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Psychodynamic Chaplaincy: Psychological and Spiritual Integration in Healthcare

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION

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The term "chaplain" is used to designate a person who provides spiritual care outside an organized religious setting.[1] Chaplaincy may occur in hospitals, schools, prisons, the military, among professionals such as firefighters or police, or in social organizations. However, chaplains' duties as spiritual care specialists vary widely[2].

In most hospitals, hospices, and other US institutions, professional chaplains receive formal preparation for the role. Termed clinical pastoral education (CPE), this training is the acceptable standard for professional spiritual care training. This model of learning originated 100 years ago, in 1925, by Anton T. Boisen (1876-1965), a Protestant minister, following his mental health crisis and extended period of hospitalization.[3] Over the century since Boisen first offered CPE (initially called "clinical pastoral training") to seminary students, the originally conceived, psychoanalytically inspired, psychodynamically oriented training of would-be chaplains has undergone significant changes.

As defined in the Consensus Statement: The Role of the Chaplain in Health Care[4] one can rightly refer to any chaplain in health care as a "clinical chaplain." However, for more than three decades, as a distinction within the field, the terms clinical chaplain and clinical chaplaincy have been explicitly used to refer to those whose practice is psychodynamically informed or oriented. Professional chaplain is a broader term that includes anyone who has fulfilled specific requirements and made chaplaincy their profession. Clinical chaplains, in the customary use of the term, while not licensed psychoanalysts or psychodynamic psychotherapists, are specialists who approach and provide spiritual care accordingly.[5] As such, "clinical chaplain" denotes clinical training and professional aims akin to other specialties. This White Paper aims to showcase psychodynamically informed chaplaincy, promote the psychodynamic training of chaplains, and advance spiritual care delivery that involves helping people find meaning and purpose amid their crisis, distress, loss, grief, or perplexity in the healthcare setting.

Clarifying Terms

Psychodynamic (or psychodynamically informed) chaplaincy incorporates principles of psychoanalytic theory into the practice of spiritual care. It explores unconscious dynamics in human relationships and how past experiences shape present emotions and behaviors. Drawing from Boisen's concept of the "living human document,"[6] it invites deep engagement with the inner world of those receiving care. As Seward Hiltner suggests, effective psychodynamic chaplaincy requires spiritual care specialists to cultivate self-awareness by reflecting on their inner lives.[7] In doing so, the chaplain creates what Donald Winnicott described as a "holding environment"—a safe, empathetic space that supports emotional and spiritual growth.[8]

The distinction between chaplains whose work is psychodynamically based and other chaplaincy professionals can be confusing in part because, *by longstanding tradition, no matter the content or methods employed,* the term "clinical" is enshrined in the name of every clinical pastoral education (or training) program that prepares persons for professional spiritual care delivery "in the clinical setting" and not just those whose training and practice are psychodynamically oriented.[9]

Psychoanalytic Origins of Psychodynamic Chaplaincy

The beginning of the 20th century saw two key turning points directly relevant to the future of chaplaincy. The first was the revolution in psychology based upon the emergence of psychoanalysis's theory and practice. Sigmund Freud, psychoanalysis's founder, was a medical doctor whose frustration with the limits of his neurological specialty motivated him to develop non-medical means to help patients understand and overcome their problems. The second key event was the publication in 1910 of the Flexner Report[10], which radically shifted how doctors train. An important aspect was to focus on supervised encounters with actual patients. In establishing his chaplaincy training program, Boisen acknowledged his debt to Freud and the recent reforms in training physicians.[11]

Boisen was not alone in recognizing the implications of Freud's work for chaplaincy. One of Freud's earliest, most ardent, and lifelong followers was the Swiss Lutheran pastor Oskar Pfister (1873-1956). Aware of the longstanding Christian tradition of clergy responsibility for *cura animarum* ("the cure of souls"), Pfister joined Freud in taking up the position that psychoanalytic methods and training were not only for doctors[12] and he became a lay psychoanalyst who used such methods as part of his care for suffering souls. Pfister wrote extensively about psychoanalysis, including a significant text on the analytic method (to which Freud wrote the introduction[13]) and other texts devoted to a psychodynamic approach to spiritual care delivery.

