degree programs did not receive comparably high ratings in any domain, respondents acknowledged their contributions in specific areas, particularly ethics (54%), increasing self-awareness (52%), and preparation for leading public ceremonies and services (just over 50%).

Despite these strengths, several competencies were identified as needing further attention. For CPE, relatively lower ratings were given for behavioral sciences (74%), organizational dynamics (74%) and ethics (71%), with more pronounced concerns in research literacy (49%) and preparation for leading public ceremonies and services (49%). Graduate programs were rated lower across nearly all domains, with especially low ratings in organizational dynamics (37%) and behavioral sciences (38%). These findings suggest that while CPE offers robust preparation in many practical competencies, both training pathways would benefit from enhancements to better meet the complex demands of contemporary healthcare chaplaincy.

Perspectives on chaplaincy education structure and design

Beyond evaluating their preparation in these areas, we also asked respondents to share their perspectives on the overall structure and design of healthcare chaplaincy education (see Table 5). The survey highlighted a strong preference for CPE residencies, with 71% advocating for the residency to be in a healthcare context and 67% endorsing that a residency year offers better preparation than multiple single CPE units. Slightly more

Table 5. Perspectives on the structure and design of chaplaincy education.

	Affirmative Responses[a]	
	Count	Percent
Healthcare chaplains should be required to complete a CPE residency in a healthcare context. ($n = 286$)	204	(71%)
A CPE residency in a healthcare setting is better preparation for healthcare chaplains than taking several single CPE units in a healthcare setting. ($n = 284$)	191	(67%)
Healthcare chaplains should be required to complete a CPE residency after they finish their graduate degree. ($n = 285$)	146	(51%)
Future healthcare chaplains would be better equipped if they could earn a graduate degree designed explicitly for them, e.g., a master's of healthcare chaplaincy. ($n = 284$)	142	(50%)
All CPE units should be integrated into a graduate degree for healthcare chaplains, not taken before or after. ($n = 284$)	88	(31%)

[a]Affirmative responses were responses of 5 (agree) or 6 (strongly agree) on a scale ranging from 1 (strongly disagree) to 6 (strongly agree).

than half (51%) agreed that HCCs should be required to complete a CPE residency after their graduate degree. Half of the respondents strongly endorsed the idea that future HCCs would benefit from a graduate degree specifically designed for their role, such as a master's in healthcare chaplaincy. However, opinions were divided on integrating all CPE units into a graduate degree, with only 31% in favor.

ECHCs' opinions about CPE

We asked participants open-ended questions about the most and least helpful aspects of their CPE experience (see Table 6). Through our analysis, we developed themes that highlighted a sequential educational process that began with the clinical method of learning. The process incorporated various educational methods, including verbatims, individual supervision, interpersonal relations (IPR) groups, and mentoring by staff chaplains. These led to two primary outcomes: the development of self-awareness and practical skills.

Participants found the clinical method of learning (a cycle of action, reflection, and re-action) to be crucial for developing the ability to self-critique, integrate new knowledge, and improve care delivery. For example, one respondent wrote, "This model of education helped me to provide care, think about what happened and what could have been different, and then try again. Trial and error helped shape the chaplain I am today." However, challenges arose from group dynamics and the variability in educational content, highlighting the importance of effective facilitation and standardized learning objectives across CPE programs.

The most prominent methods that ECHCs found helpful were verbatims, individual supervision, and IPR groups. Regarding outcomes, the ECHCs reported a significant growth in self-awareness through CPE, emphasizing the value of understanding personal strengths, biases, and triggers. One participant said, "I believe the strength of chaplaincy resides in the self-awareness of the chaplain." Some noted the potential for redundancy in verbatims, individual supervision, and IPR groups and the distraction from developing practical skills, especially when supervision resembled therapy.

Developing practical skills was a key outcome of CPE, with participants highlighting various methods such as direct mentorship from staff chaplains, applying learned

Table 6. Opinions about CPE.