It is worth noting that the term translated as "mind" in all English editions of Freud's works is *Seelenapparat* in the original German, a compound word meaning "apparatus of the soul."[14]

Psychodynamic Chaplaincy From Boisen To Today

In the century since its beginnings, CPE has notably changed how persons prepare for chaplaincy. Those changes began even during Boisen's lifetime and resulted in a split into two or more approaches.[15] Nevertheless, CPE – or clinical pastoral training (CPT) as Boisen called it – has its deepest roots in a psychodynamic approach to spiritual care delivery – to understanding the deeper goings-on in the soul of a patient to help a suffering person to find meaning and purpose amid their crisis, distress, loss, grief or perplexity.

Since psychodynamic chaplaincy's beginnings, a steady stream of practitioners and theorists have kept the Boisenian vision alive and moved it forward, most notably Wayne Oates (1917-1999), Seward Hiltner (1909-1984), Charles V. Gerkin (1922-2004), J. Harold Ellens (1932-2018), Donald Capps (1939-2015, Glenn H. Asquith, Jr. (1946-2017), and most recently Robert C. Dykstra (1956-). Over the past 35 years, Raymond J. Lawrence has written extensively, often polemically, to promote a psychodynamically-based chaplaincy, including a memoir[16] and brief monographs that demonstrate the application of the psychodynamic case study method.[17] In 1990, Lawrence, key collaborator Perry Miller, and a small group of CPE supervisors founded the College of Pastoral Supervision and Psychotherapy to restore Boisen's original psychodynamic vision to the work of chaplaincy. A decade earlier, psychiatrist Robert Charles Powell, MD, PhD, who researched the beginnings of the clinical pastoral movement, its principal aims, and key figures, spoke to CPE supervisors at their annual conference in 1975. He pointed out that Boisen's name appeared nowhere on their program and called them back to their psychodynamic roots.[18] Today, a renaissance in psychodynamic chaplaincy and spiritual psychotherapy[19] is underway with the influence of Pamela Cooper-White, whose insights into "shared wisdom,"[20] "thick theory,"[21] "braided selves,"[22] a relational understanding of persons[23], health and unhealth[24] and other areas in light of psychoanalytic principles have significantly advanced the tradition.

In pursuit of a deeper understanding of the soul/mind, Boisen first read Freud and then worked closely with the relational psychoanalyst Harry Stack Sullivan (1892-1949). Paul Pruyser (1916-1987), a psychologist at the renowned Menninger Clinic, was a proponent of the psychodynamic approach to chaplaincy, and his contributions continue to offer fresh insights into spiritual care.[25] Today, the work of psychoanalytic psychotherapist Nancy McWilliams is preeminently influential among those training psychodynamic chaplains.[26]

In 2023, neuroscientist and psychoanalyst Mark Solms, translator of the complete 24-volume revised standard edition of Freud's psychoanalytic works[27] and the preeminent figure in the emerging field known as neuropsychoanalysis[28], began working with clinical chaplains in a two-day immersive seminar in San Anselmo, California. Recent advances in affective neuroscience – especially the pioneering research of Solms' collaborator Jaak Panksepp on the universal, primary emotional systems and its reformulation of Freud's drive (*trieb*) theory -- provide clinical chaplains with vital new resources for ministry.[29] Solms' translation of the complete correspondence between Freud and Oskar Pfister is planned for publication in 2026.[30]