Theme	Topic	Quotes—Helpful	Quotes—Unhelpful
Clinical Method of Learning		"Action/Reflection/Action. This model of education helped me to provide care, think about what happened and what could have been different, and then try again. Trial and error helped shape the chaplain I am today." "The loop of action, reflection, re-action was helpful in that it gave me the skills to critique my own practice, integrate new knowledge, and improve my care." "[A]ction/reflection model was key to my learning. Being willing to be vulnerable and accept challenge, support, and clarifying my practice created space for growth."	"CPE being highly individualized depending on your educators. What didactics and things I learned from the educators or guests was not necessarily what other groups learned, leading to high variability in fund of knowledge around certain skills, modalities, and more." "Group feedback where no one would give feedback. Poor facilitation of conflict among peers. Book discussions where people hadn't read the material. I attended CPE to learn and was frustrated by the apparent lack of commitment to group learning that our cohort experienced."
Self-Awareness	Improved Practice	"It became a practice for self-reflection that enabled me to better serve patients." "Without that self reflection, we are much more apt to allow our own issues to affect those that we care for, as opposed to letting their own spirituality guide our interventions." "Become better aware of what I bring to care encounters was vital learning for being better able to listen and care for patient."	"[T]his is the fundamental flaw of CPE, it's not designed to create effective chaplains, it's an elongated self-reflection process that uses a healthcare context as a medium. CPE would be far more functional and effective if it actually put emphasis on teaching clear, concrete clinical skills." "The focus on introspection and work relationships often distracted from learning and practical chaplaincy skills." "The focus on emotions was good but at some point, it felt there needs to be more. I felt my CPE was lacking in teaching skills and other spiritual assessment tools."
Self-Awareness	Verbatims	"Verbatim presentations opened up a great deal of self awareness for me and allowed me to explore other students' self awareness in a learning environment." " … [I]mportant to see things that peers point out that were blindspots for me." "Verbatims because they showed me my own weaknesses and others for me to glean from."	" … after 10-15 verbatims, there becomes little to talk about, and the process is tedious.' "Verbatims. There are so many required, and it seems repetitious to a fault. It gets to the point that they are tedious and unhelpful."
Self-Awareness	Individual Supervision	"Supervision pushed me to greater self understanding and further self healing." "Individual supervision was the safest place to explore the sources of my bling spots, and to receive professional spiritual care."	"IS-individual supervision that turns into therapy is not helpful, especially when this is coupled with the fact that the supervisor is your workplace manager. The focus on introspection and work relationship often distracted from learning and practical chaplaincy skills."

(*continued*)

Table 6. Continued.

Theme	Topic	Quotes—Helpful	Quotes—Unhelpful
Self-Awareness	IPR[a]	"IPR and learning goals helped me become better aware and strive to grow personally, interpersonally, and professionally. I am a better more self-reflective person than I was before taking clinical pastoral education." "IPR, finding where your own edges and sinkholes are, and how you manage them." "Increased self awareness of my unconscious biases and their impact on my ability to understand and communicate through the IPRs."	"Group time-we sat in a circle and it was tear down your fellow student time for some of the participants in the group with their own issues." "My group made such little space for constructive criticism that I don't think anyone was going to grow … " "IPR - generally caused a great deal of grief and harm in my units, was not productive and only caused conflict and discord in the group."
Practical Sills	Verbatims	"Collegial interactions around verbatims … These were the most applicable to actual practice and personal development." " … learning what someone else might do and taking that into your own repertoire."	"[H]earing other presentations from other residents didn't usually add to my skill set or ability to be an effective chaplain."
Practical Sills	Individual Supervision	"Individual supervision helped me learn how to process meaningful experiences and build my awareness of my triggers and my reaction to them, as well as teaching me how to supervise myself, which is essential to the practice of a chaplain as well as developing models of self-care."	"Supervisory sessions – Never been used in care or to inform my care practices."
Practical Sills	IPR	"IPR taught me how to remain present and in relationship through conflict." "IPR seminars helped me to advance my practice with a cohort of like-minded individuals, and showed my strengths and growing edges." "IPR went a long way to helping me understand how I am know[n], which has been invaluable to my understanding of how I enter into a spiritual care conversation."	"IPR did not benefit my care for patients in any way." "We spent a lot of time in IPR, which has its value, but it came at the expense of not having as much time to learn/practice assessment, interventions, and charting."
Practical Sills	Mentor Staff Chaplain	"Mentoring, individual instruction on patient visits. The feedback provided me the confidence to visit ANY patient." "The practice of chaplain work with mentors on site. This is where I felt my time was used best and where my growth as a professional happened." " … receiving feedback and getting to ask questions to trained chaplains elevated my practice."	" … I didn't have a lot of examples of good care from seasoned chaplains." "Pairing with staff chaplain mentors was hit and miss. I had five total, two of which were not helpful and did not understand boundaries between CPE and clinical experience."

[a]IPR: Interpersonal Relations group is a facilitated group process focused on enhancing participants' self-awareness, emotional intelligence, and communication skills through interactions, feedback, and reflection within a small peer group setting.

techniques in patient care, and participation in IPR groups, verbatim presentations, and individual supervision. For instance, one respondent wrote, "The practice of chaplain work with mentors on-site [was helpful]. This is where I felt my time was used best and where my growth as a professional happened." IPR groups, verbatim presentations, and individual supervision were noted for enhancing presence, relationship-building, and self-supervision skills. However, some participants felt an overemphasis on self-awareness and interpersonal dynamics detracted from learning essential chaplaincy skills such as spiritual assessment and intervention strategies.

While CPE was acknowledged for its clinical method of learning, which fostered self-awareness and practical skills for chaplaincy, participants' comments also underscored the need for balanced educational approaches that equally prioritize clinical skill development and effective group learning experiences.