It is important to note that chaplain-patient encounters are not genuinely one-on-one. Whom the patient considers to be family and loved ones are spiritually connected extensions of the individual. Furthermore, the interdisciplinary team providing patient care adds to what is known as the "ever-present others." As a result, psychodynamic chaplains have incorporated Group Relations theory and practice [31]into their work. Inspired by psychoanalyst Wilfred Bion's work at the Tavistock Institute of Group Relations[32] the psychodynamic chaplain focuses on understanding conscious intentions, unconscious needs, drives and processes, and explicit and implicit boundaries, authority, roles, and tasks within groups.[33] For more than a decade, led by a group of consultants affiliated with the A.K. Rice Institute for the Study of Social Systems, clinical chaplains have enhanced the quality of care to patients and their loved ones and positively impacted care teams and the institutions they serve. The group, led by Jack Lampl, has named itself the "soul group" partly in response to their encounter with chaplains and the ongoing evolution of their work in this partnership.[34]

Clinical Chaplaincy: Diagnosis, Collaboration, and Scope Of Service

The perception of psychodynamically informed clinical chaplains is that they are encroaching upon the domains of mental health providers such as clinical social workers, professional counselors, psychologists, or other licensed therapists[35]. Although these specialties' scope of service boundaries are not entirely distinct, one distinction remains. While psychodynamically trained clinical chaplains may utilize resources such as the Psychodynamic Diagnostic Manual
(PDM) and/or the Diagnostic and Statistical Manual of Mental Disorders (DSM) in their assessment of patients, they do not offer mental health diagnoses.

Gone are the days when chaplains visited a patient uninformed and siloed, like a member of the community clergy. Like every other clinical team member, the psychodynamically trained clinical chaplain does not work alone. Coordination, collaboration, and communication with other clinicians are necessary to ensure quality of care. Similarly, the clinical chaplain may serve as a supportive liaison to a particular faith community or other spiritual community, and those relationships may foster greater wellness.[36]

The standard *Handbook of Nursing Diagnosis* includes "Spiritual Distress," "Religiosity, Impaired," and other related topics. Its definition of Spiritual Distress is "the state in which an individual or group experiences, or is at risk of experiencing, a disturbance in the belief or value system that provides strength, hope, and meaning in life." [37][38] Nurses may diagnose Spiritual Distress, but collaboration with a psychodynamically trained clinical chaplain will provide optimal, psychodynamically based care for the patient. While the topic of psychodynamically based "pastoral diagnosis" -- perhaps more accurately referred to as "clinical chaplaincy diagnosis" -- was addressed half a century ago by Paul Pruyser[39], recent advances such as the identification of seven primary emotional systems [40], for example, invite a thorough refining and revision of diagnostic categories in psychodynamically based chaplaincy.

Clinical Chaplaincy: Training Chaplains for the 21st Century

Boisen explicitly positioned theology among the ever-changing social sciences.[41] As such, he no doubt would have anticipated adapting the work of chaplains to changes in our time, including the decline in membership of religious congregations and the rapid emergence of a population that describes itself as "spiritual but not religious."[42] Boisen was a close collaborator with the relational psychoanalyst Harry Stack Sullivan, who published Boisen's articles in the journal *Psychiatry*.

Boisen's footprint is currently in other fields, including anthropology. Had he lived just a short while longer, he likely would have embraced interpretive anthropologist Clifford Geertz's non-sectarian, non-institutional definition of religion, which is prescient for today's chaplaincy: 1) a system of symbols that acts to 2) establish powerful, pervasive and long-lasting moods and motivations in [persons] by 3) formulating conceptions of a general order of existence and 4) clothing these conceptions with such an aura of factuality that 5) the moods and motivations seem uniquely realistic."[43] By adopting Geertz's definition and removing from the equation the traditional idea of a faith group, the clinical chaplain can provide spiritual care equally well for a person who identifies with a particular faith or none at all, for the person who identifies as spiritual but not religious, and for the person for whom, for example, the health food movement[44] or CrossFit[45] are central to how they find meaning and purpose in their lives.

The objectives of clinical chaplaincy training should be both grounded in the Boisenian tradition and on the cutting edge. They should include both well-established aspects of psychodynamic learning and the most current advances in related areas such as affective neuroscience, neuropsychoanalysis, and Group Relations.