ECHCs' opinions about their graduate degree(s)

Our analysis of the ECHCs' comments about their graduate degrees yielded one prominent theme: "Relevance and Irrelevance to the Practice of Healthcare Chaplaincy" (see Table 7). This theme had two dimensions—context and content—each of which was perceived as significantly impacting the preparedness and effectiveness of chaplains in healthcare settings.

Regarding the context, many respondents indicated their belief that their graduate theological degrees were designed with a congregational ministry context in mind, which ECHCs found to be largely irrelevant to the healthcare environment. This discrepancy is highlighted by feedback indicating that the focus on parish-oriented training does not translate well to the healthcare setting, where chaplains engage with a diverse patient population and face unique challenges. As one chaplain noted, "I completed an M.Div., so there are a lot of classes in there that are not necessarily relevant - church administration related classes etc. Also received my education from a Christian seminary - that education is important for formation but not always relevant specifically for spiritual care work."

Regarding course content, notable segments of the curriculum, particularly biblical languages and studies, church history, and preaching, were frequently cited as not pertinent to the day-to-day roles of HCCs. For example, one chaplain articulated, "While [biblical languages] may be personally beneficial, they are specific to translating and exegeting biblical texts. This is not necessary to do the work of a healthcare chaplain." Church history was viewed as largely irrelevant to the practice of HCC. Respondents noted that very few patients desire discussions about church history. A Buddhist respondent noted that Buddhist history increased understanding of the tradition rather than the practice of chaplaincy. Another mentioned that they would rather have had a course on world religions than church history. Preaching was also noted as mainly irrelevant to the practice of HCC. One exception, however, involved developing greater comfort with public speaking and conducting services in the hospital. One respondent noted, "It's helpful for public speaking, and being comfortable putting together religious services for the hospital, but it's not a practical class for [a] chaplain." These sentiments underscored a significant gap between traditional theological education and the

Table 7. Opinions about the graduate degree.

Theme	Topic	Quotes about Irrelevance	Quotes about Relevance
Relevance and Irrelevance to the Practice of Healthcare Chaplaincy	Focus on the Congregational Context	"Most of my graduate degree focused on parish ministry, which is significantly different from healthcare chaplaincy." "Christian history, preaching, missions, worship, research and writing, Greek, Hebrew. These are great for a pastor in a church but not very useful in a trauma setting like I am in." "Pastoral care courses. A lot of the tricks of the trades of pastoral care that work in the church setting are not very helpful in the hospital setting. I had to learn to unlearn a lot of what I had learned."	"Ethics, pastoral counseling, leadership. These were the most generally applicable outside of a church setting."
	General Degree Content	"I completed an M.Div. so there are a lot of classes in there that aren't necessarily relevant - church administration related classes, etc. Also received my education from a Christian seminary - that education is important for formation but not always relevant specifically for spiritual care work." "In my graduate program, many courses were designed with the expectation that students would be pursuing a PhD in a related field, and as such were highly academic and disconnected from lived religious experience." "I would actually say my MSW has been more helpful than my theology degree. Learning about family dynamics, human behavior, mental. Illness, and addiction has been useful every day of my chaplaincy career."	"My M.Div. program had a strong Pastoral Care component that worked well with the 4 semesters of Theological Field Education and the verbatim process. This pastoral focus along with a solid ethics foundation has been very useful since I draw from it all the time in my chaplaincy." "Spiritual formation, Ethics, Leadership, Counseling, Communication, and Pastoral Care. I utilize princip[les] and methodologies I learned from these classes daily in my hospital work." "Spiritual formation, pastoral care and counseling, ministry skills and techniques. These classes taught a skillset I could use in my ministry, as opposed to simply academic ideas."
	Biblical Languages	"I really enjoyed studying the languages, but it's not as useful in my chaplaincy, and I don't think any chaplain who hasn't studied it is going to be ineffective." "I never use any of that information in my job. It helped with my own spiritual formation, but I could've done that outside of my MDiv and think the course time could've been better focused on counseling." "Patients really don't care how verbs are parsed."	"Perhaps my classes learning ancient Hebrew and Greek were the least helpful. However, I needed these courses to delve deep into the original texts, and therein lies so much storytelling and family dynamics- which are also helpful in chaplaincy." "[L]anguages [I] don't use. [M]y knowledge of ancient [G]reek or [H]ebrew texts, however I do see the need to understand how they have been interpreted over the years."
	Biblical Studies	"Bible study courses. Chaplaincy incorporates a wide range of spiritual traditions or lack-there-of. Being an expert on one religion is not very helpful."	"Biblical studies were helpful for formulating beliefs and biblical understanding, but it is only helpful to provide spiritual guidance or to apply scripture to

(*continued*)

Table 7. Continued.

Theme	Topic	Quotes about Irrelevance	Quotes about Relevance
		"The bible requirements beyond introduction levels were too much, especially as a non-Christian. I don't use the bible that often in my clinical work"	a [patient's] spiritual needs if of the same faith."
		"Probably Bible. It didn't focus on what is practical (e.g., Psalms)."	"All of my theology, ethics, and bible courses [were helpful]. I believe one thing that chaplains can provide to patients/families who are struggling with their own faith/theologies is alternatives. But in order to do that, you have to know alternative theologies."
			"Hebrew Bible gave me a strong grounding in the texts and stories that many of my patients use to make meaning."
	Church History	"Probably some of my required courses in church history … They're not relevant to my daily work in healthcare."	"Church history was helpful for understanding the context of my own faith background with the world but has less importance as I am providing spiritual care to both Christians and non-Christians."
		"Buddhist History. It was helpful for the knowledge of my tradition but not utilized in the hospital."	
		"History of Late Antiquity. Knowing the history of Christianity does not come up often in my work."	"Church history is not something that comes up often when I see a suffering [patient]. But, it is useful if I have to explain the development of a sacrament."
	Preaching	"As a chaplain, I am not preaching a sermon or teaching a class. I am not trying to convert anyone to my faith."	"Preaching and some of the higher level theology classes, although I would argue even those help me think theologically and communicate shared values in a chaplaincy setting."
		"As a hospital chaplain preaching is not something that is done on a regular basis. It's helpful for public speaking, and being comfortable putting together religious services for the hospital, but its not a practical class for chaplains."	
		"Rarely find myself preaching in the healthcare setting."	
	Pastoral Care[a]		"Pastoral care focused courses. These courses provide initial exposure and language that [w]as helpful in my initial unit of CPE."
			"Pastoral care. It helped me connect caring for other to my own theology."
			"Pastoral care is what I do, so that course was useful in preparing me in the work. Also, one of the pastoral care classes I took was taught by a director of spiritual care services at a major research hospital and he made that class relevant to those of us planning on working as healthcare chaplains."
	Pastoral Counseling[b]		"Pastoral counseling courses. They helped my patient care and assisted me in helping them process issues."

(*continued*)

Table 7. Continued.

Theme	Topic	Quotes about Irrelevance	Quotes about Relevance
			"Pastoral counseling was my cognate in my MDiv. Prepared me with the most needed skills I use everyday, as well as a good psychological basis for dealing with suffering, grief, and behavioral disturbances. Increased my empathy."
			"Courses in clinical counseling provided theories and practices to give a pastoral interpretation of spiritual suffering to the interdisciplinary team who uses medical terminology as their primary language of communication."
	Ethics[c]		"Ethical decisions made in the moment with patients and families."
			"Ethics. Healthcare chaplains are regularly asked to sit on committees and advise patients or families with complex decisions."
			"Ethics courses were a great intermixing between theological and philosophical views, Scripture, spirituality, and real practical situations which is the intermixing of what so much of chaplaincy is."
	Cultural Diversity and World Religions	"Culture studies. Cultures are varied. Can't pigeon hole people."	"Because knowing and offering pathways to healing that are not based in organized religion is becoming increasingly important. Interfaith courses, spiritual psychology were also relevant to the diverse population I serve."
		" … I took a required class on other major world religions that was not as helpful as it could have been. The material felt very surface level and didn't engage deeply with the actual people who are part of that religion, how they practice, and how to interface with them. I learned most of this through CPE and experience."	"Courses focused on cultural and religious diversity … I am more aware of differences, and more understanding, with a greater appreciation for beliefs that are different from my own, thanks to education on cultural and religious diversity."
		"Tibetan language, Buddhist rituals … Tibetan is a very specialized language, not applicable to chaplaincy. I serve in a largely white, protestant [C]hristian area and my knowledge of Buddhist rituals is hardly used."	"Courses on spiritual care that respect diversity and differences including, but not limited to culture, gender, sexual orientation, and spiritual/religious practice. Because it is important to embrace the whole person as a chaplain."

[a]There were no comments about the irrelevance of this topic.
[b]Ibid.
[c]Ibid.

Table 8. Courses and experiences early-career chaplains wished they'd had in their graduate degree(s).

Theme	Quote
Knowledge of Healthcare Settings	"Basic understanding of hospital/medical functions and some common medicine used. Comprehension of what is involve[d] in your work surrounding (e.g. hospital, hospice).
	" … some sort of general healthcare course."
	" … courses drawing explicitly from medical sciences/co-taught with medical students. Much of this was learned on the job."
	" … a class on medical terminology and basics of medical practice (for non medical students), social work classes."
Experience in the Healthcare Setting	"More simulated learning would have been helpful and more training around working with inter-professional teams. They would have better prepared me for my current role."
	"More opportunities to shadow others in different disciplines. Rotations in other hospitals aside from the one I did my residency in."
	"Field placement in various healthcare settings … The practical field experience is vital to get a broad understanding."

knowledge and skills required in healthcare chaplaincy, where the focus is on patient care rather than traditional congregational-based tasks.