Specific objectives of clinical chaplaincy training should include:

- demonstrated ability to make use of the clinical process and the clinical method of learning; -development of the self as a work in progress, and understanding the self as the principal tool in clinical chaplaincy care, which includes the ability to reflect and interpret one's own life story both psychologically and theologically;
- demonstrated ability to listen deeply, empathize, reflect, analyze problems, and identify and evaluate human behavior and religious symbols for their meaning and significance;
- demonstrated ability to establish an empathetic therapeutic bond with persons and groups of persons in various life circumstances;
- demonstrated ability to provide a critical analysis of one's spiritual and/or religious orientation and background;
- demonstrated understanding of the dynamics of group behavior and a variety of group relations;
- demonstrated ability to communicate effectively and engage in spiritual care delivery with persons across cultural and social boundaries;
- demonstrated ability to utilize individual supervision for personal and professional growth and for developing the capacity to evaluate one's spiritual growth and development;
- demonstrated ability to work effectively as a member of an interdisciplinary clinical team; and
- demonstrated ability and ongoing commitment to effectively use the behavioral and social sciences, particularly those that support a psychodynamic approach to chaplaincy.

The Future of Chaplaincy

As defined earlier, "chaplain" is venerable, dating back to the fourth century of the Christian Era[4647]. However, spiritual care delivery today has proven to go far beyond the limits of religious practice and challenges spiritual caregivers to inform themselves using various spiritual assessment tools and integrative spiritual care methods.[48] Additionally, specific considerations are imperative in the fast-changing world of healthcare, especially in the United States. Research has shown that many healthcare organizations welcome chaplains as essential interdisciplinary team members of their institutions.[4950] Some understandably wonder whether a model of providing spiritual care that matches needs based upon acuity with the most appropriate resources – including clinical and other chaplain professionals, community clergy, and para-professional spiritual care volunteers – might not be more cost-effective and efficient. Thanks to ongoing research and the daily efforts of professional clinical chaplains, spiritual care delivery that supports patient resiliency has enhanced overall patient satisfaction.[51]

From a business standpoint, positive patient satisfaction scores, reduced staff turnover, compassion fatigue, and burnout positively impact a healthcare organization's bottom line.[52] Institutional leaders' consideration of return on investment for spiritual care delivery should be based on the understanding that professional chaplains, trained in psychodynamics, significantly enhance the overall wellness of the institution and the individuals it serves. Therefore, promoting training for psychodynamically informed clinical chaplains -- whose specialization adds demonstrable value -- is vital.

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HEALTHCARE CHAPLAINCY NETWORK

Since its founding in 1961, HealthCare Chaplaincy Network (HCCN) has led the way in the integration of spiritual care in health care through clinical practice, education, research, and advocacy. The organization has grown from a small program providing hospital chaplaincy in the New York metropolitan area into an internationally recognized model for multi-faith spiritual care, education, and research. The parent company of the Spiritual Care Association (SCA) and the SCA University of Theology and Spirituality (UTS), HCCN has catalyzed spiritual care research through a grant from the John Templeton Foundation, which has resulted in ground-breaking studies that provide an evidence base for the effectiveness of spiritual care in health care. Through the publication of several key white papers, and the annual Caring for the Human Spirit Conference, HCCN's outreach and advocacy is now felt throughout the field of chaplaincy, nationally and internationally.

SPIRITUAL CARE ASSOCIATION

The Spiritual Care Association (SCA) was formed to standardize the fragmented field of professional chaplaincy training by providing resources, education, and certification backed by evidence-based practice and indicators of quality care. The ensuing development of Common Standards and Quality Indicators in spiritual care ensure that the skills and performance of SCA-trained chaplains and spiritual caregivers can be measured objectively, which is of vital importance to hiring managers in all health care settings. In addition, new methods for training and credentialing have been developed for several non-chaplain health care groups, including first responders, physicians, nurses, social workers, palliative care and hospice workers, and volunteers. The SCA's Learning Center is the most extensive and most successful online chaplain education program worldwide, and the Spiritual Care Resources app is the first online application that gives mobile access to the latest information on best practices in spiritual care for chaplains working in health care, hospice and palliative care, and first responder settings.

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