In contrast, specific courses stood out for their direct relevance and applicability to healthcare chaplaincy, specifically pastoral care/counseling, ethics, cultural diversity, and world religions. These areas were consistently recognized for equipping ECHCs with the essential tools to respond to the complex spiritual, ethical, and cultural needs they face in healthcare settings.

When asked which courses they wished they had taken in graduate school, ECHCs overwhelmingly said pastoral care and counseling courses. Many respondents underscored the absence of mandatory pastoral care courses within their curricula, elucidating a gap between academic preparation and the practical exigencies of chaplaincy. As one participant said in response to the question of courses they wished they had taken and why, "More pastoral care courses. They are directly related to the work," highlighting the direct connection between such courses and the practical duties of a healthcare chaplain. Distinguishing pastoral care and counseling, one respondent wrote, "Pastoral care. To emphasize its importance and foundations in theology." Some respondents recognized the need for a theological background that underpinned their care.

Regarding counseling, one person wrote, "Though chaplains are not counselors per se, being literate in different forms of counseling theory would be helpful." The distinction between pastoral care and counseling is important in the chaplaincy role. While chaplains may not serve as traditional counselors, they encounter situations where counseling theories, particularly those related to spiritual/religious coping, trauma, grief, and meaning-making, are valuable.

The call for more advanced psychology and pastoral care studies underscores these disciplines' integral role in the chaplain's day-to-day functions. As one ECHC observed, "More advanced studies in psychology and pastoral care. I draw on those the most in my care," suggesting that the depth of understanding required in these areas exceeds the current educational offerings. Moreover, the need for courses to enhance listening skills and understand human and spiritual development throughout the lifespan indicates a broader educational need. This broader educational need encompasses the ability to provide support and perform spiritual assessments, a distinct and essential skill to the chaplain's role. As one

chaplain lamented, "I wish I had taken a course on spiritual assessment," pointing out a critical oversight in current educational frameworks for chaplains.

Ethics education was viewed as helpful to ECHCs in their professional development and daily practice. The practical application of ethics in patient care, the fostering of new and critical ways of thinking, and the preparation for participation in ethics committees were meaningful in shaping chaplains capable of navigating the complex ethical dilemmas in healthcare. Furthermore, the types of ethics courses, including general ethics, biomedical ethics, and ethics from specific religious points of view, were noted for providing foundational knowledge beneficial for more specialized courses in healthcare ethics.

Respondents indicated their appreciation of education on cultural and religious/spiritual diversity. They mentioned the relevance and practical application of diversity in healthcare chaplaincy, the improvement of interactions with non-religious or differently religious individuals, the cultivation of a greater appreciation for varied beliefs, the ability to meet people where they are, and the fostering of new ways of thinking.

People who identify as spiritual but not religious - a growing demographic within the U.S. - were explicitly mentioned as benefiting from chaplains' diversity education. Chaplains reported that learning about different religious, cultural, and spiritual perspectives enabled them to offer pathways to healing that transcend organized religion, recognizing the increasing importance of such approaches in contemporary chaplaincy. As one respondent stated, " … offering pathways to healing that are not based in organized religion is becoming increasingly important."

One outcome of diversity education noted by respondents was a broadened understanding and appreciation for beliefs and practices different from their own. Their broadened understanding and appreciation for diverse beliefs and practices were considered crucial for providing effective spiritual care and building rapport with patients from various backgrounds: "I am more aware of differences, and more understanding, with a greater appreciation for beliefs that are different from my own, thanks to education on cultural and religious diversity."

The concept of meeting people where they are, central to effective chaplaincy, was also referenced. Courses on diversity were reported to equip chaplains with the skills to embrace and support the whole person, acknowledging their unique cultural, religious, and personal backgrounds: "These classes taught me how to … meet people where they are … "

Diversity education also contributed to new ways of thinking, promoting open-mindedness and the ability to view situations from multiple perspectives. This new way of thinking was highlighted in the context of understanding different religious and social locations and race and theology: "Readings in race and theology taught me how to look at a firmly held belief from another's viewpoint."

Courses on race and racism, anti-bias, social justice, and specific cultural studies (such as those offered in Spanish and Hispanic cultures) were also mentioned as helpful for relating to diverse groups of people in healthcare contexts. These courses equipped chaplains with knowledge and strategies to confront and address biases and systemic inequalities within healthcare settings.

Desired courses and experiences

In exploring educational opportunities beyond formal coursework, ECHCs expressed a significant interest in acquiring practical healthcare knowledge and experience (see Table 8). The overarching theme we developed from their responses centered on the necessity for a deeper understanding of healthcare settings, underlining a perceived gap between their theological training and the practical demands of healthcare chaplaincy. As one participant stated, "I wish I had learned more about the medical side of health care," pointing to the need for chaplaincy education to encompass fundamental healthcare information. This sentiment was further elucidated by another ECHC who advocated for "Healthcare-specific classes to provide an intro into the hospital, including hospital policy/reporting structure, areas of medicine, who is who in the hospital, role of the social worker, etc.," illustrating the desire for a more holistic educational approach that prepares students for the interdisciplinary nature of healthcare teams.

Shadowing experienced healthcare professionals, including chaplains, was a recurrent theme, with ECHCs indicating a need for early and ongoing exposure to real-world chaplaincy. One individual lamented, "I wish we'd been able to shadow chaplains early in our studies to give us a more realistic idea of what day-to-day chaplaincy can look like," highlighting the gap between academic preparation and practical application.

The importance of simulated learning experiences was also emphasized, with respondents valuing the opportunity for hands-on practice in safe, educational environments. "More time in the Learning Lab with mock visits … was so helpful and boosted my confidence in my work," shared one chaplain, underlining the benefits of practical, experiential learning.

Additionally, respondents expressed regret over missed internship opportunities. One articulated, "I did an internship in my first year of Div school … I learned and adapted my courses to what I learned I needed," contrasting sharply with those who felt sidelined from real healthcare settings. Thus, internships are pivotal in bridging educational content with clinical context.

Furthermore, the need to understand the complex organizational cultures and systems of healthcare was a recurring theme. As one ECHC put it, "I wish I had more education/context for how to navigate the 'system' … Working within such large systems, it can feel challenging to move towards change." Participants expressed a desire not only to better understand how healthcare systems operate in practical terms but also to develop a systemic way of thinking that allows them to navigate and influence these environments more effectively. This dual focus highlights their need to be prepared not just spiritually and emotionally, but also practically and systemically for the multifaceted challenges of healthcare chaplaincy.

Discussion

This study explored the perceived strengths and weaknesses in chaplaincy education among ECHCs by asking: What do ECHCs identify as strengths and weaknesses in their educational preparation, both academic and clinical? Using a web-based survey with fixed-choice and open-text questions, we gathered data on the educational experiences of ECHCs. The findings from this investigation offer critical insights that could guide the development of academic and CPE curricula, ultimately improving the preparedness

of future chaplains to address the diverse spiritual needs of patients within healthcare environments.

Academic degree preparation

Our study adds to the ongoing dialogue on the future of healthcare chaplaincy education, highlighting the need for reform in both CPE and academic education. The evidence suggests that current educational models, particularly the M.Div. degree, fall short of adequately preparing HCCs for the complexities of their roles in modern healthcare environments. This challenges the long-held perception of the M.Div. as the "gold standard" for healthcare chaplaincy training. Rambo and Giles (2022) have similarly called for theological educators to rethink pedagogy, revise core degree components, and incorporate a broader range of literature and models to better address the evolving needs of spiritual care. Likewise, Cadge (2012) advocates for a complete redesign of chaplaincy education, shifting away from programs primarily focused on congregational leadership. Our findings support these arguments, revealing that the M.Div. remains primarily oriented toward preparing individuals for Christian congregational roles, which leaves significant gaps in preparing chaplains for healthcare-specific demands.

Respondents in our study pointed to several areas of academic coursework that felt disconnected from their work in healthcare. While useful for other ministry contexts, and preparation for ordination, courses on biblical languages, church history, and homiletics were largely irrelevant to their roles in healthcare chaplaincy. This underscores the need for academic programs to better align with the realities of healthcare environments, focusing more on the practical and interdisciplinary demands chaplains face in healthcare. While some courses contributed to skills like public speaking, which is particularly helpful in conducting hospital services, most coursework did not provide the direct preparation required for effective spiritual care in healthcare.

On the other hand, specific courses such as pastoral care, counseling, ethics, cultural diversity, and world religions were seen as highly beneficial. These subjects were directly applicable to healthcare chaplaincy and essential for addressing the diverse spiritual needs of patients and staff. However, respondents still noted the challenge of transferring knowledge from a congregational to a healthcare context. This suggests a need for academic curricula explicitly designed for HCCs that remove the burden of adapting learning from one context to another.

Finally, our study found that even chaplaincy concentrations within academic degrees do not sufficiently improve healthcare chaplaincy preparation. This may be due to the dilution of healthcare-specific content with a broader focus on chaplaincy across various contexts. These findings suggest that academic programs should adopt a more targeted approach, focusing specifically on the competencies and practical skills required for chaplaincy in healthcare.

Clinical pastoral education

ECHCs highly valued CPE for its ability to foster self-awareness and develop practical chaplaincy skills, both of which are essential in the complex environment of healthcare

(Jankowski et al., 2008; Szilagyi et al., 2024; Trothen, 2000; Vanderstelt et al., 2023). Participants emphasized that the clinical method of learning, including verbatim writing, individual supervision, process groups, and mentoring by staff chaplains, not only enhanced their practical abilities but also helped them understand how to apply their chaplaincy training in real-world healthcare settings.

Mentorship from staff chaplains emerged as a particularly significant aspect of CPE for many participants. Although research on the informal and formal roles of staff chaplains in the education of healthcare chaplaincy students is limited, previous studies confirm the benefits of mentorship and shadowing in the professional development of chaplains (Clevenger et al., 2021; Nash-Williams, 2001). However, more research is needed to explore the prevalence and efficacy of these practices within CPE programs.

Despite its many benefits, CPE was also subject to criticism. Some participants noted its redundancy, an occasional resemblance to therapy, and issues with group facilitation, such as low engagement or unresolved conflicts. Massey (2014) noted that he encountered what he called a "saturation point" in CPE due to the curriculum's "lack of true progression" (p. 147). To address this issue, the ACPE implemented new learning outcomes and indicators in 2024 to improve curriculum progression (Appelbaum, 2023; Doehring, 2024), although their effectiveness has yet to be studied.

Massey (2014) and Tartaglia (2015) further questioned the sufficiency of CPE in preparing chaplains for the increasing focus on evidence-based and patient-centered outcomes in healthcare. Massey argued that CPE was not designed to meet these new demands and that adapting it to do so might compromise its original purpose. Our findings support this critique: while CPE is highly valued for its practical training, it may not fully prepare chaplains for the diverse challenges they face in healthcare. Between 15% and 50% of ECHCs rated certain aspects of CPE unfavorably, suggesting significant room for improvement in its ability to deliver professional education for healthcare chaplaincy.

This gap in CPE's ability to address the full breadth of healthcare chaplaincy competencies aligns with Little's (2010) emphasis on the importance of integrating both forms of knowledge—propositional knowledge, which includes facts, theories, and ideas, and practical knowledge, which involves hands-on experience—into chaplaincy training. Little (2010) argued that CPE alone cannot deliver the foundational theoretical education required for healthcare chaplains and that theological education should provide this knowledge before students enter CPE. Our findings support this view, suggesting a need for complementary academic training that provides chaplains with the theoretical frameworks, skills, and competencies necessary to succeed in healthcare.

In summary, CPE provides valuable practical experience but requires greater integration with academic training to offer a more holistic preparation for healthcare chaplains. By balancing propositional knowledge from academic institutions with the practical training offered in CPE, chaplaincy education could better equip future chaplains with the advanced skills required in today's healthcare environments.

Siloed approach to healthcare chaplaincy education

The inefficiencies of the current siloed approach to chaplaincy education, where academic and clinical training are treated as separate domains, are well-documented

(Cadge et al., 2020, 2022). Our data further underscores these inefficiencies, with respondents reporting disjointed experiences between their academic preparation and clinical training. Many ECHCs noted that their academic education, which often emphasized congregational leadership, lacked relevance to healthcare contexts. Although CPE provided essential practical skills, it did not sufficiently address the theoretical foundations needed for healthcare chaplaincy. This disconnect contributed to inconsistencies in the overall training and readiness of chaplains.

These findings reinforce the need for a unified and comprehensive set of curriculum standards that bridge the gap between academic learning and clinical practice. Tartaglia (2015) similarly called for revisions to existing educational models to better meet the needs of healthcare chaplaincy. Our study supports this call, particularly in research literacy and practical chaplaincy skills, where current academic programs fall short. Integrating academic content with clinical competencies is necessary to ensure chaplains are adequately prepared for the complex demands of healthcare environments.

While Tartaglia (2015) suggested extending the clinical training of chaplains from one year to two, our findings suggest that significant challenges stem from gaps in academic preparation rather than from CPE alone. These gaps may place added pressure on clinical pastoral educators to address foundational topics more commonly associated with graduate-level instruction. Tartaglia (2015) rightly emphasized the value of healthcare-based CPE in providing exposure and practical resources. However, it remains important to consider the role of academic institutions in equipping students with essential knowledge. A more balanced and collaborative model, in which academic programs provide a strong theoretical framework and CPE offers experiential learning and professional formation, may better support the comprehensive preparation of healthcare chaplains.

This study marks the first attempt to gather and analyze the perspectives of ECHCs on their chaplaincy education, providing valuable insights into the strengths and weaknesses of both academic and clinical training programs. The large and diverse sample of respondents enhances the credibility of our findings and contributes to the broader conversation about how to reform chaplaincy education. Although we encountered challenges with survey bots, a rigorous data-cleaning process ensured the integrity of our results.

It is worth noting, however, that our study relied on self-reported data, which may be subject to personal biases or incomplete assessments of educational gaps. Additionally, since this is a cross-sectional study, it only captures the views of ECHCs at a specific point in time. Future longitudinal studies could provide a more comprehensive understanding of how chaplains' perspectives evolve throughout their careers.

The focus groups that provided feedback during survey development differed in characteristics from the final study sample. While survey participants had two to five years of post-CPE experience, the pilot group consisted of chaplains just emerging from residency. This distinction was intentional, as we aimed to ensure the survey was accessible and relevant to chaplains at the earliest stages of their professional development.

Our use of convenience sampling via social media platforms may have resulted in an overrepresentation of certain institutions. Because we did not collect data on the number of distinct academic programs represented, our ability to assess the generalizability of the findings is limited. Despite these limitations, our study significantly contributes to the ongoing dialogue on healthcare chaplaincy education.

In conclusion, our results highlight the fragmented approach to training HCCs in both academic and clinical settings, identifying specific strengths and weaknesses in the current educational model. CPE was highly valued for fostering self-awareness and practical chaplaincy skills, but it was not without its limitations, with some ECHCs identifying areas where it falls short, particularly in its ability to address the full breadth of competencies required for healthcare chaplaincy. Moving forward, we see two primary paths for reform: Theological seminaries could revise their programs by updating curricula or developing healthcare-specific concentrations, while schools of allied health or health sciences could create new graduate degrees tailored explicitly for healthcare chaplains. Regardless of the path chosen, it is essential that new curricula for healthcare chaplaincy integrate both theoretical knowledge and practical experience alongside a structured professional formation process. By rethinking healthcare chaplaincy education—whether through creating new degree programs, relocating training to academic medical centers, or establishing comprehensive curriculum standards—we can better prepare future healthcare chaplains. These reforms will ensure they have the critical skills and competencies to deliver high-quality spiritual care in increasingly complex healthcare environments.

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Appendix A

Select survey questions related to Table 4

How Well Did Your Chaplaincy Education Prepare You?

The questions below are based on the 2017 Common Qualifications and Competencies for Professional Chaplains. For more information about these, please visit: https://www.apchaplains.org/standards/standards-of-practice-for-professional-chaplains/

Chaplaincy education consists of an academic degree (e.g., M.Div. or similar) and clinical pastoral education (CPE).

When you think back on your experience of chaplaincy education to what extent did each component…

Graduate Degree (select not at all, a little, somewhat, moderately, or a great deal)
CPE (select not at all, a little, somewhat, moderately, or a great deal)

1. Help you develop your theologies/philosophies of spiritual care?
   An example of developing your theologies/philosophies of spiritual care includes articulating an approach to spiritual care rooted in one's faith/spiritual tradition that is integrated with a theory of professional practice.
2. Teach you about various behavioral sciences related to spiritual care?
   Examples of spiritual care competencies related to the behavioral sciences include:
   - Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of spiritual care.
   - Incorporate the spiritual and emotional dimensions of human development into one's practice of care.
3. Teach you about groups and organizations?
   Examples of group and organizational competencies include:
   - Articulate a conceptual understanding of group dynamics and organizational behavior.
   - Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups.
   - Promote the integration of spiritual care into the life and service of the institution in which one functions.
   - Establish and maintain professional and interdisciplinary relationships.
   - Understand and function within the institutional culture and systems, including utilizing business principles and practices appropriate to one's role in the organization.
4. Teach you research literacy?
   An example of research literacy includes articulating how primary research and research literature inform the profession of chaplaincy and one's spiritual care practice.
5. Increase your self-awareness?
   Examples of self-awareness competencies include the ability to:
   - Be self-reflective, including identifying one's professional strengths and limitations in the provision of care.
   - Articulate ways in which one's feelings, attitudes, values, and assumptions affect professional practice.
   - Attend to one's own physical, emotional, and spiritual well-being.
   - Use one's professional authority as a spiritual care provider appropriately.
6. Teach you knowledge and skills related to ethics?
   Examples of ethical competencies include the ability to:

- Incorporate a working knowledge of different ethical theories appropriate to one's professional context.
- Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Clinical Pastoral Educators, and Students.
- Promote, facilitate, and support ethical decision-making in one's workplace.

7. Prepare you to practice spiritual care?
   Examples of spiritual care practices include the ability to:
   - Function in a manner that respects the physical, emotional, cultural, and spiritual boundaries of others.
   - Advocate for the persons in one's care.
   - Establish, deepen, and conclude professional spiritual care relationships with sensitivity, openness, and respect.
   - Provide effective spiritual support that contributes to the well-being of the care recipients, their families, and staff.
   - Provide spiritual care that respects diversity and differences including, but not limited to culture, gender, sexual orientation, and spiritual/religious practices.
   - Triage and manage crises in the practice of spiritual care.
   - Provide spiritual care to persons experiencing loss and grief.
   - Facilitate theological/spiritual reflection for those in one's care practice.
   - Provide religious/spiritual resources appropriate to the care recipients, families, and staff.
   - Foster a collaborative relationship with community clergy and faith group leaders.
8. Prepare you to perform public ceremonies/services in diverse settings?
   An example of a competency related to public ceremonies/service includes the ability to develop, coordinate, and facilitate public worship/spiritual practices appropriate to diverse settings and needs.
9. Prepare you to use spiritual assessments, interventions, outcomes, care plans, and document your spiritual care?
   Examples of these competencies include the ability to:
   - Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care.
   - Document one's spiritual care effectively in the appropriate records.